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Needle Exchange [2]

gf43

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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.

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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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.

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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American Medical Association

Physicians dedicated to the health of America



Statement

Statement attributable to: **Nancy W. Dickey, MD**
President-Elect
American Medical Association

"The American Medical Association recognized one year ago, in a policy statement adopted by our House of Delegates, that important advances to arrest the AIDS epidemic could be made through responsible needle exchange and drug treatment programs. Traditionally, AMA policy follows science, and as Secretary Shalala notes scientific evidence clearly shows that needle exchange is effective in curtailing HIV transmission and that the availability of clean needles does not increase drug abuse.

"We hope that drug treatment programs review the growing body of evidence concerning these serious public health issues, and take appropriate actions to intervene effectively."

-4-20-98-

For further information, contact: James Stacey 202 789-7419

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?

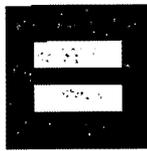
A. According to the latest data reported to the CDC, needle exchange programs are operating in 28 states and one U.S. territory.

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.



HUMAN
RIGHTS
CAMPAIGN

Needle exchange R6

MEMORANDUM

TO: Appropriations/Health Staff
FROM: Seth Kilbourn, Senior Health Policy Advocate
SUBJECT: Amendment to Labor/HHS Appropriations Bill on Needle Exchange
DATE: September 4, 1997

Background

When the House considers the Labor/HHS Appropriations bill this week, we understand an amendment may be offered which will prohibit local communities from using federal funds for needle exchange programs. Current language in the Labor/HHS bill prohibits such use of federal funds unless the Secretary determines that needle exchange programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs.

It is vital that the authority to determine federal policy on this issue remain with public health officials. The Human Rights Campaign considers a vote on this issue a "key vote" and it will be used in the compilation of HRC's Congressional voting record at the end of this session.

Local Control

- The Department of Health and Human Services issued a report in February concluding 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 implement them". HHS reviewed all the available scientific literature on the subject before reaching this conclusion.
- Policy on the use of federal funds should not be based on political expediency. Maintaining the Secretary's authority ensures that any needle exchange decision will be made on the basis of sound scientific evidence and public health need.
- Federal funding for needle exchange programs does not require local communities to implement them. Local communities will be able to implement needle exchange programs only if they feel that such programs will be an effective component of an overall HIV prevention plan.
- Because the HIV epidemic is different in various parts of the country, communities should be able to develop their own HIV prevention plans, without unnecessary limitations from the federal government. These plans should be based on the size and demographics of the local epidemic, community values, and a local decision making process.

WORKING FOR LESBIAN AND GAY EQUAL RIGHTS.

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Support for Needle Exchange

- A growing number of respected organizations are in favor of needle exchange programs, including the American Bar Association, the American Medical Association, the American Public Health Association, the Association of State and Territorial Health Officers, the National Academy of Sciences, the National Black Caucus of State Legislators and the United States Conference of Mayors.
- Beyond the support from public health, scientific and legal experts, needle exchange programs are earning favor with a majority of Americans. Fifty-five percent of voters support such programs, according to a bipartisan poll commissioned by the Human Rights Campaign. A March 1996 survey by the Kaiser Family Foundation found that 66 percent of Americans favor "having clinics make clean needles available to IV drug users to help stop the spread of AIDS."
- Editorials in support of needle exchange have appeared in 1997 in: The Washington Post, The New York Times, The Los Angeles Times, Chicago Tribune, Denver Post, The Cleveland Plain Dealer, and the Seattle Times.

Facts on Needle Exchange

- Approximately one-third of reported AIDS cases are related to injection drug use. Sixty-six percent of all AIDS cases among women -- and more than half of such cases among children -- are related to injection drug use. Intravenous drug use is responsible for the greatest number of new AIDS cases among the heterosexual population.
- Studies completed by the National Commission on AIDS (1991), the General Accounting Office (1993), the University of California (1993), the National Academy of Sciences (1995), and the Office of Technology Assessment (1995) have concluded that needle exchange programs reduce HIV transmission and do not increase drug use.
- In February, an independent, non-Governmental panel of public health experts at the National Institutes of Health concluded that needle exchange programs are a powerful and proven weapon in the war against AIDS.
- Needle exchange programs have been implemented in more than 100 communities around the country and have reduced needle sharing among drug users by as much as 80 percent (Tacoma, WA) and have resulted in an estimated 30 percent reduction in new HIV infections (New Haven, CT).
- In addition to offering HIV prevention information and medical and support services to hard-to-reach populations, virtually every needle exchange program operating in this country provides referrals to drug treatment programs and can demonstrate a clear track record in linking injecting drug users to drug treatment.
- The Family Research Council, attempting to make a case against needle exchange programs, cited one ill-conceived experiment in Switzerland. That program, which began in 1988 and ended in 1992, coincided with a tidal wave of hard drugs hitting Europe as a result of the United States' cracking down on illegal drugs and saturation of the U.S. drug market. Plus, Switzerland allowed the open use of hard drugs in some cities. Clearly, the Swiss experiment bears little resemblance to needle exchange programs in the United States, none of which tolerate the open use of hard drugs.

Date: April 29, 1997
To: The Human Rights Campaign
From: Lori Gudermuth
The Tarrance Group (R)

Celinda Lake, Jennifer Sosin and Dana Stanley
Lake Sosin Snell & Associates (D)

Re: **AMERICANS SUPPORT NEEDLE EXCHANGE**

A new national poll by the Tarrance Group (R) and Lake Sosin Snell & Associates (D) shows that a majority (55%) of the American public favors needle exchange programs:

Some local communities have adopted "needle exchange" programs as a way to curb the spread of AIDS and HIV. "Needle exchange" programs allow drug users to trade in USED needles for CLEAN needles. Generally speaking, do you FAVOR or OPPOSE these kinds of "needle exchange" programs?

[FOLLOW-UP:] *Is that STRONGLY (favor/oppose), or SOMEWHAT (favor/oppose)?*

<i>strongly favor</i>	32	55
<i>somewhat favor</i>	23	
<i>somewhat oppose</i>	9	
<i>strongly oppose</i>	29	37
<i>(don't know)</i>	8	

Republicans are split evenly on this issue (45% favor, 48% oppose, 7% don't know), and moderate-liberal Republicans favor needle exchange by 17 percentage points (57% favor, 40% oppose, 3% don't know). Strong majorities of both independents (58% favor, 33% oppose, 9% don't know) and Democrats (64% favor, 29% oppose, 7% don't know) are in favor. Needle exchange also finds support in every region of the country: 60%-32% in the Northeast, 49%-44% in the Midwest, 51%-40% in the South, and 64%-30% in the West.

This memorandum reports the findings from a national survey of 1,000 adults who indicated they are registered to vote, conducted April 8-10, 1997, by The Tarrance Group and Lake Sosin Snell & Associates. The overall margin of error is ±3.1 percent.

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SUPPORT FOR NEEDLE EXCHANGE

The authority of the Secretary of Health and Human Services to determine if federal funds can be used for needle exchange programs is under attack by those who would put politics before public health. Needle exchange has been proven to prevent HIV infection among injection drug users, their partners and children – a group which now represents almost 50% of new HIV infections. Studies show that needle exchange **does not** lead to increased drug use. Respected public health and medical experts agree. Protect the Secretary's authority. Let science -- not politics -- lead public health policy.

Scientific Evidence Supports Needle Exchange...

National Commission on AIDS, 1991 (federally funded study)
General Accounting Office, 1993 (federally funded study)
University of California, San Francisco for the Centers for Disease
Control and Prevention, 1993 (federally funded study)
National Academy of Sciences, 1995 (federally funded study)
Office of Technology Assessment, 1995 (federally funded study)
Consensus Development Conference, NIH, 1997 (federally funded analysis)

The American Public Supports Needle Exchange...

66% of Americans support needle exchange (Kaiser Family Foundation survey)
55% of voters favor needle exchange (Tarrance Group/Lake, Sosin, et al)
Editorials supporting needle exchange published in 1997 by: The Washington Post, The New York Times, Los Angeles Times, Chicago Tribune, Denver Post, The Cleveland Plain Dealer, Seattle Times

Public Health and Medical Experts Support Needle Exchange...

American Public Health Association (APHA)
American Medical Association (AMA)
National Academy of Sciences (NAS)
American Nurses Association (ANA)
American Academy of Pediatrics (AAP)
Dr. Harold Varmus, Director, National Institutes of Health (NIH)

Public Officials and Legal Groups Support Needle Exchange...

U.S. Conference of Mayors (USCM)
National Black Caucus of State Legislators (NBCSL)
Association of State and Territorial Health Officers (ASTHO)
American Bar Association (ABA)

NORA

A coalition convened by
AIDS Action Council

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LET SCIENCE LEAD – NOT POLITICS!

"A coalition of over 175 organizations responding to AIDS with resolve and action."

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September 4, 1997

Dear Representative:

We understand that an amendment may be offered during floor consideration of H.R. 2264, the FY98 appropriations bill for the Departments of Labor, Health and Human Services and Education, which would revoke the authority of the Secretary of Health and Human Services to remove the restriction on federal funding for hypodermic needle exchange programs upon a showing that such programs are effective in preventing the spread of HIV and result in reduced drug abuse. In addition, the amendment may propose an absolute ban on needle exchange programs. We are writing to urge you to defeat any such amendment.

Last month, the American Bar Association adopted the following policy on the subject of needle exchange programs:

Resolved, That in order to further scientifically based public health objectives to reduce HIV infection and other blood-borne diseases, and in support of our long-standing opposition to substance abuse, the American Bar Association supports the removal of legal barriers to the establishment and operation of approved needle exchange programs that include a component of drug counseling and drug treatment referrals.

There is uncontroverted evidence that the overall proportion of HIV cases attributable to injection drug use has steadily and dramatically increased over the last fifteen years; in fact, injection drug users now account for almost two-thirds of all cases of newly acquired HIV infection.

At the same time, there is mounting public health evidence, compiled and evaluated by the Centers for Disease Control, the National Research Council, and the National Institutes of Health, that needle exchange programs significantly reduce the rate of HIV transmission, do not increase illicit drug activity, prevent contaminated needles from being

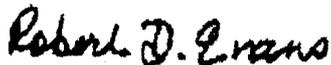
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disposed of in ways that could endanger others, and increase the opportunity for counseling drug addicts and encouraging their participation in appropriate treatment programs.

Since there is no cure for HIV and no vaccine to protect against HIV infection, it is essential that public health officials have the ability to use all reasonable methods to protect the uninfected public and to counsel and provide treatment to infected individuals who engage in high-risk behavior such as intravenous drug use. Needle exchange programs are currently operating in at least 46 cities in 21 states, according to a survey conducted by the U.S. Conference of Mayors, and are supported by the American medical community; indeed, the American Medical Association has strongly encouraged the expansion of needle exchange programs and the Centers for Disease Control have stated that such programs are one part of a comprehensive approach to the prevention of HIV in intravenous drug users and their sexual partners and children.

The proposed amendment would erect a substantial barrier to the establishment and expansion of such programs. By revoking a provision that has been in the last eight appropriations bills for the Department of Health and Human Services that would allow federal funds to be used for needle exchange programs if the Secretary (previously the Surgeon General) determines that there is conclusive evidence of their value, the proposed amendment would remove this medical and public health decision from the province of public health officials and would ban the use of a potentially powerful method for reducing HIV transmission and intravenous drug abuse. The American Bar Association therefore urges you to reject the proposed amendment.

Sincerely,



Robert D. Evans

September 4, 1997

The Honorable Bob Livingston, Chair
House Appropriations Committee
H218 The Capitol
Washington, DC 20515-6015

The Honorable John Porter, Chair
Labor, Health and Human Services and Education and
Related Agencies Subcommittee
House Appropriations Committee
2358 Rayburn House Office Building
Washington DC 20515

The Honorable David Obey, Ranking Minority Member
House Appropriations
1016 Longworth House Office Building
Washington DC 20515

Dear Sirs:

Current law, by way of Labor, Health and Human Services, Education and Related Agencies Appropriations authority, provides that no funds may be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs.

We understand that there may be an effort underway to remove this Secretarial discretion and to impose an absolute ban on federal funding for needle exchange programs. Such an action would inappropriately remove this decision from public health experts and place it in the political domain. We, the undersigned organizations, oppose any effort to remove the Secretary's authority and strongly support a determination based on public health and science.

It is well established that the sharing of injection equipment among drug users is a leading cause of HIV transmission, exposing the more than one million Americans who inject illicit drugs to this preventable disease. Approximately one-third of all reported adult AIDS cases are directly or indirectly associated with injection drug use and drug users account for approximately two-thirds of all cases of newly acquired HIV infection.

Needle exchange programs offer sterile syringes to replace used ones in an effort to discourage the sharing or reusing of injection equipment with its risk of transmission of HIV and other blood-borne diseases. Numerous respected organizations have reviewed scientific research on needle exchange programs and concluded that these programs are an effective component of a comprehensive HIV prevention strategy that also includes drug treatment and outreach.

The groups represented below ask you to retain Secretarial discretion in the funding of needle exchange programs, as you consider the Labor-HHS Appropriations bill. Thank you for your consideration of this important public health issue.

American Academy of Pediatrics
American Medical Association
American Nurses Association
American Public Health Association
Association of Schools of Public Health
National Alliance of State and Territorial AIDS Directors
National Association of County and City Health Officials
National Black Caucus of State Legislators
United State Conference of Mayors

cc: The Honorable Newt Gingrich, Speaker
The Honorable Richard Gephardt, Minority Leader
Members House Appropriations Committee

File needle exchange

A.M.A. Backs Drug-User Needle Exchanges

By KATHARINE Q. SEELYE

Lenon Wilson, a longtime heroin addict in Chicago with puffy scars the size of leeches on his arms, climbed into an unmarked silver van and unfurled a paper bag concealing 28 dirty hypodermic needles.

"If the van wasn't here, I'd use the same needle three, four, five times, even when it's dirty and has bacteria running through it, and then I'd use somebody else's when I couldn't use mine anymore," said Mr. Wilson, known as Smoky, as he scooped up 33 clean needles in exchange for his 28. The volunteers for the Chicago Recovery Alliance at this mobile van in Harvey, Ill., 25 miles from downtown Chicago, like to give out a bonus of five to their regulars.

"You get a better hit with a clean needle, and it leaves less of a scar," Mr. Wilson said. "It's more hygienic all the way around."

It was people like Mr. Wilson that the American Medical Association had in mind yesterday when it joined a growing chorus of voices and called for a change in laws to allow intravenous drug users easier access to clean needles to help block the spread of H.I.V., the virus that causes AIDS.

