

HEALTH
EMERGENCY
2001

The Spread of
Drug-Related
AIDS and
Hepatitis C
Among
African Americans
and Latinos

Dawn Day, PhD

*with a Foreword by Joycelyn Elders, MD
Former US Surgeon General*

Executive Summary

Health Emergency Among African Americans

- Some 10,000 African Americans who inject drugs are getting infected with HIV each year.
- The HIV/AIDS epidemic has fallen much more harshly upon African Americans than on whites who inject drugs. Among those who inject drugs, African Americans are five times as likely as whites to get AIDS.
- AIDS was the second leading cause of death among African Americans between the ages of 25 and 44 in 1998. Half of those deaths were caused by injections with contaminated needles.

Health Emergency Among Latinos

- Some 4,500 Latinos who inject drugs are getting infected with HIV each year.
- The HIV/AIDS epidemic has fallen more harshly upon Latinos than on whites who inject drugs. Among those who inject drugs, Latinos are at least one and a half times as likely as whites to get AIDS.
- AIDS was the fourth leading cause of death among Latinos age 25 to 44 in 1998. Half of those deaths were caused by injections with contaminated needles.

What Must Be Done

We must improve drug education. We must expand drug treatment programs. We must also implement the proven public health interventions that can reduce substantially the spread of AIDS and other deadly blood-borne diseases among people who inject drugs by reforming our laws and regulations to:

- Permit possession of sterile needles
- Permit pharmacies to sell syringes without prescriptions
- Permit and fund needle exchange programs

Foreword

This powerful report brings home the severity of the problem of AIDS spread through dirty needles.

It makes me angry!

We have got to be about preventing disease! We have better drugs, but we still don't have a vaccine or a cure for this disease. We have watched people die from this disease; now they must learn how to live with HIV/AIDS. But why can't we help prevent this disease by providing clean needles? We do not allow people to get the clean needles that would reduce the spread of HIV disease, yet we spend thousands of dollars to treat each person who develops AIDS, to take care of them, to watch them die. That makes no sense! We have got to be about preventing problems, not fixing things after they are broken.

Our best scientific research shows that needle exchange programs do not increase drug use, but do reduce the spread of HIV. We need to speak out. Silence about the importance of needle exchange programs is causing the deaths of thousands of our bright young black and Latino men and women. Time is slipping away. Our bright young people are slipping away.

We must recognize the spread of AIDS through dirty needles as the public health problem that it is. We must accept the scientific data and stand up for needle exchange programs and begin to save precious lives!

Dr. Joycelyn Elders
Former U.S. Surgeon General



Dr. Elders

About the Author

This report was prepared by Dawn Day, Director of the Dogwood Center, an independent research organization in Princeton, New Jersey. Dr. Day is an activist scholar with 30 years of experience as a researcher and writer on social issues.

This report is the fourth in a series detailing the impact of the injection-related AIDS epidemic on African Americans and Latinos. Dawn Day has devoted much of the last few years to discussing the importance of needle access as HIV prevention in a variety of forums, including lectures, newspaper articles and television and radio appearances.

Dr. Day's books dealing with racial discrimination include *Adoption Agencies and the Adoption of Black Children* (Lexington Books, 1979) and *Protest, Politics and Prosperity: Black Americans in White Institutions, 1940-1975* (Pantheon, 1978; co-author).

As a Vice President at Response Analysis, in Princeton, New Jersey, Dr. Day led the team that provided the basic statistical data on American household energy consumption to the United States Department of Energy. Her work on household energy consumption has also been funded by the Ford Foundation.

Dawn Day was a member of a team funded by the Carnegie Corporation that analyzed changes in the lives of African Americans. Holding both a PhD in sociology and an MSW in social work from the University of Michigan, she has taught at Brooklyn College and the University of Maryland.

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1. Health Emergency: The Spread of AIDS Among African Americans Who Inject Drugs

Some 10,000 African Americans who inject drugs are becoming infected with HIV each year.¹ As the years pass, a number of them may well stop injecting drugs, but the HIV/AIDS disease will stay with them.

The number of current and former African American injecting drug users living with AIDS is increasing. Between 1994 and 1998, the number of African Americans infected through use of a contaminated needle and living with AIDS increased by almost 50 percent.² (See Chart 1.)

Additional thousands of African Americans are living with HIV, infected through a dirty needle, but they have not progressed to AIDS. Some of them are aware of their illness, others are not.³

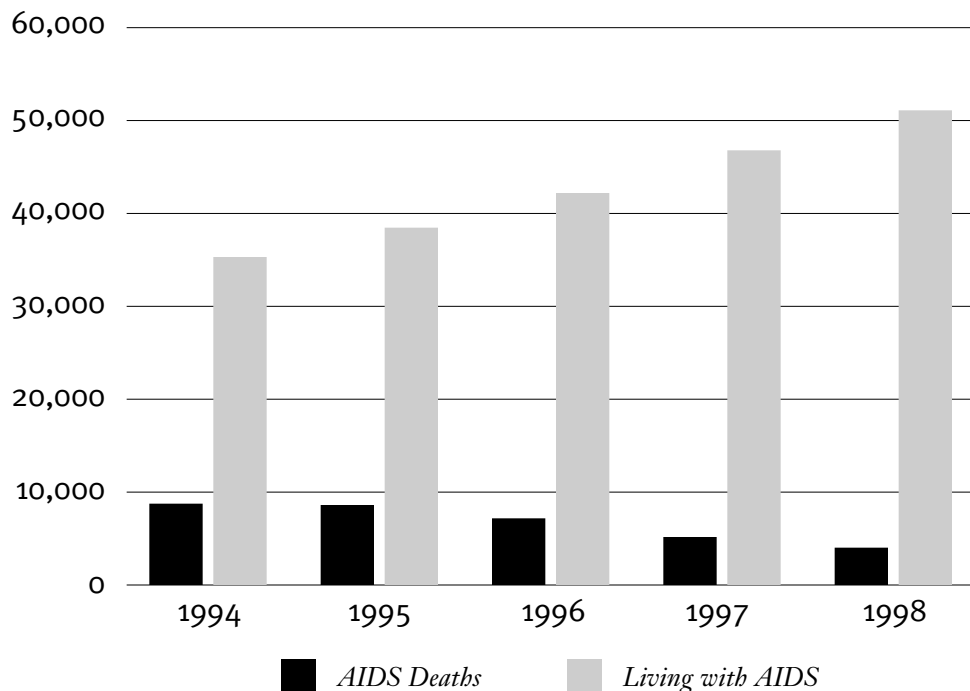
Some 10,000 African Americans who inject drugs are becoming infected with HIV each year.

With improved medical treatment, AIDS deaths among African Americans infected through use of a dirty needle have been falling since 1995. (See Chart 1.)

But AIDS deaths are still a serious problem. In 1998, AIDS was the second leading cause of death among African Americans between the ages of 25

CHART 1.

The growing AIDS epidemic among African Americans infected with HIV through use of a dirty needle.



The HIV/AIDS epidemic has fallen much more harshly upon African Americans than on whites who inject drugs. Among those who inject drugs, African Americans are five times as likely as whites to get AIDS.

and 44.⁴ Half of those deaths were caused by injections with contaminated needles.⁵

The HIV/AIDS epidemic has fallen much more harshly upon African Americans than on whites who inject drugs. Among those who inject drugs, African Americans are five times as likely as whites to get AIDS.⁶

The AIDS epidemic among African Americans infected through use of a dirty needle does not stop with them. From them, the AIDS epidemic spreads outward to non-drug-injecting wives, husbands and lovers and then to newborn babies.

The role of racial profiling and needle possession laws in the spread of AIDS

Permitting access to sterile needles could substantially reduce the spread of HIV among injecting drug users. No research has ever shown that making needle possession illegal is effective in reducing drug use in the United States. Our needle possession laws have been effective, however, in making sterile needles scarce and in creating the circumstances in which people who inject drugs share

their infected needles, resulting in the further spread of HIV and other blood-borne diseases. In this way, an ineffective policy of drug control — denying access to sterile needles — has become a major factor in the spread of deadly disease.⁷

People can avoid arrest for possession of an illicit drug by buying the drug immediately before they plan to use it. In the many states where needle possession is illegal, those who carry their own clean needles are vulnerable to arrest at any time.

