

Oregon Harm Reduction Outreach & Care Services (*OHROCS*) Guidance



HIV/HepC/STD Prevention



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- ❖ Coastal AIDS Network
- ❖ Deschutes County Health Department
- ❖ DHS - Acute and Communicable Disease Prevention Program
- ❖ DHS – HST Program
- ❖ Douglas County Health Department
- ❖ HIV Alliance
- ❖ HIV Resource Center
- ❖ Jackson County Health Department
- ❖ Josephine County Health Department
- ❖ Lane County Health Department
- ❖ Marion County Health Department
- ❖ Multnomah County Health Department
- ❖ Tillamook County Health Department
- ❖ Washington County Health Department

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"Outreach — connecting with people in their own communities — has always been an important part of HIV prevention." (CDC, 2005)

This statement exemplifies the sentiment of the Oregon Harm Reduction Outreach and Care Services program. This program is comprised of several evidence-based intervention strategies that support people who inject drugs in choosing healthy options for themselves and their communities. Through five collaborative principal activities and three recommended components, this program provides a framework from which local health departments (LHDs) and community-based organizations (CBOs) may develop or enhance public health programming targeting people who use injection drugs (IDUs) in their communities around Oregon.

Principal activities of OHROCS are firmly rooted in client-centered public health protocols.

- ❖ Access to syringes and appropriate disposal options provide a venue for all IDU to use clean syringes and supplies and dispose of biohazards appropriately, and is the first principal activity involved in the delivery of OHROCS.
- ❖ The second principal activity of OHROCS is risk reduction counseling.
- ❖ The third principal activity, delivery of harm reduction materials and care services, is designed to accompany the first two. Delivery of harm reduction materials such as clean tie-offs, condoms, lubrication, sterile water, and other materials provides mechanisms by which IDU can decrease the likelihood of blood-borne pathogen transmission either through their drug use or sexual activities.
- ❖ Care and services components takes into consideration the on-site, often street-based referrals that harm reduction outreach workers provide to IDU living with abscesses, viral infections, foot fungus, and other physical health conditions. This fourth principal activity is not considered an alternative for medical care, rather it is acknowledgement that harm reduction outreach workers are often the first contact with professionals or paraprofessionals that IDU may engage and are therefore in a unique position to provide basic health promotion education and refer clients to medical care.
- ❖ The fifth principal activity of OHROCS is appropriate referrals to HIV counseling, testing and referral services as well as sexually transmitted disease (STD) and hepatitis C virus (HCV) screening.

Principle of HR # 1: Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.

The following provides evidence-based guidance for the implementation of OHROCS. These guidelines are to be used as stepping stones for implementation of an OHROCS program in any given community; not an absolute course of action. It is anticipated that counties will utilize the principal activities and required components

to establish an infrastructure for OHROCS that can be maintained with community support and involvement.

“Effective prevention programs require a comprehensive range of coordinated services. Given the diversity of drug users and their sexual partners, no single prevention strategy will work for everyone. A comprehensive approach that can readily adapt to changing needs and circumstances is the most effective approach for preventing HIV/AIDS and other blood-borne infections in drug users, their sexual partners, and their communities. This approach should include such services as community outreach, HIV testing and counseling, drug abuse treatment, access to sterile syringes, and services delivered through community health and social service providers. Services must be carefully coordinated within a community.” (NIDAA, 2005)

Outreach

Outreach to the population of interest is the foundation for all other principal activities. HIV, HCV and STD prevention outreach, by definition, mandates that workers *reach out* to the injection drug using population of interest. This will include serving people who do not come into public health clinics and service sites. Outreach begins where the clients are – on the streets and in various community settings. Prevention information, education, risk-reduction counseling, blood-borne pathogen testing and referrals to health care, mental health, and addictions services are all-inclusive in the outreach endeavor.

The CDC (2005) recommended the following components as guidance for many levels of blood-borne pathogen outreach prevention work:

- Going to where drug users are, not waiting for them to come to you;
- Gaining the trust of IDUs;
- Accessing a wide range of IDU social networks;
- Involving peers and workers who know the community and its issues;
- Offering education that is:
 - clear and direct
 - based on actual injecting and sexual practices
 - culturally appropriate
- Going beyond education alone to offer:
 - help and assistance with immediate needs
 - referrals for care and treatment
- Giving outreach workers and peer educators:
 - adequate supervision
 - burnout/relapse prevention
 - payment/support/assistance
 - initial training

Principle of HR #2: Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others. * Establishes quality of individual and community life and well-being--not necessarily cessation of all drug use--as the criteria for successful interventions and policies.

- structured ongoing learning opportunities
- Giving outreach managers:
 - high level of training
 - flexibility
 - ability to manage a wide range of people
 - ability to handle crises and
 - changing fiscal and political circumstances .*Source: Adapted from Center's for Disease Control and Prevention and Dave Burrows, AIDS Projects Management Group, Sydney, Australia*

Additionally, the National Institute of Drug Abuse (NIDAA, 2005) performed a multi-year multi-site HIV prevention outreach study and offered the following recommendations for successful outreach to address the following:

- Relies on outreach workers who typically are indigenous to the local community, familiar with the drug use subculture, and trusted as a source of information.
- Outreach workers are uniquely able to serve as role models, educators, and advocates who can provide drug users with changing and accurate risk reduction information in settings that are familiar to them and at times of greatest risk.
- Is an effective strategy for providing at-risk populations with the means for behavior change (e.g., HIV/AIDS, HCV and STD educational materials, bleach kits for disinfecting injection equipment, and condoms for safer sex) to reduce or eliminate their HIV/AIDS and HCV transmission risk.
- It is also effective in providing drug users with referrals for HIV testing and counseling, HCV and STD screening, drug treatment, and other health services.
- Is a low-cost intervention approach that permits ongoing contact with drug users and multiple opportunities to reinforce the HIV, HCV, and STD risk reduction messages.

Benefits of prevention outreach can range from supporting people to utilize risk reduction equipment (e.g. condoms, clean tie-tie offs, cookers, cottons, and other *works*), assisting in positive behavior change, to helping people gain access to social and health services that can support them in living healthy lives. It is incumbent upon outreach providers and their colleagues in other local helping professions to ensure that wide ranges of referral opportunities are available to the target population.

Principle of HR #3: *Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.*

Syringe Access and Disposal

One-time-only use of sterile syringes for injection of any substance is considered a gold standard for all safe injection purposes (CDC). Deterrence of site of injection infections and

sharing of syringes is enhanced through access to clean syringes and one-use only practice methods (CDC). Site of injection infections can be life threatening to individual clients and costly to treat at emergency departments and urgent care clinics (McGeary & French, 2000; White, 1973; Louria & Hensle, 1967).

OHROCS distribution of harm reduction materials, including clean syringes, is an essential health promotion and disease prevention activity. Community-based access to clean syringes, through outreach activities and local pharmacy access are essential to maintain disease-prevention strategies among IDUs. Additionally,

- ❖ Evidence indicates that access to, and use of clean syringes can dramatically decrease HIV transmission, and is promoted as the **best** mechanisms for eliminating new HCV infections (CDC, 2005).
- ❖ Access to clean syringes through syringe exchange programs has been shown to not increase injection drug use and in some cases, access to clean syringes has been related to decreased injection drug use among IDU (Ksobiech, 2003; Lurie et al., 1993).

Community partnerships, discussed below, should be developed to enhance access to clean syringes. Pharmacy and other retail outlets that sell syringes in affordable quantities should be engaged to promote this good public health practice. Retail providers of syringes play an integral role in maximizing access to clean syringes and promoting healthful behaviors through one-on-one education, and other risk reduction educational opportunities that may not be feasible in an *on-the-street* outreach encounter.

Community-based safe syringe disposal is another essential part of a syringe access and disposal program aimed at reducing blood-borne pathogen transmission to IDU and other community members. .

Nationwide, community-based administration of legal and illegal drugs constitutes approximately 2.68 billion injections every year (CDC, 2005). Providing community-based venues for safe disposal of injection equipment used in these procedures is a necessary public health service.

Safe syringe disposal options range from utilization of personal sharps biohazard containers to fixed-site syringe drop box kiosks. State of Oregon Public Health supports all forms of safe syringe disposal options that are in compliance with the guidelines identified by the Occupational Safety and Health Administrative (OSHA) regulations. These guidelines can be found in Appendix D of this document.

When it is fiscally feasible to do so, OHROCS workers should attempt to have personal and large sharps disposal containers available for IDUs to dispose of their syringes safely. Prevention of needle-stick injuries associated with safe sharps disposal is of primary importance in all OHROCS outreach endeavors. Actively promoting safe disposal of syringes among IDUs is inherent in good risk reduction counseling. Many IDUs are fearful of carrying used syringes as they may be used against them in legal proceedings. However, all reasonable means of encouraging IDUs to safely dispose of syringes are encouraged. Such methods will vary from outreach encounter site and county, dependent up on availability of community disposal options.

It is clear that not all OHROCS programs will have the opportunity to provide clean syringes to IDU directly. This does not preclude those programs from providing other sex and drug-related harm reduction/health promotion materials to individuals at risk for blood-borne pathogen transmission.

Specifically, research indicates that the hepatitis C virus can be effectively transmitted through contaminated water, cookers, tie-offs, and other equipment used for injection drug preparation and use (Alter, 2002). Male and female condoms, dental dams, lubrication to avoid orifice tears, as well as education on proper use are also integral to OHROCS outreach services. It may be appropriate to gain support for the delivery of some harm reduction materials from the local Medical Officer through standing orders. Such orders add legitimacy and support to the outreach work and health promotion materials delivered. This is an area in which public health Administrators may assist OHROCS staff in further development.