More than one-third of all new AIDS cases in the nation are caused by contaminated needles or sex with drug users. And drug users now account for the highest rates of new H.I.V. infection — at nearly twice that of homosexual men.

The medical association had previously "encouraged" needle-exchange programs, in which addicts turn in dirty needles in exchange for clean ones. But yesterday, citing an "urgent public health need," it was broader and more emphatic. The association's policy-making House of Delegates, meeting in Chicago, voted overwhelmingly to work with members of Congress to initiate legislation revoking the 1983 ban on Federal financing for needle-exchange programs and to encourage state medi-

cal societies strongly to initiate state legislation relaxing drug paraphernalia laws so users can legally buy and possess needles.

"There is more and more evidence that the advantages of needle exchange outweigh the disadvantages," Dr. Nancy Dickey, chairwoman of the board of trustees and president-elect of the medical association, which represents half the nation's doctors, said in an interview. "We're addressing a public health epidemic."

The association said that if the ban continued to the year 2000, the United States would have failed to prevent up to 11,000 cases of AIDS, including those among heterosexual partners of drug users and their children, at a cost of up to \$630 million for medical treatment.

Public health professionals applauded the association, saying that its action, combined with a similar bipartisan resolution from the United States Conference of Mayors earlier this week, could increase pressure on the politically sensitive Clinton Administration and a reluctant, conservative Congress to reverse the Federal ban on financing needle-exchange programs.

In San Francisco, Roslyn Allen, project director at the AIDS Foundation H.I.V. Prevention Project, the nation's largest needle-exchange program, said of the medical association's decision, "It sends a message to other agencies that still view this as a dark and sinister practice."

Outside, Allison, a 28-year-old prostitute with bruises on her arm, said the clean needles were safer. Referring to the bad needles she used until recently, she said: "Works would get clogged, broken and it was pretty common for people to pass them around."

Dr. Peter Lurie, a researcher at the University of Michigan who is one of the world's foremost experts on needle exchange programs, said the public health benefits of needle

exchange had been evident for years.

"If an infection is spread from person to person by an inanimate object, you can prevent it by removing that object," he said. "This is not rocket science."

But what is obvious to public-health professionals is less clear-cut for politicians. The medical group's action was greeted coolly in Washington, which remains fearful of putting its official imprimatur on something that many perceive as tantamount to promoting drug use.

Some critics see needle exchange

An influential group speaks out to help drug users avoid AIDS.

as a foot in the door toward legalizing drugs. They say that the exchange may help addicts avoid AIDS, but that they may die instead of overdosing. Focusing on needle exchange, they argue, takes attention away from treatment.

Beyond that, while many programs offer condoms to those who arrive for clean needles, critics say the needle exchange ignores the vast number of cases of H.I.V. infection that are transmitted through sex. And addicts still need money for drugs, so clean needles do nothing to reduce robberies or violent crime.

One critic of needle exchange is Representative Charles B. Rangel, a Democrat whose Harlem district is home to some of the worst drug-infestations in urban America. Mr. Rangel said needle exchange is acceptable as part of a drug rehabilitation program, but, "if the budget is just for clean needles, I don't want it."

When Congress prohibited the spending of Federal money for needle exchange, it said the ban could be lifted only when such programs met two conditions: that they be shown to reduce transmission of H.I.V. and not to increase illegal drug use. The medical association came to just that conclusion yesterday.

Previously, numerous studies, including ones by the Federal Centers for Disease Control and Prevention, the National Institutes of Health, the General Accounting Office and the National Academy of Sciences, have generally found that needle exchanges are effective in slowing the spread of H.I.V. and that they have not increased drug use.

But no one in Congress has even tried to lift the ban, and signals from the Clinton Administration, which has the authority to lift the ban, have been cautious.

Dr. David Lewis, director of the Brown University Center for Alcohol and Addiction Studies, said of the mood: "The Administration is scared. If they move to bring the issue up, Congress will be even more strict and make it harder for addicts to obtain clean needles."

Representative Jesse L. Jackson Jr., Democrat of Chicago, who supports needle-exchange, said the "demagoguing" on the issue "sometimes makes it hard for politicians to vote or do the right or healthy thing."

But Gary Bauer, president of the Family Research Council, a conservative group, said the collective mind-set in Congress was so opposed to needle exchange that conservatives felt no need to organize against the issue. "It strikes the average voter in the gut as being against common sense," he said. He said the matter was "untouchable" for Mr. Clinton because drug use had gone up on his watch. "I don't see how this Administration could do anything on this that wouldn't blow up in their face," he said.

Army Criticized on Survey on Harassment

By ERIC SCHMITT

WASHINGTON, June 26 — A high-level Army panel studying how the service deals with sexual harassment removed several questions from a major survey given to thousands of soldiers and disregarded information from an early version of the questionnaire, the Army said tonight.

Six questions — including ones dealing with the prevalence of soldiers who go to strip clubs, watch "X-rated" movies and brag about their sexual activities — were deleted from a 153-question survey, after copies were sent out to about 9,000 soldiers in February.

One of the panel's advisers who analyzed some of the preliminary information from the survey said the Army had removed the questions because senior Army officials feared that the responses could be highly embarrassing to the Army.

"The panel's apparent intent is to suppress this information in order to avoid making the Army look bad," said the adviser, Dr. Leora N. Rosen, a social anthropologist at the Walter Reed Army Institute of Research in Washington, who helped write the survey questions.

Dr. Rosen, who was an adviser to the panel until February, suggested that the soldiers' responses to the questions at issue showed an intriguing correlation with high levels of sexual harassment in their unit. She said the panel was "purposely planning to conceal important facts from the public."

For the last few days, the Army had refused to comment on Dr. Rosen's allegations. But tonight, after several reporters inquired, the Army issued a one-page statement saying the questions had been dropped because they were "inflammatory and offensive" and that soldiers who responded to preliminary surveys had protested that the questions violated their privacy. "Some of them refused to complete the survey," said Col. John A. Smith, an Army spokesman.

Colonel Smith acknowledged that the information from the questions at issue had not been used in preparing the report's final analysis. But he said information collected by other means, including focus groups and individual interviews, would provide that same data.

Soldiers' attitudes toward sexual misconduct is important at a time when the armed forces, as never before, are under attack because of a series of cases in which servicemen have been accused of rape, assault and other sexual abuse.

Dr. Rosen's concerns were echoed by the another consultant, Madeline Morris, a Duke University law professor who was a special consultant to Army Secretary Togo D. West Jr. until May. Professor Morris complained to Mr. West in a letter on Feb. 27 about the removal of the six questions. She declined today to describe Mr. West's response.

The questions were not included in a second survey sent to about 5,000 additional soldiers a little more than a month later.

The two consultants said they did not know each other and raised their issues independently. They both warned that the Army's handling of the survey could undermine the credibility of the panel's final report, which is two weeks late and is expected to be released in mid-July.

Professor Morris said, "The question is raised why one whole area of inquiry is eliminated from consideration prior to a full exploration of its possible significance."

Copies of the survey, "Command and Soldier: Climate Assessment," with and without the questions at issue, were provided to The New York Times by someone who criticized removal of those questions.

An Army official familiar with the panel's work played down the allegations by the two consultants.

"Some questions were deleted because they weren't relevant," said the official, speaking on the condition of anonymity. "They may or may not have anything to do with sexual harassment. You can prove anything you want statistically if you work hard enough at it."

But in a preliminary batch of 613 surveys, Dr. Rosen said she was struck by correlations between the responses and high levels of sexual harassment in any unit. In April, she said, data from the 9,000 surveys showed a similar correlation.

The Army official suggested that Dr. Rosen and another consultant, Lieut. Col. Leonard Wong, put the six questions on the survey to advance their own professional goals and did not remove the questions when other panel advisers objected to them as inflammatory. Dr. Rosen today denied that accusation. Colonel Wong declined to comment on the issue.

Dr. Rosen's superiors rallied to her support today.

"She's an extremely intelligent and insightful person, and the quality of her work has been excellent," said Col. Robert K. Gifford, the chief of military psychiatry at Walter Reed.

Secretary West created the panel in November after reports that said drill sergeants at the Aberdeen Proving Ground in Maryland and other Army training bases had sexually assaulted young female trainees.

The panel ran into problems when it got off to a slow start in conducting the individual interviews. Then in February, two of the panel's nine original members stepped down: Gene C. McKinney, the Sergeant Major of the Army, who was accused of sexual misconduct by a former public-affairs assistant, and Maj. Gen. Robert F. Foley, who may ultimately decide Sergeant Major McKinney's fate if he is tried by court-martial.

The New York Times

FRIDAY, JUNE 27, 1997

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File Needle Exchange

NATIONAL GOVERNORS ASSOCIATION

NGA Policy



HR-38. HIV/AIDS

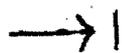
38.1 Preamble

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

38.2 Education, Prevention, Counseling, and Testing

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

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



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

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

Finally, special education efforts must be made to ensure that all members of the medical and health care community are knowledgeable and have current information about HIV/AIDS prevention. Health providers must be more diligent in identifying people who are at risk or who are infected with

HIV, particularly in populations such as women and adolescents who are not as frequently recognized as at risk. The Governors also recognize the importance of educating providers on the appropriate use of emerging treatments and primary prevention and care services within managed care settings.

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

Re: *Cowles* →

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

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

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

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

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

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

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

In an effort to comply with the targeted perinatal caseload reductions mandated by the Ryan White CARE Act, every state will be forced to redirect funds from other equally vital and more effective

HIV/AIDS prevention activities. States will no longer be able to develop comprehensive prevention strategies to meet the particular needs of their communities. Instead, federal mandates will require states to focus available resources on one particular category of need. Unfortunately, the science of prevention is not so exact that there is any guarantee that any level of intervention will produce the desired result in any state. The Governors would like to work closely with Congress and the administration to develop prevention strategies that achieve the goal we all support of keeping babies healthy, without jeopardizing funding for other important HIV/AIDS prevention and treatment efforts.

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

38.3 Research

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

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

38.4 Treatment

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

At the same time, we need to provide appropriate services to those individuals presently suffering from HIV/AIDS. Treatment needs are changing with the advent of promising multidrug combination therapies, which are helping many HIV/AIDS patients live longer and healthier lives. Treatment protocols relating to chronic disease management of HIV/AIDS, developed in partnership among federal, state, and private efforts, will lead to changes in existing systems of care.

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

38.5 Ryan White CARE Act

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

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

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

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

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

Time limited (effective Winter Meeting 1997-Meeting 1999)

Adopted Annual Meeting 1987; reaffirmed Winter Meeting 1992; revised Winter Meeting 1995 and Winter Meeting 1997 (formerly Policy C-17).

**OFFICE OF NATIONAL AIDS POLICY
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FACSIMILE COVER SHEET

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FAX NUMBER: 456-5557

FROM: Daniel C. Montoya

DATE: 6/27/97

PAGES INCLUDING COVER SHEET: (3)

COMMENTS:

National Report

The New York Times

FRIDAY, JUNE 27, 1997

A.M.A. Backs Drug-User Needle Exchange

By KATHARINE Q. SEELYE

Lenon Wilson, a longtime heroin addict in Chicago with puffy scars the size of leeches on his arms, climbed into an unmarked silver van and unfurled a paper bag concealing 28 dirty hypodermic needles.

"If the van wasn't here, I'd use the same needle three, four, five times, even when it's dirty and has bacteria running through it, and then I'd use somebody else's when I couldn't use mine anymore," said Mr. Wilson, known as Smoky, as he scooped up 33 clean needles in exchange for his 28. The volunteers for the Chicago Recovery Alliance at this mobile van in Harvey, Ill., 25 miles from downtown Chicago, like to give out a bonus of five to their regulars.

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It was people like Mr. Wilson that the American Medical Association had in mind yesterday when it joined a growing chorus of voices and called for a change in laws to allow intravenous drug users easier access to clean needles to help block the spread of H.I.V., the virus that causes AIDS.

More than one-third of all new AIDS cases in the nation are caused by contaminated needles or sex with drug users. And drug users now account for the highest rates of new H.I.V. infection — at nearly twice that of homosexual men.

The medical association had previously encouraged needle-exchange programs, in which addicts turn in dirty needles in exchange for clean ones. But yesterday, citing an "urgent public health need," it was broader and more emphatic. The association's policy-making House of Delegates, meeting in Chicago, voted overwhelmingly to work with members of Congress to initiate legislation revoking the 1988 ban on Federal financing for needle-exchange programs and to encourage state medi-

cal societies strongly to initiate state legislation relaxing drug paraphernalia laws so users can legally buy and possess needles.

"There is more and more evidence that the advantages of needle exchange outweigh the disadvantages," Dr. Nancy Dickey, chairwoman of the board of trustees and president-elect of the medical association, which represents half the nation's doctors, said in an interview. "We're addressing a public health epidemic."

The association said that if the ban continued to the year 2000, the United States would have failed to prevent up to 11,000 cases of AIDS, including those among heterosexual partners of drug users and their children at a cost of up to \$630 million for medical treatment.

Public health professionals applauded the association, saying that its action, combined with a similar bipartisan resolution from the United States Conference of Mayors earlier this week, could increase pressure on the politically sensitive Clinton Administration and a reluctant, conservative Congress to reverse the Federal ban on financing needle-exchange programs.

In San Francisco, Koslyn Allen, project director at the AIDS Foundation H.I.V. Prevention Project, the nation's largest needle-exchange program, said of the medical association's decision, "It sends a message to other agencies that still view this as a dark and sinister practice."

Outside, Allison, a 26-year-old prostitute with bruises on her arm, said the clean needles were safer. Referring to the bad needles she used until recently, she said, "Works would get clogged, broken and it was pretty common for people to pass them around."

Dr. Peterurie, a researcher at the University of Michigan who is one of the world's foremost experts on needle exchange programs, said the public health benefits of needle

exchange had been evident for years.

"If an infection is spread from person to person by an inanimate object, you can prevent it by removing that object," he said. "This is not rocket science."

But what is obvious to public-health professionals is less clear-cut for politicians. The medical group's action was greeted coolly in Washington, which remains fearful of putting its official imprimatur on something that many perceive as tantamount to promoting drug use.

Some critics see needle exchange

An influential group speaks out to help drug users avoid AIDS.

as a foot in the door toward legalizing drugs. They say that the exchange may help addicts avoid AIDS, but that they may die instead of overdoses. Focusing on needle exchange, they argue, takes attention away from treatment.

