HIV/AIDS Among Intravenous Drug Users: 
The Fight for Legitimate Access to Sterile Syringes

Master of Public Administration 
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Dr. Fred M. Jacobs  
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Dear Dr. Jacobs,

It is my pleasure to submit to you *HIV/AIDS Among Intravenous Drug Users: The Fight for Legitimate Access to Sterile Syringes*. I authored this report in fulfillment of my two Master’s degrees in Criminology and Public Administration at The Florida State University. Intravenous drug use and unsafe sexual practices are cited as the two most significant driving forces of the HIV/AIDS epidemic. Individuals who engage in such deviant behaviors and lifestyles are at the greatest risk of contracting or transmitting HIV/AIDS. This report examines the political underpinnings of America’s War on Drugs and specifically addresses its impact on drug policymaking and on the HIV/AIDS epidemic.

This study, in supporting New Jersey’s “Needle Bill” (A-1852/S-494), provides valuable background information as well as academic research that may be a helpful source of reference for the New Jersey Health and Senior Services. The Center for Disease Control and Prevention, the National Institute on Drug Abuse, and several other public health organizations agree that needle exchange programs are the most viable harm reduction intervention method for curbing the incidence of HIV/AIDS among intravenous drug users.

My study simultaneously tackles several complex issues regarding the philosophical and political overtones of drug control and health policymaking. There is a need to educate the public, criminal justice agencies, and others in order to overcome an epidemic that has long plagued our country and countries throughout the world. Politicians must use the guidance from medical professionals and public health organizations, rather than relying on mere moral guidance, to address the many facets of this issue.

Sincerely,

Nicole Rena Chinn
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Executive Summary

How society should regulate psychoactive and habit-forming substances has become a staple of American public policy discourse, whether the substance is legal (e.g., the harms associated with tobacco use seem to grow daily in number and severity), or illegal (e.g., cocaine, which is highly debated on whether prohibition does more harm than good). There is strong evidence that suggests the United States’ drug policies are punitive (in both rhetoric and reality), divisive (by race, class, and age), intrusive (depending on certain groups of people), and expensive (an estimated $40 billion annually). Even more distressing is the fact that the United States has a “drug problem” that is more severe than that of any other Western-industrialized nation, whether measured in terms of the extent of drug use, dependence on expensive drugs, the incidence of HIV/AIDS stemming from intravenous drug use, or the level of violence and corruption associated with black-market drugs (Nadelmann, 2004; Reuter, 1997).

Many claim the American drug problem is the result of the nation’s failed drug policy strategies. Under the current system, drug users are often regarded as criminals first, and secondarily as individuals in dire need of treatment. Since the birth of the HIV/AIDS epidemic during the Reagan Administration in 1981, intravenous drug use has been identified as a driving force in the spread of the disease. As of 2004, the Center for Disease Control and Prevention (CDC) claimed that intravenous drug users accounted for one-fifth of HIV and other blood-borne infections in the United States. Furthermore, the CDC identified needle sharing and the reuse of dirty needles as the direct causes of HIV/AIDS infection. Strictly enforced drug paraphernalia laws, syringe prescription laws, pharmacy regulations and practice guidelines, and restrictions on needle exchange programs were identified as the indirect causes of the disease. While liberals contend the harshness of the overall drug policy regime has generated HIV/AIDS and the violent crime that surrounds drug use, conservatives argue that the lack of stringent drug enforcement
explains why drugs are so widely used and available. Both sides are neither right nor wrong. The United States’ handling of its drug problems is rooted in (political) ideology and dominated by criminal justice agencies. Severe sanctions have been applied to violators in a futile effort to discourage their further involvement in illegal enterprises and deter others from following the same path. An objective and principal defense of the American prohibition system is its (moral) necessity to prevent far greater numbers of people from becoming involved with drugs and drug-related behaviors in ways that harm themselves and others.

Five solution/policy options are evaluated through an analysis of available literature; a review of current and proposed legislation; and government and advocacy group Internet web sites. These options include the following: (1) primary drug prevention with the Controlled Substance Act of 1970 as its legal foundation, (2) needle exchange program legislation, (3) physicians’ prescription of syringes, (4) community outreach programs, and (5) needle disinfection. The options are divided into two categories – traditional and comprehensive – which are evaluated according to five criteria: (1) effectiveness, (2) costs/efficiency, (3) equity, (4) administrative burden, and (5) political feasibility. Based on the assessment of options using the criteria, the recommended option is needle exchange program legislation. As a comprehensive approach similar to harm reduction, needle exchange programs have been demonstrated as the most capable in curbing the incidence of HIV/AIDS in the United States and beyond. The remaining options under the comprehensive category – physicians’ prescription of syringes, community outreach programs, and needle disinfection – are also found to be more capable of reducing the incidence of HIV/AIDS than the traditional category, primary drug prevention.
I. Problem Statement

The issues of substance abuse, addiction, and HIV/AIDS transmission related to intravenous drug use remain serious public health challenges, and the need to define and implement effective public health interventions remains urgent. Scientific research continues to define the unique role that comprehensive harm reduction programs can play in curtailing the expansion of the HIV/AIDS epidemic in vulnerable American populations affected by substance abuse, as part of a well designed and implemented comprehensive HIV/AIDS prevention strategy (Evidence-Based Findings on the Efficacy of Syringe Exchange Programs).

America’s War on Drugs and stringent drug legislation has affected drug use and the availability of sterile syringes as well as the health of intravenous drug users. The drug war was intended to intensively enforce the Controlled Substances Act of 1970\(^1\). The emergence of new cases (in addition to confirmed cases) of HIV/AIDS infections directly related to intravenous drug use, sexual contact, and babies borne to HIV-infected mothers has begun to emphasize America’s need for drug policy reform (Holmberg, 1996; Evidence-Based Findings on the Efficacy of Syringe Exchange Programs). “Drug addiction is not just a brain disease; there are contributions of biology, behavior, and environment” (Millstein & Leshner 2000:151). While an individual’s biological heritage cannot be controlled or changed, prevention programs, often sponsored by public health organizations, emphasize the behavioral and environmental dimensions of drug use that are likely to have the greatest impact on various health outcomes\(^2\).

Intravenous drug use, drug-using cultures, and unsafe sexual and drug-using practices, which have contributed to the spread of HIV/AIDS and other blood-borne diseases, have been

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\(^1\) The Controlled Substances Act (CSA), or Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, is the legal basis of the war on drugs. The CSA categorizes all known substances into five schedules, based on three criteria: (1) medical use, (2) potential for abuse, and (3) safety of use. America’s drug war, specifically, focuses on enforcing those substances classified under Schedule I and Schedule II.

\(^2\) Notably, however, such programs are the least amenable to rigorous impact evaluations given that it is typically difficult to randomly assign interventions across communities.
documented by countless academics and medical and health care professionals. Intravenous
drug-using behaviors that contribute to the spread of HIV/AIDS include needle sharing, reuse,
According to some of the most recent ethnographic works on the intravenous drug-using culture,
needle sharing is the result of limited or restricted access to sterile injection equipment (Koester,
1994; Des Jarlais, 1988); in a sense, the criminal justice approach to drug use and syringe
availability reinforces the drug-taking behaviors of the injection-drug-using culture.

“[A]ddressing the sharing and reuse of syringes by IDUs\(^3\), and the scarcity of syringes that
encourages it, is a major public health priority,” and that which can greatly reduce the

The focus of this Action Report is to examine the politics of public health and drug
control policymaking regarding HIV/AIDS and intravenous drug use. Issues to be addressed
include the political underpinnings of legislation that appears to condone illegal drug use and the
legal barriers to legitimate sterile syringe access. Past and present efforts taken to address
similar issues will be reviewed for adaptation when addressing public health and drug control
policies and drug-related behavior. The purpose of this Action Report is two-fold: (1) to
examine alternative legislative solutions to reduce the incidence of HIV/AIDS among
intravenous drug users, and (2) to recommend necessary actions that will serve as a model
available for use by any jurisdiction to target HIV/AIDS among a significant population affected
with the disease: intravenous drug users.

\(^3\) “IDUs” refers to intravenous drug users.
II. Background and Literature Review

Background

America’s War on Drugs has been a highly debated topic since its official declaration in 1972 by the Nixon Administration. “President Nixon started a war on drugs [as] the first intensive effort to enforce the prohibition of drugs since the original Harrison Act” (Friedman & Szasz 1992:49). Over the years, an enormous amount of academic literature, government reports, media and Internet sources has been produced by an array of professionals and academics of various political and non-political affiliations. Liberal academics and public health professionals tackle the social, economic, and political consequences of stringent drug control legislation. Pharmaceutical practices and guidelines and needle prescription laws, to name a few, govern physician-prescribed syringes and pharmaceutical sales of syringes to intravenous drug users. As a result of these laws, research has shown that possession of a syringe can result in arrest or harassment by law enforcement (Blumenthal, et al., 1999a). Specific populations are often targeted by law enforcement – homeless, African-Americans in inner-city areas, prostitutes – which therefore stimulates a furtive intravenous drug-using culture (Koester, 1994; Blumenthal, et al., 1999b).

The beginning of the HIV/AIDS epidemic emerged during the Reagan Administration in May 1981. During most of the 1980s, HIV/AIDS was widely recognized as a “gay disease,” called gay-related immunodeficiency (GRID), because five homosexual men in Los Angeles were diagnosed by the CDC with an immunodeficiency virus, just prior to the HIV/AIDS outbreak in the United States (AIDS, 1985). Tremendous media attention and press releases on the “gay disease,” thus generated a surge of homophobia (AIDS, 1985). About one year later, the CDC discovered the disease also occurred in heterosexuals with similar symptoms. In July 1982, the CDC re-named the disease, Acquired Immune Deficiency Syndrome (AIDS) (Masci,
2000). Each year during the latter half of the 1980s, as many as 150,000 people became infected with HIV/AIDS. In the 1990s, the rate of infection dropped significantly to approximately 40,000 each year, where it remains today.

The CDC played a vital and “heroic” role by initiating AIDS research when little was known about the disease and its causes. In the mid-1980s, government and public health officials were consumed with the goals of determining the causes of the outbreak, which killed over 10,000 people prior to the CDC’s diagnosis of the disease (AIDS, 1985). Blood transfusions and insect bites were examined and, subsequently, ruled out as direct causes of AIDS. Since homosexual and heterosexual sexual behaviors were important in contracting the disease, prostitutes were implicated in the spread of AIDS. Extensive research by the CDC concluded that HIV was a precursor to the AIDS virus – a “blood disease” – which can be contracted by three means: (1) risky sexual behaviors, (2) blood contamination (e.g., blood transfusion, intravenous drug use), and (3) births by infected mothers. As a result of this finding, individuals living deviant lifestyles were implicated as carriers of the disease and, to an extent, were also blamed for the spread of the disease.

The CDC found that 72 percent of reported cases with the disease were homosexual and bisexual men, including intravenous drug users, hemophiliacs, and children born to infected mothers (AIDS, 1985). In the present, HIV/AIDS remains a disease that stereotypically originated from homosexuals (men having sex with men) and intravenous drug users (NIDA, March 2006). Specific ethnic minority populations have been identified as major carriers of the disease and, thus, perceived as an additional group that is blameworthy for the HIV/AIDS epidemic. According to a 2003 report, published by The Henry J. Kaiser Family Foundation, “African-Americans are the most significantly affected racial/ethnic group in the U.S., as reflected in incidence, prevalence, and mortality trends over time.” Such a finding generated
several false assumptions about African-Americans, specifically African-American males and those residing in inner-city neighborhoods\textsuperscript{4}, and their sexual lifestyles\textsuperscript{5}.

Political attitudes toward HIV/AIDS have created a stir of public hysteria, fear, and stigma since the Reagan Administration (Republican). The government’s principal pattern of response to HIV/AIDS as a result of intravenous drug use is silence, inaction, and the sentiment, “Give them all dirty needles and let them die!”\textsuperscript{6} Despite federal opposition and inaction to create harm reduction programs, “most states have chosen to allow at least some access to sterile syringes” in order to eliminate the risk of infection as the result of unsafe injection-drug-using practices (Scotti, 2006). In fact, 48 states permit intravenous drug users legal access to syringes with a prescription, and a mere four jurisdictions kept syringe prescription and distribution illegal (Burris, et al., 2001). Clean needles cost as little as ten cents and, each year, billions are manufactured in the United States. The major impediments to clean needles for intravenous drug users, however, are the laws regarding drug paraphernalia possession, prescribed drug use, and illegal drug use and drug sale.