Principle of HR #4: *Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.*

Risk Reduction Counseling and Care Services

According to NIDAA (2005) research, the following benefits of risk reduction counseling may come to fruition if done in accordance with client-centered outreach activities:

- Complement the role of community-based outreach workers by repeating the drug- and sex-related risk reduction messages at each contact, by providing the means for behavior change, and by making referrals to drug treatment and other health services.
- Offer opportunities to drug users to learn their serostatus for HIV, hepatitis B virus (HBV), and HCV;
- Assess and understand their personal risks; and acquire new information and skills to reduce infection risks and prevent transmission to others; and

- Enable seropositive persons to inform their drug and sex partners about potential risk of infection and the importance of getting tested and counseled for HIV, HCV and other blood-borne infections.

Additionally, engagement with clients in the outreach setting is an important part of providing risk reduction counseling. Engagement is more than simply finding people and handing out materials. Engaging clients requires that workers have a minimum skill level at providing information in a clear, concise manner that neither *talks-down-to*, nor *goes-above-the-heads* of the client. CDC's (2005) guidance on IDU client engagement suggests:

- Establishing empathetic and respectful rapport with clients;
- Enlisting clients in behavior change strategies that are collaborative and that can provide small wins for the client in the present;
- Providing factual information in a professional manner that is not value-based or judgmental.

Best practice risk reduction counseling should provide age-, gender-, and culturally specific basic disease transmission risk information and behavioral risk reduction strategies. Key constructs to address during risk reduction counseling include:

- HIV, STD, and hepatitis A, B, and C disease transmission routes;
- Risk assessment of client-specific risk behaviors;
- Non-judgmental health promotion education regarding: safe syringe cleaning techniques, condom use (male and female), vein care, wound care, and personal hygiene;
- Crisis intervention strategies (i.e. in the case of potential harm);
- Incentives appropriate to the outreach and risk reduction activities (when feasible);
- Resource referrals; and
- Any written materials on these and other safe behavioral strategies approved through appropriate program review panels as necessary.

Engaging clients using motivational interviewing skills that take into consideration the transtheoretical stages of change model can enhance the risk reduction counseling opportunity. Technical assistance on gaining skills in motivational interviewing and learning stages of change theory can be provided through the Oregon Public Health.

Research indicates that IDU who have positively engaged with outreach workers three times during a six-month period will follow-up with medical referrals when provided (Greenburg et al, 1998). Non-medical professionals in the street-based outreach risk-reduction counseling setting are often called upon to provide medical referrals as well as materials and education for IDU self-administered basic first aid. Although it is recommended that all OHROCS workers be trained in basic first aid, it is not presently a required component of this intervention, and under no circumstances should outreach workers engage in medical advice or dispensation of medical care.

Principle of HR #5: *Affirms drug users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.*

In accordance with this caveat, care services provided to IDUs on a street level may include emergent basic health promotion education regarding wound care, dental care, foot care, and other health concerns possibly experienced by people living in conditions of poverty and lack of

access to health services.

To clarify, Oregon Revised Statutes indicate that the following comprise characteristics of the provision of *medical* services and a nowhere in this guidance is it mandated or expected that outreach workers will participate in the following:

677.085 What constitutes practice of medicine. A person is practicing medicine if the person does one or more of the following:

- (1) Advertise, hold out to the public or represent in any manner that the person is authorized to practice medicine in this state.
- (2) For compensation directly or indirectly received or to be received, offer or undertake to prescribe, give or administer any drug or medicine for the use of any other person.
- (3) Offer or undertake to perform any surgical operation upon any person.
- (4) Offer or undertake to diagnose, cure or treat in any manner, or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity, defect or abnormal physical or mental condition of any person.
- (5) Except as provided in ORS 677.060, append the letters M.D. or D.O. to the name of the person, or use the words Doctor, Physician, Surgeon, or any abbreviation or combination thereof, or any letters or words of similar import in connection with the name of the person, or any trade name in which the person is interested, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human diseases or conditions mentioned in this section. [Formerly 677.030; 1989 c.830 §3]

Self-care materials distributed during the outreach encounter than can assist IDU in undertaking health promotion behaviors may include: band aids, gauze pads, sterile water, alcohol pads, condoms, oral and personal hygiene equipment including foot powder. It is expected that any client in need of professional medical attention be referred to local medical care when available and supported in obtaining that attention as determined by individual program rules and agency regulations. Support for the delivery of these items during outreach may be gained through standing orders from the

county Medical Officer. This is one avenue to explore to gain documented assistance and credibility for specific outreach items, both first aid and harm reduction in nature.

Services offered to IDU during the regular course of outreach may include HIV testing, HCV screening, viral hepatitis vaccination or any other available public health deliverable. OHROCS programs around the state will determine their own capacity to offer these services on an ongoing basis or during special projects or events intended for such purposes.

Referrals to HIV CTRS and HCV, STD Screening

HIV CTRS has been highlighted as an important element to good HIV prevention programs through the CDC's Advancing HIV Prevention initiative (2003). HIV CTRS offers IDU an opportunity to know their disease status, gain access to valuable HIV-intervention and prevention services as well as supports partner-counseling and notification efforts. HCV and STD screening are also valuable services to offer IDU for these very same reasons. Additionally, recent research indicates that there is a marginal window of opportunity to provide HCV prevention services to newly initiated IDU before they achieve HCV sero-positivity (CDC, 2005). HCV screening is therefore highly recommended as a standard referral for IDU during outreach.

Collaboration

Recommendations designed to develop the community capacity necessary to sustain OHROCS are inherent in OHROCS guidance. Three areas of collaboration that will enhance the OHROCS program and provide necessary service availability for IDU referrals noted above are:

- In-house collaborations;
- Community-based collaborations; and
- Retail-based syringe access strategies.

In-House Collaborations

Collaboration with public health staff colleagues within the local health department will enhance the services available to the target population. In-house collaborations that would ease referrals for IDU include OHROCS staff partnership development with: HIV/HCV prevention staff for CTRS, STD clinic staff for testing; and nurses within the immunization department for on-site, on-demand *Adult 317-funded* hepatitis A and B vaccines. The DHS Immunization Program provides these specific vaccines free to all participating local health departments through the use of specific funds.

Partnerships between the OHROCS staff and the family planning clinic staff can promote easy access to STD screening programs, birth control access and instruction, and may increase the use of the multiple health care

Principle of HR #6: Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

related services needed by people who are served by OHROCS.

Health department or CBO Administration can be allies in developing and promoting in-house and community-based collaborations that will sustain OHROCS. Buy-in from Administration is an essential first step when designing an OHROCS implementation strategy. Administrators may serve as conduits to other professionals in the community that can champion strategic portions of OHROCS. Additionally, Administration can work with the local political infrastructure to advance OHROCS in a way that prioritizes public health needs.

Community-Based Collaborations

Similar to in-house collaborations, key stakeholders within the community must be engaged to support and expand OHROCS program implementation. An important ingredient in OHROCS is client Care and Services (OHROCS). Some care and services, such as health promotion education and referrals to medical care when necessary often occur during the OHROCS outreach experience.

For referral services to be accessed however, community partnerships must be in place. OHROCS staff are advised to develop a local harm reduction or health promotion coalition within their communities. Such coalitions can support the assistance of unique stakeholders that can provide in-kind time and materials supports to maintain and enhance the local OHROCS program. Community collaboration can sustain OHROCS programming even when minimal funds are derived from DHS and other HIV prevention funding streams.

Services that are imperative to a holistic OHROCS approach include, but are not limited to:

- ❖ Drug and alcohol treatment access;
- ❖ Mental health care access;
- ❖ Holistic health care access;
- ❖ Health promotion and harm reduction support group access; and
- ❖ Specialty medical care access if appropriate.

Retail-Based Syringe Access

Oregon Revised Statutes (§§ 475.525, 1987) directly excludes needles from drug paraphernalia laws and expressly excludes the necessity for a prescription requirement to purchase syringes at retail pharmacies in Oregon. Evidence suggests that retail sales of clean syringes is a viable option in decreasing the transmission of blood-borne pathogens (Lurie, Jones, & Foley,2000).

Often however, our partners in retail are not aware of the important public health service they can support by providing syringe access options. Community collaboration and capacity building efforts should be directed specifically toward retail partners to expand

affordable, non-judgmental syringe access to all Oregonians commensurate with the laws of this state and guidance from national medical and public health associations.

“ The American Medical Association, American Public Health Association, Association of State and Territorial Health Officials, National Alliance of State and Territorial AIDS Directors, and the National Association of Boards of Pharmacy believe that coordinated efforts of state leaders in pharmacy, public health, and medicine are needed to address access to sterile syringes as a means of preventing further transmission of blood-borne diseases.” (1999)

Local collaborative efforts of this nature must be done in parallel with DHS-dialogue with pharmacy associations, licensing boards, and other professional affiliations. Working collaboratively on the local and state levels will increase the likelihood of developing appropriate clean syringe accessibility for Oregonians in need of such health promotion supplies.

Principle of HR #7: *Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.*

Evaluation of OHROCS Programs

Within the context of the Advancing HIV Prevention initiative, the Program Evaluation and Monitoring System (PEMS) has been developed to assist HIV prevention programs undertake ongoing performance evaluation. This system provides a viable option for people who are implementing the OHROCS program such that variables associated with outreach, counseling, and referrals are integrated into the PEMS. Presently, all participating harm reduction intervention counties use some form of evaluation mechanism internally or jointly with the HST program at Oregon Public Health. These joint evaluation measures are often in the form of client and material counts as well as capturing encounter place and times.