Beyond that, while many programs offer condoms to those who arrive for clean needles, critics say the needle exchange ignores the vast number of cases of H.I.V. infection that are transmitted through sex. And addicts still need money for drugs, so clean needles do nothing to reduce robberies or violent crime.

One critic of needle exchange is Representative Charles B. Rangel, a Democrat whose Harlem district is home to some of the worst drug infestations in urban America. Mr. Rangel said needle exchange is acceptable as part of a drug rehabilitation program, but, "if the budget is just for clean needles, I don't want it."

When Congress prohibited the spending of Federal money for needle exchange, it said the ban could be lifted only when such programs met two conditions: that they be shown to reduce transmission of H.I.V. and not to increase illegal drug use. The medical association came to just that conclusion yesterday.

Previously, numerous studies, including ones by the Federal Centers for Disease Control and Prevention, the National Institutes of Health, the General Accounting Office and the National Academy of Sciences, have generally found that needle exchanges are effective in slowing the spread of H.I.V. and that they have not increased drug use.

But no one in Congress has even tried to lift the ban, and signals from the Clinton Administration, which has the authority to lift the ban, have been cautious.

Dr. David Lewis, director of the Brown University Center for Alcohol and Addiction Studies, said of the mood: "The Administration is scared. If they move to bring the issue up, Congress will be even more strict and make it harder for addicts to obtain clean needles."

Representative Jesse L. Jackson Jr., Democrat of Chicago, who supports needle exchange, said the "demagoguing" on the issue "sometimes makes it hard for politicians to vote or do the right or healthy thing."

But Gary Bauer, president of the Family Research Council, a conservative group, said the collective mind-set in Congress was so opposed to needle exchange that conservatives felt no need to organize against the issue. "It strikes the average voter in the gut as being against common sense," he said. He said the matter was "untouchable" for Mr. Clinton because drug use had gone up on his watch. "I don't see how this Administration could do anything on this that wouldn't blow up in their face," he said.

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Draft Memorandum- Needle Exchange (5 pages)	10/23/96	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
Chris Jennings (Subject File)
OA/Box Number: 2378 Box 22

FOLDER TITLE:

Needle Exchange [2]

gf43

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 advise 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]

Needle Exchange File

W:Needle.vte

NEEDLE EXCHANGE

Ds who voted for Hastert but may be willing to change their vote	Ds who voted against Hastert who may wish to change their vote	Rs who voted against Hastert
Costello (IL) - *	Allen (ME) - ?	Campbell (CA)
Gordon (TN) - C, ?	Boucher (VA) - C	Cooksey (LA)
Green (TX) - C	Brown (CA) - ?, *	Foley (FL)
Hamilton (IN) - *, R	DeGette (CO) - C, *	Frelinghuysen (NJ)
Johnson (WI) - *, ?	Deutsch (FL) - C, *	Ganske (IA)
Klink (PA) - C, *	Eschoo (CA) - C, *	Greenwood (PA)
LaFalce (NY) - *	Evans (IL) - ?, *	Horn (CA)
Lipinski (IL) - *	Furse (OR) - C, R, *	Houghton (NY)
Luther (MN) - *, ?	Gejdenson (CT) - ?, *	Johnson (CT)
10. Karen McCarthy (MO) - *, C	Hinchey (NY) - ?, *	Kolbe (AZ)
McNulty (NY) - *	Hooley (OR) - ?, *	Leach (IA)
Minge (MN) - *	Kind (WI) - ?, *	McCrery (LA)
Oberstar (MN) - *	Kuchinich (OH) - ?*	Morella (MD)
Pascrell (NJ) - *, ?	Lampson (TX) - ?	Shays (CT)
Peterson (MN) - *,	Maloney (CT) - ?, *	Thomas (Ca)
Poshard (IL) - HO, *	Manton (NY) - C, *	Young (FL)
Roemer (IN) - *	McGovern (MA) - ?, *	
Strickland (OH) - *, C, ?	Olver (MA) - ?, *	
Stupak (MN) - *, C	Pallone (NJ) - C, *	
Visclosky (IN) - *	Pomery (ND) - ?	

	Price (NC) - ?, *	
	Sawyer (OH)- C, ?	
	Sherman (CA) - ?, *	
	Smith, Adam (WA) - ?, *	
	Snyder (Ark)- ?	
	Stabenow (MI) - , ?, *	
	Tierney (MA)- ?, *	

- C- Commerce Committee member
- * State has needle exchange program
- ? - Difficult Race
- R- retiring
- HO- seeking higher office

House Vote Detail

CONGRESS: 105 **SESSION:** 1

ROLL CALL NUMBER: 391

RESULT: Passed

VOTE DATE: 09-11-97

CONGRESSIONAL RECORD PAGE: 7233

BILL-AMEND NUMBER: H.R. 2264 - A028

SPONSOR: Hastert

VOTE TYPE: Recorded Vote

QUESTION: On agreeing to the Hastert amendment (A028)

TITLE: An amendment to delete the provisions of the bill to allow implementation of hypodermic needle exchange programs, if the Secretary of Health and Human Services determines such programs to be effective in preventing the spread of HIV and do not encourage the use of illegal drugs.

Vote Matrix: H.R. 2264 - A028				
	Y	N	PRESENT	NOT VOTING
Democratic	59	141	0	6
Republican	207	16	0	3
Other	0	1	0	0
Total	266	158	0	9

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House Information Resources

House Votes

Member Response List**Bill Number: H.R. 2264****Congress: 105-1****Roll Call: 391****View: Democrats voting AYE**

Member	ST	CD	Party	Response
Baessler	KY	06	D	AYE
Barcia	MI	05	D	AYE
Bentsen	TX	25	D	AYE
Boswell	IA	03	D	AYE
Boyd	FL	02	D	AYE
Clement	TN	05	D	AYE
Condit	CA	18	D	AYE
Costello	IL	12	D	AYE
Cramer	AL	05	D	AYE
Danner	MO	06	D	AYE
Davis (FL)	FL	11	D	AYE
Doyle	PA	18	D	AYE
Edwards	TX	11	D	AYE
Etheridge	NC	02	D	AYE
Goode	VA	05	D	AYE
Gordon	TN	06	D	AYE
Green	TX	29	D	AYE
Hall (OH)	OH	03	D	AYE
Hall (TX)	TX	04	D	AYE
Hamilton	IN	09	D	AYE
Hefner	NC	08	D	AYE
Hinojosa	TX	15	D	AYE
Holden	PA	06	D	AYE
John	LA	07	D	AYE
Johnson (WI)	WI	08	D	AYE
Kildee	MI	09	D	AYE
Kleczka	WI	04	D	AYE
Klink	PA	04	D	AYE
LaFalce	NY	29	D	AYE
Lipinski	IL	03	D	AYE
Luther	MN	06	D	AYE
Mascara	PA	20	D	AYE
McCarthy (MO)	MO	05	D	AYE
McIntyre	NC	07	D	AYE
McNulty	NY	21	D	AYE
Minge	MN	02	D	AYE

Mollohan	WV	01	D	AYE
Murtha	PA	12	D	AYE
Oberstar	MN	08	D	AYE
Ortiz	TX	27	D	AYE
Pascrell	NJ	08	D	AYE
Peterson (MN)	MN	07	D	AYE
Poshard	IL	19	D	AYE
Reyes	TX	16	D	AYE
Rodriguez	TX	28	D	AYE
Roemer	IN	03	D	AYE
Sandlin	TX	01	D	AYE
Sisisky	VA	04	D	AYE
Skelton	MO	04	D	AYE
Spratt	SC	05	D	AYE
Stenholm	TX	17	D	AYE
Strickland	OH	06	D	AYE
Stupak	MI	01	D	AYE
Tanner	TN	08	D	AYE
Taylor (MS)	MS	05	D	AYE
Traficant	OH	17	D	AYE
Turner	TX	02	D	AYE
Visclosky	IN	01	D	AYE
Wise	WV	02	D	AYE

Information Services	Votes Search
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House Information Resources

House Votes

Member Response List

Bill Number: H.R. 2264

Congress: 105-1

Roll Call: 391

View: Republicans voting NO

Member	ST	CD	Party	Response
Campbell	CA	15	R	NO
Cooksey	LA	05	R	NO
Foley	FL	16	R	NO
Frelinghuysen	NJ	11	R	NO
Ganske	IA	04	R	NO
Greenwood	PA	08	R	NO
Horn	CA	38	R	NO
Houghton	NY	31	R	NO
Johnson (CT)	CT	06	R	NO
Kolbe	AZ	05	R	NO
Leach	IA	01	R	NO
McCrery	LA	04	R	NO
Morella	MD	08	R	NO
Shays	CT	04	R	NO
Thomas	CA	21	R	NO
Young (FL)	FL	10	R	NO

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House Information Resources

--- NOES 158 ---

<i>Abercrombie</i>	<i>Furse</i>	<i>Morella</i>
<i>Ackerman</i>	<i>Ganske</i>	<i>Nadler</i>
<i>Allen</i>	<i>Gejdenson</i>	<i>Neal</i>
<i>Andrews</i>	<i>Gephardt</i>	<i>Obey</i>
<i>Baldacci</i>	<i>Greenwood</i>	<i>Olver</i>
<i>Barrett (WI)</i>	<i>Gutierrez</i>	<i>Owens</i>

<i>Becerra</i>	<i>Harman</i>	<i>Pallone</i>
<i>Berman</i>	<i>Hilliard</i>	<i>Pastor</i>
<i>Berry</i>	<i>Hinchey</i>	<i>Pelosi</i>
<i>Bishop</i>	<i>Hooley</i>	<i>Pickett</i>
<i>Blagojevich</i>	<i>Horn</i>	<i>Pomeroy</i>
<i>Blumenauer</i>	<i>Houghton</i>	<i>Price (NC)</i>
<i>Bonior</i>	<i>Hoyer</i>	<i>Rahall</i>
<i>Boucher</i>	<i>Jackson (IL)</i>	<i>Rangel</i>
<i>Brown (CA)</i>	<i>Jackson-Lee (TX)</i>	<i>Rivers</i>
<i>Brown (FL)</i>	<i>Jefferson</i>	<i>Rothman</i>
<i>Brown (OH)</i>	<i>Johnson (CT)</i>	<i>Roybal-Allard</i>
<i>Campbell</i>	<i>Johnson, E. B.</i>	<i>Rush</i>
<i>Capps</i>	<i>Kanjorski</i>	<i>Sabo</i>
<i>Cardin</i>	<i>Kaptur</i>	<i>Sanchez</i>
<i>Carson</i>	<i>Kennedy (MA)</i>	<i>Sanders</i>
<i>Clay</i>	<i>Kennedy (RI)</i>	<i>Sawyer</i>
<i>Clayton</i>	<i>Kennelly</i>	<i>Schumer</i>
<i>Clyburn</i>	<i>Kilpatrick</i>	<i>Scott</i>
<i>Conyers</i>	<i>Kind (WI)</i>	<i>Serrano</i>
<i>Cooksey</i>	<i>Kolbe</i>	<i>Shays</i>
<i>Coyne</i>	<i>Kucinich</i>	<i>Sherman</i>
<i>Cummings</i>	<i>Lampson</i>	<i>Skaggs</i>
<i>Davis (IL)</i>	<i>Lantos</i>	<i>Slaughter</i>
<i>DeFazio</i>	<i>Leach</i>	<i>Smith, Adam</i>
<i>DeGette</i>	<i>Levin</i>	<i>Snyder</i>
<i>Delahunt</i>	<i>Lewis (GA)</i>	<i>Stabenow</i>
<i>DeLauro</i>	<i>Lofgren</i>	<i>Stark</i>
<i>Deutsch</i>	<i>Lowey</i>	<i>Stokes</i>
<i>Dicks</i>	<i>Maloney (CT)</i>	<i>Tauscher</i>
<i>Dingell</i>	<i>Maloney (NY)</i>	<i>Thomas</i>
<i>Dixon</i>	<i>Manton</i>	<i>Thompson</i>
<i>Doggett</i>	<i>Markey</i>	<i>Thurman</i>
<i>Dooley</i>	<i>Martinez</i>	<i>Tierney</i>
<i>Engel</i>	<i>Matsui</i>	<i>Torres</i>
<i>Eshoo</i>	<i>McCarthy (NY)</i>	<i>Towns</i>
<i>Evans</i>	<i>McCrery</i>	<i>Velazquez</i>
<i>Farr</i>	<i>McDermott</i>	<i>Vento</i>

<i>Fattah</i>	<i>McGovern</i>	<i>Waters</i>
<i>Fazio</i>	<i>McHale</i>	<i>Watt (NC)</i>
<i>Filner</i>	<i>McKinney</i>	<i>Waxman</i>
<i>Flake</i>	<i>Meehan</i>	<i>Wexler</i>
<i>Foglietta</i>	<i>Menendez</i>	<i>Weygand</i>
<i>Foley</i>	<i>Millender-McDonald</i>	<i>Woolsey</i>
<i>Ford</i>	<i>Miller (CA)</i>	<i>Wynn</i>
<i>Frank (MA)</i>	<i>Mink</i>	<i>Yates</i>
<i>Frelinghuysen</i>	<i>Moakley</i>	<i>Young (FL)</i>
<i>Frost</i>	<i>Moran (VA)</i>	

--- NOT VOTING 9 ---

<i>Bonilla</i>	<i>Gonzalez</i>	<i>Payne</i>
<i>Borski</i>	<i>Hastings (FL)</i>	<i>Schiff</i>
<i>Dellums</i>	<i>Meek</i>	<i>Taylor (NC)</i>

105th CONGRESS

2d Session

H. R. 3717

To prohibit the expenditure of Federal funds for the distribution of needles or syringes for the hypodermic injection of illegal drugs.

IN THE HOUSE OF REPRESENTATIVES

April 23, 1998

Mr. SOLOMON (for himself, Mr. WICKER, Mr. HASTERT, Mr. BARR of Georgia, and Mr. DELAY) introduced the following bill; which was referred to the Committee on Commerce

A BILL.

To prohibit the expenditure of Federal funds for the distribution of needles or syringes for the hypodermic injection of illegal drugs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PROHIBITION REGARDING ILLEGAL DRUGS AND DISTRIBUTION OF HYPODERMIC NEEDLES.

Part B of title II of the Public Health Service Act (42 U.S.C. 238 et seq.) is amended by adding at the end the following section:

'PROHIBITION REGARDING ILLEGAL DRUGS AND DISTRIBUTION OF HYPODERMIC NEEDLES

'SEC. 247. Notwithstanding any other provision of law, none of the amounts made available under any Federal law for any fiscal year may be expended, directly or indirectly, to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.'