African Americans are more at risk in this regard because African Americans frequently have been the target of police drives to enforce drug laws.⁸ This shows up in the federal government's own data which indicate that blacks who use drugs are 2.4 times more likely to be arrested on drug charges than whites who use drugs.⁹ Official arrest records understate the situation. News stories show that, in at least some cities, police do not record the stops they make, if the stops do not result in arrests.¹⁰

We can now begin to see why the number of injection-related new AIDS cases is so high among blacks: being stopped and searched is

Spreading HIV among African Americans who inject drugs is not the deliberate policy of any state government or police department. Nevertheless, by restricting the access to sterile needles and by targeting blacks for arrest, that has been the result.

much more common among blacks than among whites. This means that the legal system, via the police, is more likely to confiscate the personal needles of blacks. Also, because black users know (correctly) that they are vulnerable to arrest, these users are likely to “choose” not to carry their own clean needles. Users who do not carry their own needles all too often end up sharing the needles and blood-borne diseases of others.

Spreading HIV among African Americans who inject drugs is not the deliberate policy of any state government or police department. Nevertheless, by restricting the access to sterile needles and by targeting blacks for arrest, that has been the result.

The infamous Tuskegee syphilis “experiment”

In our society, medical intervention goes far beyond the use of pills, bandages, and surgery; in the name of public health we remove asbestos and lead-based paint and treat water. Given the medical consensus that has emerged on the effectiveness of sterile needles as a way to avoid the spread of injection-related AIDS, it is difficult to see the denial of access to sterile needles as anything other than the denial of access to a lifesaving medical intervention.

In the history of modern medicine in the United States, there is only one other instance where a lifesaving medical intervention involving the spread of a deadly infectious disease was deliberately denied a group of people. That instance is the infamous Tuskegee syphilis “experiment.” The originators justified themselves by saying they wanted to study the course of untreated syphilis. The unfortunate victims of this study were 400 black men from Alabama, who were denied medical treatment for their syphilis from 1932, when the study began, until their deaths or, if they lived, until 1972, when the “experiment” was exposed and stopped.¹¹

It is difficult to see the denial of access to sterile needles as anything other than the denial of access to a lifesaving medical intervention.

The absence of genetic protection

Scientists have discovered that certain genes offer protection against the initial infection with HIV and/or slow the speed with which HIV/AIDS progresses. This genetic protection has been found in between 4 and 17 percent of whites and 2 percent of Puerto Ricans. So far, this genetic protection has been found to be almost nonexistent in Africans, Asians and Pacific Islanders.¹²

2. Health Emergency: The Spread of AIDS Among Latinos Who Inject Drugs

Some 4,500 Latinos who inject drugs are becoming infected with HIV each year.¹ As the years pass, a number of them may well stop injecting drugs, but the HIV/AIDS disease will stay with them.

The number of current and former Latino injecting drug users living with AIDS is increasing. Between 1994 and 1998, the number of Latinos infected through use of a contaminated needle and living with AIDS increased by over 40 percent.² (See Chart 2.)

Additional thousands of Latinos are living with HIV, infected through a dirty needle, but they have not progressed to AIDS. Some of those who are HIV positive are aware of their

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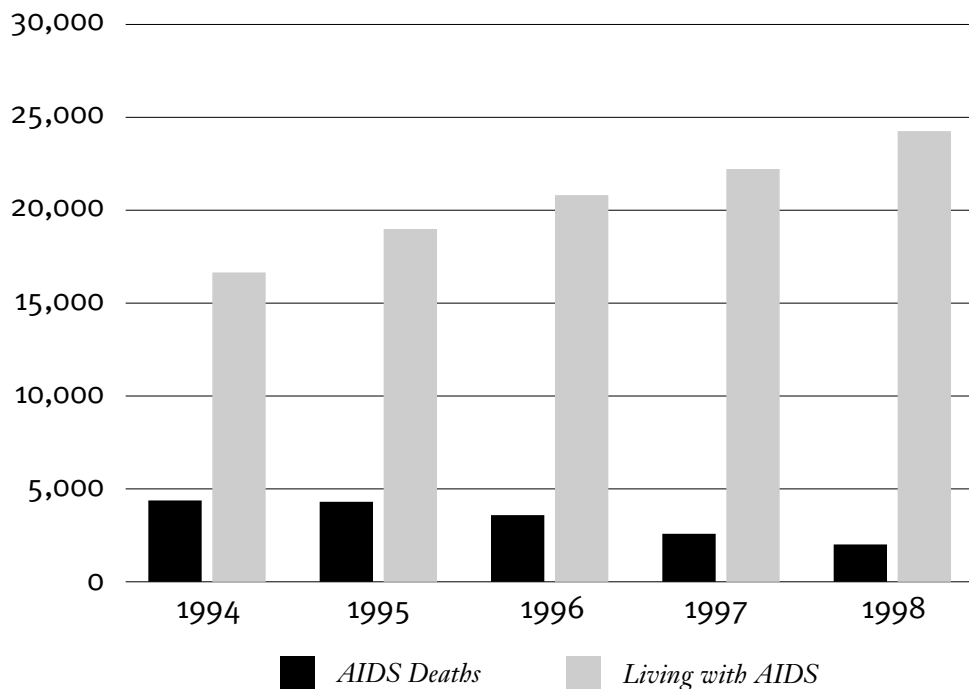
illness, others are not.³

With improved treatment, AIDS deaths among Latinos infected through use of infected needles have been falling since 1995. (See Chart 2.)

But AIDS deaths are still a serious problem. In 1998, AIDS was the fourth leading cause of

CHART 2.

The growing AIDS epidemic among Latinos infected with HIV through use of dirty a needle.



death among Latinos between the ages of 25 and 44.⁴ Half of those deaths were caused by injections with contaminated needles.⁵

The HIV/AIDS epidemic has fallen more harshly upon Latinos than on whites who inject drugs. Among those who inject drugs, Latinos are at least one and a half times as likely as whites to get AIDS. The true figure could be substantially higher.⁶

The AIDS epidemic among Latinos infected through contaminated needles does not stop with them. From them, the AIDS epidemic spreads outward to non-drug-injecting wives, husbands and lovers and then to newborn babies.

Puerto Ricans living on the island of Puerto Rico and in the United States have a higher incidence of injection-related AIDS than do other Latino groups living in the United States.⁷

Impact of migration

Migration between the United States and Central and South America is affecting the spread of HIV/AIDS as well as the statistics on HIV/AIDS in a variety of ways. For example, it is possible that the number of Latinos with HIV is understated because illegal immigrants fear any official contact, including HIV testing. Latino AIDS deaths might be understated in U.S. statistics because some migrants, after becoming HIV infected in the United States, return home to be cared for by relatives before they die.

It is also possible that some men, migrating to the United States in search of work and isolated from their families, start injecting drugs; then, because of the absence of clean needles, they become infected with HIV and ultimately carry the AIDS epidemic to their wives back home.

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3. A Neglected Opportunity: Drug Treatment as AIDS Prevention

Drug treatment is also HIV prevention. People in treatment are less likely to inject drugs. People in treatment are less likely to get involved in risky sex, another way to contract HIV.

According to the government, approximately 5 million drug users were in need of treatment in 1998, while less than half that number received it.¹ Methadone maintenance is the most effective treatment for heroin, the most commonly injected drug. But this treatment is available to only about 1 in 5 heroin users.²

The federal government spends 20 percent of the nation's drug-control budget to treat drug-dependent individuals.³ Experts, both inside and outside government, say it would be both cost effective and humane to increase the

Methadone maintenance treatment for heroin addiction costs \$3,900 a year; prison about \$20,100 a year.

It is an understatement to say that shifting drug war dollars from prison to treatment would be cost effective.

Expanding drug treatment alone cannot stop the spread of HIV among people who inject drugs. Access to sterile needles is also needed.

government's expenditures on drug treatment.⁴ Methadone maintenance treatment for heroin addiction costs \$3,900 a year, prison about \$20,100 a year.⁵ It is an understatement to say that shifting drug war dollars from prison to treatment would be cost effective.