Today, in the 25\textsuperscript{th} anniversary of the HIV/AIDS epidemic, political agendas continue to oppose sterile syringe access for intravenous drug users because “making needles more accessible suggests that government is condoning an illegal – and destructive – activity” (Chen, \textsuperscript{4}

\textsuperscript{4} In his book, \textit{The Truly Disadvantaged}, William Julius Wilson (1987) emphasized that, during the 1960s, America’s Black inner-city neighborhoods comprised of norms, which deviated from those of the mainstream. These poor, isolated communities were found and observed to have a disproportionately high number of young, unmarried mothers; single-parent, female-headed households; out-of-wedlock births; drug and alcohol addictions; crime; and welfare dependency.

\textsuperscript{5} E.g., “Homothugs”\textsuperscript{5} emerged in early 2000 as a sexual lifestyle primarily among Latino and Black males, who identify as heterosexual, but engage in (often unprotected) sex with other men. Black males, who are participants of this subculture, alternate having casual sex with other men (irregardless of their sexual orientation) while having or maintaining intimate relationships with women (usually Black women), who are oblivious to their partner’s sexual lifestyle. Such a deviant subculture with high-risk sexual practices has been cited as a cause of the HIV/AIDS epidemic among the African-American population. See Phillip, M. (March 2005). Homothugs: Hip-hop’s secret homo underside. \textit{The Guide}.

\textsuperscript{6} Scotti, 2006. The article indicated that this phrase was publicly uttered by Judge Judy (Judy Sheindlin) of daytime television, when asked about availability of sterile syringes for intravenous drug users.
Government officials also find that supporting syringe access programs “sends the wrong message” and the act of injecting drugs violates several drug laws. In the United States today, 22 percent of HIV/AIDS infections are caused by sharing contaminated needles. Public health officials claim an array of harm reduction programs not only fulfill the goal of reducing the spread of HIV/AIDS, these programs also save lives. Thus, policymakers’ refusal to adopt syringe exchange programs is grounded in maintaining America’s moral composition and reveals their refusal to save the lives of those who engage in illegal and unapproved lifestyles (Scotti, 2006). The fact that current political actors, especially the President, oppose credible solutions to the HIV/AIDS epidemic based on moral considerations confirms Light’s (1991) argument that proposed solutions to national concerns involving high political and budgetary costs will most likely be rejected (as cited by Weissert & Weissert, p. 83).

While harm reduction intervention methods remain a largely avoided policy option, policymakers as well as our drug czar, John P. Walters, are in favor of educational programs (e.g., sex education, drug education) and treatment programs to discourage drug use (Chen, 2006). According to the CDC, well-designed and well-delivered HIV/AIDS prevention programs, which include needle exchange, have contributed to safer behaviors and have helped reduce the number of new infections. Positive program results also reflect sustained, focused, and collaborative efforts among federal agencies, foundations, prevention scientists, and state and local health departments” (CDC, The Past Two Decades). Among those who benefit from such politically controversial programs are intravenous drug users, sexually active men, women, and youths who are considered high-risk, and children born to HIV-infected mothers.

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7 This article indicates that, while the common goal is to decrease the overall spread of HIV/AIDS in this country, there is no compromise on the health care practices to obtain that goal.
8 See Scotti, 2006. See also Evidence-Based Findings on the Efficacy of Syringe Exchange Programs: An Analysis from the Assistant Secretary for Health and Surgeon General of the Scientific Research Completed Since April 1998.
9 John P. Walters is the Director of the Office of National Drug Control Policy.
Since the Reagan Administration, America’s combative efforts against HIV/AIDS have demonstrated a vast improvement through the development of proven-effective intervention programs. “The CDC now spends $720 million a year on HIV prevention” (Brown, 2006). As a result, intravenous drug users are offered an array of services, which can accompany their specific needs or preferences. Such prevention efforts include HIV counseling and testing, free condom distribution, and one-on-one or small group counseling sessions. Research conducted by the National Institute of Drug Abuse (NIDA) enables government and public health officials to learn more about the pivotal role of drug abuse in the HIV/AIDS epidemic. Furthermore, NIDA has established that “drug abuse treatment is HIV prevention” (NIDA, March 2006).

Early in the epidemic, drug abuse and HIV were typically connected in people’s minds with intravenous drug use and needle sharing. This view, however, greatly underestimates the impact that drug abuse, especially intravenous drug use, can have on the spread of HIV/AIDS through the dangerous risk behaviors it engenders. In other words, intravenous drug use intoxication affects judgment and can lead to risky sexual behaviors that put people in danger of contracting or transmitting HIV/AIDS (NIDA, March 2006; Mathias, 2002). In 2002, NIDA published a report claiming that American youths engage in unsafe drug use and sexual practices as young as age 13, thus, accounting for 18 percent of the reported AIDS cases (Zickler, 2002). This finding not only adds another frail population infected with HIV/AIDS, but requires more effective strategies to prevent and treat this disease.

The National Household Survey on Drug Abuse (NHSDA) published a report in 2003 that indicated Americans between the ages of 18 and 25 engaged in more risky behaviors than any other age category and are, thus, increasingly at risk of becoming infected with HIV/AIDS. Moreover, the NHSDA reported that a significant number of Americans within this age category admitted to using injection drugs. In a recent article published by The New York Times, the state
Health Department of New Jersey reported that more than 61,000 intravenous drug users were infected with HIV and more than 45,000 have full-blown AIDS (Sullivan, 2006). The New Jersey Health Department identified a few potential causes to New Jersey’s HIV infection rate: (1) intravenous drug users either cannot afford sterile syringes or cannot obtain legitimate access to them, and (2) needle sharing and subsequent unsafe sex with an infected partner (Sullivan, 2006). The President of the American Foundation for AIDS Research (AmfAR) emphasized that, while treatment options are not accessible to everyone infected with AIDS, AIDS research investments and breakthroughs have contributed to the sharp decline in AIDS-related mortality in the United States (Rosenfeld, 2005).

Many state and local jurisdictions still criminalize the possession of syringes and limit the ability of intravenous drug users to legally purchase syringes. In 2004, the CDC found that intravenous drug users accounted for one-fifth of those infected with HIV and other blood-borne diseases (CDC, July 2004). That same year, the CDC (2005) identified the following interrelated laws and regulations that restrict intravenous drug users accessibility to sterile syringes and their willingness to possess them: drug paraphernalia laws, syringe prescription laws, pharmacy regulations and practice guidelines, and restrictions against syringe exchange programs. According to the CDC, “laws and regulations are structural barriers that create a situation in which intravenous drug users who continue to inject are advised to use only sterile syringes, but at the same time, are often prevented from carrying out this advice” (CDC, December 2005). The AIDS infection rate among Americans fluctuated between the 1980s and 2000 as a result of limited health care and treatment options for those infected and less fortunate to financially qualify for treatment (CDC, July 2002). The CDC, like NIDA, is obligated to address these structural barriers by proposing initiatives to change syringe laws and regulations. The CDC essentially advocates the politically controversial harm reduction programs (e.g., needle
exchange). The CDC has also devised policy considerations that can satisfy the interests of public health and law enforcement officials: “(1) supporting initiatives to expand and improve collaboration and understanding between public health and law enforcement; (2) educating policymakers about the facts of injection-related transmission of blood-borne pathogens and the public health benefits of providing access to sterile syringes as part of a comprehensive public health approach; and (3) carrying out initiatives to educate and inform community leaders, physicians, pharmacists, law enforcement, and the public about the importance of access to sterile syringes to intravenous drug users as one component of a comprehensive approach to stopping drug use and reducing transmission of blood-borne diseases” (CDC, December 2005).

Literature Review

The relevant literature on the topic of HIV/AIDS among intravenous drug users was found in an array of academic and public health journals, government documents, and academic research databases (e.g., CQ Researcher, ProQuest, Lexis-Nexis, WilsonWeb). The works of drug policy analysts/analysis groups and drug policy entrepreneurs were primarily used to cover two themes: (1) studies and statistics that identify the nature of the HIV/AIDS epidemic among intravenous drug users as well as the prevalence and incidence, consequences, causes, and the appropriateness of governmental intervention (See Table 1); and (2) the legislative history regarding HIV/AIDS among intravenous drug users (See Table 2).

A Foreword on Drug Policy Analysts/Analysis Groups and Drug Policy Entrepreneurs

Drug policy analysis groups, or interest groups, were originally comprised of liberal academic scholars and actors within the field of criminal justice. Today, they are additionally staffed with scholars and professionals in public health, criminal justice, and recently those in the
field of medicine. Medical and public health officials, many of who are from bureaucratic health organizations\(^\text{10}\), have become increasingly involved in policy analysis since American mortality rates of HIV/AIDS cases have remained stable since the 1990s. Their objective is to reform American drug laws and to replace the current system with effective policies (e.g., harm reduction) that do not infringe on individual rights. Drug policy analysis groups have also become global and interactive. The contributions of the various disciplines and countries have changed the perception that drug policy encompasses more than moral and ideological institutions, incapable of reform. Together, they constitute drug policy entrepreneurs\(^\text{11}\). Some of the various participants of policy analysis are specialists: medical and public health practitioners identify the health and behavioral consequence of criminalizing syringe use and possession; academics and researchers generate proposals of successful drug policy alternatives; political parties are involved with using the ideas of the practitioners and academics/researchers for lobbying or campaign purposes. This merger has also expanded the scientific community in performing vast levels of research, which is used as a method to advise or influence policymakers and, in turn, improve American drug policy.

The focus of drug policy analysis groups is the behavioral and environmental effects of intravenous drug use, based on laws governing access to drug treatment, the sale of syringes by pharmacies, and harassment and arrest by law enforcement (Heimer, et al., 1996). Drug paraphernalia, drug possession, and drug treatment laws, in the United States, control and restrict the availability of health options to intravenous drug users. In countries that adopt a harm

\(^{10}\) Bureaucratic agencies of medical and public health include the Center for Disease Control and Prevention, the National Institute on Drug Abuse, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the U.S. Preventive Services Task Force, the American Medical Association, and the Association of State and Territorial Health Officials. Those that support needle exchange programs are the American Public Health Association, the American Medical Association, the National Academy of Sciences, the National Institutes of Health Consensus Panel and the AIDS Advisory Commissions of President George H. Bush and President Clinton.

\(^{11}\) Drug policy entrepreneurs are individuals who, through creativity, strategy, and networking in and around policy circles, are able to bring ideas for policy innovation into common currency and thus promote policy change.
reduction approach\textsuperscript{12}, injection equipment may legally be prescribed to intravenous drug users—an effective method advocated by public health experts that will minimize the spread of HIV/AIDS. The harm reduction approach would also allow physicians to prescribe syringes and enable pharmacists to sell syringes to intravenous drug users without the deterrent effect of violating drug laws. Often, pharmacies in the United States do not sell syringes to suspected intravenous drug users\textsuperscript{13}, and may demand a prescription even in states without prescription laws (Compton, et al., 1992; Taussig, et al., 2000). Thus, harsh enforcement practices and limited access to sterile injection equipment will continue to significantly affect the incidence of HIV/AIDS (Bruneau, 1997). In June 2000, the American Medical Association approved a resolution asking that “our [AMA] strongly support the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases” (as cited by Burris, et al. 2001, p. 18). Currently, 31 states and territories have syringe exchange programs in operation, including 10 with statutes explicitly authorizing such programs.

Drug policy entrepreneurs consist of an array of individuals and groups who are professionals and experts in the social and medical sciences, public health, and various aspects of government. They are also characterized as liberal utilitarians, who advocate harm reduction intervention programs as a method to reduce the spread of HIV/AIDS. Their position on the drug war debate centers on drug policy extremes to our current punitive system, such as legalization and harm reduction. Their intention is to propose economical drug policy alternatives that are cost-efficient, practical, and proven to deliver desired outcomes. Drug

\textsuperscript{12} Harm reduction is a public health approach of drug policy, which is largely practiced in Western European countries. This approach maintains the idea that drug use is inevitable and should be treated as an illness or disease rather than as a criminal offense.