SEC. 2. CONFORMING AMENDMENT.

Section 506 of Public Law 105-78 is repealed.

END

The Importance 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. 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 new cases 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 linking women of childbearing age and pregnant women with prenatal care and other support.

Needle Exchange Compromise

NO SAMSHA MONEY FOR NEEDLE EXCHANGE

The AIDS community seeks access to both CDC and SAMSHA funding for needle exchange. Congress has provided a process for accessing both of these funding sources for needle exchange if the appropriate scientific criteria are met. **Part of an Administration compromise should be to propose a flat ban on the use of SAMSHA funding for needle exchange. This would send a strong message that the Administration believes that drug treatment money should NOT be diverted for needle exchange. This compromise takes approximately 90% of the potential funding for needle exchange off the table.**

- FY97 CDC HIV prevention funding= \$240 million
- FY97 SAMSHA funding= \$2.2 billion

NO NEW FUNDING FOR NEEDLE EXCHANGE

Given that most Administration announcements are coupled with new money or promises of new money, it is important to make clear that nothing in this announcement creates a national needle exchange program or provides any new resources for this purpose. The funding issue is all about local control and the ability of local communities to employ this strategy -- if they see fit.

ONLY STATES OR LOCALITIES THAT MEET THE CONGRESSIONALLY DELINEATED CRITERIA COULD PARTICIPATE IN THIS DEMONSTRATION.

--Congress laid out 6 criteria that states and localities must meet in order to use federal funds for needle exchange, including links to drug treatment and participation in ongoing HHS monitoring and evaluation. Each of these criteria narrow the pool of potential participants to those willing to operate "responsible" programs.

-- In addition, the Administration could further narrow the scope by limiting funding to those programs which operate "consistent with state or local legal requirements or waivers to those requirements". This was suggested in the HHS memo to the President to ensure that no federal funds would be used in violation of state paraphernalia laws. According to a CDC study, this would limit potential funding to approximately half of the currently operating programs (**from 110-120 programs to 50-60**). *See attached chart*

-- Finally, it is worth noting that only 6 cities (SF, LA, NY, Chicago, Houston, and Philadelphia) receive direct funding from the CDC for HIV prevention. All other funds go to state health departments. Therefore, in the vast majority of cases, no funds could be used for needle exchange unless that chief state health official deemed it to be appropriate.

THE POTENTIAL POOL OF PLACES THAT IMPLEMENT NEEDLE EXCHANGE PROGRAMS COULD BE FURTHER NARROWED FOR FY98 BY LIMITING PARTICIPATION TO THOSE AREAS WITH A SERIOUS IV DRUG RELATED HIV PROBLEM.

It is difficult to say that these programs save lives and then limit the ability of communities to responsibly implement them. However, it does make sense to limit initial participation to those areas that demonstrate a serious IV drug related problem. Therefore, eligibility for reprogramming of FY98 funding could be restricted to those areas with 25% of AIDS cases directly or indirectly related to injection drug use. We are proposing no such restriction on FY99 funds.

CRITERIA	ESTIMATE OF ELIGIBLE PROGRAMS
Currently Operating Needle Exchange Programs	110-120 programs
<p>Articulated by Congress</p> <ol style="list-style-type: none"> 1. A program for preventing HIV transmission is operating in the community; 2. The State or local health office has determined that an exchange project is likely to be an effective component of such a prevention program; 3. The exchange project provides referrals for treatment of drug abuse and for other appropriate health and social services; 4. Such project provides information on reducing the risk of transmission of HIV; 5. The project complies with established standards for the disposal of hazardous medical waste; and 6. The State or local health officer agrees that, as needs are identified by the Secretary, the officer will collaborate with federally supported programs of research and evaluation that relate to exchange projects. 	<p>90-100 programs</p> <p><i>NB: Only six cities receive HIV prevention funding directly; the remainder would have to go through State authorities for approval</i></p>
<p>Added by Secretary</p> <ol style="list-style-type: none"> 7. programs must comply with State and local legal requirements or waivers 	50-60 programs
<ol style="list-style-type: none"> 8. States or localities requesting reprogramming of FY98 funds must be those most severely impacted by injection drug-related AIDS in families and children (over 25% of most recent total AIDS cases related to injection drug use) 	<p>10-15 programs</p> <p><i>(estimated number of States or localities that are likely to complete a reprogramming process during FY98)</i></p>

DRAFT - NOT FINAL
CONTAINS EMBARGOED MATERIAL

Needle Exchange Questions and Answers

NOT FOR DISTRIBUTION OR RELEASE

Why did it take so long?

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. The evidence is air-tight.

Did political concerns delay this decision?

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. The evidence is air-tight.

Did political pressure from AIDS groups force this decision?

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.

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

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.

Does General McCaffrey agree with your decision?

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 the criteria I have put in place for the use of federal funds.

draft
#3

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

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 increase the use of illegal drugs? Some of the best scientific minds in the country have poured over the data and have concluded that both of these tests have been met. That is the basis for our decision today.

I might add that it's my job, since I run both the drug prevention and AIDS prevention programs, to be sure that the Administration's concerns are met with respect to both issues. I am satisfied that they have been.

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

Absolutely not. The intravenous use of drugs 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. As a result, the use of drugs has declined by 50 percent in the last decade. And, after six years of hard work, drug use among young people has begun to stabilize. 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.

What will you do if there is evidence found later on that NEPs do encourage drug use?

As I mentioned, an important component of any program is research and evaluation. We will be continuing to evaluate the effectiveness of these programs and watch for any signs that they are having an adverse effect on either drug use or HIV transmission. If there is a problem, we will not hesitate to act to address it.

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

Absolutely not. The AIDS epidemic is different in every community and the response to the epidemic is different in every community. And the most important component of any prevention effort is community support. That is why we will require such support before Federal funds are used. I do not anticipate that there will be a large number of communities that will apply for these funds. In fact, I think it will be quite small, at least at first -- probably fewer than 10.

How will the government police these programs to make sure that they abide by the terms you have announced today?

The Centers for Disease Control and Prevention will be very active in working with communities and state and local public health officials to make sure that programs meet the requirements we have established before funds are certified for this use. They will work with those who are operating these programs to help them meet the requirements. And they will work with them to help evaluate their success or failure.

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

The NIH Consensus Conference Report issued last April included several studies conducted in other countries. It's important to know, 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. That's why our primary focus was on the evaluation of U.S.-based programs.

Won't this policy result in fewer funds being used to prevent HIV among non-drug users?

There's no reason why it should. It is designed to allow communities that want to consider NEPs to use their money more efficiently. And let me note that we are specifically limiting the availability of Federal funds to those monies appropriated by the Congress to prevent HIV transmission. Funds appropriated to SAMHSA for drug treatment will be spent only on drug treatment.

Again, this will be up to the communities involved. In areas where HIV transmission among drug users and their partners is particularly virulent, a needle exchange program might take a high priority. In communities where that kind of transmission is relatively rare, it will have a very low priority.

How much money will the Federal government spend on needle exchange programs?

It's impossible to estimate but I would guess that it will be a relatively small amount -- a few million dollars. Most of the money that is spent on HIV prevention has already been apportioned by communities according to their priorities and to the current path of the epidemic. That may shift in the future as the nature of the epidemic changes. But right now, I would expect it to be a relatively small outlay.

Will needle exchange programs increase the prevalence of discarded needles on our streets, parks, and beaches?

No. We are specifically requiring all interested programs to limit themselves to exchanging a clean needle for a dirty needle. And we are requiring them to meet existing standards for the disposal of hazardous waste.

Are you absolutely certain that the two standards have been met? What will you do a year from now or two years from now if the evidence shows otherwise?

7
We have conducted one of the most exhaustive scientific reviews in this area in our history. We were scrupulously careful in this evaluation and believe our findings to be solid and air-tight. We will, however, continue several of the ongoing studies to make sure that these findings remain consistent and will not hesitate to act if new evidence comes in.

Will the Federal government discontinue funding for the studies currently underway, including the Alaska study?

Need an answer from NIH

Was there one particular study that provided you with convincing evidence on the question of drug use?

Need an answer from NIH

What about the two Canadian studies that seem to indicate increased drug use and increased HIV transmission in Montreal and Vancouver after needle exchange programs were begun?

We were particularly concerned by those studies and spent extra time evaluating those findings. I am sure that many of you saw the recent article in the New York Times written by the authors of those Canadian studies. They made several important points. First, the nature of the drug epidemic in those cities is very different. There is a great deal of cocaine injecting going on and that increases the risk of HIV transmission. Second, there are very tight limits on the availability of drug treatment in those cities, making it difficult for addicts to stop using.

We are establishing a set of requirements for the use of Federal funds. Included in those are a requirement that needle exchange programs in this country provide a direct referral to drug treatment. Research has shown that when such referrals are made, needle exchange programs can actually reduce the use of illegal drugs.

Why are you allowing federal funding for needle exchange but not allowing medical use of marijuana? Isn't this hypocritical?

Let me be clear: these are fundamentally different issues. The bottom line is that the science clearly shows that needle exchange programs can improve public health by helping to prevent the spread of AIDS and helping to send the message that drugs are dangerous and wrong. That's why we're taking these important steps today.

In contrast, there is no scientifically sound evidence that smoked marijuana is superior to currently available therapies. And it is well documented that smoked marijuana has harmful effects -- on the brain, heart and lungs; impairs learning, memory, perception, judgment, and complex motor skills; and exposes users to known carcinogens. As you may know, NIH is funding a research project to review this question. But, as long as the alleged benefits of marijuana as a medicine remain unproven, while harmful effects are proven, HHS remains opposed to the use of marijuana for treatment of medical conditions.

How many applications do you expect to get?

Less than 10. There are currently only 28 states [check] with NEPs operating today, and it's late in the funding cycle.

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

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.

Needle exchange SLU

ABBREVIATED TALKING POINTS ON NEEDLE EXCHANGE

The Clinton Administration A Record of Fighting the AIDS Epidemic

It has been more than 15 years since the epidemic of HIV/AIDS struck our nation. In that time, more than 600,000 Americans have been diagnosed with AIDS and more than 300,000 men, women, and children have died of AIDS. President Clinton has worked hard to reinvigorate the response to HIV and AIDS, providing new national leadership, substantially greater resources, and a closer working relationship with affected communities.

Overall Increases. Since President Clinton took office in 1993, overall funding for AIDS related programs has increased by more than 86%.

Supported the Ryan White CARE Act. President Clinton in five years has tripled funding for the Ryan White CARE Act, the largest distributor of funds for medical and support services to people living with HIV and AIDS. In 1996, the Administration earmarked Ryan White funds for the AIDS Drug Assistance Program to help those without insurance obtain much needed prescription drugs; since then, ADAP funds have increased by 450%.

Supported the National Institutes of Health. The Administration has increased NIH AIDS research funds by 50% in five years. In 1993, President Clinton signed the NIH Revitalization Act creating a permanent Office of AIDS Research at NIH and investing it with new authority to plan and carry out the AIDS research agenda.

Accelerated AIDS Drug Approval to Record Times. Since 1993, the Food and Drug Administration has approved 10 new AIDS drugs, 20 new drugs for AIDS-related conditions, and three new diagnostic tests. Included in the approvals are a class of drugs known as protease inhibitors, which, in combination with previous drugs, have shown tremendous promise in the treatment of HIV progression.

Pushed for an AIDS Vaccine. On May 18, 1997, the President challenged the nation to develop an AIDS vaccine within the next ten years. He has supported that goal by dedicating an AIDS vaccine research center at the National Institutes of Health and encouraging domestic and international collaboration among governments, medical communities and service organizations.

Increased Access to HIV Prevention Services for Youth. In a directive issued on World AIDS Day 1997, President Clinton instructed each Federal agency to identify all programs under its control that offer opportunities to youth for preventing HIV infection and develop within 180 days a plan through which those programs can increase preventative education as well as support services for those already infected.

Protected Medicaid. The President fought to preserve Medicaid coverage for people living with AIDS. Nearly 50% of people with AIDS and 92% of children with AIDS rely on Medicaid for health coverage. He also revised eligibility rules for Social Security Disability Insurance to increase the number of HIV+ persons who qualify for benefits.

Message Sent To:

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Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users

File needle to check

A National Survey on the Regulation of Syringes and Needles

Lawrence O. Gostin, JD; Zita Lazzarini, JD, MPH; T. Stephen Jones, MD, MPH; Kathleen Flaherty, JD

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

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THE MAGNITUDE OF THE EPIDEMICS OF DRUG USE AND BLOOD-BORNE DISEASES

The dual epidemics of drug use and the human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) are highly destructive of public health and social life in

America.¹ The drug-related health problems of the estimated 1.5 million injection drug users (IDUs) in the United States^{2,3} range from blood-borne infections such as hepatitis B and C, HIV/AIDS, endocarditis, and malaria⁴⁻⁷ to physical deterioration and death. Illegal drug use and the drug industry that fuels it are associated with a multitude of crimes against persons and property. Drug use induces family disintegration, child neglect, economic ruin, and social decay. Drug use exacts an estimated annual cost to society of \$58.3 billion—in lost productivity, motor vehicle crashes, crime, stolen property, and drug treatment.⁸

Injection drug use is the second most frequently reported risk for AIDS, accounting for 184 359 cases through December 1995.⁹ In 1995, 36% of all AIDS cases occurred among IDUs, their heterosexual sex partners, and children whose mothers were IDUs or sex partners of IDUs.¹⁰ In contrast, in 1981, only 12% of all reported AIDS cases were associated with injection drug use.¹¹ In some areas, seroprevalence among IDUs is as high as 65%; in other areas, the rates are significantly lower.¹²⁻¹⁷ Minorities, moreover, bear a disproportionately high burden. The rate of IDU-associated AIDS per 100 000 population is 3.5 for whites, 21.9 for Hispanics, and 50.9 for African Americans.¹⁸

Transmission of HIV infection through injection drug use has a cascading effect; infections spread from IDUs to their sexual and needle-sharing partners and from HIV-infected mothers to their children. Of the 71 818 AIDS cases among women reported through December 1995, nearly 65% were IDUs or were sexual partners of an IDU. Further, of the 6256 perinatally acquired AIDS cases reported through December 1995, 60% had mothers who were IDUs or had sex with an IDU.¹⁰ These data suggest that drug use and related behaviors¹⁹ are potent catalysts for spreading HIV throughout the population.¹¹ It has been estimated that approximately half of all new HIV infections in the United States occur among IDUs.²⁰

THE ROLE OF SYRINGES IN THE TRANSMISSION OF BLOOD-BORNE DISEASE

Injection drug users transmit HIV infection and other blood-borne diseases to other users primarily through multiperson use (often called "sharing") of syringes.²¹ (For the purpose of this article, "syringe" includes both syringes and needles.) Each time an IDU injects drugs, the syringe

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The views expressed herein are those of the authors and do not necessarily reflect the official policy of the US Department of Health and Human Services, the Carter Presidential Center, the Centers for Disease Control and Prevention, or the cosponsors of the consultation held at the Carter Presidential Center.