Even in the best of all possible worlds, with drug treatment available to all who wanted it, we would still need to be concerned about improving access to sterile needles. Drug dependence is a chronic, relapsing disease. Some in treatment will, in fact, relapse.⁶ Others, although we may think they need treatment, are not yet interested in it. All these considerations lead to the significant conclusion that expanding drug treatment alone cannot stop the spread of HIV among people who inject drugs. Access to sterile needles is also needed.

4. The Scientific Evidence: Needle Exchange Programs Prevent HIV and Can Reduce Drug Use

The scientific evidence: Sterile needles are needed for HIV prevention

Access to sterile needles is essential for HIV prevention among injecting drug users. According to the Centers for Disease Control and Prevention:

For injection drug users who cannot or will not stop injecting drugs, using sterile needles and syringes only once remains the safest, most effective approach for limiting HIV transmission.¹

Uninfected men and women who inject drugs need sterile needles so they can avoid becoming infected. People with HIV/AIDS who inject drugs need sterile needles so they will not borrow the needles of others, spreading the HIV virus further.

The scientific evidence: Needle exchange programs DO NOT INCREASE drug use

One effective way to get sterile needles to injecting drug users is to set up needle exchange programs that distribute sterile needles and collect used ones. Those opposed to needle exchange programs have expressed the concern that needle exchange programs might increase drug use.

However, extensive scientific research has been done on the relationship between access to sterile needles and drug use. Seven major government-funded studies have concluded that **needle exchange programs do not increase drug use and do not attract new people to drug use.²**

Convinced by the strong evidence that access to clean needles is essential to controlling the HIV epidemic among injecting drug users, the American Medical Association, the American Pharmaceutical Association and other professional health associations have called on their members to support the establishment of needle exchange programs and to work to reform the state laws and pharmaceutical board regulations that limit access to sterile needles.³

The scientific evidence: Needle exchange programs CAN REDUCE drug use

Surgeon General David Satcher has concluded that, under certain circumstances, needle exchange programs can actually reduce drug use.⁴ Upon reflection, this paradoxical finding makes sense. Needle exchange programs work on two levels to reduce drug use: the interpersonal and the institutional.

THE INTERPERSONAL LEVEL. Needle exchange workers often offer information counseling and a friendly ear to drug users who in many cases have little contact with individuals outside the drug-using world. This interaction, often focused on helping the drug user take better care of himself, can empower the drug user to decide for himself or herself to cut back on drug use or enter treatment.

THE INSTITUTIONAL LEVEL. Needle exchange programs have helped drug treatment agencies become more receptive to poor and minority clients. Some needle exchange programs

have negotiated agreements with drug treatment agencies, so that the exchange is guaranteed a certain number of places in the treatment organization. Other exchanges have arranged for free treatment for some injecting drug users who lack resources.

The New Haven needle exchange experience illustrates this process. While the main focus of the New Haven program was on exchanging needles, considerable effort also went into creating drug treatment opportunities for those who wished to take advantage of them. One-sixth of the injecting drug users who initially joined the needle exchange subsequently entered drug treatment programs. Referrals from the New Haven needle exchange also helped redress racial/ethnic inequities in the drug treatment system. Prior to the start of needle exchange program referrals, less than 40 percent of the injecting drug users in the area treatment programs were minorities, while over 60 percent of those placed in drug treatment by the needle exchange were minorities.⁵

Careful studies in Baltimore, Hawaii, and Seattle have all shown that needle exchange programs, given community support and the appropriate resources, can reduce drug use.⁶

Development of the interpersonal and institutional relationships that lead to reduced drug use occurs most effectively when the exchange has a secure legal status. When a needle exchange is under pressure from the police, conversations between clients and volunteers are cut short, and the program's resources to encourage change in the drug treatment agencies are limited or nonexistent.⁷

Thus, ironically, those who use police power to harass or close down needle exchange programs are not only causing the spread of HIV but are also causing a continuation of drug use by hampering the needle exchange activities that would otherwise help some drug users reduce or stop their drug use.

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5. The Legality of Saving Lives

As the Centers for Disease Control and Prevention has concluded, “For injection drug users who cannot or will not stop injecting drugs, using sterile needles and syringes only once remains the safest, most effective approach for limiting HIV transmission.”¹

The numerous state and local laws and regulations that limit access to sterile needles were put in place just as the not-yet-understood HIV/AIDS epidemic was beginning to spread across the United States. With no scientific studies to support their thinking, lawmakers merely assumed that if access to syringes were limited, injecting drug use would be reduced.²

This assumption proved tragically wrong. Limiting access to sterile needles did reduce the supply of sterile needles, but it did not reduce injecting drug use. Injecting drug use continued apace as users shared needles and, consequently, their HIV and other blood-borne infections as well.

The all-too-slow process of reform

Elimination of the barriers to accessing sterile needles is coming all too slowly. The **first wave** of reform in any city or state often occurs as a few activists, concerned with saving lives right now, set up a needle exchange, giving out sterile needles and collecting used ones.³ This direct action cuts through restrictive laws and regulations. But it is risky and requires courage. The activists see themselves as public health workers; some police, prosecutors, elected officials, and

The first wave of reform in any city or state often occurs as a few courageous activists, concerned with saving lives right now, set up a needle exchange, giving out sterile needles and collecting used ones.

community members see them as criminals.

In the **second wave** of reform, activists in a particular city gain local support, and the local legal situation is reconfigured to give the needle exchange staff and participants protection from arrest for needle possession. In the most successful instances of reform, such as in the states of Connecticut, Hawaii, and New Mexico, the state government, through its health department, begins running needle exchanges and expands service to other areas of the state where it is needed.

The **third wave** of reform involves changing laws and regulations so that pharmacists can sell syringes without a prescription. To be effective, the pharmacy effort has to include educational programs to inform pharmacists of the public health importance of over-the-counter sales of syringes. Care also must be taken that syringes

are sold without regard to race or ethnicity. A St. Louis study, for example, found that several pharmacies were willing to sell syringes to whites but not to African Americans.⁴

In the year 2000, New Hampshire, New York and Rhode Island reformed their laws, making it possible for pharmacies to sell without a prescription. California, Delaware, Illinois, Massachusetts, Nevada, New Jersey, and Pennsylvania are the only remaining states with severely restrictive syringe prescription laws or regulations.

A promising **fourth wave** of reform, just beginning, is physician prescription of syringes. Prescribing syringes to prevent the spread of HIV is a legitimate medical purpose. The relevant governing bodies in Rhode Island have recognized this to be the case, and some injecting drug users in that state are now able to get syringes by prescription from their doctor.

A **final wave** of reform involves changing the laws governing drug paraphernalia. This reform is completed in only nine states (Alaska, Connecticut, Georgia, Maine, Minnesota, New Hampshire, New York, Oregon, and Wisconsin). Laws prohibiting possession of sterile needles and other related safe injection equipment (such as cookers and cotton) need to be removed from all the state and local drug paraphernalia laws. Anything less will continue the spread of HIV and other blood-borne diseases.

Needle exchange programs today

In 1998, there were 131 needle exchange programs in the United States, up from 113 the previous year.⁵ Many major cities — including Chicago, Detroit, Honolulu, New York City, Philadelphia, and San Francisco — had needle exchange programs.

Progress in making needle exchange programs legal has been much too slow. Of the 110 exchanges responding to the 1998 survey, 59 were legal; 24 were illegal-tolerated by local officials, and 27 were illegal-underground.^{6,7}

Once legal, programs have achieved considerable success in getting public funds. In 1998, 51 programs reported receiving state or local government funds.

The illegal-tolerated exchanges are often able to exist in a relatively public fashion because, while officials have not yet reformed the needle access laws and regulations, they nonetheless understand that it makes no sense to arrest people working to stem an epidemic.