At this time, there are no recommended changes to these evaluation approaches, any changes will be commensurate with the full implementation of PEMS.

Conclusion

Research conducted over the past twenty years has indicated that HIV and HCV prevention outreach and risk reduction counseling assist IDUs in changing risky behaviors that includes:

- less injection drug use;
- less sharing and reusing of syringes, needles, and other injection equipment;
- increased disinfection of syringes; and
- increased use of condoms during sex (Coyle, Needle, & Norman, 1998).

The OHROCS program has been developed in alignment with these core values of HIV and HCV prevention. Ideally, all IDUs would have equal access to drug treatment facilities and be ready to engage in drug abstinence. Until that time, OHROCS will support maintaining the public's health through measures that are designed to decrease and eliminate blood-borne pathogen transmission associated with injection drug use and risky sexual behaviors. Implementation of OHROCS also seeks to support and refer IDUs to appropriate social and health services as an active part of health promotion for some of the hardest-to-reach people in our communities.

**OHROCS is not a
One-size-fits-all model**

The OHROCS program is designed to support communities and their most marginalized people in maintaining the Department of Human Services' over-arching public health goal of assisting people to become *independent, healthy and safe*.

If technical assistance is needed at any time during the implementation of this guidance please feel free to contact staff within the HIV Prevention Program, HST, Oregon Public Health at 971-673-0153.

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APPENDIX A

WEB-BASED RESOURCES

Suggested Resources for OHROCS Program Development

CDC

<http://www.cdc.gov/outreach/>
<http://www.cdc.gov/ncidod/diseases/hepatitis/>
<http://www.cdc.gov/nchstp/od/nchstp.html>
<http://www.cdc.gov/needledisposal>
<http://www.cdc.gov/nchstp/od/nchstp.html>

Blood-Borne Pathogen Post-Exposure Prophylaxis

[Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis](#)

MMWR, 6/29/01 vol. 50(rr-11)   [Acrobat Reader version](#) (333 KB)

Outreach Competencies, Minimum Standards for Conducting Street Outreach for Hard-to-Reach Populations

http://www.ceattc.org/OtherPDF/Counselor_competencies.PDF
<http://www.ceattc.org/chhatt.asp>

NIDAA Community-Based Outreach Model

<http://www.nida.nih.gov/CBOM/CBOM.html>

Outreach Models From a Variety of Disciplines

<http://hab.hrsa.gov/special/outreach.htm>
<http://hab.hrsa.gov/special/%5CSPNS05RPT%5Coutreach.htm>
<http://www.ndri.org/ctrs/aop.html>
<http://www.cdc.gov/hiv/PROJECTS/AESOP/storytelling.htm>
<http://cnx.org/content/m12706/latest/>

Rural Outreach Grant Mechanisms

<http://ruralhealth.hrsa.gov/funding/outreach.htm>
http://www.federalgrantswire.com/rural_health_outreach_and_rural_network_development_program.html
<http://www.tnpca.org/documents/OUTREACH%20MODEL%202.doc>

Harm Reduction

<http://www.harmreduction.org/>
<http://www.hepcproject.org/>
<http://www.hcsm.org/online-ed/>

Hepatitis C Specific Links

<http://egov.oregon.gov/DHS/ph/acd/svhpg/svhpg.shtml>
<http://oregon.gov/DHS/ph/acd/reporting/guideln/guideln.shtml>
<http://egov.oregon.gov/DHS/ph/hiv/index.shtml>
<http://www.cdc.gov/ncidod/diseases/hepatitis/c/index.htm>
<http://hcvoregon.org/>
<http://www.cascadeaids.org/>
http://cduhr.ndri.org/docs/factsheets/CDUHR_StopHepCProj_FactSheet.pdf
http://hcvets.com/data/transmission_methods/transmission.htm
<http://www.hcvadvocate.org/>
www.nasen.org/
http://nj.gov/health/cd/f_hepac.htm
<http://www.naccho.org/topics/infectious/hepatitisC.cfm>
<http://www.hepcchallenge.org/>
<http://www.hcvinprison.org/>
<http://www.anypositivechange.org/>
<http://www.1800safety2.com/>
<http://www.nhchc.org/>
<http://www.effectiveinterventions.org/>

State of Oregon Public Health

<http://egov.oregon.gov/DHS/ph/acd/svhpg/svhpg.shtml>
<http://egov.oregon.gov/DHS/ph/hiv/index.shtml>
<http://egov.oregon.gov/DHS/ph/std/index.shtml>

**Public Health Information Line ~ HCV Information:
1-866-703-4696**

Please Note: Oregon Public Health does not officially endorse any advocate, vendor, pharmaceutical, or other agency-specific website listed – these resources are to be accessed per user discretion.

APPENDIX B

OHROCS Readiness Assessment

OHROCS – Is Your Agency Ready?

Before implementing your tailored OHROCS program to people who inject drugs in your community, you will want to ensure that you have the necessary components in place. The tasks identified in this table are designed to identify the minimum foundation necessary for OHROCS implementation in your community. IF one or more of these components is *almost ready*, or *not ready*, there is more to be done before that first client is approached. Feel free to use the technical assistance provided by the HIV Prevention Staff or other colleagues using OHROCS.

Task	<i>Ready</i>	<i>Almost Ready</i>	<i>Not Ready</i>
<p>1. Portion or full fte (personnel) is identified and dedicated to materials maintenance, outreach, volunteer coordination, or staff oversight. IF not <i>Ready</i> the next steps are:</p> <ul style="list-style-type: none"> • • • 			
<p>2. Personnel has working knowledge of: harm reduction strategies, culturally appropriate communication styles, and blood-borne pathogen transmission. IF not <i>Ready</i> the next steps are:</p> <ul style="list-style-type: none"> • • • 			
<p>3. Personnel has collaborative dialogue with in-house colleagues regarding harm reduction work with IDU, including referrals. IF not <i>Ready</i> the next steps are:</p> <ul style="list-style-type: none"> • • • 			
<p>4. Personnel has collaborative dialogue with out-of-house colleagues regarding harm reduction work with IDU, including referrals. IF not <i>Ready</i> the next steps are:</p> <ul style="list-style-type: none"> • • • 			

Task	<i>Ready</i>	<i>Almost Ready</i>	<i>Not Ready</i>
5. Personnel has taken HIV and HCV trainings with the Oregon Public Health or another certification entity within the last 2 years. IF not <i>Ready</i> the next steps are: <ul style="list-style-type: none"> • • • 			
6. Personnel has gathered appropriate harm reduction materials for distribution to client population. IF not <i>Ready</i> the next steps are: <ul style="list-style-type: none"> • • • 			
7. Personnel has identified a gatekeeper within target population community to access client population. IF not <i>Ready</i> the next steps are: <ul style="list-style-type: none"> • • • 			
8. Sponsoring agency has worked with political and law enforcement agencies and gained support for harm reduction work in community. IF not <i>Ready</i> the next steps are: <ul style="list-style-type: none"> • • • 			
9. Sponsoring agency has worked with Oregon Public Health HIV prevention staff to ensure support and technical assistance. IF not <i>Ready</i> the next steps are: <ul style="list-style-type: none"> • • • 			

APPENDIX C

Oregon Revised Statute Language

Oregon Revised Statutes (§§ 475.525, 1987)

DRUG PARAPHERNALIA Section

475.525 Sale of drug paraphernalia prohibited; definition of drug paraphernalia; exceptions. (1) It is unlawful for any person to sell or **deliver, possess** with intent to sell or deliver or manufacture with intent to sell or deliver drug paraphernalia, knowing that it will be used to unlawfully plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, **prepare**, test, analyze, pack, repack, store, contain, conceal, **inject**, ingest, inhale or otherwise introduce into the human body a controlled substance as defined by ORS 475.005. (2) For the purposes of this section, "drug paraphernalia" means all equipment, products and **materials of any kind which are marketed for use or designed for use** in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, **preparing**, testing, analyzing, packaging, repackaging, storing, containing, concealing, **injecting**, ingesting, inhaling or otherwise introducing into the human body a controlled substance in violation of ORS 475.940 to 475.995. Drug paraphernalia includes, but is not limited to:

- (a) Kits marketed for use or designed for use in unlawfully planting, propagating, cultivating, growing or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived;
- (b) Kits **marketed** for use or designed for use in manufacturing, compounding, converting, producing, processing or preparing controlled substances;
- (c) Isomerization devices marketed for use or designed for use in increasing the potency of any species of plant which is a controlled substance;
- (d) Testing equipment marketed for use or designed for use in identifying or in analyzing the strength, effectiveness or purity of controlled substances;
- (e) Scales and balances marketed for use or designed for use in weighing or measuring controlled substances;
- (f) Diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose and lactose, marketed for use or designed for use in cutting controlled substances;
- (g) Separation gins and sifters marketed for use or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining marijuana;
- (h) Containers and other objects marketed for use or designed for use in storing or concealing controlled substances; and
- (i) Objects marketed for use or designed specifically for use in ingesting, inhaling or otherwise introducing marijuana, cocaine, hashish or hashish oil into the human body, such as:
 - (A) Metal, wooden, acrylic, glass, stone, plastic or ceramic pipes with or without screens, permanent screens or hashish heads;
 - (B) Water pipes;
 - (C) Carburetion tubes and devices;
 - (D) Smoking and carburetion masks;
 - (E) Roach clips, meaning objects used to hold burning material that has become too small or too short to be held in the hand, such as a marijuana cigarette;

- (F) Miniature cocaine spoons and cocaine vials;
- (G) Chamber pipes;
- (H) Carburetor pipes;
- (I) Electric pipes;
- (J) Air-driven pipes;
- (K) Chillums;
- (L) Bongs;
- (M) Ice pipes or chillers; and
- (N) Lighting equipment specifically designed for the growing of controlled substances.