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Table 1.—Drug Paraphernalia Laws*

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV
DP law†	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MDPA-based law	X		X	X	X	X	X	X	X	X	a	X	X	X			X	X	X	b	X	c	X	X	X	X	X	X	X
Exception for SEPs									X			X									X	X							
Local ordinance(s)	X												X			X													

*Footnotes after Table 3 provide full explanation of all lowercase letter designations. In all three tables, GU indicates Guam; NMI, Northern Mariana Islands; PR, Puerto Rico; SA, American Samoa; VI, Virgin Islands; DP, drug paraphernalia; MDPA, Model Drug Paraphernalia Act; and SEP, syringe exchange program.

†Drug paraphernalia laws prohibit the sale, distribution, possession, manufacture, and/or advertisement of items known to be used to introduce illicit drugs into the body.

‡The total of 46 includes two states (Oregon and Wisconsin) that specifically exclude syringes and needles from the statutory definition of drug paraphernalia.

becomes contaminated with that person's blood and blood-borne pathogens. If another IDU uses the same syringe, he or she is exposed to the previous user's blood with each injection. Decontamination efforts, such as flushing the syringe with bleach, can reduce the risk of exposure, but they are not as safe as using a new, sterile syringe for each injection.²² Reducing the circumstances in which IDUs are likely to reuse equipment lowers the probability of spreading disease. Consequently, experts in preventive medicine and public health advise persons who continue to inject drugs to use a new syringe for each injection.^{22,25} Reducing the risk of disease transmission among IDUs constitutes a legitimate medical and public health rationale for increasing access to syringes.

Multiperson use of syringes is a complex behavior initially reported as part of the subculture of the drug world; sharing was thought to be a sign of social bonding in the drug use community.²⁶⁻³¹ Increasingly, however, researchers have identified scarcity of syringes—not solely a culturally created norm—as a leading factor in sharing behavior.^{32,33} In an effort to control drugs, federal, state, and local governments made a conscious policy choice to limit the supply of sterile syringes. Thus, laws and regulations have made it difficult for IDUs to use a sterile syringe for each injection.^{25,26}

To determine the extent of laws and regulations controlling access to syringes, we conducted 2 surveys in the 50 states, the District of Columbia, and five territories concerning three sets of legal rules: drug paraphernalia laws, syringe prescription laws, and pharmacy regulations (Tables 1 through 3). A survey was sent by the Association of State and Territorial Health Officials to state and territorial attorneys general who were asked to consult with their respective health departments. A second survey was sent to state and territorial boards of pharmacy in consultation with the National Association of Boards of Pharmacy. Attorneys general and boards of pharmacy were asked to describe the law in their jurisdictions and to provide copies of relevant statutes, ordinances, and regulations. Attorneys general and boards of pharmacy were subsequently sent summaries of their laws and regulations and asked to confirm the accuracy. This article analyzes the full range of laws and regulations that restrict access to syringes and discusses potential legal and public health approaches for the prevention of HIV/AIDS and other blood-borne pathogens among IDUs, particularly those who will not or cannot stop injecting drugs.

STATE AND LOCAL DRUG PARAPHERNALIA LAWS

Drug paraphernalia statutes ban the manufacture, sale, distribution, possession, or advertising of a broad array of devices known to be used (or reasonably should be known to be used) to introduce illicit substances into the body. In contrast to syringe prescription laws, most drug paraphernalia laws include the element of intent by defining the prohibited activity

in terms of objects "intended" or "marketed" for unlawful use. Thus, selling or distributing syringes—without knowledge that they will be used to inject illicit drugs—does not constitute an offense under these statutes. For example, a pharmacist who sells syringes over-the-counter to an IDU, believing that the purchaser is a diabetic who will use the equipment to inject insulin, does not violate drug paraphernalia laws.

Legislative History

Drug paraphernalia laws were enacted as a response to the proliferation of the drug paraphernalia industry. Beginning in the late 1960s, cigarette-rolling papers began to be marketed for use with marijuana.³⁴ By 1976, drug paraphernalia had spawned a \$3 billion industry; between 15 000 and 30 000 "head shops" operated nationwide.³⁵ The Select Committee on Narcotics Abuse Control observed that "there were head shops no matter where [we] looked." An assortment of drug paraphernalia publications also appeared, ranging from books on the use of marijuana, hashish, and cocaine to magazines. Community groups and law enforcement officials expressed concern that "the drug paraphernalia industry, through its glamorizing of the drug culture, acts to undermine parental authority, as well as educational and community programs designed to prevent drug abuse among our youth."³⁶

In response, and with increasing frequency during the 1960s and 1970s, state legislatures promulgated "needle laws" and "pipe laws." Many of these laws were inherently vague and were subsequently found to be unconstitutional.^{37,38} To surmount the drafting difficulties of these early laws, the Drug Enforcement Administration in 1979 wrote the Model Drug Paraphernalia Act (MDPA), at the request of President Carter. In 1982, the Supreme Court signaled its approval by upholding a law that included a broad definition of drug paraphernalia.³⁹ Thereafter, lower courts upheld the constitutionality of statutes based on the MDPA.^{40,41}

Given the era in which they emerged—where the young celebrated drug use and entrepreneurs openly flouted drug control efforts—drug paraphernalia laws seem reasonable. The social and legislative history of drug paraphernalia laws reveal that only one group opposed government restrictions: the drug paraphernalia industry. Remarkably absent from the debate was the public health perspective, particularly regarding the health consequences of limiting IDUs' access to syringes.

Survey Results

Forty-seven states, the District of Columbia, and the Virgin Islands have enacted drug paraphernalia laws; only Alaska, Iowa, South Carolina, and four territories have no state- or territory-wide drug paraphernalia statute (Table 1). (Alaska and Iowa have local drug paraphernalia provisions covering some counties and cities.) In 44 states, the District of Columbia, and the Virgin Islands, the drug paraphernalia laws

NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	GU	NMI	PR	SA	VI	Total
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					X	49
X	X	X	X	X	X	d	X	e	X	X		X	X	X	X	X	f	X		g	X					X	48†
			X						X																		7
																										5	

are at least partially based on the MDPA. The statutes often enumerate the objects deemed to be drug paraphernalia, including, for instance, "hypodermic syringes, needles, and other objects used, intended for use, and designed for use in parenterally injecting controlled substances into the human body."⁴² Oregon and Wisconsin specifically exclude syringes from the statutory definition of "drug paraphernalia," but both states include the word "inject" in their general definition of the offense. In contrast, Montana does not expressly include or exclude syringes in its definition of "drug paraphernalia." Maine, Massachusetts, Ohio, and Virginia have enacted legislation in addition to their drug paraphernalia laws that specifically restricts the sale of syringes.

The MDPA permits states to designate the penalty for an offense. Most states classify possession as a misdemeanor and delivery as a felony. Delivery to a minor, when the seller is at least 3 years older than the purchaser, often elicits a more severe penalty. Second and subsequent offenses frequently provoke more serious punishment than a first offense. Drug paraphernalia are often subject to seizure and forfeiture. Three states and one territory assess civil, as well as criminal, penalties for violation of drug paraphernalia laws (California, Louisiana, New Hampshire, and the Virgin Islands). These civil penalties include suspension or revocation of business, liquor, and/or occupational licenses or permits. New Hampshire, for example, levies special civil penalties on pharmacists who violate the drug paraphernalia law, including a fine of up to \$5000 for repeated violations.

Five states (Hawaii, Maryland, Massachusetts, New York, and Rhode Island) and the District of Columbia carve out an exception in their drug paraphernalia laws for operators of syringe exchange programs (SEPs) and their participants. In addition, the state of Washington recognizes such an exemption based on case law that interprets the state's public health and criminal statutes.⁴³ These provisions exempt SEP participants who possess and distribute syringes from prosecution under drug paraphernalia laws. Five states require SEP users to carry a certificate or other evidence of SEP participation (Connecticut, Maryland, Massachusetts, New York, and Rhode Island).

In at least five states (Alaska, Colorado, Iowa, Maryland, and Michigan), local ordinances regulate the possession, sale, or manufacture of drug paraphernalia; of these states, only Alaska and Iowa do not also have a state-wide drug paraphernalia law. New York is the only state that explicitly construes its law to preempt local ordinances.^{44,45}

THE FEDERAL MAIL ORDER DRUG PARAPHERNALIA CONTROL ACT

The Federal Mail Order Drug Paraphernalia Control Act (Mail Order Act), passed as part of the Anti-Drug Abuse Act of 1986, was expanded in 1990.⁴⁶ At the time the Mail Order Act was enacted, the MDPA was considered a triumph; law enforcement officials had succeeded in closing head shops in 38 states. State-level efforts were so effective that they produced a different problem: the interstate commerce of drug

paraphernalia.⁴⁷ While the head shop business faltered, the mail order drug paraphernalia business flourished:

All across America children are receiving catalogs and advertisements for the bong and drug merchandise which we have worked very hard to eliminate. Some of these ads are finding their way into the family mailbox unsolicited.⁴⁸

The Mail Order Act was originally designed to prohibit the use of the US Postal Service to ship equipment to ingest drugs. The statute was later amended to proscribe "any offer for sale and transportation in interstate or foreign commerce" or import or export of drug paraphernalia. In 1994, the Supreme Court upheld the constitutionality of the Mail Order Act.⁴⁹

The Mail Order Act is significant in that it interjects federal law into an area traditionally reserved for the states.⁴⁹ In deference to public health, state and local law enforcement officials may choose to relax their enforcement of drug paraphernalia laws. State and local decisions, however, do not preclude federal authorities from vigorously enforcing the Mail Order Act.

In 1986, the year the Mail Order Act was passed, HIV was known to be a blood-borne disease, and the HIV epidemic was a widely recognized public health problem.⁴⁶ Despite the foreseeable health effects of restricting access to injection equipment during this epidemic, public health and HIV prevention were not discussed at congressional hearings. Moreover, federal courts that reviewed the Mail Order Act,^{50,51} including the Supreme Court,⁴⁹ expressed no reservations about potential health consequences.

SYRINGE PRESCRIPTION STATUTES

Syringe prescription statutes prohibit persons from dispensing or possessing hypodermic syringes without a valid medical prescription. Most prescription laws circumscribe a physician's power to prescribe syringes by requiring a legitimate medical purpose. The "legitimate medical purposes" doctrine strengthens the regulatory effect of syringe prescription laws and is intended to hold a prescription invalid unless issued for a therapeutic purpose. Unlike drug paraphernalia laws, a violation of prescription laws does not require criminal intent. For example, to violate the statute, a pharmacist who dispenses a hypodermic syringe without a prescription need not know that the buyer intends to administer illegal drugs; the very act of dispensing the syringe without a prescription constitutes an offense. The defendant, moreover, carries the burden of proving by a preponderance of the evidence that the hypodermic instrument was legally sold or obtained.^{52,53} Lacking the element of intent, prescription statutes potentially encompass many more transactions than paraphernalia laws. Furthermore, syringe prescription laws may restrict syringe displays and require pharmacists to maintain sales records. Courts have upheld the constitutionality of syringe prescription laws.^{54,55}

Legislative History

Prescription laws can be traced to the widespread use of opium, morphine, cocaine, and heroin during the late 19th and

Table 2.—Laws Limiting Syringe Sales*

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV
SP law†					X		X			m			X							n		X							
Other limitations	X	X	X	X	X	X	X	X	X					X				X					p			q		r	
Record keeping‡			X	X	X	X	X	X					X					X				X							
Disposal requirement	X	X	X	X	X	X	X	X										X											
Display limitations§			X	X	X	X	X	X										X											
Pharmacy sales	X			X	X	y	X	X												z		aa						X	
Exception for SEPs	X	X	X	X	X	X	X	X					cc									X							
Other exceptions					dd		ee	ff					gg									hh						ii	
Local ordinance(s)										pp													qq						

*Footnotes after Table 3 provide full explanation of all lowercase letter designations.

†Syringe prescription (SP) laws prohibit the sale, distribution, and possession of syringes without a valid medical prescription.

‡This total of 9 includes only those states which require a prescription by law for most sales to adults.

§"Record keeping" may include name and address of purchaser; number of syringes sold, intended use, and inspections permitted by law enforcement.

¶"Display limitations" include requirements that syringes and needles be stored in particular areas and not made available to customers on a self-service basis.

early 20th centuries. Physicians and pharmacists dispensed opium to treat a myriad of afflictions. In the 1890s, public concern led to a call for restricting physicians' freedom to dispense these drugs. The medical profession reacted with "fear that the state would dominate the practice of medicine."⁵⁶ The ensuing debate produced the 1914 Boylan Act, New York's syringe prescription law. The law's intent was to reduce drug addiction by posing obstacles to obtaining narcotic drugs and the instruments to administer them. The Boylan Act strictly regulated the distribution of syringes by pharmacists and physicians. Other states followed suit, adopting prescription laws primarily as a drug abuse prevention strategy.⁵⁷ Not surprisingly, states that have enacted syringe prescription laws are those that have experienced the longest history of, or the deepest problems with, drug abuse.

Survey Results

Eight states and one territory statutorily mandate medical prescriptions for most syringe sales (Table 2).⁵⁸ These and other jurisdictions, however, do allow exceptions for certain authorized users (eg, manufacturers, wholesalers, researchers, licensed holders, and persons using syringes for agricultural, medical, and industrial purposes).⁵⁹ Ten additional states restrict the purchase of syringes without a prescription by law or local ordinance. These laws may require prescriptions to establish a legitimate purpose for specific classes of purchasers (eg, minors) or for certain types of purchases (eg, bulk). In 1992, Connecticut amended its law to require prescriptions only for sales of more than 10 syringes. Virginia requires prescriptions for sale to individuals under the age of 16 years, and Florida requires them for sale to individuals under the age of 18 years. Maine specifies that only certain people can sell syringes; however, anyone over the age of 18 years may purchase from an authorized seller. Alternatively, states or localities may permit nonprescription sales only to persons with a legitimate medical need (eg, Michigan, Nevada, Ohio, Texas, Virginia, and Washington). For example, in Nevada, hypodermic devices may be sold without a prescription for medical, veterinary, industrial, and hobby purposes, as long as the seller is satisfied that the device will be used lawfully.