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But arrests do occur. In 1998, there were 10 arrests of needle exchange staff or volunteers in five different states. In the worst case, arrest and successful prosecution can shut down a needle exchange entirely.⁸ Arrest or the threat of arrest can reduce the effectiveness of a needle exchange by discouraging donations, by deterring volunteers from working at the exchange (effectively reducing the number of hours the exchange is open), and by frightening away prospective clients. The threat of arrest can also force a program to move to a less accessible location, making it difficult for those who need the exchange's services to find it.⁹ As pointed out in Section 4, arrest or the threat of arrest also reduces the effectiveness of needle exchange programs in getting interested drug users into drug treatment.

Needle exchanges as harm reduction organizations

Needle exchange programs see themselves as part of a larger harm reduction movement. By slowing the spread of HIV, they are reducing the harm from injecting drug use. Without calling it that, we, as a society, practice harm reduction all the time. We reduce the harm of riding a motorcycle by requiring riders to wear helmets. We reduce the harm from car accidents by requiring people to wear seat belts. We reduce the harm to non-smokers by requiring that smoking be done only in designated areas. We reduce the harm from excessive drinking at parties and bars by encouraging the use of a designated driver who does not drink. By preventing the spread of HIV and other blood-borne diseases, needle exchange programs reduce the harm that comes from injecting drug use.

Making police into partners

Police education is a key component in the development of a successful needle exchange program. In 1998, some 45 programs reported police harassment of people coming to use the exchange. The most common form of harassment occurred when officers confiscated syringes or forced exchange participants to break the points off their syringes.

Participant harassment occurred at legal as well as underground programs. In 1998, participants in 17 legal needle exchange programs, 15 illegal-tolerated programs and 13 illegal-underground programs experienced police harassment.

Although individual police officers can remain confused about the role of needle exchange programs in disease prevention, when it is explained to them, many officers see both their own personal advantage and the public health benefits of needle exchange programs.

An officer patting down a suspect is much less likely to get a dangerous needle stick when the suspect is carrying a new syringe with its protec-

tive cap (which is legal and the suspect feels free to mention) than when a suspect is hiding a used and (perhaps infected), illegal needle whose protective cap has long since been lost.

The continuing epidemic

For those concerned about the spread of HIV/AIDS among injecting drug users, their non-drug-using sexual partners, and newborn children, the pace of needle access reform has been far too slow. Of the ten states with the highest rates of injection-related AIDS in 1998, substantial progress in reform has been made in three (Connecticut, New York, and Rhode Island). Some progress had been made in another three (Maryland, Massachusetts, and Pennsylvania), but virtually no progress had been made in four (Delaware, Louisiana, New Jersey, and Florida).¹⁰

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With 50 people in the United States being infected every day with HIV as a result of intravenous drug use, it is clear we must do more.¹¹ We need to continue to educate people to the harms of drug use, particularly injection drug use. And we must listen to the expertise and wisdom of our public health officials and make sterile needles legally available to people who inject drugs.

We must:

- Eliminate the drug paraphernalia and drug prescription laws and regulations so that there will be no ambiguity about the legality of needle exchange programs and so that drug users can purchase and carry their own clean, safe needles without fear of arrest.
- Recognize that HIV prevention is a legitimate medical purpose, and encourage physicians to write syringe prescriptions for people who inject drugs.

As a humane society, we must reach the point where injecting drug users in every state can legally protect themselves from HIV and other blood-borne diseases and where needle exchange workers in every state are treated not as criminals but as the public health workers they are.

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6. Saving Lives and Saving Billions of Health Care Dollars

The main purpose of HIV prevention among injecting drug users is to prevent suffering and save lives. But it turns out that effective HIV prevention can also save several billion health care dollars.

Health care researchers have explored what it would cost society if sterile injection equipment were made available across the United States through needle exchange programs and pharmacy sales of syringes. Their conclusions are:

- It is three times more expensive to provide medical treatment for one person sick with HIV/AIDS than to prevent one new HIV infection using needle exchange programs and pharmacy sale of syringes.¹
- Each year, without increased access to sterile syringes by injecting drug users, as many as 12,350 persons in the United States will become infected with HIV, leading to an estimated \$1.3 billion in future medical costs for them.

Tragically — and irresponsibly — no federal HIV prevention funds are being used for needle exchange programs.² The failure to permit federal funding of needle exchange programs has brought angry criticism from, among others, Dr. R. Scott Hitt, head of the President’s Advisory Council on HIV and AIDS: “At best [the prohibition on federal funding of needle exchange] is hypocrisy. At worst, it’s a lie. And no matter what, it’s immoral.”³

Representative Maxine Waters of the Congressional Black Caucus, a strong supporter of federal funding, put it this way: “This is a

It is three times more expensive to provide medical treatment for one person sick with HIV/AIDS than to prevent one new HIV infection using needle exchange programs and pharmacy sale of syringes.

life-and-death issue. We can save lives with needle exchange as we try to work at getting rid of drugs in our society.”⁴ Representative Xavier Becerra of the Congressional Hispanic Caucus has championed federal funding for needle exchange.⁵ The NAACP has taken a stand in favor of needle exchange.⁶

So, here is the situation. Our best science shows that a combination of needle exchange programs and pharmacy sales of syringes could save thousands of lives and several billion health care dollars. Yet, the federal government is not funding needle exchange programs. The result is that the federal government is spending billions⁷ to provide medical treatment as people suffer with HIV/AIDS, a debilitating and often deadly illness, while refusing to spend any money for a key prevention technique — needle exchange programs.

7. Health Emergency: African American and Latina Women And Their Children

The AIDS epidemic among women is expanding. The number of women living with AIDS increased by more than 75 percent in the five years ending in 1998. African American and Latina women are the hardest hit; they accounted for over 75 percent of all women living with AIDS in 1998.¹

The women most affected by the AIDS epidemic are current and former injecting drug users and those exposed to AIDS through heterosexual sex. A large proportion of women infected heterosexually are infected through sex with an injecting drug user.²

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The crisis for African American women

- In 1998, more than 14,200 African American women were living with AIDS acquired through injecting drug use. An additional 18,000 African American women were living with AIDS acquired through heterosexual sex, often through sex with an injecting drug user. Thousands more were infected with HIV.
- AIDS was the third leading cause of death among African American women age 25 to 44 in 1998. In that year, the AIDS death rate for African American women age 25 to 44 was twenty times higher than the AIDS death rate for white women.³

The crisis for Latinas

- In 1998 more than 4,500 Latinas were living with AIDS acquired through injecting drug use. An additional 6,700 Latinas were living with AIDS acquired through heterosexual sex, often through sex with an injecting drug user. Thousands more were infected with HIV.
- AIDS was the fourth leading cause of death among Latinas age 25 to 44 in 1998. In 1998, the AIDS death rate for Latinas age 25 to 44 was more than three times higher than the AIDS death rate for white women.

Infants with HIV

The thousands of women infected with HIV/AIDS are mainly in their child-bearing years. So it is no wonder that some babies are HIV positive. Of the 233 infants with HIV reported in 34 states in 1999, 66 percent were African American and 14 percent were Latino.⁴ With better medical care, some, but not all, of these babies could have avoided HIV/AIDS infection.

Infants born with HIV, however, are not the only children we need to be concerned about. There is another, even larger group of children about whom we need to be concerned: AIDS orphans.

AIDS orphans

As women become infected and die of AIDS, they leave children behind. In 1998, there were 67,000 American children under the age of 18, mostly children of color, who had lost their mothers to the AIDS epidemic. More than half of these children were 12 or younger.⁵

Most of these orphans were not infected with HIV. Some were born before their mothers became HIV-positive. Others were born free of HIV, even though they were born after their mothers were infected.

Throughout the HIV/AIDS epidemic, the majority of babies born to mothers with HIV have not been born infected with HIV. In the absence of any medical treatment, about 75 out of 100 infants of HIV-infected mothers are born free of HIV. Given appropriate medical treatment during pregnancy and birth, an infant's chance of being born free of HIV disease now rises to as high as 98 in 100.⁶

About 17 percent of the mothers of the now-orphaned children never injected drugs themselves but were unfortunate in their relationships, infected through heterosexual sex with a man who at one time injected drugs.⁷

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who had lost their mothers to
the AIDS epidemic.*

About 45 percent of the mothers of these now orphaned children became HIV positive because the mothers themselves injected drugs. We should not assume that, had these mothers lived, they would not have been good parents. Women who inject drugs at one point in their lives are not necessarily drug users for life. Some experiment for only a short time; others use drugs for longer periods and then stop successfully.