\textsuperscript{13} Case, P., et al. (1998). Access to sterile syringes in Maine: pharmacy practice after the 1993 repeal of the syringe prescription law. \textit{Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology}, 18: p. S94. This article found that pharmacists choose to not sell syringes to suspected intravenous drug users despite the legalized sale of syringes without a prescription.
policy entrepreneurs manifest these qualities by demonstrating their determination to develop
resolutions to countless drug-related issues, worldwide.

Drug policy analysts have focused on media and publications (i.e., books, journal
articles) as major sources to garner official attention. These publications are featured and made
available through a variety of means: state and local libraries, agency- or government-affiliated
websites, the Internet, and encyclopedias. On the other hand, drug policy analysts have garnered
most of their attention from the press by attending or presenting at seminars. By attending
seminars, drug policy analysts are networking in and around the “policy circles”; by presenting
at seminars, drug policy analysts will be able to “‘go public,’ or take their case to the American
public, in the hope that constituents will then pressure…members of Congress” (Weissert &
Weissert, p. 78) to support their policy proposal. The aforementioned tactics used by drug policy
analysts to acquire public interest have enabled more groups and individuals to enlist into the
drug policy realm. These tactics have been, particularly, useful in academic institutions, such as
a university; for example, student-based coalitions exploring drug policy and drug-related issues
have recently emerged in universities, nationwide.

The President addresses issues on the public agenda by using resources compiled by drug
policy entrepreneurs and analysts – bureaucrats in planning, evaluation, and budget offices; the
White House staff; academics; interest groups; and researchers. The President weighs the
political costs and benefits when selecting issues to put on the public agenda. He often chooses
specific issues – mainly older issues that have appeared on previous agendas rather than new
issues – for strategic, political gain (Weisser & Weissert, p. 82). However, when serious issues
present a national concern, such as the HIV/AIDS epidemic among African-Americans in 2000
(CDC, February 2006), those issues are generally “propelled to the top of the nation’s policy
agenda” (Weissert & Weissert, p. 82). The President selects solution options based on budgetary
and political costs and constraints – the higher the costs, the more likely the solution option will be rejected. In addition, the President adopts a satisficing approach\(^{14}\), “choosing the first alternative that meets the policy needs rather than continuing the search for a ‘better’ solution” (Weissert & Weissert, p. 83). Since the President disapproves of the development of harm reduction programs as a method to reduce the prevalence and incidence rate of HIV/AIDS on moral grounds, he strategically supports traditional solution options that would educate and discourage risky behaviors associated with the disease (i.e., abstinence-only programs, drug education, drug treatment).

\(^{14}\)“Satisficing” refers to notion that administrators are inherently incapable of making the best possible decisions; rather, he/she attempts to make a good decision under a given circumstance.
III. Methodology and Evaluative Criteria

Methodology

Information for this Action Report was collected using the following methods:

- Reviewing *Governing Health* (2nd ed.), by Weisert & Weisert.
- Analyses of relevant academic and public health journals and media sources;
- Review of relevant statutes; and

- Review of governmental and advocacy group Internet websites, including publications from the Center for Disease Control and Prevention (e.g., Morbidity & Mortality Weekly Report), Drug Policy Alliance, and hearings from state health committees.

*Governing Health* (2nd ed.), by Weisert & Weisert (2002), was predominantly used as an aid in understanding the health policymaking process and the institutions that shape policymaking decisions. Pertinent themes to the formulation of drug policy and health policy, including political ideology, were addressed through the lens of political science theory.

The search for relevant statutes, academics and public health journals was conducted by using an online subscription service for academic and informational databases, including HeinOnline, WilsonWeb, Newsbank, and ProQuest databases. The academic and public health journals provided empirical research on the prevalence and incidence of HIV/AIDS among intravenous drug users, the behavioral implications of drug control laws and health policies, and the effectiveness and efficiency of programs that have been used to address HIV/AIDS among intravenous drug users. The media sources provided updated information on public opinion, the opinions of government officials, and the HIV/AIDS epidemic of individual states and cities.

State and federal statutes and hearings from state health committees that addressed intravenous drug use were primarily retrieved from the Lexis-Nexis database. A review of relevant statutes and committee hearings provided information on current and proposed language regarding HIV/AIDS among intravenous drug users. Finally, the review of the Internet websites

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of governmental and advocacy groups provided additional and unbiased educational and statistical information concerning HIV/AIDS among intravenous drug users.

**Evaluative Criteria**

The goal of this Action Report is to examine and compare five solution/policy options – Primary Drug Prevention (War on Drugs), needle exchange programs legislation, syringe prescription, community outreach programs, and needle disinfection. The options are divided into two categories, traditional and comprehensive, with the primary drug prevention option as the traditional category and the remaining options as the comprehensive category. All options will be evaluated according to five criteria: effectiveness, costs/efficiency, equity, administrative burden, and political feasibility. The options under the comprehensive category are evaluated together due to their vast similarities (See Table 3).

Solution/policy options are numerically assessed alongside each criterion based on the overtones of public health and drug policy reviews, which were conducted by a conglomeration of drug policy analysis groups and experts of public health and criminal justice. Each criterion is rank-ordered and assigned a weight factor between 1 and 5, with 1 being the least important factor to the solution option and 5 being the most important factor to the solution option. Each solution option is assigned a score, between 1 and 10, with 1 through 3 rated as low, 4 through 6 rated as medium, and 7 through 10 rated as high. A low score indicates that the specified solution option does not accomplish the aforementioned criteria. A medium score indicates that there is an average accomplishment of the criteria for the specified solution option. A high indicates that the specified solution option thoroughly fulfills the criteria.

The weighted score for each criterion is calculated by multiplying the weight factor of each criterion with the scores assigned to each solution option. The weighted score measures the
degree in which the solution/policy option has fulfilled each criterion based on personal perception and scientific review. A total unweighted score and a total weighted score is recorded after all scores have been assigned and calculated. The total unweighted score measures the solution/policy option based on research and personal inferences on whether the solution option fulfills (or is capable of fulfilling) the criteria. A high unweighted score falls between 70 and 100 percent; a medium unweighted score falls between 40 and 69 percent; and a low unweighted score falls between 0 and 39 percent. The total weighted score measures the degree to which each solution option satisfies the five criteria. A high weighted score falls between 70 and 100 percent; a medium weighted score falls between 40 and 69 percent; and a low weighted score falls between 0 and 39 percent.

The effectiveness of a solution option is determined by its ability to solve public health-related issues regarding HIV/AIDS among intravenous drug users. The ability to conquer such issues is manifested by a program’s ability to: (1) prevent the spread of HIV/AIDS among intravenous drug users, (2) reduce the spread of HIV/AIDS in each state per capita, (3) reduce new cases of HIV/AIDS per year, (4) decrease further drug use, and (5) increase entries into drug rehabilitation. Effectiveness is assigned a weight factor of 5 because this criterion is recognized among various sources as the most important in fulfilling the priorities in public health and drug control policies.

Along the same lines as effectiveness, a solution option is efficient when the amount of time, money, and effort expended produces optimum results with minimal waste. While the federal government spends billions each year on drug control, prevention efforts, and treatment options for those living with HIV/AIDS, state governments incorporate alternative intervention methods emphasizing risk-reduction that only cost a few million dollars. Without support from the federal government, state governments have established sterile syringe access legislation
(i.e., needle exchange, prescription or non-prescription sale of syringes). These intervention methods, in the form of legislation, have decreased the incidence of HIV/AIDS and unsafe injection drug use practices among intravenous drug users, while providing an avenue for intravenous drug users, regardless of socioeconomic status, to have access to social services, such as drug rehabilitation. Efficiency is assigned a weight factor of 3 given the pattern that the federal and state governments are more focused on the outcomes rather than the costs of operating or funding a solution option.

Drug control and public health policies are highly debated between liberals and conservatives regarding the distribution of services on the basis of the beneficiaries’ income, or ability to pay for services. For this reason, there are two types of equity – vertical and horizontal. Vertical equity refers to cost burdens falling on those who can afford health care; the idea that those who can pay should pay. Horizontal equity, on the other hand, refers to the allocation of services based on need regardless of an individual’s income and the racial composition of the neighborhoods that provide such services; the idea that those who need these services should get it. Equity is assigned a weight factor of 1 as the least important criterion of a solution option due to the majority of free-riders, who benefit from the effectiveness of a solution option, regardless of one’s involvement in shaping it.

Administrative burden reflects a solution option’s level of maintenance and its effect on beneficiaries, taxpayers, and state governments (as another beneficiary). Examples of administration burden include reporting requirements, costs of reporting, higher demand of physician labor, and invasion of privacy. Administrative burden is assigned a weighted factor of 2 given that specific burdens placed on beneficiaries may substantially affect the implementation and/or outcome of a solution option.
A solution option is politically feasible if the public policy issue – the HIV/AIDS epidemic influenced by unsafe drug using practices among intravenous drug users – can survive the policymaking process while meeting all of the aforementioned criteria. The comprehensive approaches to drug control and public health generate several issues, which, in turn, slows the implementation process while heightening the uncertainty of (political and budgetary) costs and successful implementation. Common issues concerning the five solution options include (but are not limited to) substantial ideological differences, disagreement among experts and politicians, excessive costs, and technical feasibility. Political feasibility is assigned a weighted score of 4 because solution options must be able to withstand additional issue-related concerns, legislative processing factors such as saliency and timing, and obtain political, institutional support.
This section explains five of the most viable solution/legislation options for addressing the issue of HIV/AIDS among intravenous drug users: (1) primary drug prevention, (2) needle exchange programs/legislation, (3) physicians’ prescription legislation to sterile syringes, (4) community outreach programs, and (5) needle disinfection. The primary drug prevention option is classified under the traditional approach while the remaining options are grouped under the comprehensive approach. While there may be other solution/legislative options available, the options assessed in this Action Report are those that are either currently in use or have been proposed to state governments. These options will be evaluated by category using the five criteria addressed in the previous section.

The simultaneous fight against HIV/AIDS and the war on drugs is multifaceted and often leads to the creation and implementation of laws and approaches that oppose one another on the basis of ideology and feasibility. Intravenous drug use is largely perceived as voluntary behavior. The one-best solution to prevent the spread of HIV/AIDS among intravenous drug users is abstention from injection drug use (and unsafe sexual practices), as advised by health and medical experts. The federal government, however, reinforces this message by forming “zero-tolerance” laws as America’s primary drug prevention method – the “traditional” policy option. Comprehensive solution options for intravenous drug-using behaviors, as alternatives to the traditional approach, include: (1) needle disinfection, (2) needle exchange programs, (3) community outreach programs, and (4) prescribed syringes by physicians. These approaches emphasize the safety and well-being of: those who are considering injecting drugs, intravenous drug users who choose to continue drug use, and intravenous drug users who have relapsed. Furthermore, they deliver harm reduction and risk-reduction messages to intravenous drug users.
while also presenting to them the means to reduce their risks of contracting or transmitting HIV/AIDS and other blood-borne infections.

The underlying assumption of comprehensive approaches is synonymous with that of harm reduction, which identifies drug addiction as an illness that must be treated as such, and not as criminal behavior. Several sources indicate that, while the traditional approach fails to prevent drug addiction and HIV/AIDS, the comprehensive approach has become a vital mechanism in not only fulfilling its unique objectives, but also offsetting the destructive impacts of the traditional approach. Both NIDA and the CDC agree “a comprehensive approach is the most effective strategy for preventing HIV/AIDS and other blood-borne infections in drug-using populations and their communities” (NIDA, Principles of HIV Prevention in Drug-Using Populations). Since 1998, federal law prohibits federal funding for some comprehensive policies based on political ideology and the misconception that comprehensive policies are simply ineffective (Needle Exchange Programs Prohibition Act of 1998).