In addition to criminal penalties, physicians and pharmacists may face sanctions from professional licensing boards for violating state laws concerning syringes. In 1994, the California Board of Pharmacy, for example, accused a pharmacy of allowing a nonpharmacist employee to sell syringes

without asking for identification or recording the sale. The board fined the pharmacy and temporarily suspended the licenses of the pharmacy and the pharmacist.⁶⁰

Only three states specifically exempt SEP operators and participants from syringe prescription laws (Connecticut, Massachusetts, and Rhode Island). These states usually require SEP users to carry a syringe exchange card or other proof of participation. The exemption applies only to possession of equipment obtained from the SEP.

Several localities have promulgated syringe prescription ordinances. Michigan does not require prescriptions for sale of needles and syringes; the cities of Warren, Westland, and Detroit, however, place certain restrictions on the purchase or possession of syringes. Florida state law does not require a prescription for adults purchasing syringes; yet Dade and several other counties have prescription ordinances that regulate the sale of syringes. Local ordinances may exist in other states, but they were not reported in this survey.

PHARMACY REGULATIONS AND PRACTICE GUIDELINES

Pharmacy regulations are established under state law by pharmacy boards or other governmental agencies such as a department of consumer protection, department of health, or department of drug control. Pharmacists are legally required to comply with regulations for the sale of syringes. Practice guidelines are typically established by state pharmacy boards. While these guidelines do not have the force of law and technically are not legally binding, failure to comply could leave the pharmacist susceptible to professional sanction or civil liability under state tort law. Legal and public health scholarship has not previously recognized the importance of pharmacy regulations and practice guidelines in restricting access to sterile syringes. While it was previously assumed that over-the-counter sale of syringes was regulated in only a small minority of states with syringe prescription laws, this survey reveals that restrictive regulations are in force in many of the United States.

Twenty-three jurisdictions have pharmacy regulations or practice guidelines that restrict access to syringes by IDUs and persons who need sterile syringes for medical conditions (Table 3).⁶¹ Seventeen of these states do not have syringe prescription laws.⁶² In 11 of these states, regulations or mandatory practice standards significantly impede IDUs' access.⁶³ These rules require the seller to demand purchasers identification and a prescription or other proof of medical need and/or impose record-keeping requirements. Pharmacists are

NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	GU	NMI	PR	SA	VI	Total
X	X		X							X																X	9†
						s		t						u			v	w									8
X	X		X			X				X							X									X	14
						X				X																X	7
						X																					5
X	X									bb							X										11
										X																	3
jj	kk		ll			mm				nn							oo									rr	13
																											2

often expressly authorized to refuse to sell syringes if they believe the intended use is illegal (eg, Georgia, Maryland, South Carolina, and Tennessee). Some states require purchasers to produce valid identification such as a driver's license (eg, Indiana, South Carolina, and Virginia).

Eighteen jurisdictions track the sale of needles and syringes by law or regulations requiring pharmacists to maintain records⁶⁴ and to permit their inspection by various state agencies. The information requested often includes the purchaser's name and address and the intended use. Purchasers may also be required to sign a register. Pharmacists must usually retain the records for a period of time set forth in the regulations and ensure their availability for inspection by law enforcement or other government agencies.

Seven states and one territory regulate the traffic in syringes to guard against having lawfully obtained equipment used for nonlegitimate purposes.⁶⁵

Three states require syringe purchasers to carry evidence of lawful possession (Delaware, Illinois, and Rhode Island). Delaware and Illinois laws require some or all persons possessing syringes to have a certificate of medical need authorized by a physician or allied medical practitioner. The Rhode Island health department advises patients to carry the pharmacy's dispensing label when transporting syringes.

At least three states that do not require prescriptions for syringe sales report having "voluntary" syringe prescription requirements or guidelines to determine legitimate users (Missouri, New Mexico, and Wyoming). In these states, pharmacists voluntarily screen syringe purchasers and sell only to persons whom the pharmacists consider to have a legitimate medical need for syringes. Missouri has no law restricting syringe purchases, but individual pharmacies may establish their own policies; some require purchasers to present a written statement of legitimate medical need. Moreover, the Missouri Board of Pharmacy maintains that pharmacists are ethically obligated to ascertain whether syringes will be used lawfully. In New Mexico, pharmacists voluntarily question syringe and needle purchasers about their intended use and may refuse the sale. In other states—including those without specific laws or regulations requiring prescriptions—pharmacist discretion likely plays a key role in syringe sales.⁶⁶

PUBLIC HEALTH EFFECTS OF SYRINGE REGULATION: ANALYSIS OF SURVEY RESULTS

The survey reveals that every state and the District of Columbia have enacted state or local laws that restrict the sale, distribution, or possession of syringes (Table 2). Only four territories did not report any restrictions. Forty-nine states, the District of Columbia, and the Virgin Islands have passed drug paraphernalia statutes or local ordinances. Only South Carolina

and four territories do not have drug paraphernalia provisions. Ten states and one territory have statutes, regulations, or local ordinances that require a prescription for the purchase of syringes.⁶⁷ Sixteen additional states have statutes, regulations, practice guidelines, or local ordinances that can significantly limit the sale and purchase of syringes.⁶⁸ To the extent that these laws, regulations, and ordinances restrict access to sterile syringes, they contribute to the spread of blood-borne diseases among IDUs, their sexual contacts, and their children. In addition, because of criminal and professional sanctions, they deter pharmacists, physicians, and public health professionals from providing important HIV prevention services to persons who continue to inject drugs.

RESTRICTIONS ON ACCESS TO SYRINGES AND THE TRANSMISSION OF BLOOD-BORNE PATHOGENS

Legal restrictions on access to syringes are a contributing factor in the multiperson use of syringes, the primary risk behavior in the blood-borne spread of infection. Researchers from a variety of different vantage points conclude that IDUs will use sterile syringes if given the opportunity and the means.⁶⁹ First, IDUs report, and ethnographers confirm, that legal restrictions are a primary reason for sharing syringes.^{32,33} Second, IDUs who receive syringes from pharmacists rather than street sellers are less likely to share syringes or to attend shooting galleries.⁷⁰ Third, IDUs with a history of diabetes have significantly lower HIV seroprevalence than nondiabetic IDUs. This is attributed to safer injection practices afforded by their legal access to sterile syringes.⁷¹ Finally, a significant increase in pharmacy sales of syringes to IDUs and a substantial reduction in the multiperson use of contaminated syringes were reported after Connecticut partially deregulated the sale and possession of syringes.^{72,73}

The principal concern about syringe deregulation or SEPs is that they could result in increased initiation into injection drug use or encourage continued drug use. However, despite careful study, most researchers have found no correlation between greater availability of syringes and increased drug use.^{11,74} Moreover, since legal access to syringes, particularly through SEPs, affords greater opportunities for referrals to drug treatment and counseling messages about the harms of drug use, it is possible that SEPs and deregulation of syringes could facilitate, rather than hinder, drug control efforts. The effect of increased access to syringes on drug use is important from a public health perspective and deserves rigorous evaluation.

IMPLEMENTATION OF DISEASE PREVENTION AMONG IDUS

Obtaining and using a sterile syringe to avoid transmission of blood-borne disease can pose acute legal problems for

Table 3.—Regulations Limiting Syringe Sales

	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV	
Prescription required																														
"Medical need"																														
Pharmacy sales					X																									
Display limitations [§]					X			X																						
Disposal requirements					X			X																						
Record keeping					X																									
Any restriction(s) [¶]					X			X	X	X	X		X	X					X	X	X		X	X		X	X		X	

- *Totals do not include pharmacy rules from Louisiana, which were never implemented.
- †Includes only states that require a prescription by regulation for most sales to adults.
- ‡Syringe purchaser must present proof of medical need or legitimate purpose.
- §"Display limitations" include requirements that syringes and needles be stored in particular areas and not made available to customers on a self-service basis.
- ||"Record keeping" may include name and address of purchaser, number of syringes sold, intended use, and inspections permitted by law enforcement.
- ¶Includes significant restrictions imposed by law or local ordinance (Table 2) as well as regulations, rules, and practice guidelines (Table 3).
- a. GA, drug paraphernalia (DP) law is partially based on MDPA.
- b. ME, has a drug paraphernalia law based on MDPA but also regulates syringe and needle violations under a separate statute.
- c. MA, has a DP law based on MDPA but also regulates needles and syringes under a separate statute.
- d. OH, law is based on the MDPA; there is an additional statute regarding the possession of needles/syringes.
- e. OR, specifically excludes needles/syringes from the definition of DP.
- f. VA, in addition to DP law, there is a specific regulation on syringes and needles.
- g. WI, specifically excludes needles/syringes from the definition of DP.
- h. WA, *Health District v Brocket*, 839 P2d 324 (Wash 1992); syringe exchange program subject to specific public health statute and not general criminal drug paraphernalia law.
- i. CO, Denver, Colorado Springs, and Aurora.
- j. MD, Annapolis and Howard County.
- k. MI, cities of Dearborn, Detroit, Sterling Heights, Warren, and Westland.
- l. CT, only applies to sale of more than 10 syringes.
- m. FL, purchasers under 18 years of age must have a prescription for syringes.
- n. ME, only persons eighteen years of age or older may purchase syringes without a prescription.
- o. VA, purchasers under 16 years of age must have a prescription for syringes.
- p. MI, local ordinances restrict access to and possession of syringes.
- q. MO, no statutory requirement; individual pharmacies may set own policies, some require physician's written statement that buyer has legitimate medical need.
- r. NV, no state law mandates prescription for syringe purchases. However, the seller must be satisfied that the customer's intended use is legitimate.
- s. OH, no prescription is required, but pharmacist must know or reasonably believe user is authorized.
- t. OR, minors must have authorization of physician, parent, or guardian or "other acceptable" party to purchase syringes.
- u. TX, pharmacists may sell if in their judgment the sale is "for legitimate purposes."
- v. VA, sale requires identification and written evidence of legitimate purpose.
- w. WA, seller must be satisfied that use will be for "legal purposes."
- y. CT, health professionals may also sell/distribute needles and syringes.
- z. ME, licenses authorized sellers (pharmacies and certain others); any person aged 18 years or older may buy from an authorized seller.
- aa. MA, specified professionals, persons licensed by Department of Public Health, and manufacturers are also permitted to sell syringes.
- bb. RI, sellers must be licensed by RI Department of Public Health.
- cc. IL, the Chicago City Attorney has interpreted the research exception to the state syringe prescription law to include syringe exchange programs.
- dd. CA, no prescription required for syringes used for insulin or adrenaline, for animals, or by manufacturers, wholesalers, or surgical suppliers.
- ee. CT, manufacturers, wholesalers; licensed holders, researchers, agricultural, medical, or industrial users.
- ff. DE, agricultural, wholesale, jobbers, manufacturers, and industrial users.

IDUs, including prosecution for possessing drug injection equipment.⁷⁶ An IDU is unlikely to present a legally acceptable reason for requiring a syringe and, thus, is likely to violate both syringe prescription and drug paraphernalia laws. Drug users may be arrested for carrying syringes.⁷⁶

Why would the potential legal consequences of carrying injection equipment dissuade a drug user, when he or she is already engaged in far more serious criminal behavior? From the IDU's perspective, laws that penalize the possession of syringes are problematic for a number of reasons. First, drug users who are arrested on a drug paraphernalia charge are subject to fines and possible incarceration.⁸² Second, the violation itself marks the person as a drug user and may subject him or her to more intense police surveillance.⁷⁷ Third, once an individual is found to possess drug paraphernalia, he or she is more likely to undergo a police search for illicit drugs.^{82,77} Discovery of a syringe, or even bleach, may provide probable cause under the Fourth Amendment to conduct a broader search of the drug user and his or her possessions, leading to confiscation of illicit drugs and prosecution for sale or use.

Ethnographic studies vividly illustrate that drug users, fearing detection of syringes under these laws, often fail to carry sterile syringes.^{82,77,78} Syringe laws and regulations, therefore, create a marked disincentive for drug users to possess sterile syringes when they purchase or inject drugs. Ironically, this is precisely the time when users most need sterile injection equipment because they will otherwise share

blood-contaminated syringes and potentially transmit blood-borne pathogens. The threat of arrest and prosecution for possession of drug injection equipment makes it less likely that active IDUs will use sterile syringes.

OVER-THE-COUNTER SALE OF SYRINGES: THE ROLE OF PHARMACISTS

Pharmacists face substantial legal and professional hurdles in selling syringes to IDUs. By requiring prescriptions or proof of medical need, identification, and record-keeping, states impede pharmacists and customers from instituting safer means for drug injection. Drug users, wary of the legal consequences, may avoid pharmacies out of apprehension of intrusive questioning.⁷⁹ Pharmacists, wary of criminal prohibitions and professional sanctions, may decline to sell syringes to suspected IDUs.