Children need their parents. We need to be following policies which ensure that as few children as possible are orphaned by AIDS.

Prevention through safe sex and sterile needles

Because HIV/AIDS spread first among gay men in the United States, some Americans do not realize how pervasive and devastating HIV can become in a heterosexual population. To see that, we need only look to Africa where the infection rates of the 16 hardest hit countries range from 10 percent to an almost incomprehensible 36 percent.⁸ Nearly all adult Africans with AIDS have been infected through heterosexual sex.

In the United States, HIV acquired through injecting drug use is an important source of the HIV that is spreading to heterosexuals. African American women and Latinas are the groups hardest hit.⁹ Preventing HIV among injecting drug users is a significant way to prevent HIV among their heterosexual partners.

With thousands of motherless children and about 60 percent of all AIDS cases among women caused directly or indirectly by HIV-infected needles, the case for clean-needle programs to save the lives of women and children and prevent the destruction of families could not be stronger.

The inescapable conclusion

With thousands of motherless children and about 60 percent of all AIDS cases among women caused directly or indirectly by HIV-infected needles,¹¹ the case for clean-needle programs to save the lives of women and children and prevent the destruction of families could not be stronger.

Persuading men to use condoms during sex is not a simple task.¹⁰ The Centers for Disease Control and Prevention has spent millions of dollars researching this topic and has yet to find an easy approach. Because so many heterosexual men are already infected with HIV, women, to protect their own health, will need to continue to persuade their men to use condoms for years to come. Given the sexual attitudes of substantial numbers of American men, many women are going to fail in these efforts.

To protect women and men who do not use drugs, we need to do everything we can to keep the number of HIV-positive people as small as possible. We need sterile needle programs to save the lives of non-drug-injecting women and men, as much as we need sterile needle programs to save the lives of persons who inject drugs themselves.

8. Hepatitis C – A Sometimes Deadly Disease Where Sterile Needles Can Save Lives and Dollars

Hepatitis C is a blood-borne virus that spreads rapidly when people share needles. Difficult to treat, hepatitis C can result in death.

There is no vaccine available to prevent its spread.

People who inject drugs acquire hepatitis C infection rapidly through shared needles, with 50 to 80 percent of users testing positive within 6 to 12 months of beginning injection drug use. Injection drug use accounts for at least 60 percent of chronic hepatitis C infections in the United States.¹

Some people with hepatitis C live a normal life span without the virus significantly damaging the liver; other people develop irreversible scarring and distortion of the organ, resulting in fatal liver failure or liver cancer. After two decades, 10 to 20 percent those infected with hepatitis C are predicted to develop cirrhosis and 1 to 5 percent develop liver cancer. Persons infected with both HIV and chronic hepatitis C experience a faster progression of HIV disease than those infected only with HIV.

The treatment of last resort is a liver transplant. Each transplant costs an average of \$300,000. It is estimated that, short of transplant, standard care for a person with advanced cirrhosis of the liver or liver cancer costs \$20,000 a year.

Prior to 1992, when an effective test for the presence of hepatitis C in donated blood was developed, people who had blood transfusions were at risk for hepatitis C. That risk is now extremely low, in the range of 1 in 100,000 units transfused.

The risk of sexual transmission of hepatitis C, though much lower than the risk associated with contaminated needles, is still present. The highest rates of sexual transmission are associated with multiple sex partners, and the increased risk may be associated with traumatic sex that results in blood exposure. Long-term monogamous sexual partners of persons infected with hepatitis C have very low rates of becoming infected (0 to 4 percent).

Thus, as with AIDS, we have a deadly epidemic of a blood-borne disease where exposure through blood transfusion has been almost eliminated and where a major factor in the spread of the disease is sharing needles.²

The first step in the prevention of hepatitis C among people who inject drugs — needle exchange — is very inexpensive. Without prevention, there can be pain, suffering, death — and expensive medical bills.

*With hepatitis C,
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is sharing needles.*

9 Medical Treatment for AIDS Is AIDS Prevention: African Americans and Latinos Are Disadvantaged

The new AIDS medicines and related services have extended life for many thousands of people with HIV/AIDS. Unfortunately, African American and Latino AIDS patients are not benefiting as much as whites from these new medicines and services. One study found that the racial/ethnic differences in receipt of treatment could not be explained by other key characteristics of the patients.¹

The racial/ethnic differentials in AIDS treatment are reflected in the 1998 AIDS death statistics.

- The AIDS death rate for African Americans who injected drugs was one-third higher than the rate for whites who injected drugs.
- The AIDS death rate for Latinos who injected drugs was 10 percent higher than the rate for whites who injected drugs.²

Lack of appropriate care is a personal tragedy for any person with HIV/AIDS, but its consequences extend beyond that person out into the surrounding community. Patients whose viral load is low are much less likely to transmit HIV to their partners during unprotected sex than AIDS patients whose viral load is high.³ Since sexual partners are often drawn from an individual's own racial/ethnic group, this means it is likely that the suboptimal care received by African American and Latino AIDS patients is translating into more new infections among blacks and Latinos than might be the case if the black and Latino AIDS patients were receiving optimal care.

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Latino migration, AIDS care, and new infections

Poor Latino immigrants who have come to the United States without proper documentation are not eligible for financial assistance with their medical care.⁴ This means they are less likely to be tested for HIV and if tested, to get appropriate medical treatment. The U.S. Immigration and Naturalization Service might eventually find these ill individuals and deport them. But, in the meantime, they are here. If they have HIV, they may well have contracted the disease here; but, in any case, they are human beings who need medical help. They need help both for their own sake, and for the sake of their wives, husbands and lovers who are their uninfected sexual partners.

10. What Must Be Done

As a society, we claim to be concerned about the health and welfare of our citizens who use illegal drugs. Yet we provide methadone maintenance, the most effective treatment for heroin addiction, to less than one heroin user in five, at the same time that we provide almost unlimited funds to imprison users.

The Centers for Disease Control and Prevention tells us that the most effective way to prevent the spread of AIDS among injecting drug users is to make sure that each injection is made with a new, sterile needle; yet, in many cities and states, we use the government's police power to prevent injecting drug users from getting access to sterile needles.

We believe in equality before the law, but in at least some cities and states, we permit the police to practice racial profiling, causing HIV to spread much more rapidly among African Americans and Latinos than among whites who inject drugs — when, in reality, we do not want anyone to get HIV.

We spend hundreds of millions of dollars for HIV prevention, yet not one federal prevention dollar can be spent for needle exchange programs, the most effective prevention technique for injection drug users, the group that now accounts for half of all new HIV infections.

We are concerned about rising medical costs, yet ignore the fact that it costs much less to prevent the spread of HIV through needle exchange programs than it does to treat HIV.

We spend hundreds of millions of dollars to treat people with HIV. No one would defend having racial preferences in how we spend those dollars. Yet our best information is that, because of inade-

quate treatment, African Americans and Latinos who inject drugs are dying from AIDS in proportionately higher numbers than whites who inject drugs.

Every year, 10,000 African Americans who inject drugs are infected with HIV. Every year, 4,500 Latinos who inject drugs are infected with HIV. Every year, 5,500 people of other races who inject drugs are infected with HIV. We must meet this challenge:

- We must make drug treatment available to all who need it, regardless of race/ethnicity.
- We must make AIDS treatment available to all who need it, regardless of race/ethnicity.
- We must make federal HIV prevention dollars available for needle exchange programs and other programs that increase access to sterile syringes.
- We must follow the lead of states like Connecticut and Hawaii. We must reform our state laws and regulations to:
 - Permit and fund needle exchange programs
 - Permit pharmacies to sell syringes without prescriptions
 - Permit possession of sterile needles and related injection equipment
 - Recognize that HIV prevention is a legitimate medical purpose and encourage physicians to write syringe prescriptions for people who inject drugs.

As a humane society, we can do no less.