Option One: Primary Drug Prevention (America’s War on Drugs)

Typically known as the traditional approach, primary drug prevention efforts seek to eliminate the harms associated with drug use by preventing first use (of drugs) among adolescents and teens, as well as prohibiting and criminalizing drug-related behaviors associated with drug use and addiction\(^\text{15}\). Drug use abstention programs, stringent drug control laws, and intense law enforcement practices are federally funded. Put simply, the traditional approach is prioritized in the following order: (1) prevention, (2) criminalization, (3) retribution/restitution,
and (4) drug treatment/rehabilitation. This rank-ordering of priorities has been especially evident in the budgets of previous Administrations.

**Option Two: Needle Exchange Programs Legislation**

needles with sterile ones. The exchange involves a high level of interaction between trained health professionals and intravenous drug users. Sterile syringes are distributed by one of two ways. The first method involves needle exchange professionals to drive around targeted communities (typically in minivans), as specified by the state’s needle exchange law, and provide sterile syringes to drug dealers and drug users. The second method involves intravenous drug users to visit the needle exchange clinic in order to obtain sterile syringes. For both methods, the transaction process begins with the drug users disposing used and dirty needles into large, impermeable, heavy-duty containers with a narrow opening for needle insertion (e.g., empty Clorox-brand bottles). Needle exchange personnel administer sterile syringes in the same amount as those disposed by drug users.

**Option Three: Physicians’ Prescription (Legislation) to Sterile Syringes**

As many as 13 states require a physician’s prescription to syringe access. In other states, pharmacists require buyers to demonstrate or provide proof that their purchase of syringes will be used for legitimate medical purposes. Syringe prescription has become a useful and

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16 Under the primary drug prevention option, drug treatment/rehabilitation is either imposed on or made available to drug users who are incarcerated or under some type of community supervision.

17 The majority of federal funding, between the terms of Reagan and George W. Bush, were allocated to education, defense, and justice. However, in the current Fiscal Year 2007, substantial budget cuts were made in education. Drug prevention education programs (the Safe and Drug-Free Schools program) were eliminated, and more funding was granted to the Partnership For a Drug-Free America (responsible for printing and televising anti-drug messages) and drug courts. See Bush Administration Budget. Retrieved from the Democratic Whip website: http://democraticwhip.house.gov.
indispensable method for intravenous drug users to access sterile syringes. The prescription legislation enables physicians to protect their injection drug using clients from the risk of contracting or transmitting HIV/AIDS. Syringe prescriptions – in addition to other comprehensive approaches – also provide another avenue for intravenous drug users to legitimately access sterile syringes given that law enforcement and pharmaceutical practices may deter drug users from possessing or accessing syringes in the first place.

**Option Four: Community Outreach Programs**

Community outreach programs and its staff members are sensitized and knowledgeable to the unique issues and needs within their community. Outreach workers, comprised of medical professionals and volunteers, exhibit several responsibilities as educators and distributors of information pertinent to harm reduction and risk-reduction regarding HIV/AIDS, drug use, and sexual practices. Most importantly, outreach programs’ intervention methods are highly accessible to intravenous drug users because educators are welcoming of individuals who seek referrals to social services, consultation, or information about highly sensitive issues. These programs are considered as zones of trust among all types of drug users and those at risk of contracting or transmitting HIV/AIDS.

**Option Five: Needle Disinfection (Bleaching Kits)**

Needle disinfection became an HIV/AIDS prevention strategy originally initiated in California during the 1980s. The CDC defines *disinfection* as “using something to kill viruses and bacteria that causes infection” (CDC, July 2004). The use of household bleach is one method of disinfecting dirty needles, which is cheap, quick, and accessible to intravenous drug users. Before sterile syringes were legally made accessible to intravenous drug users in most
states, needle disinfection was advised by the CDC as a method to kill viral and infectious residue on dirty needles. A bleaching kit consists of one, one-ounce-size bottle of full-strength household bleach with step-by-step instructions included. Currently, needle exchange programs and community outreach programs are the primary venues where bleaching kits are distributed and accessed by intravenous drug users.

**Evaluation of the Option Under the Traditional Category**

**Effectiveness:** Stringent drug laws significantly impact the health and well-being of all drug users simply because they are perceived as criminals, unlike those who take drugs for legitimate purposes such as an illness\(^\text{18}\). Furthermore, physicians and pharmacists are deterred from prescribing and dispensing syringes (even in states that allow the non-prescription sale of syringes) to known intravenous drug users because they fear violating drug laws, which could lead to prosecution and/or the revocation of their professional licenses. Stringent drug laws have also enhanced the powers of law enforcement in its ability to, in a sense, “entrap” intravenous drug users for violating anti-drug paraphernalia and anti-drug possession laws (Burris, et al., 2001). For these reasons, unsafe drug-using alternatives, behaviors, and subcultures have arisen, promoting needle sharing, reuse, and the purchase of possibly contaminated syringes from the black market\(^\text{19}\).

**Costs/Efficiency:** In 2003, former Secretary of the Department of Health and Human Services, Tommy Thompson, and the current drug czar, John P. Walters, announced a substantial decline in teen drug use, which was credited to the President’s first National Drug Control

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\(^{18}\) The criminal justice system perceives illegal drug users as criminals and, as a result, they do not have the same privileges as someone who is clinically ill and needs legal, prescription drugs to stay healthy. Without help from authorities, drug-using subcultures (e.g., needle sharing) and black markets are formed to provide drug users access to products (of inadequate quality and safety) inaccessible in the mainstream. *See* Burris, et al., 2001.

\(^{19}\) It is estimated that the street prices of syringes were much higher when drug laws were perceived to be strictly enforced, costing an average of $3.66 per needle compared to an average $2.08 in a pharmacy. *See* Rich, et al., 2000.
Strategy released in February 2002 (NIDA, December 2003). In spite of the decline in teen drug use and billions spent on the drug war, teen drug use, drug-related crime, and the availability of street drugs remain high. Each year, drug offenders expand the nation’s prison population, yet several politicians claim that criminalizing drug-related behaviors is beneficial in combating the “evils” of drug use. The war on drugs – costing the federal and state governments as much as $40 billion in 2000 alone – is best known among experts and drug policy entrepreneurs as the war against drug users and non-violent drug offenders. In 2000, the Department of Justice issued a report indicating that state and federal prisons were operating 15 to 30 percent above maximum capacity (DPA, 2002). The increase of sentenced, non-violent drug offenders, especially Black males, under state jurisdiction caused an additional $9.4 billion in prison expenses. It is estimated that the cost of incarcerating one individual is $34,000 per year compared to only $26,000 per person admitted into drug treatment. These estimates suggest politicians ignore such cost-benefit analyses based on their fear of appearing “soft” on crime (Brune, 2005; DPA, 2002).

**Equity:** There is some vertical equity and high horizontal equity for primary drug prevention efforts. Primary drug prevention efforts, such as drug education in schools, drug treatment programs, and law enforcement, have high horizontal equity because these services are offered to all individuals regardless of race, income, and status as a drug user. There is some vertical equity, however, because the burdens of cost are placed on state and local taxpayers who reside in the areas in which drug prevention services are administered, thus creating a free-rider problem among those who cannot pay.

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20 Drug users and non-violent drug offenders comprise two-thirds of the prison population. See Brune, 2005.
Administrative Burden: Politicians perceive the traditional approach as less burdensome than the comprehensive approaches. Most Americans, experts, and other stakeholders value some aspects of the traditional approach, such as drug education and drug treatment, but perceive stringent drug control efforts as counterproductive in combating the country’s drug crisis. Yet, “[o]ver the past 30 years, the government has spent 70 percent of drug war resources on police, prisons, and the military with only 30 percent devoted to drug education and treatment” (Brune, 2005). This estimate suggests a large portion of administrative burdens is placed on criminal justice professionals, who primarily enforce or contribute to the provisions of the drug war: police, courts, politicians, and corrections. For example, the enhancement of police discretionary powers stimulates the arrest rate of nonviolent (drug) offenders; high arrest rates generate an overload in paperwork for the police. Minor drug offenders will usually receive criminal conviction(s) from the court judges, whose priority is to keep cases moving along. Finally, prisons must accept more inmates beyond capacity, which significantly skews the inmate-correctional worker ratio in the prison.

Political Feasibility: The budget-busting traditional approach has been (and always will be) the most superior of approaches used to target the nation’s drug problem, yet indirectly affecting the HIV/AIDS epidemic. For decades, the traditional approach has retained its political feasibility and political “staying power” by forming efforts intended to combat the country’s drug crisis. HIV/AIDS is dealt with as a separate issue, apart from the drug crisis in which medical programs do not treat addicted drug users infected with HIV/AIDS. Medical experts, drug policy analysts, and politicians disagree on the ideological implications of the drug war. Conservative politicians continue to support the drug war in order to avoid “stirring the political

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21 Politicians are comfortable with the traditional policy option, based on its certain moral value; they fear and perceive comprehensive approaches as containing additional burdens of costs and complexity associated with uncertainty and possible failure. See Weissert & Weissert, p. 275.
pot,” which would result in supporting “radical” comprehensive options (Brune, 2005). Since the inception of the drug war, “get tough” laws have not only increased bureaucratic power, but also bureaucratic staying power. Thus, majoritarian agencies underscoring the drug war, such as the Office of National Drug Control Policy (ONDCP), “distribute broad benefits and impose broad costs…[having] little interest-group involvement” (Weissert & Weissert, p. 164).

Evaluation of the Options Under the Comprehensive Category

Effectiveness: The comprehensive approach is cited as the most effective tool against the country’s drug crisis and HIV/AIDS epidemic. Needle exchange programs, community outreach programs, and syringe prescriptions, essentially, enable intravenous drug users to access sterile syringes and other services (e.g., HIV-testing, counseling, drug treatment, mental health)22.

Trained professionals and personnel, who are a part of the comprehensive approach, predominantly serve intravenous drug users by referring them to social services, educating them on safer drug use and sexual practices, and distributing information and materials pertinent to HIV/AIDS prevention and risk-reduction, which includes bleaching kits23, contraceptives, and brochures. An important characteristic of needle exchange programs and outreach programs, in particular, is that they “play a unique role in engaging hard-to-reach populations at high risk for HIV infection in meaningful prevention interventions and treatment opportunities” (NIDA, Principles of HIV Prevention in Drug-Using Populations). It is estimated that participants of needle exchange programs and community outreach programs are more likely to enter drug rehabilitation programs than those who have never used these programs24.

22 These are essentially services in which intravenous drug users can be referred.
23 A bleaching kit consists of a small one-ounce size bottle of full-strength household bleach with instructions of use included. Needle exchange programs and community outreach programs are the primary venues where bleaching kits are distributed. See CDC, July 2004.
24 This finding is based on the research of interest groups such as the American Civil Liberties Union (ACLU), the Drug Policy Alliance (DPA), and the Public Citizens Health Research Group (HRG); research from medical and
While the success of needle exchange programs and syringe prescriptions (as laws) is generally associated with providing intravenous drug users with legitimate access to sterile syringes, outreach programs are sensitized to the unique problems of intravenous drug users in their community. Outreach workers, specifically, are the most recognized and trusted sources of information for intravenous drug users. “An outreach worker can help drug users understand their personal risks for HIV and other blood-borne diseases and identify the preventive steps they need to take. As a peer, the indigenous outreach worker can encourage drug users to stop or reduce using and injecting drugs and enter drug abuse treatment” (NIDA, *Principles of HIV Prevention in Drug-Using Populations*). The National AIDS Demonstration Research (NADR) Project, initiated by NIDA, found that, between 1987 and 1992, outreach programs encouraged significant reductions in risk behaviors associated with intravenous drug use. NADR estimated that 46 percent of its participants reduced or stopped injection drug use, 37 percent reduced or stopped sharing needles, 50 percent reduced or stopped borrowing needles, and 60 percent reduced or stopped sharing injection equipment (Swan, 1995). Bureaucratic estimates of the effectiveness of needle disinfection, on the other hand, remain inconclusive “because of limited scientific studies, varying recommendations on the right way to disinfect, and evidence suggesting that IDUs do not use this approach very much” (CDC, July 2004).