(3) Drug paraphernalia **does not include hypodermic syringes or needles.**

(4) In determining whether an object is drug paraphernalia, a trier of fact should consider, in addition to all other relevant factors, the following:

- (a) Instructions, oral or written, provided with the object concerning its use;
- (b) Descriptive materials accompanying the object which explain or depict its use;
- (c) National and local advertising concerning its use;
- (d) The manner in which the object is displayed for sale;
- (e) The existence and scope of legitimate uses for the object in the community; and
- (f) Any expert testimony which may be introduced concerning its use.

(5) The provisions of ORS 475.525 to 475.565 do not apply to persons registered under the provisions of ORS 475.125 or to persons specified as exempt from registration under the provisions of that statute. [1989 c.1077 s.1; 1995 c.440 s.10]

475.535 Action to enforce ORS 475.525 to 475.565. The State of Oregon, any political subdivision of the state, or any official or agency of the state or its political subdivisions may bring an action to enforce ORS 475.525 to 475.565. The court shall award costs and reasonable attorney fees to the prevailing party in any such action. [1989 c.1077 s.2]

475.545 Order of forfeiture of paraphernalia; effect. If, at the trial or upon a hearing, the trier of fact finds any item received into evidence at the trial or hearing to be drug paraphernalia, the court may order the item forfeited upon motion of the district attorney. The drug paraphernalia may then be destroyed or, if the paraphernalia is of substantial value and is not contraband, may be sold, the proceeds to be deposited in the Common School Fund. [1989 c.1077 s.3]

475.555 Seizure of drug paraphernalia. An official of the state, its political subdivisions or any agency thereof may seize drug paraphernalia when:

- (1) The drug paraphernalia is the subject of an adverse judgment under ORS 475.525 to 475.565;
- (2) The seizure is in the course of a constitutionally valid arrest or search;
- (3) The owner or person in possession of the drug paraphernalia consents to the seizure; or
- (4) The seizure is pursuant to a lawful order of a court, including an order issued under ORCP 83 or ORS 166.725. [1989 c.1077 s.5]

HYPODERMIC DEVICES

475.805 Providing hypodermic device to minor prohibited; exception. (1) No person shall sell or give a hypodermic device to a minor unless the minor demonstrates a lawful need therefor by authorization of a physician, parent or legal guardian or by other means acceptable to the seller or donor.

(2) As used in this section, "hypodermic device" means a hypodermic needle or syringe or medication packaged in a hypodermic syringe or any instrument adapted for the subcutaneous injection of a controlled substance as defined in ORS 475.005.
[1983 c.738 s.1]

APPENDIX D

Sharps Standards & Regulations

**National Institute of Occupational Safety and Health
and
Occupational Safety and Health Administration (OSHA)
Guidelines Regarding Disposable Sharps**

NIOSH Sharps Disposal Manual available from:

<http://www.cdc.gov/niosh/sharps1.html>

OSHA Sharps Guidelines available from:

[http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051#1910.1030\(d\)\(2\)\(i\)](http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051#1910.1030(d)(2)(i))

Per OSHA: Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be:

1910.1030(d)(2)(viii)(A)

Puncture resistant;

1910.1030(d)(2)(viii)(B)

Labeled or color-coded in accordance with this standard;

1910.1030(d)(2)(viii)(C)

Leakproof on the sides and bottom; and

1910.1030(d)(2)(viii)(D)

In accordance with the requirements set forth in paragraph (d)(4)(ii)(E) for reusable sharps.

APPENDIX E

Harm Reduction Fact Sheets

Your County/CBO Logo Here

Fact Sheet: Syringe Access & Disposal Programs

It is estimated that an individual IDU injects about 1,000 times a year. This adds up to millions of injections, creating an enormous need for reliable sources of sterile syringes. Syringe exchange programs (SEPs) provide a way for those IDUs who continue to inject to safely dispose of used syringes and to obtain sterile syringes at no cost. (CDC, 2005)

- ❖ Adequate community-based syringe disposal sites have been found to decrease the number of contaminated syringes found in areas where bystanders could come in contact with them.^{1,2,3,4}
- ❖ According to the Center's for Disease Control and Prevention, use of clean injection drug equipment is the best way to prevent new hepatitis C infections, and decrease HIV infections among people who inject drugs.¹
- ❖ Syringe exchange programs have been shown to not increase injection drug use.^{5,6}
- ❖ Evidence suggests that IDUs who utilize syringe exchange are less likely to share needles or drug paraphernalia compared to those that do not utilize syringe exchange programs.⁷
- ❖ Syringe exchange programs have demonstrated the ability to link IDUs to drug treatment and other health services.^{8,9,10}

References

1. Centers for Disease Control (2005). *Morbidity and Mortality Weekly Report*. 54(27), 673-676.
2. Doherty, M. C., Junge, B., Rathouz, P., Garfein, R. S., Riley, E. & Vlahov, D. (2000). The effect of a needle exchange program on numbers of discarded needles: A 2-year follow up. *American Journal of Public Health*. 90(6), 936-939.
3. Watters, J. K. & Estilo, M. J. (1994). Syringe and needle exchange as HIV/AIDS prevention for injection drug users. *JAMA*. 271(2), 115.
4. Lurie, P., Reingold, A. L., Bowser, B., Chen, D., Foley, J., Guydish, J., et al. (1993) *The public health impacts of needle exchange programs*. Retrieved November 15, 2005, from University of California, San Francisco: <http://www.caps.ucsf.edu/publications/needlereport.html>
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9. Hagan, H. & McGough, J. P. (2000). Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment*, 19(3), p. 247.
10. Brooner R., Kidorf M., King V., Beilenson P., Svikis D., & Vlahov D. (1998). Drug Abuse Treatment Success Among Needle Exchange Participants. *Public Health Reports*, 113(Supp.1), p. 129-139.

Fact Sheet: Why Pharmacy Access to Syringes Is Important

- ❖ Lack of access to sterile syringes increases the chance of sharing syringes. Sharing contaminated needles can lead to the transmission of diseases such as HIV, HBV, and HCV.
- ❖ IDUs will legally purchase needles and engage in safer behaviors if they have the ability to do so.¹
- ❖ Pharmacies are reliable sources of sterile syringes, **and can provide:**
 - conveniently located in most neighborhoods and often have extended hours of operation;
 - trained staff and licensed health care professionals who are able to provide sound medical advice and to make referrals for a variety of related services, including HIV testing and counseling, substance abuse treatment, health care and other community services;
 - the existing infrastructure, including the staff and inventory, to offer syringe sales as part of their ongoing services, without the expenditure of public funds;
 - privacy for the person who does not want to be identified as an IDU; and
 - some disposal options for used syringes.²

References

1. Groseclose, S. L., Weisnstein, B., Jones, T. S., Valleroy, L. A., Fehrs, L. J. & Kassler, W. J. (1995). Impact of increased legal access to needles and syringes on community pharmacies' needle and syringe sales-Connecticut, 1992-1993. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 10, 73-81.
2. Centers for Disease Control (2005). *Pharmacy sales of sterile syringes*. *National Center for HIV, STD, and TB Prevention*, Retrieved May 20, 2006, from http://www.cdc.gov/idu/facts/aed_idu_phar.

Your County/CBO Logo Here

Fact Sheet: What is the Harm Reduction Approach

7 key principles of Harm Reduction¹:

1. Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
2. Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others. * Establishes quality of individual and community life and well-being--not necessarily cessation of all drug use--as the criteria for successful interventions and policies.
3. Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
4. Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them
5. Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
6. Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
7. Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

References

1. Harm Reduction Coalition <http://www.harmreduction.org/>

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Fact Sheet: Defending the Harm Reduction Approach Intra-Agency Tool

Often in the course of harm reduction program planning, policy development and implementation the need for educating non-harm reductionists can occur. Although unusual in most professional fields, proponents of harm reduction programs not only need to provide evidence supporting their programs they must also provide evidence against the *enabling* mentality often associated with this work. The following strategies for engagement are adapted from a workshop delivered at the National Harm Reduction Conference in Oakland, California in November 2006.

- ❖ **Acknowledge the knowledge of others.** People *know* that taking drugs is a harmful activity, thus the perceptions of supporting people in activities that make drug-taking safe is considered *enabling* and in some cases immoral.
- ❖ **Acknowledge the experience of others.** Often people have personal real-life experiences associated with drug use and/or abuse. These experiences can be valuable in assisting others to see that a variety of methods can be used to decrease harms associated with experiences like theirs.
- ❖ **Acknowledge the skills of others.** Self-esteem is closely linked to one's skill or abilities. If people are used to doing a certain thing one way (i.e. drug and alcohol abstinence counseling) asking them to attain a whole new skill set (i.e. harm reduction counseling techniques) can appear daunting. Provide support for new skill development as part of the harm reduction dialogue.

When people come into a training, meeting or presentation they usually have some years of experience working in their field – they may have more experience working with people who use drugs than we do. Consequently, when people begin to object, question, or protest harm reduction program methodologies they may be considering changing their attitudes, knowledge base, and skill sets that have supported them throughout this work. Being supportive of this process and clear with the evidence from the harm reduction field can provide a strong foundation to help non-harm reductionists move across the stages of change to become a strong ally of program development, policy, or implementation.