11 • Endnotes

1. Health Emergency: The Spread of AIDS Among African Americans Who Inject Drugs

¹ **The Centers for Disease Control and Prevention (CDC) estimates there are 40,000 new HIV infections every year.** CDC, “Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome,” *Morbidity and Mortality Weekly Report*, 1999, vol. 48, no. RR-13, page 19. **Our best estimate is that half of all new HIV infections are occurring among injecting drug users.** See Scott D. Holmberg, “The Estimated Prevalence and Incidence of HIV in 96 Large U.S. Metropolitan Areas,” *American Journal of Public Health*, May 1996, vol. 86, no. 5, pages 642-654. **The breakdown of the 20,000 new infections among injecting drug users by race is based on the distribution of new AIDS cases by race for 1999.** See CDC, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1999, vol. 11, no. 2, tables 9 and 11.

² Excludes heterosexual partners of IDUs. Unpublished data from the CDC. Definitions are the same as in CDC, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1999, vol. 11, no. 2, tables 26-31.

³ Data from emergency departments in hospitals in areas where the prevalence of HIV infection is high indicate that half of infected persons are unaware of their HIV infection. CDC, *Morbidity and Mortality Weekly Report*, “Anonymous or Confidential HIV Counseling and Voluntary Testing in Federally Funded Testing Sites – United States, 1995-1997,” June 25, 1999, vol. 48, no. 4, pages 509-513.

⁴ CDC, “Deaths: Final Data for 1998,” National Vital Statistics Reports, Hyattsville, MD: National Center for Health Statistics, by Sherry L. Murphy, vol. 48, no. 11, July 24, 2000.

⁵ For African Americans, this estimate is based on the number of IDUs and MSM living with AIDS plus 39 percent of the number living with AIDS exposed through heterosexual sex in 1998 as taken from a special tabulation from the CDC. The “39 percent” for those exposed through heterosexual sex with an IDU is derived from the distribution of cumulative AIDS cases among African Americans reported in CDC, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1998, vol. 10, no. 2.

⁶ See Dawn Day and Reuben Cohen, “Race and the Spread of HIV/AIDS Related to Injection Drug Use,” Princeton, NJ: Dogwood Center, April 1996, 11 pages (available on the web at www.dogwoodcenter.org keyword “Dogwood Center publications”); and a CDC survey of HIV seroprevalence among persons in drug treatment in 1991 and 1992. In that study, the median HIV seroprevalence for blacks was 18.4 percent; for whites, it was 3.8 percent. CDC, *National HIV Serosurveillance Summary: Results Through 1992*, vol. 3, page 19.

⁷ David R. Holtgrave, Steven D. Pinkerton, T. Stephen Jones, Peter Lurie, and David Vlahov, “Cost and Cost-Effectiveness of Increasing Access to Sterile Syringes and Needles as an HIV Prevention Intervention in the United States,” *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, vol. 18 (supplement), 1998, pages S133-S138.

⁸ For more information on racial profiling and its consequences, on the web, go to www.dogwoodcenter.org and then to the keyword “racial profiling.”

⁹ Based on unpublished arrest data from the FBI, blacks were about 4.4 times as likely to be arrested on drug charges than whites. Based on data from the National Household Survey on Drug Abuse, blacks were about 1.8 times as likely as whites to use heroin or inject drugs in the past year. Taken together, this means that black drug users were about 2.4 times as likely to be arrested as white drug users. The drug use data are from U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, *National Household Survey on Drug Abuse: Population Estimates 1998*.

¹⁰ William K. Rashbaum, “Review Board Staff Faults Police on Stop-and-Frisk Reports,” *New York Times*, April 28, 2000, page B1.

¹¹ J.H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment*, New York: Free Press, 1993, 2nd edition. For more information, on the web, go to www.dogwoodcenter.org and then to the keyword “Tuskegee syphilis experiment.”

¹² Y. Lu, V.R. Nerurkar, W.M. Dashwood, C.L. Woodward, and others, “Frequencies of the CC Chemokine Receptor 5 Delta 32 Allele in Various Populations of Defined Racial Background,” *International Journal of Infectious Diseases*, Summer 1999, vol. 3, no. 4, pages 186-191; F. Libert, P. Cochaux, G. Beckman, M. Samson, and others, “The Deltacrt Mutation Conferring Protection Against HIV-1 in Caucasian Populations Has a Single and Recent Origin in Northeastern Europe,” *Human Molecular Genetics*, March 1998, vol. 5, no. 3, pages 399-406.

2. Health Emergency: The Spread of AIDS Among Latinos Who Inject Drugs

¹ **The Centers for Disease Control and Prevention (CDC) estimates that there are 40,000 new HIV infections every year.** CDC, “Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome,” *Morbidity and Mortality Weekly Report*, 1999, vol. 48, No. RR-13, page 19. **Our best estimate is that half of all new HIV infections are occurring among injecting drug users.** See Scott D. Holmberg, “The Estimated Prevalence and Incidence of HIV in 96 Large U.S. Metropolitan Areas,” *American Journal of Public Health*, May 1996, vol. 86, no. 5, pages 642-654. **The breakdown of the 20,000 new infections among injecting drug users by race is based on the distribution of new AIDS cases by race for 1999.** See CDC, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1999, vol. 11, no. 2, tables 9 and 11.

² Excludes heterosexual partners of IDUs. Unpublished data from the CDC. Definitions are the same as in CDC, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1999, vol. 11, no. 2, tables 26-31.

³ Data from emergency departments in hospitals in areas where the prevalence of HIV infection is high indicate that half of infected persons are unaware of their HIV infection. CDC, *Morbidity and Mortality Weekly Report*, “Anonymous or Confidential HIV Counseling and Voluntary Testing in Federally Funded Testing Sites – United States, 1995-1997,” June 25, 1999, vol. 48, no. 4, pages 509-513.

⁴ CDC, “*Deaths: Final Data for 1998*,” National Vital Statistics Reports, Hyattsville, MD: National Center for Health Statistics, by Sherry L. Murphy, vol. 48, no. 11, July 24, 2000.

⁵ For Latinos, this estimate is based on the number of IDUs and MSM living with AIDS plus 41 percent of the number living with AIDS exposed through heterosexual sex in 1998 as taken from a special tabulation from the CDC. The “41 percent” for those exposed through heterosexual sex with an IDU is derived from the distribution of cumulative AIDS cases among Latinos reported in CDC, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1998, vol. 10, no. 2.

⁶ The estimate of 1.5 to 1 is derived from a study of injecting drug users in drug treatment, done in 1991-92. CDC, *National HIV Serosurveillance Summary, Results Through 1992*, vol. 3, page 19. Based on a comparison in heroin use and needle use in the past year (3-year average for 1996 - 1998) and AIDS cases among injecting drug users by race/ethnicity for 1998, the difference between the two groups would be even greater, with Latinos who inject drugs about four times as likely as whites to get AIDS. The drug use data are from the *National Household Survey of Drug Abuse*. The AIDS data are unpublished data from the CDC.

⁷ CDC, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1999, vol. 11, no. 2, table 20.

3. A Neglected Opportunity: Drug Treatment as AIDS Prevention

¹ Office of National Drug Control Policy, *National Drug Control Strategy: 2000 Annual Report*, Washington, D.C.: U.S. Government Printing Office, page 54.

² New federal rules for methadone maintenance have been proposed that are intended to increase accessibility, quality, and oversight of methadone treatment. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration, “*New Federal Rules Proposed to Improve Quality and Oversight of Methadone Treatment*,” press release, July 22, 1999.

³ Luran Neergaard, “Study: Treatment Best for Addicts,” Associated Press, March 18, 1999.

⁴ Christopher S. Wren, “Top U.S. Drug Official Proposes Shift in Criminal Justice Policy,” *New York Times*, December 9, 1999, page A23; and George D. Lundberg, “New Winds Blowing for American Drug Policies,” *Journal of the American Medical Association*, September 17, 1999, pages 946-947.

⁵ Cost of methadone maintenance from David C. Lewis and June E. Osborn, “A Waste of Lives and Money,” *Washington Post*, July 20, 1998, page A17. Cost of prison from Office of National Drug Control Policy, *National Drug Control Strategy: 2000 Annual Report*, Washington, D.C.: U.S. Government Printing Office, page 63.