**Costs/Efficiency:** The United States manufactures billions of syringes each year, with each needle costing between ten cents to a quarter, depending on the quantity of syringes purchased. It is estimated that, on average, intravenous drug users inject drugs 1,000 times per annum, therefore, emphasizing the importance of comprehensive solutions and related policy
options (CDC, December 2005). Burris, et al. (2001) claims the following about the comprehensive policy options:

[C]ost-benefit analysis indicates that a policy of funding syringe exchange programs, pharmacy sales, and syringe disposal to cover all illicit drug injections would cost an estimated $34,278 per HIV infection averted, a figure well below the estimated lifetime cost of medical care for a person with HIV. There is now strong consensus among public health and medical authorities that IDUs should use sterile equipment for every injection (p. 11).

In 2002, 110 out of 126 needle exchange programs operating nationwide reported budgets totaling only $13 million (compared to the $40 billion spent on the drug war), with individual fixed budgets of needle exchange programs ranging from $0 to $1,035,831 (mean: $118,273; median: $53,500). The New Jersey needle bill, which includes a partner provision allowing for the non-prescription sale of syringes in pharmacies, permits needle exchange programs to distribute sterile syringes, at no cost, to persons ages 18 and older. Community outreach programs, also offered at no cost to intravenous drug users, are essentially administered and sponsored by several universities in partnership with health and medical organizations at the national, state, and local levels. Due to some funding restrictions, however, the diffusion of these programs may be limited throughout the state and, as a result, not all drug users will have access to them. Peter Lurie’s (2006) testimony, before the New Jersey Senate, made it clear that HIV/AIDS prevention effort through the use of any comprehensive model requires its providers to:

25 The needle exchange programs also reported multiple sources of financial support from individual contributors, foundations, and state and local governments. See Update: syringe exchange programs – United States, 2002, July 2005.
26 As written Blood-Borne Diseases Harm Reduction Act, New Jersey Bill A-2339/S-823, pharmacies are allowed to sell up to 10 syringes to their clients (ages 18 and older) without a prescription. See State of New Jersey, Senate Health, Human Services, and Senior Citizens Committee, No. 494.
27 Such organizations and partnerships are in the fields of health, medicine, law enforcement, and education (to name a few). These sponsoring organizations strive to strengthen community relationships and targets specific issues relative to the organizations’ interests.
28 Peter Lurie is the Deputy Director of the Public Citizen Health Research Group. He provided this testimony before the New Jersey Senate Health Committee on the health policy issues that underpin the New Jersey “needle bill” (A-1852/S-494).
…tailor our efforts to reach all sectors of the at-risk community, not insist upon a one-size-fits-all approach. This means reaching out to drug users who cannot or will not stop injecting drugs in the near future. It also means having an array of outlets for such persons to obtain syringes; both needle exchanges and pharmacy availability are critical, because they have been shown repeatedly to reach different populations of injection drug users (HRG Publication# 1786).

**Equity:** Despite physicians and conservative politicians “fearing” dependency among poor intravenous drug users receiving free care, the distribution of cost for the traditional and comprehensive solutions has high horizontal equity because these services are provided as government assistance for all regardless of race, income, and status as a drug user. There is high vertical equity for needle exchange programs, outreach programs, and bleaching kits, and some vertical equity for the traditional approach because the burdens of cost are placed on state and local taxpayers who reside in the areas in which these services are administered. Prescribed syringes, however, have high vertical equity due to means testing because access to health care and ability to pay for care are based on an individual’s income; there is some horizontal equity because low-income individuals receive subsidies and other forms of assistance from the government (e.g., Medicaid).

**Administrative Burden:** Comprehensive harm reduction policies, as philosophically radical to the current regime, have the greatest amount of administrative burden as innovative medicinal and public health practices are required for such solution options to be successfully implemented. A common administrative burden among the comprehensive solutions involves the role of the personnel, as educators for intravenous drug users and distributors of information and materials relative to promoting safer drug-using behaviors and preventing the spread of HIV/AIDS. Furthermore, the comprehensive approaches stimulate a higher (free-rider) demand

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29 The services provided by the traditional approach (e.g., police, prisons, drug education) are meant as a public service staple more so than services provided by the comprehensive approaches.

30 According to Weissert & Weissert, “means testing is an approach to limiting government’s role and making proposals more affordable” (p. 272). Since syringe prescription is required by most states, physicians want to be able to earn income and do not want dependent free-riders.
of goods and services—e.g., needle exchange programs and outreach programs increase the demand for sterile syringes and bleaching kits from manufacturers; intravenous drug users demand appointments with physicians in order to obtain a prescription for sterile syringes. Syringe prescriptions also place a burden on pharmacies/pharmacists, who must regularly process and refill prescriptions for intravenous drug users. Community outreach programs, needle exchange programs, and physicians are not only obligated to maintain their professional responsibility of protecting their clients from HIV/AIDS, but must also maintain a close relationship with the referral programs available for intravenous drug users. The outreach programs and needle exchange programs, in particular, must also recognize the unique needs of intravenous drug users in the community in which they operate. The sole burden among intravenous drug users is the invasion of privacy; that is, intravenous drug users must reveal their status as drug addicts to their service providers.

**Political Feasibility:** A policy proposal is politically feasible “if a problem meets all the criteria of a public policy problem” and, if it does, “it is more likely to gain a place on the agenda and a solution options is more likely to survive the policy-making process” (Weissert & Weissert, p. 275). Whether the comprehensive solutions are politically feasible is at the pinnacle of debate among public health professionals and drug control politicians. According to Weissert & Weissert, “Comprehensive proposals invariably offend many well-placed interests that are enjoying the benefits from the way things are” (p. 275). Drug control politicians, who are considered the protectors of the moral majority, have criticized comprehensive policy options with short-sided (ideological) beliefs. Moreover, comprehensive solutions are mainly unsupported by most conservatives who tend to avoid “stirring the political pot” (Brune, 2005). Academic sources have indicated politicians fear supporting radical policy options and falsely assume their approval of such policies would cut into their voter base; thus, their fear evolves
into a matter of job preservation for the elected politicians\textsuperscript{31}. Public health experts, interest
groups, and academics largely agree on the political and technical feasibility of comprehensive
policy options, based on scientific evidence claiming their effectiveness and efficiency in
directly reducing the incidence of HIV/AIDS among intravenous drug users. Needle
disinfection, however, is not widely supported among experts because, for one, there is no
universal technique of needle disinfection and, second, needle disinfection, by itself, is merely a
temporary HIV/AIDS prevention strategy\textsuperscript{32}. For this reason, needle disinfection is the only
comprehensive option that has low technical feasibility. In general, the comprehensive
approaches are diffuse in costs and narrow in benefits – while intravenous drug users enjoy most
of the benefits, costs of care are “widely spread across the population” (Weissert & Weissert, p.
164).

Although federal law prohibits federal funding for needle exchange programs, in
particular, state and local governments play a heroic role by implementing needle exchange
legislation with allocated funding. Delaware’s needle exchange initiative\textsuperscript{33}, passed recently in
June 2006 by the state Senate, cited a series of government studies demonstrating that
comprehensive models, such as needle exchange programs, will significantly cut – by 20 to 30
percent – new cases of HIV/AIDS in the state by the year 2010\textsuperscript{34}. One study about needle
exchange programs in New York City, operating for nearly 20 years, has shown a 70 percent
decrease in HIV/AIDS incidence (Des Jarlais, et al., 1996). Needle exchange legislation (which

\textsuperscript{31} This largely extended to former President Clinton, who encouraged the expansion of needle exchange programs
under state jurisdictions, but denied them of federal funds because “the country was politically not ready” for them. An example of Zeitgeist.
\textsuperscript{32} The CDC claims that bleaching kits may cause syringes to rust and induce additional wear on injection equipment. The experts advise intravenous drug users on the one-time use only of new and sterile syringes. See CDC, July
2004.
\textsuperscript{33} The initiative was popularly known as the Henry Bill, named after its primary sponsor, Senator Margaret Rose
Henry (D).
\textsuperscript{34} These figures were backed by research from the Kaiser Family Foundation, U.S. Department of Health and
Human Services, Drug Policy Alliance, and the Center for Disease Control and Prevention. See The Kaiser Daily
Health Policy Report, August 2006. See also Delaware State Senate. Senate Bill No. 60.
is mainly partnered with syringe prescription laws and community outreach) is widely supported among experts and state governments as the most effective and efficient tool used simultaneously in the fight against HIV/AIDS and America’s drug problem.
V. Recommendation for Action

This Action Report examined five solution/policy options and found the comprehensive approaches much more suitable for reducing high-risk behaviors associated with intravenous drug use and the spread of HIV/AIDS than the currently used traditional approach. Among the comprehensive approaches – needle exchange legislation, prescribed syringes, community outreach, and needle disinfection – legislation for needle exchange programs was ranked the highest according to the calculation of five criteria, which determines a solution option’s ability to achieve the desired outcome of: effectiveness, costs/efficiency, equity, administrative burden, and political feasibility. Thus, the implementation of needle exchange legislation is recommended for federal and state governments as a competent solution option for intravenous drug use intervention, in addition to the fight against HIV/AIDS (See Table 3).

The state of New Jersey, for example, is the remaining U.S. state that continues to prohibit sterile syringe access to intravenous drug users (DPA, July 2006; Schwaneberg & Hester, 2006). Contrary to conventional wisdom, the ban on federal funding for needle exchange programs does not restrict state and local governments from providing funding to these programs. According to the CDC, needle exchange programs are supported by state, local, and private funding, which provide “a direct linkage to drug treatment and counseling as well as needed medical services” (CDC, 1998). The New Jersey Legislature, however, is currently in the midst of implementing the “Needle Bill.”
New Jersey’s “Needle Bill”

Recently, in July 2006, Delaware became the 49th state to pass a needle exchange bill. Since 2004, the Delaware Legislature took an interest in needle exchange programs “to prevent the spread of HIV and AIDS among IV-drug users” (Chalmers, 2004). The Legislature became attracted to several state and federal studies finding that needle exchange programs not only decreased drug use, but would help reduce the incidence of HIV/AIDS by 20 to 30 percent by the year 2010 (The Kaiser Daily Health Policy Report, August 2006; Jackson, 2004; Delaware State Senate, Bill No. 60). Delaware’s needle exchange bill, nicknamed the Henry bill, was strongly endorsed by Senate Majority Leader Harris B. McDowell, III (D) and by Senate Health and Social Services Committee Chairwoman Patricia M. Blevins (D). The Henry bill was amended only once to include an Oversight Committee.

The majority of the Delaware Senate is affiliated with the Democratic Party; the majority of the House is identified as Republican. The Henry bill was largely opposed by members of the House because, according to Majority Leader Wayne A. Smith and House Speaker Terry R. Spence, “it sends the wrong message to people…that we are condoning drug use” (Jackson, 2004; Chalmers, 2004). This opposing view of the Henry bill is identical to the view raised by the U.S. Senate in the passing of The Needle Exchange Programs Prohibition Act of 1998. The Henry bill was approved by the Senate by a 20-1 vote, which proves that lawmakers recognize the threat posed by AIDS in the state’s grandest city, Wilmington. After the bill passed in the

35 The Delaware Legislature is comprised of 41 members in the House of Representatives and 21 members in the Senate.
36 The Delaware needle exchange bill (SB-60/SB-209) was named after Senator Margaret Rose Henry, who succeeded in getting the bill passed by the state Senate. She was one of the primary sponsors of the bill.
37 The Oversight Committee, according to SB-60, is charged with providing “assistance and advice in the oversight of the program.” The Oversight Committee must include one representative of law enforcement, one physician, at least one recovered intravenous drug user, one legislator from both the House and the Senate, and one representative of the faith community appointed by the mayor. See Delaware State Senate Bill No. 60.
Senate in June 2004, the enabling legislation died in the House. For a while, the House and the Senate remained torn between the benefits of needle exchange programs and its moral example.