Source

1. Alessandra Ross: aross@dhs.ca.gov

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Fact Sheet: Public Health and Public Safety – Partnership

- ❖ Public health and law enforcement efforts are increasingly overlapping in relation to public health interventions.¹
- ❖ Public health and law enforcement have different methods of determining resolution of overall public safety.²
- ❖ Public health and law enforcement can work effectively together if good communication is engaged upon by the parties involved.³
- ❖ Public health and law enforcement can work together to support good public health interventions through bridge-building efforts at the local level.³

References

1. Butler JC, Cohen ML, Friedman CR, Scripp RM, Watz CG. Collaboration between public health and law enforcement: new paradigms and partnerships for bioterrorism planning and response. Emerg Infect Dis [serial online] 2002 Oct [date cited];8. Available from: URL: <http://www.cdc.gov/ncidod/EID/vol8no10/02-0400.htm>
2. Sidel VW, Cohen HW, Gould RM. [Good intentions and the road to bioterrorism preparedness](#). Am J Public Health 2001; 91:716–8.
3. Khan AS, Morse S, Lillibridge S. [Public-health preparedness for biological terrorism in the USA](#). Lancet 2000;356:1179–82

APPENDIX F

Program Procedures & Guideline
~Examples~



EXAMPLE

Lane County Public Health

HIV and Hepatitis Prevention Programs

Policies/Procedures

for

Outreach to MSM and IDU

August 16, 2005

Lane County Public Health

HIV and Hepatitis Prevention Programs

The following policies and procedures are hereby approved for directing the HIV and Hepatitis Prevention Programs outreach services provided by Lane County Public Health.

Sarah Hendrickson, M.D.

Date

Betsy Meredith, R.N., M.S.N

Date

LANE COUNTY PUBLIC HEALTH

HIV & Hepatitis Prevention Programs

Policies/Procedures: Outreach to MSM and IDU

August 16, 2005

- I. Introduction
- II. Outreach and Intervention Policies
- III. Procedures
 1. General and Personal Safety
 2. The location
 3. Types of Interventions that We Do Offer
 4. Types of Interventions that We Do Not Offer
 5. Needle Exchange Services
 6. Personal Boundaries
 7. Confidentiality
 8. Non-dual Relationships with Clients
 9. Volunteers
 10. HIV Counseling & Testing in the Field
 11. Money
 12. Not identifying clients to those in the area

LANE COUNTY PUBLIC HEALTH

HIV & Hepatitis Prevention Programs

Policies/Procedures: Outreach to MSM and IDU

August 16, 2005

I. INTRODUCTION

Lane County Public Health (LCPH) offers HIV and Hepatitis prevention outreach and services to those at high-risk for HIV & HCV infection and transmission. Specifically, we target Men who have Sex with Men (MSM) and Injection Drug Users (IDU). These two populations are also at-risk for Hepatitis A&B, which are both communicable diseases themselves, and can cause complications with an HIV or HCV infection.

Within the MSM and IDU populations, we work to reach those most at-risk and to shift community and population norms to less risky behavior. We offer some of our services cooperatively with other Lane County programs (Methadone, Adult Corrections), HIV Alliance, and other local organizations and agencies. Our outreach and intervention services are offered in-house, on the streets, and in areas where high-risk clients gather. Incentives (safer sex and harm reduction supplies, money, vouchers) to seek our prevention services (including HIV Testing) may be offered when available. The provision of outreach and HIV & Hepatitis prevention services to high-risk populations is not primarily fee-based.

II. OUTREACH AND INTERVENTION POLICIES

1. **All information about persons who inquire about our services, who request our services, and who seek our services will be handled with the highest degree of confidentiality (see current Lane County Confidentiality policy, Lane County Health and Human Services HIPPA policy, and Confidentiality in section 6 of this document).**
2. **The relationship between an outreach worker (staff or volunteer) and a client shall be governed by the guidelines listed in this Policy and Procedures manual. See Non-dual Relationships with Clients (section 7) for those guidelines and the definition of “client”.**
3. **Clients can seek our services without sharing their identities.**
4. **All services, supplies, brochures, educational materials, and interventions will use the harm reduction and risk reduction model (section 3).**
5. **LCPH HIV & Hepatitis Prevention outreach workers may offer Needle Exchange services.**
6. **LCPH HIV & Hepatitis Prevention outreach workers shall not offer medical advice to our clients. That service may be offered by other agencies that work with us during outreach.**
7. **HIV tests that are given during outreach will follow the LCPH 2004 Policies/Procedures for HIV Counseling and Testing (see “Testing in**

the Field,” section V. B. 2004) and 2005 Rapid HIV Testing Standing Order (see “Site Specific Issues” 2005).

8. Outreach and intervention services will operate in accordance with the laws of Oregon, Lane County, Eugene, Springfield, and any other jurisdictions that may apply.
9. All staff and volunteers participating in the outreach programs of LCPH shall attend trainings on HIV Prevention & Harm Reduction and Street Outreach (offered regularly by LCPH and may include other agencies).
10. All volunteers must be qualified and on the active list of volunteers for Lane County Health and Human Services/Public Health/HIV & Hepatitis Program to continue to participate in Lane County HIV & Hepatitis outreach programs (including a finger print check and/or LEDS check).
11. Outreach staff and volunteers shall not represent the program to media without prior clearance from a Public Health supervisor or program manager.
12. In the course of outreach activities, outreach staff and volunteers will work to not identify clients as MSM or IDU to other people in the outreach area.

III. OUTREACH AND INTERVENTION PROCEDURES

1. General and Personal Safety

- a. Two or more workers: Outreach will only be conducted with more than 1 outreach worker (2+ staff and volunteers). This may include staff and volunteers from other agencies (HIV Alliance, New Roads) as well as LCPH.
- b. Cell Phone: Outreach workers will always carry a cell phone. The cell phone number will be left with the front office staff at LCPH. The phone will remain on at all times that the staff and volunteers are out of the LCPH building during outreach.
- c. Checking-out and checking-in: Outreach workers will check out at the front office before leaving for outreach. This will include noting a clear return time on the check-out board.
- d. Assessing the Setting and Situation: The outreach workers will assess each new setting and situation before entering it.
- e. Leaving the Situation or Area: The outreach workers will leave anytime the interaction with a client(s) or the overall situation feels unsafe.
- f. Assessing a Client: All outreach workers shall assess whether a client is safe and appropriate before approaching him/her.
- g. Refusing Services: Each outreach worker is responsible for setting his/her boundaries ahead of time and knowing how s/he will turn down a client.

- h. Terminating HIV Testing with a Client: A counselor may terminate a testing session for safety of the client, counselor, outreach worker, or other persons.
- i. Personal Safety Devices: All outreach workers will have the option of carrying a personal alarm (pull-string sound alarm) during outreach.
- j. No Weapons: Outreach workers are not allowed to carry or possess weapons of any kind (gun, knife, stun gun) during outreach.
- k. Needle Stick Safety: No staff/volunteer will touch used needles. Clients will deposit their own needles into a sharps container or return their used needles in a closed sharps container. All volunteers will be trained in needle stick prevention. (See Needle Stick Response under #5 Needle Exchange Services.)
- l. Emergency: All staff/volunteers will know the emergency numbers for LCPH or have them programmed into their personal/agency cell phone. For emergency medical situations, call 911.
- m. Incident Report: When necessary, all staff/volunteers will fill out an incident report form in accordance with LCPH policy.

2. The Location

- a. Outreach workers will visit new high-risk locations prior to doing outreach there and assess the areas for potential outreach.

- b. When visiting homeless camps, staff will try to arrange an invitation and be escorted by a client who either lives at the camp or visits there so as to have a smooth transition into each camp.

3. Types of Interventions that We Do Offer

Note: All of our services are based on the principles of Harm Reduction/Risk Reduction (as defined by the Harm Reduction Coalition)

- a. Information sharing: facts about HIV, Hepatitis, risk reduction, harm reduction
- b. Needle Exchange: Lane County Public Health offers clean needles and needle exchange and disposal services
- c. Supplies: safer sex and safer injection (harm reduction) supplies including sharps containers (biohazard containers) and sharps/needle disposal.
- d. Counseling and skill building: improve client's self-perception of risk for HIV/Hepatitis/STDs, support attempts that the client has already made, offer skills building and insights into risk reduction, negotiate realistic plan for reducing risk.
- e. Referrals which include but are not limited to: HIV testing, HIV care, STD screening and treatment, Hep A & B vaccinations, Needle Exchange services, Hepatitis C testing and treatment, Drug and

Alcohol Detoxification, Drug and Alcohol treatment, Medical treatment, Mental Health Services, and other basic social services

- f. HIV Counseling & Testing Services
- g. Educational brochures and promotional materials

4. Types of Interventions that We Do Not Offer

- a. Medical advice. We do not offer or give medical advice to clients. We refer all medical questions to a doctor or an Emergency Room that has policy of serving homeless and IDU clients with dignity and respect.

5. Needle Exchange Services

- a. Listed below are the two state laws that affect the operations of syringe exchange programs in Oregon:

- i. ORS 475.525(3)

Section 1 Line 27 (3)

Drug paraphernalia does not include hypodermic syringes or needles

- ii. ORS 475.805

Hypodermic Devices

475.805 Providing hypodermic device to minor prohibited; exception

(1) No person shall sell or give a hypodermic device to a minor unless the minor demonstrates a lawful need therefore by

authorization of a physician, parent or legal guardian or by other means acceptable to the seller or donor.