⁶ Office of National Drug Control Policy, *National Drug Control Strategy: 2000 Annual Report*, Washington, D.C., U.S. Government Printing Office, page 54.

4. The Scientific Evidence: Needle Exchange Programs Prevent HIV and Can Reduce Drug Use

¹ Centers for Disease Control and Prevention (CDC), “Drug-Associated HIV Transmission Continues in the United States,” August 1999. For a link to this pamphlet, go to the keyword “Centers for Disease Control and Prevention,” on www.dogwoodcenter.org.

² The reports are by the (1) National Commission on AIDS, (2) General Accounting Office, (3) University of California, (4) National Research Council and Institute of Medicine, (5) Office of Technology Assessment of the U.S. Congress, (6) National Institutes of Health Consensus, and most recently, in March 2000, (7) Surgeon General David Satcher. The reports are available in their entirety (5 reports) or in executive summary (2 reports) on the web at www.dogwoodcenter.org. Go to the keyword “needle exchange, scientific evidence for.”

³ For a link to the American Medical Association website on this issue go to www.dogwoodcenter.org. Then go to keyword “American Medical Association.” For a link to the statement by the American Pharmaceutical Association and other professional associations on pharmacy sale of syringes, go to www.dogwoodcenter.org. Then go to the keyword “American Pharmaceutical Association.”

⁴ David Satcher, “Evidence-Based Findings on the Efficacy of Syringe Exchange Programs: An Analysis of the Scientific Research Completed Since April 1998, Washington, D.C.: U.S. Department of Health and Human Services, March 17, 2000. Report sent from Secretary Donna Shalala to Congresswoman Nancy Pelosi. Available on the web at www.dogwoodcenter.org. Go to the keyword “needle exchange programs, scientific evidence for.”

⁵ Edward H. Kaplan and Elaine O’Keefe, “Let the Needles Do the Talking! Evaluating the New Haven Needle Exchange,” *Interfaces*, January-February 1993, vol. 23, no. 1, pages 7-26. Robert Heimer, Kaveh Khoshnood, P. Clay Stephens, Bini Jariwala Freeman, and Edward H. Kaplan, “Evaluating a Needle Exchange Programme: Models for Testing HIV-1 Risk Reduction,” *International Journal of Drug Policy*, vol. 7, no. 2, 1996, pages 123-129.

⁶ **Baltimore:** R. Brooner, M. Kidorf, V. King, P. Bielensohn, D. Svikis, and D. Vlahov, “A Drug Abuse Treatment Success Among Needle Exchange Participants,” *Public Health Reports*, vol. 113, supplement 1, pages 130-139, June 1998. S. Strathdee, D. Celentano, and others, “Needle Exchange Attendance and Health Care Utilization Promote Entry into Detoxification,” *Journal of Urban Health*, in press. **Seattle:** H. Hagen, J.P. McGough, and others, “Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle Exchange Participation in Seattle Drug Injections,” *Journal of Substance Abuse Treatment*, in press. **Hawaii:** Don C. Des Jarlais, Mark Breda, and Suzette Smetka, *Hawaii Syringe Exchange Program: 1997 Evaluation Report*, available from the Chow Project, 710 North King Street, Room #5, Honolulu, Hawaii, 96817; 37 pages plus figures.

⁷ Ricky N. Bluthenthal, “Impact of Law Enforcement on Syringe Exchange Programs: A Look at Oakland and San Francisco,” *Medical Anthropology*, 1997, vol. 18, pages 61-83.

5. The Legality of Saving Lives

¹ Centers for Disease Control and Prevention (CDC). “Drug-Associated HIV Transmission Continues in the United States,” August 1999. For a link to this pamphlet, go to the keyword “Centers for Disease Control and Prevention” on www.dogwoodcenter.org.

² Lawrence O. Gostin, Zita Lazzarine, T. Stephen Jones, and Kathleen Flaherty, “Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users: A National Survey on the Regulation of Syringes and Needles,” *Journal of the American Medical Association*, January 1, 1997, vol. 277, pages 53-62.

³ **The overview of the process of needle access reform** is based on Dr. Dawn Day’s numerous conversations with leaders in the needle exchange movement. **The information on the legal situation** in particular states with regard to prescription laws or paraphernalia laws is taken from Scott Burris, Peter Lurie, Daniel Abrahamson, and Josiah D. Rich, “Physician Prescribing of Sterile Injection Equipment to Prevent HIV Infection: Time for Action,” *Annals of Internal Medicine*, August 2000, vol. 133, pages 218-226. **The information on the physician prescription experience in Rhode Island** is taken from Josiah D. Rich, “Physician Syringe Prescription to Prevent HIV in Rhode Island,” presentation at the North American Syringe Exchange Convention, Portland, Oregon, April 2000. **For more information** on “physician prescription of syringes” and “drug paraphernalia laws,” see those keywords at www.dogwoodcenter.org.

⁴ W. M. Compton, L. B. Cottler, S. H. Decker, and others, “Legal Needle Buying in St. Louis,” *American Journal of Public Health*, 1992, vol. 82, no. 4, pages 595-596. Another study found that when the state closed the local needle exchange, the pharmacists in the area who previously had been selling needles over the counter began refusing to sell syringes without a prescription. Robert S. Broadhead, Yael van Hulst, and Douglas D. Heckathorn, “The Impact of a Needle Exchange’s Closure,” *Public Health Reports*, September/October 1999, vol. 114, pages 439-447.

⁵ The information on needle exchange programs in 1998 is taken from Denise Panoë, Don C. Des Jarlais, Mytri Pritam Singh, Courtney McKnight, and Stephen Titus, “National Syringe Exchange Survey 1998,” presentation at the North American Syringe Exchange Convention, Portland, Oregon, April 2000. The 1997 information is from “Update: Syringe Exchange Programs – United States, 1997,” *Morbidity and Mortality Weekly Report*, August 14, 1998, vol. 47, no. 3, pages 652-655.

⁶ Paone and her colleagues define legal needle exchange programs as those operating in states that had no law requiring a prescription to purchase a hypodermic syringe or that had an exemption to the law allowing the program to operate. Illegal-tolerated programs operated in states with a prescription law and received a formal vote of support or approval of a local elected body such as a city council. Illegal-underground exchanged operated in states with a prescription law and did not have formal support of local elected officials.

⁷ Scott Burris, Davis Finucane, Heather Gallagher, and Joseph Grace, “The Legal Strategies Used in Operating Syringe Exchange Programs in the United States,” *American Journal of Public Health*, August 1996, vol. 86, pages 1161-1166.

⁸ This is what happened in New Jersey. See Dawn Day, “Sad Termination of a Life-Saving Project,” *Trenton Times*, December 25, 1998, page A13. Available on the web at www.dogwoodcenter.org. Go to the keyword “Dogwood Center Publications.”

⁹ Ricky N. Bluthenthal, Alex H. Kral, Jennifer Lorvick, and John K. Watters, 1997, "Impact of Law Enforcement on Syringe Exchange Programs: A Look at Oakland and San Francisco," *Medical Anthropology*, vol. 18, pages 61-83.

¹⁰ Dawn Day, *States and Metro Areas Hardest Hit by the HIV/AIDS Epidemic*, Princeton, N.J.: Dogwood Center, November 1999. For the full report, go to www.dogwoodcenter.org; then go to the keyword "States in the U.S. with the highest rates of injection-related AIDS."

¹¹ The figure of 50 new HIV infections each day from using HIV-infected needles comes from dividing 20,000 by 365. **The CDC estimates there are 40,000 new HIV infections every year.** CDC, "Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome," *Morbidity and Mortality Weekly Report*, 1999, vol. 48, no. RR-13, page 19. *Our best estimate is that half of all new HIV infections are occurring among injecting drug users.* See Scott D. Holmberg, "The Estimated Prevalence and Incidence of HIV in 96 Large U.S. Metropolitan Areas," *American Journal of Public Health*, May 1996, vol. 86, no. 5, pages 642-654.