The Delaware Legislature passed the Henry bill in response to districts having been “ravaged” by AIDS and drug abuse (Barrish, 2006). A report by the Kaiser Family Foundation indicated that 48 percent of AIDS patients in Delaware were infected as a result of intravenous drug use alone. The Henry bill permitted the state to operate needle exchange programs and “required a state Division of Public Health van to travel to areas of the city [of Wilmington] where drug use is known to be an issue and offer injection users clean needles in exchange for used needles” (The Kaiser Daily Health Policy Report, July 2006). Delaware’s Governor, Ruth Ann Minner, did not hesitate to sign the Henry bill into law on July 17, 2006. Soon after, the five-year needle exchange pilot program became established in the state’s major city, Wilmington (Taylor, 2006). In its first year, the pilot program will cost $315,000. Clients who participate in needle exchange programs will be offered HIV testing, counseling, and a referral to a drug treatment program (The Kaiser Daily Health Policy Report, August 2006).

The New Jersey Legislature was pressured to follow Delaware by passing the Bloodborne Disease Harm Reduction Act, nicknamed the “Needle Bill” (A-1852/S-494; A-2839/S-823). If implemented, the needle bill will establish a five-year needle exchange pilot program, which will operate in six municipalities under a $10 million grant (A-1852/S-494), and will permit the sale of sterile syringes to intravenous drug users without a prescription (A-2839/S-823). A recent report found that “New Jersey has the fifth highest number of adult HIV cases, the third highest number of pediatric HIV cases and the highest proportion of HIV infections among women in the nation” (DPA, September 2006). The state Health Department estimated that over 61,000

38 The moral message of the Henry bill was the reason earlier versions of the bill died in the House. See Chalmers, 2004.
39 The “Needle Bill” (A-1852/S-494) is partnered with the original Bloodborne Disease Harm Reduction Act (S-823/A-2339).
people are HIV positive, while more than 45,000 have full-blown AIDS; the incidence of infection was traced to needle sharing among intravenous drug users (Sullivan, 2004).

Several needle exchange bills have been proposed in New Jersey since 1993, but none have made it to the Governor’s desk. In October 2004, the General Assembly passed the needle bill that would have allowed for the earlier creation of municipal needle exchange programs and non-prescription pharmacy sale of syringes; however, these efforts have been blocked repeatedly by both Republican and Democratic legislators, despite support from several (Democratic) leaders of the legislature. The Senate Health Committee Chairman, Sen. Joseph Vitale (D), has also expressed his support for the needle bill. “Turf is a big deal among the committees, and one job of the chair is to fight hard to maintain responsibility for the committee’s issues” (Weissert & Weissert, p. 37). Opponents of the needle bill – U.S. Senate candidate Tom Kearn, Jr. (R), Sen. Ronald Rice (D), drug czar John Walters, and former New Jersey Governors Christie T. Whitman (R) and Jim McGreevey (D) – perceive needle exchange programs “as a calculated assault on poor and minority neighborhoods” (Amick, 2006), and believe that these programs will claim more lives than actually save them.

The New Jersey needle bill was formally introduced and referred to the Senate Health Committee in January 2006. The needle bill is sponsored by the Democratic majority party. The bill “would allow cities or towns to apply to the state Department of Health and Senior Services, which would select six cities or towns among the applicants to begin NEPs” (The Kaiser Daily Health Policy Report, September 2006). The bill includes a $10 million appropriation bill for inpatient and outpatient drug treatment programs, which “is critical to the success of such a

40 Several of the first needle exchange bills in 1993 died in the Senate Health Committee.
41 The leaders of the New Jersey Legislature who support needle exchange programs as a “tool to slow the spread of the HIV virus,” include Gov. Corzine, Assembly Speaker Joseph Roberts, Senate President Richard J. Codey (D), Senate Commerce Chairwoman Nia H. Gill (D), Senate Health Committee Chairman Joseph Vitale, and Health and Senior Services Commissioner Fred Jacobs (McAleer, 2006).
42 Senator Ronald L. Rice (D) formed an alliance with critics of the minority party as well as with drug czar, John Walters, all of whom oppose the needle bill and intended to keep the legislation “bottled up” in committee.
program as well as for individuals whose primary diagnosis is drug abuse” (National Council on Alcoholism and Drug Dependence – New Jersey). The consensus among New Jersey lawmakers is best stated by Sen. Robert Singer (R):

I am certainly anti-drug and I understand the harm drugs cause….but I also understand what is being created by dirty needles. It is creating an epidemic in our state (Sullivan, 2004).

New Jersey’s Governor, Jon S. Corzine (D), and the State Assembly plan to legalize needle exchange programs and are also preparing to open up the pilot program in certain municipalities with the highest infection rate of HIV/AIDS and other blood-borne diseases (State of New Jersey, Senate, No. 494). Gov. Corzine and Assembly Speaker43, Joseph J. Roberts, Jr. (D), argued that the lack of progress toward the establishment of needle exchange programs will make the HIV/AIDS infection rate in the state become even more problematic than it already is (Sullivan, 2004).

In mid-September 2006, the Senate Health Committee, the bill’s perennial executioner, approved the needle bill with a 5-2 vote, with one abstention. The bill was amended to establish needle exchange programs in six cities, provide $10 million to drug treatment programs in the state, and subject them to re-evaluation after five years. The five votes were needed to put the bill in position for a first-ever vote by the full Senate (Amick, 2006). The amended bill, decided in the House Rules Committee44, “as is,” became a compromise bill between the leaders of the two opposing parties, which “gave both their parties much of what they wanted, but not everything” (Weissert & Weissert, p. 35).

43 The majority party in this instance “selects the Speaker of the House [Joseph Roberts] – the majority leader in the Senate – who makes the decisions on scheduling, committee membership, which committees bills are referred to, who sites on the conference committees to resolve differences in legislation passed by the two houses, and more.” See Weissert & Weissert 2002, p. 24.
44 Prior to the passing of a bill, the bill must become finalized in the House Rules Committee. See Weissert & Weissert, p. 34.
Although legislative committees, at the federal level, are considered the “workhorses” of the legislature, members simply cannot participate in everything; that is, individual members’ participation and impact on committees dealing with certain issues are highly selective. This is also true in the New Jersey Legislature whereby “the typical game is played by the few, not by the many” (Weissert & Weissert, p. 60). The legislators sponsoring the needle bill, in particular, are a part of an invisible covenant of drug policy entrepreneurs and drug policy analysts, who have an impact on drug control legislation. For the legislators, their own ideological, political, and personal preferences on salient issues become shaped as well as confronted by the demands of constituents and drug policy analysis groups that desire the implementation of effective drug laws. The authority of the Senate Health Committee, with its power of controlling the agenda and legislative progress of health-related bills, is an “a priori endowment because…[its authority] precede the legislative process” while post hoc authority is wielded subsequent to full house action (Weissert & Weissert, p. 30-31).

The primary sponsors of the needle bill are senators of the majority Democratic Party, who represent the northeast regions of the state. The senators who are representing districts with high rates of HIV/AIDS infection and “drug problems” are actively participating in moving the bill along. The northeast, central, and southeast regions of New Jersey are largely infected with HIV/AIDS as a result of intravenous drug use. Furthermore, the ethnic population of these regions is largely comprised of Hispanics and African-Americans. The senators (some of whom

45 Politically, the state of New Jersey is Democratic; however, specific regions of the state have different political affiliations depending on its structural and demographic composition. The state’s major Democratic strongholds include large urban cities, predominantly located in the northeast (e.g., Bergen, Essex, and Hudson Counties), central (e.g., Middlesex and Mercer Counties), and southeast regions (e.g., Camden, Cape May, and Atlantic Counties). The Republican Party, on the other hand, dominates the suburban areas of the northwestern (e.g., Sussex, Morris, and Warren Counties) and coastal counties (e.g., Ocean and Monmouth Counties), which are mountainous regions. After the 2006 New Jersey state election, the state Senate and General Assembly continue to be led by Democrats. Furthermore, “[t]he political balance in the upper [State] house favors Democrats by a 22-18 margin” (Manion, 2006).

46 Despite the majority party acquiring support by almost every major scientific and research organization at the federal level, “[o]ne [opposing] senator can temporarily halt floor action with a filibuster, which can be stopped only with [three-fourths majority] votes” (Weissert & Weissert, p. 23).
are ethnic minorities) who represent these districts are, in a sense, obligated to participate in the legislative progression (or regression) of the needle bill. These members of the Senate are devoting all of their “intensity,” as described by Hall (1996), on “measures important to a small number of attentive groups or people in their district, to those in which they have a personal interest owing to their experience or background, or to those of strong interest to the [governor]” (Weissert & Weissert, p. 70).

One state-level caucus, called the New Jersey Legislative Black and Latino Caucus (NJLBLC), strongly believe that needle exchange programs are a comprehensive method to effectively reduce the spread of HIV/AIDS among intravenous drug users. Some of the primary sponsors for and against the needle bill, including Sen. Nia Gill, Sen. Rice, and Sen. Nilsa Cruz-Perez – are Assembly members of the NJLBLC. There were also national caucuses that have voiced their support for needle exchange programs, such as the National Black Caucus of State Legislatures, the U.S. Conference of Mayors, and the Congressional Black Caucus. These caucuses not only support needle exchange programs as a mechanism to hinder the spread of HIV/AIDS that stem from intravenous drug use, but also address discrimination issues in health care, and are dedicated to “health care education, access, insurance and reform for all Americans” (National Black Caucus of State Legislators).

The needle bill’s “policy image” merely suggests that legitimate sterile syringe access will effectively reduce the HIV/AIDS infection rate among intravenous drug users. As explained by Peter Lurie (2006):

There is not a single behavioral HIV intervention that has been proven effective in reducing the number of new HIV infections in a randomized, controlled trial: not condoms, not bleach for disinfecting syringes, not blood screening, not drug treatment…etc. Indeed, the only HIV prevention interventions that have been proven effective in that manner are those in which the intervention is literally in the hands of the

47 A concept cited by Weissert & Weissert, p. 131.
researcher so he or she can decide who will get the intervention and who will not (HRG Publication# 1786).

The needle bill also acquired majority support among New Jersey lawmakers for its financial implications. Several studies have shown that one syringe costs an average 50 cents to manufacture and that needle exchange programs cost between $75 and $100 per year for each participant, compared to thousands of dollars per year on AIDS treatment options. Since the bill has been approved by both Houses, for the most part, it can be legitimately presumed the General Assembly is just as eager as the Senate for the needle bill to become law. The bill must be approved by the Senate Budget and Appropriations Committee in order to go to the full Senate and Assembly for consideration; the bill is currently pending in this Committee\textsuperscript{48}.

VI. Conclusion

The global HIV/AIDS epidemic as well as the establishment of needle exchange programs⁴⁹ in response to the epidemic has a short history, which dates back as early as the mid-1980s. In the United States, the initial advancement of needle exchange programs to target the intravenous drug using population at risk of contracting HIV/AIDS was a difficult task for public health officials and supporting legislators. Officials of public health and criminal justice, in collaboration with drug policy analysts and entrepreneurs, argued in favor of harm reduction strategies, which have been proven, in Western European countries, as an effective form of drug legislation in reducing the harms associated with drug use⁵⁰. In 2001, a research report found that 160 needle exchange programs were operating in the U.S., and only 48 states permitted intravenous drug users prescription access to sterile syringes (Burris, et al., 2001).

The way in which the public views the HIV/AIDS epidemic and the creation of needle exchange programs for intravenous drug users is crucial to public health experts, in their efforts of devising various drug treatment options. A 1999 study was conducted to measure public attitudes toward intravenous drug users, HIV/AIDS, and needle exchange programs. The results revealed that the majority “believed that the availability of clean needles would reduce the transmission of HIV. However, a substantial percentage of respondents were still concerned that needle exchange programs could increase drug use. Support for the use of state revenues to fund needle exchange programs was somewhat low, which may reflect the prevailing sentiment of the 1990s on less government expenditure” on needle exchange programs (Quinn 1999:1428).