(2) As used in this, “hypodermic device” means a hypodermic needle or syringe or medication packaged in a hypodermic syringe or any instrument adapted for the subcutaneous injection of a controlled substance as defined in ORS 475.005. [1983 c.738]

- b. Age Limit: No client under the age of 18 may receive new needles from our program unless allowed in accordance with Oregon State law. Clients under the age of 18 can access all other services.
- c. Needles: Staff/volunteers will never handle used needles.
- d. Counting Needles: Staff/volunteers will never handle used needles. Clients will estimate the number of used needles they are exchanging. If a client has no needles to exchange, then they may take a 10-pack (a bag with safer-injection and harm reduction supplies).
- e. Needle Stick Response: All staff and volunteers who are participating in IDU Outreach and needle exchange will receive a copy of Lane County Public Health’s Needle Stick Protocol.

6. Personal Boundaries

- a. To protect the outreach workers as well as clients and potential clients, outreach workers should:

- i. Identify oneself as an outreach worker within the first 3 sentences after approaching or being approached by a client
- ii. Deflect come-ons and immediately share with the client that staff and volunteers are on agency time and are there to provide services
- iii. Wear identifying clothing or outreach bag so clients can learn to recognize outreach workers as being on agency time and available to provide services
- iv. Not accept personal gifts from anyone during outreach (donations to LCPH and agency programs are permissible)
- v. Not be at outreach sites on agency time and personal time within the same 24-hour period (same day)

7. Confidentiality

- a. Staff/volunteers will sign and comply with the Lane County Health & Human Services Confidentiality Policy
- b. Staff/volunteers will comply with the Lane County Health & Human Services HIPPA Policy
- c. Staff/volunteers will not share information about a client to law enforcement, other service agencies, other clients, or anyone else unless there is a release form signed by the client or it is required by law.

8. Non-dual Relationships with Clients

- a. Many people will be approached during outreach. Those who access our services (HIV CTRS or harm/risk reduction counseling) are considered clients.
- b. All people in corrections, detention, and treatment centers where we provide testing services or prevention/education are considered clients.
- c. All minors in any group presentations are considered clients.
- d. All people exchanging needles or getting clean needles and harm reduction supplies are considered clients.
- e. People getting supplies, event information, and general information without asking for HIV or Hepatitis information or services (and other interactions that are not classified as harm/risk reduction counseling) are not considered a client.
- f. It is our goal to be dedicated to the well-being of clients, including for staff and volunteers to recognize the potential vulnerability of clients as well as potential power imbalance in the county-client relationship.
- g. To protect the welfare of the client, staff/volunteers of LCPH cannot have a dual relationship with clients for at least three months after the client last sought services at LCPH HIV/Hepatitis/STD program where the staff/volunteer worked and performed services for the client.

- h. "Dual relationships" are defined as any relationship, separate and in addition to the one established by a client's access and use of county services.
- i. In order to assist in avoiding the possibility of client confusion about multiple relationships after a client has received services, staff and volunteers should avoid intentional personal contact with clients for 3 months after the client last sought services at LCPH HIV/Hepatitis/STD program where the staff/volunteer worked and performed services for the client.
- j. For HIV Counseling and Testing services, see existing restrictions listed in HIV Testing Policies and Procedures (2004).

9. Volunteers

- a. Criminal History Checks are part of the screening process for volunteers.
- b. Training/Qualification: Volunteers must qualify by being trained in HIV Prevention & Harm Reduction and Street Outreach. NEX volunteers will also be trained in blood-borne pathogens prevention and needle stick prevention. Volunteers may be trained by other agencies, but must be signed off by LCPH HIV program staff and/or the Nursing Supervisor before being on the Active List of volunteers.

- c. Active List: Volunteers must be on the LCPH list of active volunteers in order to provide HIV prevention services to clients. HIV program staff and the Nursing Supervisor have copies of the active list of volunteers.
- d. Warrant: A volunteer/staff cannot participate in outreach or provide services in the field if s/he has a warrant out for his/her arrest.
- e. Background: A volunteer/staff cannot participate in outreach or provide services in the field if s/he has been convicted of sexual assault, sex with a minor, or any other charges that may create a real or perceived threat to a client or the program.
- f. Alcohol/Drugs: Volunteers will not report for assignment under the influence of alcohol or other drugs. Volunteers cannot use alcohol or other drugs during outreach or when providing services for LCPH. Volunteers will not possess, distribute, or sell alcohol or other drugs when providing services for LCPH [or at the same locations where LCPH services were provided within the same 24-hour period (same day)]. See #6 a.v.].
- g. Vaccinations: MSM volunteers will have a current TB test. NEX volunteers will have a current TB test, be current for Tetanus vaccination, and are strongly encourage to be vaccinated against Hepatitis A and B.
- h. Guests: Guests are not allowed unless they are from another agency providing HIV or harm reduction services or are invited by LCPH

outreach staff. All guests must be cleared through the Nursing Supervisor first.

10. HIV CTS in the Field

- a. See Field Testing in HIV Testing Policies and Procedures (2004)
- b. See Rapid HIV Testing Standing Order (2005)

11. Money

- a. Staff and volunteers shall have no more than \$80 (each) in their possession (agency testing incentive money and personal) during outreach that involves HIV testing.

12. Not identifying clients to those in the area

- a. Outreach workers should try to diminish the chances of identifying clients as MSM (men cruising for sex) or IDU (drug users) to anyone in the outreach area including the general public.



Lane County Public Health
HIV and Hepatitis Prevention among Injection Drug
Users
New Program for 2004-2005
7 October 2004

I. SERVICES:

1. Rural Needle Exchange (Creswell & Cottage Grove – including secondary exchanges)
2. IDU Street Outreach & Needle Exchange (parks and homeless camps)
3. Harm Reduction Education and HIV Testing in:
 - alcohol and drug treatment centers
 - Lane County Community Correction Center (CCC)
4. IDU Clinics providing: HIV testing, Hepatitis A/B vaccinations, Hepatitis C education
5. Integrate other Public Health Services into outreach and referrals

II. PROGRAM STRUCTURE:

1. Work to increase state and federal funding coming from Oregon Department of Human Services to Lane County Public Health for HIV and Hepatitis Prevention among Injection Drug Users
2. Create and maintain a core group of volunteers

III. COMMUNITY EDUCATION & COLLABORATION¹:

1. Increase accessibility to clean needles through pharmacies
2. Increase accessibility for proper disposal of needles (24-hour drop sites)
3. Harm Reduction education with key community members:
 - staff in alcohol and drug treatment centers
 - law enforcement
 - doctors, nurses, and case managers in hospitals
 - city, county, and other officials
4. Request support from city, county, and other officials for community-wide Harm Reduction and Needle Exchange programs.

¹ In conjunction with HIV Alliance and the Sana Needle Exchange Advisory Board

OUTREACH WORKER INDUSTRY STANDARDS		updated 3-9-04
<p>GOAL: outreach workers in Clark, Douglas and Multnomah County will define our ideal industry standards for worker safety and quality assurance.</p>		
<p>OBJECTIVES:</p> <p>1] an ideal industry standard will be created, approved by HRC, and adopted by our sponsoring agencies as of May 1, 2004.</p> <p>2] our work group is dedicated to being inclusive in gathering input and sharing the finished product.</p>		
<p>“Outreach” applies to: workers who seek out clients and/or provide services in the field.</p>	<p>Types</p> <ul style="list-style-type: none"> - NEX fixed - NEX mobile - bath house - bar/club/studio - street 	<p>Players</p> <ul style="list-style-type: none"> - WIAR - OI - CAP - MCHD - YBR - Clark Co. - Douglas Co.
<p>INDUSTRY STANDARDS</p> <p>1] sponsoring agencies will provide adequate supplies and safety equipment in line with program goals.</p> <p>2] for needle exchange interactions, participants will receive at least three new syringes even if they do not bring back used syringes.</p> <p>3] outreach efforts (methods, times, days, locations) will be evaluated regularly.</p> <p>4] workers will have access to a (cell) phone during each shift.</p> <p>5] workers will always have the option of working with a partner during outreach.</p> <p>6] sponsoring agencies will adequately train outreach workers, and provide access to further education in their line of work.</p> <p>7] outreach workers will be guaranteed support from sponsoring agencies in working with local law enforcement, business owners, and media.</p> <p>8] it is never okay for an outreach worker to be harassed (verbally, sexually, etc).</p>		
<p>METHOD:</p> <ul style="list-style-type: none"> - HRC votes by consensus at the March 16 meeting to accept this industry standard, or to revise it. - If not accepted, HRC members revise until it is accepted. - When accepted, members of HRC bring it back to their agency outreach workers (volunteer and staff) for approval. - We are looking for consent and strength in numbers: HRC members show this standard to all outreach workers at their agency, ask for their approval, take a headcount for who agrees with it, and bring this info back to the HRC meeting on April 20. 		

UNDERSTANDING HIV PREVENTION "OUTREACH"

SOME DEFINITIONS ~ **Multnomah County**

CDC Definition

". . . educational intervention generally conducted by peer or paraprofessional educators face-to-face with high risk individuals in the client's neighborhoods or other areas where clients typically congregate. Outreach usually included distribution of condoms, bleach, sexual responsibility kits, and educational materials . . . "

Delaware Division of Public Health Definitions

(Adopted from: Delaware Comprehensive HIV Prevention Plan 2005-2009, Chapter 5)

The following definitions have been created to supplement the CDC guidelines and to meet the need of outreach workers to describe the quality of the continuum of interactions experienced in the field.