Nationwide, pharmacists retain considerable discretion in deciding whether, and to whom, to sell syringes. Some pharmacists sell to all buyers; others refuse to sell to purchasers who demonstrate visible signs of injection drug use or who cannot offer a plausible medical justification; still others refuse sales for apparently discriminatory or capricious reasons.^{80,81} Pharmacist discretion yields wide variation in the willingness to sell to IDUs.⁸² Biases against, for example, racial minorities, young people, and homeless persons potentially limit opportunities for pharmacy customers to purchase syringes.^{83,84}

NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	GU	NMI	PR	SA	VI	Total*
									X																		1
	aaa										bbb	X			ccc		ddd				eee						12
		X				iii			X		iii	X							X								12
	X					X						X			kkk	X				X	eee						14
			X																								4
			X			mmm					nnn					X		X									10
X	X	X			X				X	X	X		X	X			X	X	X						X		27

- gg. IL, medical professionals, farmers, and researchers may purchase syringes without a prescription. Persons who have lost prescriptions may purchase without a prescription but must sign an affidavit that is given to the state police.
- hh. MA, health professionals, persons licensed by the Department of Public Health, manufacturers, and researchers can buy syringes without a prescription.
- ii. NV, prescriptions are not required for sale to or for asthmatics, diabetics, injection of medication prescribed by a practitioner, use in ambulances and by firefighters, veterinary uses, commercial or industrial, embalming, licensed medical use, research, and hobbyists "if the seller is satisfied that the device will be used for legitimate purposes."
- jj. NH, industrial, medical, and research users can buy syringes without a prescription.
- kk. NJ, health professionals, veterinarians, undertakers, clinical laboratories, and medical institutions can buy syringes without a prescription.
- ll. NY, persons authorized by the health commissioner to obtain/possess syringes can purchase without a prescription.
- mm. OH, manufacturers, medical, lawful, and agricultural users can buy syringes without a prescription.
- nn. RI, manufacturers, wholesalers, dealers, embalmers, and medical users may purchase syringes without a prescription.
- oo. VA, physicians, dentists, podiatrists, veterinarians, funeral directors, and embalmers may possess or distribute syringes without a prescription.
- pp. FL, Dade and other counties require prescriptions, but no statewide requirement.
- qq. MI, the cities of Detroit, Warren, and Westland restrict access to and possession of syringes.
- rr. VI, health care professionals, veterinarians, undertakers, or registered pharmacies, hospitals, laboratories, or medical institutions may obtain syringes without a prescription.
- ss. GA, sales shall not be made if seller has reasonable cause to believe that syringes would be used for unlawful purpose.
- tt. LA, pharmacy rule, never implemented, would limit sales to authorized sellers, require identification and proof of medical need, impose display and record-keeping requirements, and provide for inspections.
- uu. MD, purchasers must show identification and show good-faith indication of legitimate need.
- vv. MS, pharmacists may sell without a prescription, some require proof of medical need or buyer signing a log before purchase.
- ww. MO, according to state Board of Pharmacy, pharmacists have an ethical responsibility to decide whether needles/syringes would be used for legal purpose.
- yy. NE, pharmacists are expected to exercise their professional judgment at the time of sale.
- zz. NV, no state law mandates a prescription for syringe purchases. However, the seller must be satisfied that the customer's intended use is legitimate.
- aaa. NM, no state law requires a prescription, but some pharmacists question potential purchasers about intended use and may refuse to sell.
- bbb. SC, pharmacists must obtain either oral or written affirmation from purchasers that sale is for legitimate medical use.
- ccc. VT, the Board of Pharmacy discourages sales of syringes not grounded in medical necessity.
- ddd. WA, seller must determine whether syringe is to be used for a legal purpose.
- eee. WY, guidelines, strictly voluntary, suggest syringes be kept in prescription department. Pharmacists may ask for identification or about intended use.
- fff. CT, health professionals may also sell syringes.
- ggg. GA, only pharmacies and physicians may sell syringes.
- hhh. MA, persons licensed by the Department of Public Health (eg, manufacturers, dealers) may also sell syringes.
- iii. OH, authorized dealers, hospitals, practitioners, and pharmacies are permitted to sell syringes.
- jjj. SC, only pharmacists are permitted to make sales without prescriptions.
- kkk. VT, the Board of Pharmacy encourages pharmacists to keep needles and syringes behind the counter.
- lll. KY, pharmacists must keep records for nonprescription sales; pharmacists are not required to keep records of sales made with prescriptions.
- mmm. OH, pharmacists may sell without prescription but pharmacists must keep records of sale and purchaser must provide identification.
- nnn. SC, pharmacists must keep records of nonprescription sales.

'LEGITIMATE MEDICAL PURPOSES': THE ROLE OF PHYSICIANS AND OTHER HEALTH PROFESSIONALS

Physicians and other health professionals face potentially dire legal consequences when they prescribe syringes or otherwise directly assist IDUs in obtaining sterile syringes. Physician prescription practices, in particular, are guided by the "legitimate medical purposes" doctrine. Courts have held that physicians who prescribe controlled substances "for the purpose of maintaining [a patient's] habit" are not acting in the course of their professional duty.^{85,86} It is unclear, however, whether physicians would be liable for prescribing syringes to a drug injector if they had a good faith intention to prevent the drug user from contracting or transmitting HIV infection. Many public health experts believe that increasing IDU access to sterile syringes will reduce the needle-borne transmission of disease.^{23,26} Indeed, in other contexts, courts have concluded that physicians do not violate prescription laws if they act in good faith in accordance with reasonable medical judgment.⁸⁷ The most important characteristic of the physician-patient relationship is "the physician using [his or her] best efforts and expertise to promote the patient's total health."⁸⁸ If laws and regulations do not recognize access to sterile syringes as a legitimate means of preventing blood-borne disease, how can physicians and other health care professionals provide comprehensive prevention services to persons who will not or cannot stop injecting drugs?

THE LAWFUL OPERATION OF SYRINGE EXCHANGES

Although the users of one SEP were reported to have higher HIV incidence than nonusers,⁸⁹ the preponderance of research suggests that SEPs lower the rates of multiperson use of syringes⁹⁰⁻⁹³; offer a referral source for social services, health care, and drug abuse treatment; and serve as a conduit to HIV testing and counseling, health education, and condom distribution.⁷⁴ The National Research Council's review of the data concludes that SEPs constitute a vital component of a comprehensive strategy to prevent infectious disease. Syringe exchange programs reduce the number of contaminated syringes in circulation, which lowers a major risk factor for infectious disease transmission.¹¹

Public health professionals or community advocates who run SEPs understand that distributed syringes will be used to inject illicit drugs; thus, absent some separate legal authority, SEPs appear to operate unlawfully under drug paraphernalia laws. Even where law enforcement agencies choose to ignore intent under drug paraphernalia laws, SEPs may be legally vulnerable. For example, SEP operators, who distribute syringes without prescriptions in states with syringe prescription laws or regulations, do so unlawfully. Consequently, in many jurisdictions, federal, state, or municipal police are authorized to arrest SEP participants, and the attorney general is entitled to seek an injunction against the program. At the very least, their uncertain legal status may

discourage drug users from participating in SEPs and communities from establishing SEPs.⁹⁴

Public health officials and community activists have sought to support the lawfulness of SEPs through judicial declaration,^{95,96} assertion of public health emergency,^{97,99} and invocation of the necessity defense for prosecution of drug paraphernalia^{100,101} and syringe prescription laws.^{102,103} The results have been mixed.¹⁰⁴ Clearly, the cooperation of public health and law enforcement are essential for effective prevention of HIV transmission associated with illicit drug use.

PREVENTION OF BLOOD-BORNE DISEASE AMONG IDUS

Many public health,¹⁰⁵ medical,^{11,106} and legal^{107,108} organizations have supported the deregulation of syringes as a strategy to prevent HIV/AIDS and other blood-borne diseases among IDUs. Most laws, regulations, and practice guidelines that restrict the sale, possession, or distribution of syringes were promulgated (1) before HIV/AIDS among IDUs was recognized as a pressing public health problem and (2) without carefully contemplating the health implications. Since that time, the interconnected epidemics of drug use and HIV/AIDS have produced illness and death, particularly among poor, urban, minority communities.

We present the following legal and public health approaches that could be used to increase access to sterile syringes for persons who continue to inject drugs in order to reduce the transmission of blood-borne disease among IDUs, their sex partners, and children. These approaches would not affect current criminal proscriptions against the importation, sale, or possession of illicit drugs.

1. *Clarify the legitimate medical purposes of sterile syringes.* Possession and use of sterile syringes by IDUs serves the legitimate medical purpose of preventing blood-borne diseases. Distinguishing syringes from other drug paraphernalia would allow IDUs to legally buy and possess syringes, legitimize the professional decisions of physicians and pharmacists, and clarify the laws on which criminal justice authorities rely.

2. *Modify drug paraphernalia laws.* Drug paraphernalia laws could be modified to exempt authorized sellers, distributors, or possessors of syringes (eg, pharmacists, physicians, public health officials, registered SEPs, and their patients/clients). Permitting IDUs to obtain syringes from reliable sources would enable them to comply with public health advice to use a new syringe for each injection. The law could justifiably continue to criminalize the unauthorized sale of drug paraphernalia by drug dealers, shooting galleries, head shops, and mail order firms; but the law should not criminalize simple possession of syringes by IDUs. Unauthorized sellers are dubious sources of sterile injection equipment; dealers and shooting gallery proprietors, for example, sometimes repackage used syringes and sell them as new.¹⁰⁹

3. *Repeal syringe prescription laws.* Repeal of syringe prescription laws would legalize over-the-counter sale of syringes in pharmacies and would promote several public health benefits. Repeal would enable IDUs and persons who need sterile syringes for medical conditions such as insulin-dependent diabetes to secure sterile syringes, free physicians and pharmacists from risking criminal liability or professional sanction for prescribing or dispensing syringes to prevent transmission of blood-borne infections, and allow pharmacists

to participate in public health efforts by educating and counseling customers about safer sex and drug injection practices. If permitted to perform within the scope of their professional practices, physicians and pharmacists could serve as a link to drug abuse treatment and education. Medical and pharmacy boards would retain the authority to sanction unprofessional behavior (eg, physicians or pharmacists who improperly encourage, or assist in, the illicit sale or use of drugs). Over-the-counter sale of syringes is likely to be a highly cost-effective means of increasing the availability of syringes: the extensive network, diverse locations, and extended hours of operation of pharmacies, together with the expertise of pharmacists, would help ensure wide access to syringes and professional advice. Furthermore, over-the-counter sales of syringes would remain within the private sector.

4. *Repeal restrictive pharmacy regulations and practice guidelines.* Repeal of restrictive pharmacy regulations and practice guidelines would increase the availability of sterile syringes to IDUs. States could achieve this public health objective by repealing regulations and guidelines that require purchasers to present prescriptions or other proof of legitimate medical need, proffer identification, or sign a log book prior to purchasing sterile injection equipment. Although they seem reasonable on their face, these regulations and guidelines impede both pharmacists and their clients in transactions involving sterile syringes. Reasonable practice guidelines could be maintained to ensure high professional standards and to limit sales of syringes to licensed pharmacies.

5. *Promote professional training.* Professional in-service training for pharmacists, other health professionals, and criminal justice personnel would advance public health goals. Education about the transmission of blood-borne infections would equip pharmacists to make well-informed decisions about the sale of syringes, encourage health care professionals to offer the best prevention education to IDUs, and inform criminal justice personnel about public health prevention strategies.

6. *Permit local discretion in establishing SEPs.* Permitting public health officials to establish SEPs would augment public health strategies to prevent blood-borne diseases. Many communities have found SEPs to be an important element of a comprehensive HIV prevention program. Local health officials are best situated to assess the community's response to, and the potential effectiveness of, such a program.

7. *Design programs for safe syringe disposal.* Public health officials, health care professionals, and pharmacists are well situated to collaborate in designing and directing effective programs for safe syringe disposal. Programs to ensure the safe disposal of used drug injection equipment would decrease the number of contaminated syringes in circulation and reduce health risks to the public. Indeed, criminal penalties for possession can thwart initiatives for safe disposal of syringes. Injection drug users may discard their syringes once they have been used rather than returning them to an SEP or taking them to a place for safe disposal.

CONCLUSION: HARMONIZING PERSPECTIVES ON DRUG USE AND HIV/AIDS

Public health efforts to control the spread of HIV/AIDS and other blood-borne infections must respect the legitimate concerns of the community and law enforcement about the moral and societal aspects of drug use. Law enforcement and community leaders (eg, police, churches, businesses, parents,

teachers, and residents) are understandably concerned that allowing access to syringes sends the wrong message, encourages initiation into drug use, and accelerates the disintegration of families. Residents and business owners fear increased street crime, lower property values, and health risks from discarded syringes. Respecting community views requires both public health and law enforcement to work closely with neighborhood groups.

The evidence suggests that deregulation of syringe sale and possession would reduce morbidity and mortality associated with blood-borne disease among IDUs, their sexual partners, and their children and can be implemented without harmful social repercussions. Deregulation of syringe sale and possession does not itself increase the availability of illicit drugs and is not equivalent to condoning drug use. These observations, however, require rigorous ongoing evaluation.

Finally, it is important to emphasize that deregulation of syringe sale and possession should constitute only one component of a comprehensive, well-financed strategy to impede the dual epidemics of drug use and HIV/AIDS.¹⁰⁶ A realistic and sound national program must devote sufficient resources for expanded access to high-quality treatment for drug and alcohol dependency; education and counseling regarding the harms of illicit drugs; effective community efforts to discourage drug use; crime prevention in schools and communities; rehabilitation for offenders; and support and community activities for families and young people. Ultimately, both law enforcement and public health seek the same end—to promote the health and safety of the population through a comprehensive program designed to prevent HIV/AIDS and drug dependency.

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The full report of the syringe law project will become available from the National AIDS Information Clearinghouse, and a considerably expanded article will appear in the *Emory Law Review*.

References

1. Gostin LO. The interconnected epidemics of drug dependency and AIDS. *Harvard CR-CL Law Rev*. 1991;26:113-184.
2. Turner C, Miller H, Moses L. *AIDS: Sexual Behavior and Intravenous Drug Use*. Washington, DC: National Academy Press; 1989.
3. Centers for Disease Control. Human immunodeficiency virus infection in the United States: a review of current knowledge. *MMWR Morb Mortal Wkly Rep*. 1987;36(suppl 5-6):1-48.
4. Garfein RS, Vlahov D, Galai N, et al. Viral infections in short-term injection