⁴⁹ Needle exchange programs are mainly established in Western countries, such as Canada, Western Europe, the United States, the United Kingdom, and U.S. and U.K. territories.
⁵⁰ Drug control legislation with prevention as the forefront has two goals: (1) reducing drug use, and (2) reduce the harms associated with drug use. Harm reduction is largely focused on the second goal because at-risk behaviors are perceived as more “preventable.”
The debate on whether to implement needle exchange programs for intravenous drug users remains the center of controversy in the United States. On one hand, drug policy analysts\(^{51}\) and government reports claim “[i]ncreasing sterile syringe availability through needle exchange programs, pharmacy sales, and physician prescription reduces needle sharing among intravenous drug users, which decreases transmission of HIV/AIDS and hepatitis” (DPA, May 2006). On the other hand, the federal government maintains that, as civil servants, they are morally obligated to preserve zero-tolerance drug policies in order to eliminate the availability of street drugs and prevent drug addiction (Wren, 1998). Despite Donna Shalala’s\(^{52}\) announcement 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” (Department of Health and Human Services, April 1998; Carey, 1998), politics and cultural taboos continue to derail harm reduction programs, including syringe access, comprehensive sex education, and free condom distribution.

In all Congresses, there is no dispute that HIV/AIDS and drug abuse are major public health issues. The Republican and Democratic parties, however, tend to compete with each other on what they believe are effective intervention strategies and solution options that target HIV/AIDS among intravenous drug users. Most Republicans favor abstinence-only, educational, and drug treatment programs; several Democrats favor needle exchange programs, comprehensive sex education programs, and free condom/contraceptive distribution (Bettelheim, 1998). Weissert & Weissert claimed that “[c]ongressional history is replete with pendulum shifts

\(^{51}\) Drug policy analysts are professionals within an array of fields, such as medicine, public health, criminal justice, and government (to name a few). Most are specialists within the realm of drug policy and drug-related issues.

\(^{52}\) Donna Shalala is the former Secretary of the U.S. Department of Health and Human Services. Her title as the Secretary of HHS gives her legal authority to determine whether needle exchange programs are effective at reducing HIV/AIDS infection rates and do not encourage further illegal drug use.
in the predominant source of power” (p. 24). This lack of unity between the two parties is bound to make one party more powerful, by moral majority, than the other.

The U.S. Senate’s Committee on Labor and Human Resources strongly opposes needle exchange programs, as indicated in the Needle Exchange Programs Prohibition Act of 1998, which prohibited “the expenditure of Federal funds to provide or support programs to provide individuals with hypodermic needles or syringes for the use of illegal drugs”. The Act passed the day after HHS Secretary Shalala announced her support for such programs. U.S. Senators Ashcroft, Coverdell, and Brownback introduced the Act, citing the failures of only two needle exchange programs in Vancouver, British Columbia. The bill clearly divided President Clinton’s two main policy advisers, then-drug czar General Barry McCaffrey, and Office of National AIDS Policy Director, Sandra L. Thurman. A report by General McCaffrey claimed “HIV infections were higher among users of free needles than those without access to them” (The Needle Exchange Prohibition Act of 1998; Schechter, 2002). Director Thurman, on the other hand, advocated federal spending on needle exchange programs “as a way of saving lives by reducing the incidence of AIDS contracted from shared needles” (Wren, 1998). The U.S. Congress has prohibited federal funding for needle exchange programs since 1998 and continues to do so. U.S. congressional members, essentially, do not want to appear “soft on drugs,” especially during a Congressional election year.

In 2005, former President Clinton (D) was interviewed by Frontline News about why his Administration neither pursued needle exchange legislation nor financially supported these programs. Despite his recognition of numerous public health testimonies confirming the program’s effectiveness, the former President responded:

53 General Barry McCaffrey was the Director of the Office of National Drug Control Policy (ONDCP) between 1996-2001.
54 U.S. Senators are elected or eligible for re-election every six years, and members of the House, every 2 years.
A lot of people wanted needle exchange because of the role of dirty needles in infecting drug users, but the opposition to it was simply overwhelming. Politically the country wasn’t ready for it.\footnote{This is an example of Zeitgeist. See \textit{Frontline News}. (May 2006). Needle exchange: A primer. Retrieved from the Public Broadcasting Service (PBS) webpage: http://www.pbs.org.}

All states that have implemented needle exchange legislation (or are in the process of considering it) have been confronted with a similar dilemma of whether the benefits of needle exchange programs outweigh socially instilled morals, or vice versa.

Harm reduction intervention methods, however, have significantly shocked political ideology and policymaking in the United States since its inception in the 1980s. Drug policy analysts and drug policy entrepreneurs are largely responsible for this “paradigm shift” by initiating and supporting some “smoking gun” studies in an attempt to prove the effectiveness of politically controversial alternatives to the current regime. Harm reduction encompasses abstinence as a desirable goal, but recognizes that when abstinence is not possible, it is not ethical to ignore the other available means of reducing human suffering. For this reason, lobbyists and coalitions have successfully influenced state lawmaking authorities to implement laws permitting intravenous drug users to legitimately access sterile syringes. Supporters of harm reduction emphasize that the comprehensive approach “becomes important where [primary drug] prevention [efforts] fails” in the never-ending fight against the global HIV/AIDS epidemic (Gunn, et al., 1998:1192).

The American Medical Association, the American Nurses Association, the American Public Health Association, the American Society of Addiction Medicine, the American Bar Association, and the Society of Christian Ethics are some agencies that endorse needle exchange programs as the primary harm reduction intervention method. Yet, without adequate support from Congress, the Administration, the bureaucracy, the media, and the public, no one will ever
know for sure whether needle exchange programs are truly effective methods to combat the country’s drug problem or the HIV/AIDS epidemic.
**Table 1: Studies/Statistics**

<table>
<thead>
<tr>
<th>Nature of Problem</th>
<th>National Institute on Drug Abuse</th>
<th>Center for Disease Control &amp; Prevention</th>
<th>CQ Researcher</th>
<th>Other</th>
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<tr>
<td>Adolescents as young as age 13 engage in unprotected sex and intravenous drug use. Intravenous drug users are at a greater risk of becoming infected with AIDS by engaging in high-risk sexual behaviors, not sharing needles used to inject drugs.</td>
<td><em>Laws and regulations governing sterile syringe access to intravenous drug users reinforce needle sharing and reuse.</em></td>
<td><em>In June 1981, AIDS was first documented in the United States as a disease among American homosexual men.</em></td>
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<td>In 2002, young Americans between the ages of 13 and 24 “account for 18% of reported HIV cases.”</td>
<td><em>As of 2004, injection drug use accounted for about one-fifth of all HIV infections and most hepatitis C infections in the United States.</em></td>
<td><em>72% of reported AIDS cases were among homosexual and bisexual men, including intravenous drug users, hemophiliacs, and children born to infected mothers.</em></td>
<td><em>Americans between the ages of 18-25 are at risk of becoming infected with HIV.</em></td>
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<tr>
<td>As of 2006, 4 out of 10 U.S. AIDS deaths are related to drug abuse.</td>
<td><em>The incidence of AIDS increased rapidly throughout the 1980s, peaked in the early 1990s, and then declined in 2000.</em></td>
<td><em>In the mid-1980s, homophobia grew worse as a result of sensationalized media attention.</em></td>
<td><em>The sharing of HIV-contaminated needles made up 24% of the AIDS diagnosis in the United States.</em></td>
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<tr>
<td>In June 1981, AIDS was first documented in the United States as a disease among American homosexual men.</td>
<td><em>In 1985, male homosexual contact was the primary means of HIV/AIDS transmission (formerly known as gay-related immunodeficiency, or GRID).</em></td>
<td><em>As of 2006, 4 out of 10 U.S. AIDS deaths are related to drug abuse.</em></td>
<td><em>As of 2006, there are 61,698 intravenous drug users infected with HIV and 45,256 with full-blown AIDS in New Jersey alone.</em></td>
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</table>

1. *Adolescents as young as age 13 engage in unprotected sex and intravenous drug use.*
2. “Intravenous drug users are at a greater risk of becoming infected with AIDS by engaging in high-risk sexual behaviors, not sharing needles used to inject drugs.”
3. In 2002, young Americans between the ages of 13 and 24 “account for 18% of reported HIV cases.”
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5. The incidence of AIDS increased rapidly throughout the 1980s, peaked in the early 1990s, and then declined in 2000.
6. In the mid-1980s, homophobia grew worse as a result of sensationalized media attention.
7. The sharing of HIV-contaminated needles made up 24% of the AIDS diagnosis in the United States.
8. As of 2006, there are 61,698 intravenous drug users infected with HIV and 45,256 with full-blown AIDS in New Jersey alone.
| Causes                                                                 | *Intravenous drug use and sexual contact with infected partners*³.  
|                                                                     | *Drug paraphernalia laws, syringe prescription laws, pharmacy regulations and practice guidelines, and restrictions on needle exchange programs*⁴.  
|                                                                     | *In 1985, evidence in the United States suggested that prostitutes transmitted AIDS⁷.  
|                                                                     | *Unprotected sex and needle sharing with infected partners are the primary means of HIV/AIDS transmission⁸.  
|                                                                     | *Intravenous drug users either cannot afford or obtain legitimate access to sterile syringes¹¹.  
|                                                                     | *Intravenous drug use and subsequent unsafe sexual activity with an infected partner¹².  
| Appropriateness of Governmental Intervention                          | *Counseling, lifestyle coaching, and intervention programs further reduced the spread of substance abuse, high-risk sexual behaviors, and the spread of HIV/AIDS¹.  
|                                                                     | *Risk reduction and needle exchange programs decreases the spread of HIV/AIDS and provides a safe environment for intravenous drug users without the risk of police searches, arrest, and criminal prosecution⁴.  
|                                                                     | *HIV/AIDS is no longer a “gay-disease”⁷.  
|                                                                     | *Politically controversial harm reduction intervention methods such as free condom/conception distribution, needle exchange programs, and comprehensive sex education for schools⁸.  
|                                                                     | *“AIDS research investments are clearly evident in the sharp decline in AIDS-related mortality among those fortunate enough to have access to treatment”¹³.  

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Table 2: Legislative History of Drug Control and HIV/AIDS

Compiled from various state, government, research/academic, and popular media sources, including CDC, FDA, DPA, NIDA, AmfAR, ACT UP, and the CQ Researcher database

1970 – The Controlled Substances Act (CSA), which is Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, was enacted by Congress and intended to consolidate all drug legislation written over the course of the last 60 years.

1971 – President Richard Nixon intensified America’s War on Drugs by enhancing drug prohibition and announcing illegal drug (ab)use as “America’s Public Enemy Number One.”


1981 – Birth of HIV/AIDS epidemic in the United States. CDC documents the first cases of a mysterious immunodeficiency virus in five gay men of Los Angeles. U.S. agencies (e.g., CIA, HHS, CDC) begin formal tracking of all U.S. AIDS cases.

1982 – First U.S. Congressional hearings on the U.S. and global AIDS epidemic. CDC labels the “mystery disease” Acquired Immune Deficiency Syndrome (AIDS). CDC discovers AIDS is linked to blood disease and transmitted through sexual contact or infected blood.

1983 – First recommendations issued by the U.S. Public Health Service to prevent the transmission of HIV through sexual contact and blood transfusions. Congress passes the Orphan Drug Act to provide incentives for pharmaceuticals to develop therapies for rare diseases.

1984 – Amsterdam, Netherlands establishes the first needle exchange program to combat the spread of HIV/AIDS among intravenous drug users. CDC identified intravenous drug use as another cause of HIV/AIDS transmission, and claimed abstention from needle sharing will reduce the transmission of the disease.

1985 – First international AIDS conference held in Atlanta, GA, hosted by the Department of Health and Human Services (HHS) and the World Health Organization (WHO). Food and Drug Administration (FDA) approves the first blood screening tests to detect the presence of HIV antibodies. To reduce the risks of spreading the disease through blood transfusions, U.S. blood banks introduce blood-screening tests. U.S. Public Health Services issues first recommendation in preventing the transmission of HIV/AIDS from mother to child.


1987 – President Reagan launched the Presidential Commission on AIDS. FDA approves the first AIDS vaccine, called AZT, which was marketed as Retrovir by Burroughs Wellcome, Inc. Congress approves $30 million of emergency funding for AZT vaccine.
1988 – First comprehensive needle exchange program was established in Tacoma, WA by David Purchase. The first major needle exchange programs begin in New York City, NY and San Francisco, CA. New York City program was highly regulated and required a rehabilitation visit from its participants; San Francisco program was illegal but tolerated. CDC and the Surgeon General mailed 107 million brochures titled Understanding AIDS to all U.S. households, marking the launch of the first nationwide AIDS education campaign. Congress officially prohibits federal funding to implement needle exchange programs or any program of sterile needle distribution to intravenous drug users.