6. Saving Lives and Saving Billions of Health Care Dollars

¹ David R. Holtgrave, Steven D. Pinkerton, T. Stephen Jones, Peter Lurie, and David Vlahov, "Cost and Cost-Effectiveness of Increasing Access to Sterile Syringes and Needles as an HIV Prevention Intervention in the United States," *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 18 (supplement), 1998, pages S133-S138.

² In 1989, Congress declared that no federal money could be spent to support clean-needle programs until the federal government could provide scientific evidence that such programs both reduced the spread of HIV and did not encourage drug use. In April 1998, after a meticulous review of the scientific evidence, Health and Human Services Secretary Donna Shalala certified that the congressional mandate had been met. While Secretary Shalala did certify that needle exchange programs are effective, she did not release federal HIV prevention funds for this purpose. As of this writing, she has still not done so. For more detail, see www.dogwoodcenter.org, keyword "needle exchange, federal ban on funding."

³ Sheryl Gay Stolberg, "Clinton Decides Not to Finance Needle Program," *New York Times*, April 21, 1998, page A1.

⁴ Paul Bedard, "'Black Caucus Targets Drug Czar," *Washington Times*, April 25, 1998, page 1.

⁵ Letter from Representative Xavier Becerra and Representative Maxine Waters to Secretary of Health and Human Services Donna Shalala, February 9, 1998.

⁶ Kweisi Mfume, chief executive of the NAACP, "Letter to the Editor," *New York Times*, July 11, 1998, page A10.

⁷ In fiscal year 1999, the federal government spent \$6.8 billion on care and assistance to people with HIV/AIDS. Since the number of people infected through injecting drug use were over a third of all persons living with AIDS in the United States in 1998, a substantial portion of these funds being spent for AIDS treatment is being spent for treatment for them. Richard Sorian and Jennifer Kates, “The State of the HIV/AIDS Epidemic in America,” Kaiser Family Foundation Capitol Hill Briefing Series on HIV/AIDS, April 2000, Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1999, vol. 11, no. 2, table 28.

7. Health Emergency: African American and Latina Women and Their Children.

¹ In this section, information on women living with AIDS is from the Centers for Disease Control and Prevention (CDC), *HIV/AIDS Surveillance Report*, Cases Reported Through December 1999, vol. 11, no. 2, and from a special tabulation from the CDC.

² CDC, Fact Sheet: “HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk.” On CDC website, updated August 1999.

³ In this section, information on AIDS death rates for both African American women and Latinas is taken from table 9, CDC, “Deaths: Final Data for 1998,” National Vital Statistics Reports, Hyattsville, MD: National Center for Health Statistics, by Sherry L. Murphy, vol. 48, no. 11, July 24, 2000.

⁴ CDC, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1999, vol. 11, no. 2, table 16.

⁵ The estimate takes into account the deaths to AIDS-infected children, so the estimate refers only to children alive in 1998. Personal communication from David Michaels based on his article, “Estimates of the Number of Motherless Youth Orphaned by AIDS in the United States,” *Journal of the American Medical Association*, December 23/30, 1992, vol. 268, no. 24. UNAIDS reported an estimate of 70,000 orphans for the United States for 1997. UNAIDS, *Report on the Global HIV/AIDS Epidemic*, New York City: UNAIDS, June 1998, page 66.

⁶ Howard Minkoff and Nanette Santoro, “Ethical Considerations in the Treatment of Infertility in Women with Human Immunodeficiency Virus Infection,” *New England Journal of Medicine*, June 8, 2000, vol. 342, no. 23, pages 1748-1750.

⁷ Based on cumulative AIDS cases among women through 1998. CDC, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1998, vol. 10, no. 2.

⁸ The 16 African countries and their infection rates are: Botswana (36 percent), Swaziland (25 percent), Zimbabwe (25 percent), Lesotho (24 percent), Zambia (20 percent), South African (20 percent), Namibia (20 percent) Malawi (16 percent), Kenya (14 percent), Central African Republic (14 percent), Mozambique (13 percent), Djibouti (12 percent), Burundi (11 percent), Rwanda (11 percent), Ivory Coast (11 percent) and Ethiopia (11 percent). Lawrence K. Altman, “U.N. Warning AIDS Imperils Africa’s Youth,” *New York Times*, June 28, 2000, page A1.

⁹ Special tabulation from the CDC.

¹⁰ Kathleen J. Sikkema, Jeffrey A. Kelly, Richard A. Winette, Laura J. Solomon, and others, “Outcomes of a Randomized Community-Level HIV Prevention Intervention for Women Living in 18 Low-Income Housing Developments,” *American Journal of Public Health*, January 2000, vol. 90, no. 1, pages 57-63.

¹¹ Based on cumulative AIDS cases through 1999. CDC, *HIV/AIDS Surveillance Report*, Cases Reported Through December 1999, vol. 11, no. 2.

8. Hepatitis C – Another Serious Disease Where Sterile Needles Can Save Lives and Dollars

¹ This section is based on material from 3 sources: (1) National Institutes of Health Consensus Development Statement, Management of Hepatitis C, March 24-26, 1997, 30 pages; (2) Jerome Groopman, “The Shadow Epidemic,” *New Yorker*, May 11, 1998, pages 48-60; and (3) National Institute on Drug Abuse, Community Drug Alert Bulletin, “Hepatitis C,” May 2000; 4 pages.

² Although not as widespread as hepatitis C, hepatitis B is another virus infecting the liver that spreads through sharing infected syringes or unprotected vaginal, anal, or oral sex. Most people recover from hepatitis B within six months and afterward develop immunity. Some 5 to 10 percent of the people who get hepatitis B remain contagious for the rest of their lives and develop chronic liver disease, with all its attendant problems. The presence of either hepatitis A or hepatitis B causes the disease of a person with hepatitis C to progress more rapidly. “Hepatitis Facts for Injectors,” distributed by the University of California, San Francisco, and the Department of Epidemiology and Biostatistics, San Francisco, General Hospital, March 1997.

9. Medical Treatment for AIDS Is AIDS Prevention: African Americans and Latinos Are Disadvantaged

¹ This finding comes from a study involving a nationally representative sample of the U.S. population infected with HIV receiving regular medical care and covering the period 1996 to early 1998. AIDS care improved throughout the study period, but that at the end of the study period, Blacks and Latinos still had less desirable patterns of AIDS care than whites. Women, the uninsured and Medicaid-insured also had less desirable patterns of care. M.F. Shapiro, S.C. Morton, D.F. McCaffrey, J.W. Senterfitt, and others, “Variations in the Care of HIV-Infected Adults in the United States: Results from the HIV Cost and Services Utilization Study,” *Journal of the American Medical Association*, June 23-30, 1999, vol. 281, no. 24, pages 2305-2314.

A March 2000 General Accounting Office (GAO) study reported that U.S. AIDS funds serve vulnerable groups in higher proportions than their representation in the AIDS population. The apparent conflict between this study and the study by Shapiro and others cited above can be resolved by recognizing that U.S. AIDS funds are a safety net and that many people pay for their AIDS care with private insurance. The GAO study included only government funds. Shapiro’s study looked at resources available to AIDS patients from both public and private sources. GAO, *HIV/AIDS: Use of Ryan White CARE Act and Other Assistance Grant Funds*, letter report, March 1, 2000, GAO/HEHS-00-54.

² AIDS deaths to injecting drug users in 1998, divided by the number of IDUs living with AIDS in 1998 for each racial/ethnic group. Data from a special tabulation from the Centers for Disease Control and Prevention. By definition, people living with AIDS already have the disease, so the genetic protection that whites have from contracting HIV is not a factor here. It is very likely that U.S. statistics on Latino AIDS deaths are low because unknown numbers of legal and illegal immigrants return to their home country to be with family when they die.

³ Thomas C.Quinn, Maria J. Wawer, Nelson Sewankambo, David Serwadda, and others, “Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1,” *New England Journal of Medicine*, March 30, 2000, vol. 342, no. 13, pages 921-929.

⁴ Somini Sengupta, “Law Curtails Help for Illegal Immigrants with AIDS,” *New York Times*, December 29, 1997, page B1.

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