Materials Distribution

- Materials dropped at an unmanned site for access by target audience without staff contact. This would be recorded by number of items left at each site and number of units taken.
- The primary objective of this service is to provide an easy point of access to materials and equipment used to educate and to reduce risk of HIV/STD infection.

Promotional Contact (no minimum time)

- An interaction in which the program's promotional materials are distributed directly to the contact by the outreach worker to increase awareness of the services the program provides and does not involve educational/risk-reduction materials or conversation that is directly related to risk reduction/skills building for HIV/AIDS/STD infection.
- The primary purpose of this interaction is to advertise the program and its services.

Rapport Building Contact (no minimum time)

- An interaction in which promotional and educational/risk-reduction materials are distributed directly to the contact by the outreach worker and includes a rapport building conversation ("small talk") in which information directly related to risk reduction/skills building is not the primary content.
- The purpose of this interaction is to establish rapport with the contact that can be built upon during a subsequent interaction.

Standard Contact (minimum time: 10 minutes for traditional outreach, 5 minutes for indigenous/peer modalities for hard to reach populations)

- An interaction in which promotional and educational/risk-reduction materials are distributed by the outreach worker directly to the contact and in which education directly related to skill building risk reduction is provided. This interaction does not delve into the client's personal risks, but rather provides general education materials, skills that the client applies to him/herself without assistance from the worker.
- The purpose of this interaction is to provide general education relative to skills building/risk reduction and to provide referrals, reference materials, and/or equipment for future use.

In-Depth Contact (minimum time: 15 minutes)

- An interaction in which promotional and educational/risk-reduction materials are distributed by the outreach worker directly to the contact and in which education directly related to skills building/risk reduction specific to the contact is provided. In this interaction, the client reveals personal risks and asks the worker to provide specific education/materials that the client applies

to him/herself with assistance from the worker. Though, the contact may or may not result in a plan for behavioral change, it generally does not involve a formal plan for follow-up (as in an ILI).

- The purpose of this interaction is to provide client-specific, in-the-moment, education relative to skills building/risk reduction as requested by the client and to provide referrals, reference materials, and/or equipment for future use

Possible Evaluation Points for Outreach

Process Evaluation and Monitoring

1. Is the intervention based on a consistent curricula/procedure?
2. To what extent are standardized forms and tools use consistently and reliably?
3. To what extent are services adherent to the definitions of outreach services?
4. To what extent does the contacted client population match the demographics of the target population specified in the contract?
5. Length and content of sessions.
6. Number/percent of clients that are linked/referred to appropriate services.
7. Materials distributed
8. FTE hours devoted to this intervention
9. Qualifications of provider
10. Other resources devoted to this service

Outcome Monitoring

1. Number of clients referred from outreach to other services.

Louisiana Department of Public Health Definition (2001)

(website content)

Street Outreach - Street outreach is a community-level intervention that occurs on the street and/or in community settings rather than at clinics or agency offices. This activity is a one-on-one contact and/or encounter with targeted persons to decrease high-risk behaviors and increase risk reducing behaviors.

The interaction between the client and outreach worker is the fundamental element of any street outreach activity. The street outreach worker provides prevention messages, practical information on methods to reduce the risk of acquiring or transmitting HIV and distributes appropriate materials (i.e., information on obtaining other related services, condoms, bleach kits and coupons). Outreach workers are encouraged to hold encounters with target persons and not just contacts.

A contact is defined as an event in which a worker provides minimal HIV risk and referral information and condoms to clients.

An encounter is defined as an episode in which a worker has an extensive dialogue with the client, including but not limited to, providing a condom demonstration, a risk-reduction discussion, referrals, following up on a referral or risk-reduction plan and/or HIV/STD education.

Outreach is done in the same area by the same outreach workers on a regular basis to facilitate the building of relationships and trust in the community. The recommended frequency is at least twice per month. Street outreach is conducted in street settings including housing developments, store fronts, recreation centers, neighborhoods and hangouts during non-traditional hours (generally after 3pm). Safety of outreach workers is of utmost importance.

Venue-Based Outreach - Venue-based outreach targets different levels of intervention. It includes multi-strategy educational programs targeting high risk persons in a particular venue to increase health promoting behaviors and to decrease high risk behaviors.

Venue-based outreach should include as one of its strategies an environmental/structural component (such as posters or materials with risk reduction messages, referrals to services, or promotion of STD and HIV testing). Activities should be performed primarily by individuals who are members of the target population. Outreach activities should respect the operating conditions at, and contribute to the spirit of, the venue.

This intervention includes a combination of face-to-face, small group and large group interactions. Some examples of programs are a beauty salon/barber shop where the staff is trained to provide prevention messages to clients; where posters are displayed in the shop promoting HIV testing, STD screening and risk reduction; where HIV prevention counseling is periodically offered; and where condoms are available to clients.

Another example is a bar setting where the popular opinion leader model is implemented and complimented by training staff to give referrals; where posters promoting risk reduction are displayed; where HIV prevention counseling and testing is periodically offered; where condoms are available; and where periodic outreach blitzes are conducted.

A final example is a gay pride festival, where clearly identified outreach workers are handing out condoms, an information table is set up, HIV and STD testing is available and some special activity is planned.

Appendix G

NEX Materials Literature

Developed 2005 by:

Multnomah County Health Department

HIV and Hepatitis C Community Program-Syringe Exchange Supply Justification

Illicit drug use has much harm associated with it, to individuals, families and communities. As a public health program we recognize these drug related harms of which the spread of infectious diseases is one. Our public health program does not promote or condone drug use; we meet people where they are in their readiness to change and try to provide means for the prevention of disease transmission while promoting other services that reduce drug related harm, such as referring exchange participants to available alcohol and drug treatment programs and other social services that can help provide life stability. Repeated studies have shown that individuals who participate in exchange services are more likely to access other health care and social services as a result of being referred by syringe exchange programs. New York City based syringe exchange has reported an increase in follow through on HIV testing and counseling.² Additionally many syringe exchange programs act as a conduit to drug treatment, in Seattle it has been reported that new users of syringe exchange were 5 times more likely to seek drug treatment than those who had never been to syringe exchange and IDUs who had attended a syringe exchange were more likely to remain in drug treatment.³

An ounce of prevention is worth a pound of cure. We know that the current medical costs associated with both HIV and HCV have the potential to cause a serious burden on an already over-extended health care system. Recent studies indicate that over the next 10 to 20 years HCV may lead to a substantial health and economic burden. One model projects that from 2010 to 2019, 165,900 deaths will result from chronic liver disease related to HCV and \$10.7 billion will be spent in direct medical expenditure as a result of HCV. The total societal cost, **outside of medical expenditures**, is figured between \$21.3 and \$54.2 billion, this estimate is based on years of decompensated cirrhosis, hepatocellular carcinoma and leading ultimately to millions of lost years of life for those less than 65 years of age.⁴ These same figures have also been independently established by the Centers for Disease Control and Prevention. Additional economic studies examining the costs associated with HIV infection have found that the cost per HIV infection prevented by syringe exchange runs about \$4,000 to \$12,000, considerably less than the estimated \$190,000 medical costs of treating a person infected with HIV.⁵

Special thanks to: Jessica Guernsey-Camargo, MPH

² Des Jarlais C, Perlis T, Friedman SR, et al. ***Behavioral risk reduction in a declining HIV epidemic: injection drug users in New York City, 1990-1997.*** American Journal of Public Health. 2000; 90: 1112-1126.

³ Hagan H, McGough JP, Thiende H, et al. ***Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors.*** Journal of Substance Abuse and Treatment. 2000; 19: 247-252.

⁴ JB Wong et al. ***Estimating future hepatitis C morbidity, mortality, and costs in the United States.*** American Journal of Public Health, Vol 90, Issue 10 1562-1569, 2000.

⁵ Holtgrave, DR, Pinkerton SD. ***Updates of cost of illness and quality of life estimates for use in economic evaluations of HIV prevention programs.*** Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 1997; 16: 54-62.

<i>Supply item</i>	<i>Public health purpose-why do we provide this supply item?</i>	<i>Primary health messages-what messages do we emphasize in conjunction with distribution of this supply item?</i>	<i>Staff training-how do staff learn why we distribute this supply item and what health messages are associated with this supply item?</i>	<i>Research-what scientific research supports the distribution of this supply item and associated health messages that are discussed with exchange clients?</i>
<i>Syringes</i>	Exchange of syringes reduces the amount of disease in a community by removing infected syringes out of the pool of use and increasing the number of clean syringes in the pool of use. Providing syringe exchange services also decreases the amount of improperly disposed syringes in public settings such as parks, garbage receptacles,. Etc.	<ul style="list-style-type: none"> • Don't share needles or any other IDU equipment. • One needle, one time. • Dispose of syringes and other IDU equipment at NEX safely. 	<ul style="list-style-type: none"> • Local training videos • On site training with more experience staff • Selected readings-NEX program agreements/pr ocedures, research articles • Staff meeting standing agenda item-time to review why we do what we do and how it is going 	<p>Centers for Disease Control and Prevention. Risk Behaviors Associated with Infection by HIV and Other Blood-borne Infections. http://www.cdc.gov/idu/pubs/ca/risk.htm</p> <p>Institute of Medicine. No Time to Lose: Getting More from HIV Prevention. 2001.</p> <p>Prevalence of hepatitis C among injection drug users in England and Wales: is harm reduction working? American Journal of Public Health, Vol 91, Issue 1 38-42. 2001</p> <p>Surgeon General David Satcher. Evidence-based findings on the efficacy of syringe exchange programs: an analysis of the scientific research completed since 1998. March 17th, 2000.</p> <p>U.S. Department of Health and Human Services. Needle Exchange Programs: Part of a Comprehensive HIV Prevention Strategy (Fact Sheet). April 20, 1998.</p>
<i>Cookers</i>	Cookers are used to dissolve (cook up) powdered	<ul style="list-style-type: none"> • Don't share cookers or any other IDU 	<ul style="list-style-type: none"> • Local training videos • On site training with 	<p>Centers for Disease Control and Prevention. Risk Behaviors Associated with Infection by HIV and Other Blood-borne Infections. http://www.cdc.gov/idu/pubs/ca/risk.htm</p>