1990 – Ryan White Comprehensive AIDS Resources Emergency (CARE) Act first enacted by Congress, providing federal funds for community-based care and treatment services. Americans with Disabilities Act was also enacted by Congress, prohibiting discrimination against people with disabilities, including those living with HIV/AIDS.

1991 – Congress enacts law restricting the practices of HIV-positive health care workers, as advised by CDC.

1994, 1995 – AIDS is the leading cause of death for all Americans between the ages of 25 to 44.

1997 – HHS Secretary, Donna Shalala, issues a report to Congress confirming that needle exchange programs are an “effective component of a comprehensive strategy to prevent HIV and other blood-borne infectious diseases in communities that choose to include them.”

1998 – U.S. Senate passes The Needle Exchange Programs Prohibition Act (S-1959) to the Committee on Labor and Human Resources. The Act “prohibits the expenditure of federal funds to provide or support programs to provide individuals with hypodermic needles or syringes for the use of illegal drugs.”

2000 – In the U.S, there were 154 needle exchange programs operating in 35 states and 106 cities.

2001 – The openly homosexual Director of the White House Office of National AIDS Policy, Scott Evertz, publicly endorses federal funding for clean needle exchange programs, which appeared in two newspapers for homosexual audiences. U.S. Secretary of State, Colin Powell, reaffirms previous U.S. statement that HIV/AIDS is a national security threat.

2002 – Bush Administration promotes abstinence-only and HIV/AIDS prevention programs and opposes programs that do otherwise for audits by the Office of the Inspector General of HHS. Condom Facts Sheets from the ‘Programs that Work’ section of the HHS website are removed by Bush Administration; revised copies of the facts sheet were reposted on the website.

2003 – President Bush establishes the President’s Emergency Plan for AIDS Relief (PEPFAR), a five-year, worldwide initiative costing $15 billion to fight HIV/AIDS and other blood-borne diseases in Africa and the Caribbean.


2006 – The 25th anniversary of the HIV/AIDS epidemic in the U.S. New Jersey remains the only state that prohibits needle exchange programs and sterile syringe sales without a prescription.
<table>
<thead>
<tr>
<th>Effectiveness based on the following:</th>
<th>Primary Drug Prevention (War on Drugs, Controlled Substances Act of 1970)</th>
<th>Needle Exchange Programs/Legislation (NJ Bill, A-1852/S-494)</th>
<th>Physician’s Prescription (Legislation) to Sterile Syringes (NJ Bill, A-2339/S-823)</th>
<th>Community Outreach Programs</th>
<th>Needle Disinfection (Bleaching Kits)</th>
</tr>
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<tbody>
<tr>
<td>--Preventing the spread of HIV/AIDS among IDUs.</td>
<td>Low – Score of 2 &lt;br&gt; --Opposes harm reduction and first-use of drugs. &lt;br&gt; --Prison-based drug treatment programs can decrease further drug use and recidivism¹. &lt;br&gt; --Law enforcement practices target IDUs relying on anti-drug paraphernalia and anti-drug possession laws¹. &lt;br&gt; --As gatekeepers to syringe access, pharmacists are deterred from violating state/federal drug laws².</td>
<td>High – Score of 9 &lt;br&gt; --Advocates harm/risk-reduction. &lt;br&gt; --Legislation enables IDUs to have access to sterile syringes. &lt;br&gt; --IDUs can voluntarily be referred to other services, such as HIV-testing, drug treatment/rehabilitation, and mental health. &lt;br&gt; --Decreases needle sharing and reuse. &lt;br&gt; --Distributes information about HIV/AIDS prevention.</td>
<td>High – Score of 8 &lt;br&gt; --Advocates harm/risk-reduction. &lt;br&gt; --Permits IDUs access to health care and drug treatment programs. &lt;br&gt; --Enables IDUs access to purchase sterile syringes from pharmacies, despite legal barriers. &lt;br&gt; --For medical purposes, allows physicians to protect patients from HIV/AIDS and other blood-borne diseases. &lt;br&gt; --Adds another option for sterile syringe access.</td>
<td>High – Score of 8 &lt;br&gt; --Advocates harm/risk-reduction. &lt;br&gt; --Disseminates prevention information and materials to IDUs (e.g., brochures, condoms, bleaching kits). &lt;br&gt; --Receptive of the community’s unique issues. &lt;br&gt; --Has contact with hard-to-reach IDUs. &lt;br&gt; --Outreach workers are trusted by IDUs, which can encourage IDUs to stop using drugs and enter rehabilitation/treatment.</td>
<td>Low – Score of 3 &lt;br&gt; --Advocates harm/risk-reduction. &lt;br&gt; --Used as a back-up method in preventing HIV/AIDS in which sterile syringes are not immediately accessible. &lt;br&gt; --Distributed by a variety of community-based programs with trained personnel, who instruct IDUs on proper needle disinfection.</td>
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<tr>
<td>--Reducing the spread of HIV/AIDS in each state per capita.</td>
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<tr>
<td>--Decreasing further drug use.</td>
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<tr>
<td>--Increasing entry of IDUs into drug rehabilitation.</td>
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<td>Weight Factor = 5</td>
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<td>Weighted Score: 5 x 2 = 10</td>
<td>Weighted Score: 5 x 9 = 45</td>
<td>Weighted Score: 5 x 8 = 40</td>
<td>Weighted Score: 5 x 8 = 40</td>
<td>Weighted Score: 5 x 3 = 15</td>
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</tbody>
</table>

Costs/Efficiency:  | Low – Score of 3 <br> --Addiction, teen drug use, drug-related/organized crime, and availability of street drugs decreases, but remains high despite billions spent on drug war. <br> --For every dollar spent on treating addicted offenders, society saves $3⁷. <br> --On average, state/federal governments incarcerate 459,131 nonviolent drug offenders per annum, which adds $9.4 billion in prison expenses. <br> --Law enforcement costs 15 times more than treatment to achieve same reduction in societal costs³. | High – Score of 9 <br> --The cost of one needle ranges between ten cents to a quarter. <br> --Cost-benefit analysis indicates NEPs will cost substantially lower than a lifetime of medical care for a person living with HIV/AIDS⁷. <br> --Nationwide, NEPs operate on an average fixed budget of $118,273⁴. <br> --In Tacoma, WA, the average cost per contact with IDUs is $2.25, and may slightly vary by state. | Medium – Score of 6 <br> --Street prices of syringes were much higher when anti-drug paraphernalia laws were perceived to be strictly enforced ($3.66 vs. $2.08)⁶. <br> --Cost-benefit analysis indicates syringe prescriptions will cost substantially lower than a lifetime of medical care for a person living with HIV/AIDS². | Medium – Score of 6 <br> --The cost of educating IDUs about safer injection practices outweighs the lifetime costs of HIV/AIDS medical care. <br> --Outreach programs are 90% effective in changing high risk behaviors among IDUs and increase their use of HIV/AIDS prevention techniques⁹. | High – Score of 8 <br> --Community-based programs are 80% effective in educating and encouraging IDUs to use bleach disinfection kits³. <br> --Overall, a cheap, quick, and available method for all IDUs to disinfect their injection equipment (with household bleach) and reduce their risk of contracting and transmitting HIV/AIDS. |
| Weight Factor = 3 | Weighted Score: 3 x 3 = 9 | Weighted Score: 3 x 9 = 27 | Weighted Score: 6 x 3 = 18 | Weighted Score: 3 x 6 = 18 | Weighted Score: 3 x 8 = 24 |
## Equity:

<table>
<thead>
<tr>
<th>Score</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low – Score of 3</td>
<td>--Some vertical equity because burdens of cost are placed on taxpayers. High horizontal equity because of issue’s saliency regardless of race and class.</td>
</tr>
<tr>
<td>Medium – Score of 6</td>
<td>--High vertical equity because burdens of cost are placed on taxpayers. High horizontal equity because services are provided for all IDUs, at no cost.</td>
</tr>
<tr>
<td>High – Score of 8</td>
<td>--High vertical equity because of means-testing. Some horizontal equity because low-income may receive assistance from state.</td>
</tr>
<tr>
<td>Medium – Score of 8</td>
<td>--High vertical equity because burdens of cost are placed on taxpayers. High horizontal equity because services are provided for all IDUs, at not cost.</td>
</tr>
<tr>
<td>High – Score of 8</td>
<td>--High vertical equity because bleeding kits are provided for all IDUs, at no cost.</td>
</tr>
</tbody>
</table>

**Weight Factor = 1**

### Administrative Burden/Transaction Costs affecting beneficiaries

<table>
<thead>
<tr>
<th>Score</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High – Score of 8</td>
<td>--Self-interested politicians only care about keeping their jobs. --Paperwork overload for police after arresting drug offenders. --Overcrowded jails/prisons and supervisory burdens placed on correctional employees. --Case overload/scheduling burdens for drug courts.</td>
</tr>
<tr>
<td>Medium – Score of 7</td>
<td>--Some problems in targeting high drug-using communities in which to operate NEPs. --Increases demand for syringe manufacturers to produce more syringes. --Needle exchange workers driving throughout the city to exchange needles with IDUs. --IDUs must reveal their statuses as IDUs.</td>
</tr>
<tr>
<td>Medium – Score of 4</td>
<td>--Physicians bear the burden of scheduling appointments with IDUs, conducting physicals, providing HIV/AIDS prevention information, and writing up the syringe prescription. --Pharmacists must routinely process/refill the prescriptions. --IDUs must reveal their statuses as IDUs.</td>
</tr>
<tr>
<td>Medium – Score of 5</td>
<td>--Outreach workers are charged with developing effective intervention methods which are unique to the community’s subgroups and populations. --The program bears the burden of educating IDUs on safer behaviors, distributing information, and maintaining ties with referral services. --IDUs must reveal their statuses as IDUs.</td>
</tr>
<tr>
<td>Low – Score of 2</td>
<td>--Overcrowded jails/prisons and supervisory burdens placed on correctional employees.</td>
</tr>
</tbody>
</table>

**Weight Factor = 2**

### Political Feasibility:

<table>
<thead>
<tr>
<th>Score</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium – Score of 6</td>
<td>--Ideological differences between political parties. --Fits Zeitgeist. --Technically feasible. --Highly supported by research, experts, and drug policy entrepreneurs. --Costs diffuse, narrow benefits (client). --Not budget-busting. --Comprehensive.</td>
</tr>
<tr>
<td>Medium – Score of 9</td>
<td>--Ideological differences between political parties. --Has high technical feasibility. --Comprehensive. --Supported by research, experts. --Costs diffuse, narrow benefits (client).</td>
</tr>
<tr>
<td>Low – Score of 2</td>
<td>--Ideological differences between political parties. --Has low technical feasibility, given that experts cannot agree on a proper needle disinfection technique. --No consensus among experts. --Costs diffuse, narrow benefits (client). --Comprehensive.</td>
</tr>
</tbody>
</table>

**Weight Factor = 4**

### Costs affecting beneficiaries

<table>
<thead>
<tr>
<th>Score</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/50 = 40% (Low)</td>
<td></td>
</tr>
<tr>
<td>39/50 = 78% (High)</td>
<td></td>
</tr>
<tr>
<td>33/50 = 66% (Medium)</td>
<td></td>
</tr>
<tr>
<td>36/50 = 72% (High)</td>
<td></td>
</tr>
<tr>
<td>23/50 = 46% (Low)</td>
<td></td>
</tr>
</tbody>
</table>

### Total (unweighted)

<table>
<thead>
<tr>
<th>Score</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>54/150 = 36% (Low)</td>
<td></td>
</tr>
<tr>
<td>118/150 = 78.7% (High)</td>
<td></td>
</tr>
<tr>
<td>82/150 = 54.7% (Medium)</td>
<td></td>
</tr>
<tr>
<td>112/150 = 74.7% (High)</td>
<td></td>
</tr>
<tr>
<td>61/150 = 40.7% (Medium)</td>
<td></td>
</tr>
</tbody>
</table>

References


Delaware State Senate Bill No. 60. Retrieved from the Delaware Legislature website: http://www.legis.state.de.us.