5. Cherubin CE, Sapira JD. The medical complications of drug addiction and the medical assessment of the IV drug user: twenty-five years later. *Ann Intern Med*. 1993;119:1017-1028.
6. Hagan H, Reid T, Des Jarlais D, et al. The incidence of HBV infection and syringe exchange programs. *JAMA*. 1991;266:1646-1647.
7. Alter MJ. Epidemiology of hepatitis C in the West. *Semin Liver Dis*. 1995;15:5-14.
8. Rice DP, Kelman S, Miller LS. Estimates of economic costs of alcohol and drug abuse and mental illness, 1985 and 1988. *Public Health Rep*. 1991;106:280-292.
9. Centers for Disease Control and Prevention. First 500,000 AIDS cases—United States, 1995. *MMWR Morb Mortal Wkly Rep*. 1996;44:849-853.
10. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 1995*. Atlanta, Ga: US Dept of Health and Human Services, Public Health Service; 1996.
11. Normand J, Vlahov D, Moses LE, eds. *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*. Washington, DC: National Academy Press; 1995.
12. Hahn RA, Onorato IM, Jones S, Dougherty J. Prevalence of HIV infection among intravenous drug users in the United States. *JAMA*. 1989;261:2677-2684.
13. Prevost DR, Allen DM, Lehman JS, et al. Trends in HIV seroprevalence among injection drug users entering drug treatment centers, United States, 1988-1993. *Am J Epidemiol*. 1996;143:733-742.
14. Allen DM, Onorato IM, Green TA. HIV infection in intravenous drug users entering drug treatment, United States, 1988-1989. *Am J Public Health*. 1992;82:541-546.
15. Des Jarlais DC, Friedman SR, Novick DM, et al. HIV-1 infection among intravenous drug users in Manhattan, New York City, from 1977 through 1987. *JAMA*. 1989;261:1008-1012.
16. Newmeyer JA. The prevalence of drug use in San Francisco in 1987. *J Psychoactive Drugs*. 1988;20:185-189.
17. Chaisson R, Moss A, Onishi R, et al. Human immunodeficiency virus infection in heterosexual intravenous drug users in San Francisco. *Am J Public Health*. 1987;77:169-172.
18. Centers for Disease Control and Prevention. AIDS associated with injecting drug use—United States, 1995. *MMWR Morb Mortal Wkly Rep*. 1996;45:392-398.
19. Paone D, Caloir S, Des Jarlais DC. Sex, drugs, and syringe exchange in New York City: women's experiences. *J Am Fam Assoc*. 1996;50:109-114.
20. Holmberg SD. The estimated prevalence and incidence of HIV in 96 large US metropolitan areas. *Am J Public Health*. 1996;86:642-654.
21. Friedland GH, Klein RS. Transmission of the human immunodeficiency virus. *N Engl J Med*. 1987;317:1125-1135.
22. Haverkos HIV, Jones TS. HIV, drug-use paraphernalia, and bleach. *J Acquir Immune Defic Syndr*. 1994;7:741-742.
23. US Preventive Services Task Force. *Guide to Clinical Preventive Services*. 2nd ed. Baltimore, Md: Williams & Wilkins; 1996.
24. Centers for Disease Control and Prevention. Improper infection control practices during employee vaccination programs—District of Columbia and Pennsylvania, 1993. *MMWR Morb Mortal Wkly Rep*. 1993;42:969-971.
25. American Medical Association. *A Physician Guide to HIV Prevention*. Chicago, Ill: American Medical Association; 1996.
26. Des Jarlais DC, Friedman SK. The psychology of preventing AIDS among intravenous drug users. *Am Psychologist*. 1988;43:865-869.
27. Donoghoe MC, Stimson GV, Dolan K, et al. Changes in HIV risk behavior in clients of syringe-exchange schemes in England and Scotland. *AIDS*. 1989;3:267-272.
28. Black JL, Dolan MP, Deford HA, et al. Sharing of needles among users of intravenous drugs. *N Engl J Med*. 1986;314:446-447.
29. Magura S, Grossman JI, Lipton DS, et al. Determinants of needle sharing among intravenous drug users. *Am J Public Health*. 1989;79:459-462.
30. Koester S, Booth R, Wiebel W. The risk of HIV transmission from sharing water, drug-mixing containers, and cotton filters among intravenous drug users. *Int J Drug Policy*. 1990;1:28-30.
31. Celentano DD, Vlahov D, Cohn S, et al. Risk factors for shooting gallery use and cessation among intravenous drug users. *Am J Public Health*. 1991;81:1291-1295.
32. Koester SK. Copping, running, and paraphernalia laws: contextual variables and needle risk behavior among injection drug users in Denver. *Hum Organization*. 1994;53:287-295.
33. Heimer R, Kaplan EH, O'Keefe E, et al. Three years of needle exchange in New Haven: what have we learned? *AIDS Public Policy J*. 1994;9:59-74.
34. Veal GR. The Model Drug Paraphernalia Act: can we outlaw head shops—and should we? *Georgia Law Rev*. 1981;16:137-169.
35. *Drug Paraphernalia: Hearing Before the House Select Committee on Narcotics Abuse and Control*, 96th Cong, 1st Sess, 1979:79 (testimony of Dan Leonard, staff investigator for the House Select Committee on Narcotics Abuse and Control).
36. *Mid-Atlantic Accessories Trade Ass'n v Maryland*, 500 Supp 834, 841 (D Md 1980).
37. *McKoy v United States (Case 2)*, 263 A2d 649 (DC 1970).
38. *Geiger v City of Eagan*, 618 F2d 26 (8th Cir 1980).
39. *Village of Hoffman Estates v Flipside, Hoffman Estates, Inc*, 456 US 489, reh'g denied, 456 US 950 (1982).

40. *Garner v White*, 726 F2d 1274 (8th Cir 1984).
41. *Camille Corp v Phares*, 706 F2d 223 (7th Cir 1983).
42. See, eg, Neb Code 28-439(3).
43. *Spokane County Health District v Brockett*, 839 P2d 324 (Wash 1992).
44. *Dougal v County of Suffolk*, 477 NYS2d 381 (App Div 1984), *aff'd*, 481 NE2d 254 (NY 1985).
45. *Gless v City of New York*, 483 NYS2d 715 (App Div), *aff'd*, 481 NE2d 254 (NY 1985).
46. 21 USC §857, reenacted 21 USC §863 (1990).
47. *Mail Order Drug Paraphernalia Control Act, 1986: Hearings on HR 1625 Before the Subcommittee on Crime of the House Committee on the Judiciary*, 99th Cong, 2nd Sess, 1986:16 (testimony of Joyce Nalepka, president of the National Federation of Parents for a Drug-Free Youth).
48. *Posters 'N' Things Ltd v United States*, 114 S Ct 1747, *reh'g denied*, 114 S Ct 2771 (1994).
49. Pascal C. Intravenous drug abuse and AIDS transmission: federal and state laws regulating needle availability. In: Battjes RJ, Pickens RW, eds. *Needle Sharing Among Intravenous Drug Abusers: National and International Perspectives*. Rockville, Md: National Institute on Drug Abuse; 1988. NIDA monograph No. 80.
50. *United States v 57,261 Items of Drug Paraphernalia*, 869 F2d 955 (6th Cir), *cert denied*, 493 US 933 (1989).
51. *United States v Murphy*, 977 F2d 503 (10th Cir 1992).
52. *People v Sauli*, 176 NYS2d 405 (Columbia County Ct 1958).
53. *People v Strong*, 365 NYS2d 310 (4th Dept 1975), *aff'd*, 366 NE2d 867 (NY 1977).
54. *People v Bellfield*, 230 NYS2d 79 (Sup Ct 1961), *aff'd*, 183 NE2d 230 (NY 1962).
55. *Dyton v State*, 250 A2d 383 (Del 1969).
56. Musto DF. *The American Disease. Origins of Narcotic Control*. New York, NY: Oxford University Press; 1987.
57. Fernando MD. *AIDS and Intravenous Drug Use: The Influence of Morality, Politics, Social Science, and Race in the Making of a Tragedy*. Westport, Conn: Praeger; 1993:44, 55.
58. CA, DE, IL, MA, NH, NJ, NY, RI, VI.
59. CA, CT, DE, IL, MA, NV, NH, NJ, NY, OH, RI, VA.
60. Case No. 1640, accusation against SAV-ON-DRUGS (decision effective March 4, 1994).
61. CA, CT, DE, GA, IN, KY, MD, MA, MN, MO, NV, NJ, NY, ND, OH, PA, SC, TN, VT, VA, WV, WI, WY.
62. GA, IN, KY, MD, MN, MO, NV, ND, OH, PA, SC, TN, VT, VA, WV, WI, WY.
63. GA, IN, KY, MD, NV, OH, PA, SC, TN, VA, WV.
64. AR, CA, CT, DC, IL, IN, KY, MD, MA, NH, NJ, NY, OH, RI, SC, VA, VI, WV.
65. CA, CT, DE, KY, ND, OH, RI, VI.
66. Compton WM, Cottler LB, Decker SH, et al. Legal needle buying in St. Louis. *Am J Public Health*. 1992;82:595-596.
67. CA, DE, FL, IL, MA, NH, NJ, NY, PA, RI, VI.
68. DC, GA, IN, KY, MD, MI, MS, MO, NV, OH, SC, TN, TX, VA, WA, WV.
69. Des Jarlais DC, Friedman SR, Southern JL, et al. Continuity and change within an HIV epidemic: injecting drug users in New York City, 1984-1992. *JAMA*. 1994;271:121-127.
70. Gleghorn AA, Jones TS, Doherty M, et al. Acquisition and use of needles and syringes by injecting drug users in Baltimore, Maryland. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995;10:97-103.
71. Nelson KE, Vlahov D, Cohn S, et al. Human immunodeficiency virus infection in diabetic intravenous drug users. *JAMA*. 1991;266:2259-2261.
72. Singer M, Weeks MR, Himmelgreen D. Sale and exchange of syringes. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995;10:104.
73. Groseclose SL, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on practices of injecting-drug users and police officers—Connecticut, 1992-1993. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995;10:82-89.
74. Lurie P, Reingold AL, Bowser B, et al. *The Public Health Impact of Needle Exchange Programs in the United States and Abroad*. San Francisco: University of California, Institute for Health Policy Studies; 1993:vol 1.
75. In response to the survey, Boise, Idaho, Boston and Cambridge, Mass, and the state of New Jersey reported arrests and/or convictions for possession of drug paraphernalia or syringes.
76. Stryker J. IV drug use and AIDS: public policies and dirty needles. *J Health Policy Politics Law*. 1989;14:719-740.
77. Grund J-PC, Heckathorn DD, Broadhead RS, Anthony DL. In Eastern Connecticut, IDUs purchase syringes from pharmacies but don't carry syringes. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995;10:104-105.
78. Feldman HIV, Biernacki P. The ethnography of needle sharing among intravenous drug users and implications for public policies and intervention strategies. In: Battjes RJ, Pickens RW, eds. *Needle Sharing Among Intravenous Drug Abusers: National and International Perspectives*. Rockville, Md: National Institute on Drug Abuse; 1988:28-39. NIDA Monograph No. 80.
79. Valleroy LA, Weinstein B, Jones TS, et al. Impact of increased legal access to needles and syringes on community pharmacies' needle and syringe sales—Connecticut, 1992-1993. *J Acquir Immune Defic Syndr Hum Retrovirol*. 1995;10:73-81.
80. Croatto JP, Ewart FJ, Hage BH, et al. The role of the pharmacist in preventing a 'second wave' of the HIV epidemic among IV drug users. *Aust J Pharm*. 1987;68:602-604.
81. Glantz A, Byrne C, Jackson P. Role of community pharmacies in prevention of AIDS among injecting drug misusers: findings of a survey in England and Wales. *BMJ*. 1989;299:1076-1079.
82. Ettelson R. Sell needles and syringes to IV drug abusers? *Pharm Times*. 1991;57:107-114.
83. Compton WM III, Cottler LB, Decker SH, et al. Legal needle buying in St. Louis. *Am J Public Health*. 1992;82:595-596.
84. Zellmer WA. Pharmacist involvement in needle exchange programs. *Am Pharm*. 1994;34(9):48-51.
85. *People v Lipton*, 429 NE2d 1059 (NY 1981).
86. *People v Goldberg*, 369 NYS2d 989 (Sup Ct 1975).
87. *People v Lonergan*, 267 Cal Rptr 887 (Ct App), *review denied*, 1990 Cal LEXIS 2801 (Cal June 27, 1990).
88. *Perzik v Superior Court*, 4 Cal Rptr 2d 1 (Ct App 1991).
89. Bruneau J, Franco E, Lamothe F, et al. Increased HIV seroprevalence and seroincidence associated with participation in needle exchange program: unexpected findings from the Saint-Luc cohort study in Montreal. In: Proceedings and abstracts from the XI International Conference on AIDS; July 1996, Vancouver, British Columbia. Abstract Tu.C.323.
90. Watters JK. Syringe and needle exchange as HIV/AIDS prevention for injection drug users. *JAMA*. 1994;271:115-120.
91. Kaplan EH, Heimer K. HIV prevalence among intravenous drug users: model-based estimates from New Haven's legal needle exchange. *J Acquir Immune Defic Syndr*. 1992;5:163-169.
92. Hartgers C, Buning ED, van Santen GW, Vester AD, Coutinho RA. The impact of the needle and syringe exchange programme in Amsterdam in injecting risk behavior. *J Acquir Immune Defic Syndr*. 1989;3:571-576.
93. Ljunberg B, Christensson B, Tuning K, et al. HIV prevention among injecting drug users: three years' experience from a syringe exchange program in Sweden. *J Acquir Immune Defic Syndr*. 1991;4:890-896.
94. Burrell S, Finucane D, Gallagher H, Grace J. The legal strategies used in operating syringe exchange programs in the United States. *Am J Public Health*. 1996;86:1161-1166.
95. *Spokane County Health District v Brockett*, 839 P2d 324 (Wash 1992).
96. *Allen v City of Tacoma*, No. 89-2-09067-3 (Wash Super Ct, Pierce County, May 9, 1990).
97. Clark C. Grand jury calls for needle exchange. *San Diego Union-Tribune*. June 29, 1994:B1.
98. Hoge P. Needle laws force a political balancing act. *Sacramento Bee*. December 5, 1994:A1.
99. Cheevers J. Needle exchanges battle AIDS and the law; addicts spread HIV by sharing contaminated syringes. *Los Angeles Times*. January 9, 1996:A1.
100. *Commonwealth v Parker*, No. 89-0123 (Boston Mun Crim Ct January 23, 1991) (Order and Findings); Bench Ruling No. 89-01213, January 9, 1990 (defendant acquitted).
101. *State v Sorry*, 691 A2d 1382 (NJ Super Ct Law Div 1991) (necessity defense unsuccessful, conviction upheld).
102. *People v Bordowitz*, 588 NYS2d 507 (Crim Ct 1991) (defendants acquitted).
103. *Commonwealth v Leno*, 616 NE2d 453 (Mass 1993) (necessity defense not allowed, conviction upheld).
104. Gostin LO. Law and policy. In: Stryker J, Smith MD, eds. *Dimensions of HIV Prevention: Needle Exchange*. Menlo Park, Calif: Henry J Kaiser Family Foundation; 1993.
105. National Commission on AIDS. *The Twin Epidemics of Substance Use and HIV*. Washington, DC: Presidential Commission on AIDS; 1991.
106. American Medical Association. House of Delegates Resolution 405 (1996): Intravenous drug use, syringes, substance abuse treatment, and HIV prevention. Chicago, Ill: American Medical Association; 1996.
107. Committee on Medicine and Law. *Legalization of Non-Prescription Sale of Hypodermic Needles: A Response to the AIDS Crisis*. New York, NY: Association of the Bar of the City of New York; 1986.
108. ABA AIDS Coordinating Committee. *AIDS: The Legal Issues*. Washington, DC: American Bar Association; 1988.
109. Des Jarlais DC, Hopkins W. 'Free' needles for intravenous drug users at risk for AIDS: current developments in New York City. *N Engl J Med*. 1985;318:1476.