	<p>and solid drugs for injection. Like a used syringe, it should never be shared because doing so can transmit viruses and other infection from one person to another.</p> <p>Recent research examining the risk of hepatitis C transmission has revealed that sharing cookers was the strongest predictor of HCV seroconversion after adjusting for syringe sharing. One study of 317 IDUs in Seattle found that 54% of HCV infection in those who did not share syringes could be attributed to cookers or cotton.</p>	<p>equipment.</p> <ul style="list-style-type: none"> • Dispose of cookers as biohazardous material- bring them to exchange with your syringes to dispose. 	<p>more experience staff</p> <ul style="list-style-type: none"> • Selected readings-NEX program agreements/procedures, research articles • Staff meeting standing agenda item-time to review why we do what we do and how it is going 	<p>Risk of Hepatitis C Virus Infection among Young Adult Injection Drug Users Who Share Injection Equipment. American Journal of Epidemiology. Vol. 155, No.7: 645-653. 2002.</p> <p>Sharing of drug preparation equipment as a risk factor for Hepatitis C. American Journal of Public Health, Vol. 91, Issue 42-46. 2001</p> <p>Viral hepatitis and Injection Drug Users. Centers for Disease Control and Prevention. September 2002. www.cdc.gov/idu/hepatitis/viral_hep_drug_use.htm</p>
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<p>Cotton</p>	<p>Most people who inject will draw their drug solution from a cooker or spoon into a syringe with some sort of filter-most likely some form of cotton. The filter keeps out foreign objects that you don't want to inject.</p> <p>Recent research suggests that after controlling for sharing syringes and/or cookers, sharing cotton filters is a strong predictor of HCV seroconversion.</p>	<ul style="list-style-type: none"> • Don't share cotton or any other IDU equipment. • Dispose of cotton as biohazardous material-bring them to exchange with your syringes to dispose. 	<ul style="list-style-type: none"> • Local training videos • On site training with more experience staff • Selected readings-NEX program agreements/procedures, research articles • Staff meeting standing agenda item-time to review why we do what we do and how it is going 	<p>Centers for Disease Control and Prevention. Risk Behaviors Associated with Infection by HIV and Other Blood-borne Infections. http://www.cdc.gov/idu/pubs/ca/risk.htm</p> <p>Risk of Hepatitis C Virus Infection among Young Adult Injection Drug Users Who Share Injection Equipment. American Journal of Epidemiology. Vol. 155, No.7: 645-653. 2002.</p> <p>Sharing of drug preparation equipment as a risk factor for Hepatitis C. American Journal of Public Health, Vol. 91, Issue 42-46. 2001</p> <p>Factors associated with prevalent hepatitis C: differences among young adult injection drug users in lower and upper Manhattan, New York City. American Journal of Public Health, Vol 91, Issue 23-30. 2001.</p> <p>Viral hepatitis and Injection Drug Users. Centers for Disease Control and Prevention. September 2002. www.cdc.gov/idu/hepatitis/viral_hep_drug_use.htm</p>
<p>Sterile water</p>	<p>Water is needed to dissolve drugs and is used to flush syringes after use. Using sterile water for disease</p>	<ul style="list-style-type: none"> • Don't share water for dissolving drugs, backloading, frontloading or rinsing syringes-contaminate 	<ul style="list-style-type: none"> • Local training videos • On site training with more experience staff • Selected readings-NEX 	<p>Centers for Disease Control and Prevention. Risk Behaviors Associated with Infection by HIV and Other Blood-borne Infections. http://www.cdc.gov/idu/pubs/ca/risk.htm</p> <p>Risk of Hepatitis C Virus Infection among Young Adult Injection Drug Users Who Share Injection Equipment. American Journal of Epidemiology. Vol. 155, No.7: 645-653. 2002.</p> <p>Sharing of drug preparation equipment as a risk factor for Hepatitis C.</p>

	<p>prevention is the best option, but not the only option. Like other shared equipment, contaminated water can transmit bacteria and viruses.</p> <p>Utilizing sterile water to inject can also reduce the chance of developing an abscess, as abscesses are often caused by bacteria injected under the skin's protective barrier generally caused by some sort of unhygienic injection practices.</p>	<p>d water can spread virus and bacteria.</p> <ul style="list-style-type: none"> Consider your options-boil tap water, use fresh, cold tap water or bottled water, use toilet TANK water (never the bowl), carry a plastic bottle with water and don't ever share it. 	<p>program agreements/procedures, research articles</p> <ul style="list-style-type: none"> Staff meeting standing agenda item-time to review why we do what we do and how it is going 	<p>American Journal of Public Health, Vol. 91, Issue 42-46. 2001</p> <p>Viral hepatitis and Injection Drug Users. Centers for Disease Control and Prevention. September 2002. www.cdc.gov/idu/hepatitis/viral_hep_drug_use.htm</p>
Matches	<p>Matches have been used as a popular mechanism to disseminate specific health</p>	<p>Varies depending on promotion them:</p> <ul style="list-style-type: none"> Overdose prevention: <i>Know your stuff</i> 	<ul style="list-style-type: none"> Local training videos On site training with more experience 	<p>No specific research associated.</p>

	<p>messages to clients accessing exchange (and other prevention) services.</p>	<ul style="list-style-type: none"> • Syphilis prevention/c are: <i>This one doesn't burn</i> • Social service: <i>Outreach and engagement-swing by for a visit</i> • Website promotion: www.man2manpdx.us 	<p>staff</p> <ul style="list-style-type: none"> • Selected readings-NEX program agreements/pr ocedures, research articles • Staff meeting standing agenda item-time to review why we do what we do and how it is going 	
Alcohol pads	<p>While alcohol pads will not prevent the spread of HIV/HCV per se, proper use of alcohol pads to clean an injection site will greatly reduce the chance of bacterial infections which can lead to dangerous abscesses.</p> <p>Prevention of abscesses has been identified as a health priority by</p>	<ul style="list-style-type: none"> • Use soap and warm water or an alcohol pad to clean an injection site prior to injecting to prevent bacteria from entering the bloodstream . If using an alcohol pad, only wipe in one direction and not in a circular motion as this will cause dirt 	<ul style="list-style-type: none"> • Local training videos • On site training with more experience staff • Selected readings-NEX program agreements/pr ocedures, research articles • Staff meeting standing agenda item-time to review why we do what we do and how it is going 	<p>Getting off right-a safety manual for injection drug users. Harm Reduction Coalition. 1998. http://www.harmreduction.org/gor.html</p> <p>Chicago Recovery Alliance. Come to know the power of any positive change. http://www.anypositivechange.org/bvcsi.html</p>

	exchange clients.	and germs to stay on the skin.		
<i>Band aids, gauze, medical tape</i>	<p>Covering injection sites and/or cleaning and re-packing abscess wounds is important for general health care among injection drug users.</p> <p>As cited with alcohol pads, prevention and care of abscess wounds have been identified as a health priority by exchange clients.</p>	<ul style="list-style-type: none"> • A draining abscess should be covered with sterile gauze and ideally changed twice a day until the abscess is completely healed. Gauze that directly touches the wound should ideally be dampened with sterile saline and then covered with dry gauze and medical tape. Properly dressing an abscess will help keep it from further infection and speed the healing process. 	<ul style="list-style-type: none"> • Local training videos • On site training with more experience staff • Selected readings-NEX program agreements/pr ocedures, research articles • Staff meeting standing agenda item-time to review why we do what we do and how it is going 	<p>Getting off right-a safety manual for injection drug users. Harm Reduction Coalition. 1998. http://www.harmreduction.org/gor.html</p>

		<ul style="list-style-type: none"> • If an abscess refuses to completely drain- seek immediate medical attention. • If you feel feverish, chills, extreme fatigue, or pain in the abscess area seek medical attention immediately -you could have a serious blood infection. 		
Biohazard bins	Proper disposal of biohazardous materials is a priority for syringe exchange programs. In the absence of exchange programs people will dispose of syringes and other drug paraphernalia at a higher rate	<ul style="list-style-type: none"> • Thank you for caring about your health and the health of the community. Using a biohazard container will prevent accidental sticks/contact with syringes and other biohazardou 	<ul style="list-style-type: none"> • Local training videos • On site training with more experience staff • Selected readings-NEX program agreements/pr ocedures, research articles • Staff meeting standing agenda item- 	Centers for Disease Control and Prevention. Syringe Disposal. January 2002. http://www.cdc.gov/idu/facts/aed_idu_dis.htm American Medical Association. 2005. http://www.ama-assn.org/ama/pub/category/13639.html

	<p>in parks, garbage containers, bodies of water, and so on. In an effort to protect the health and vitality of the larger community, syringe exchange distributes and encourages proper use of biohazard containers.</p> <p>Utilizing biohazard bins also provide occupational safety to staff and volunteers who work within syringe exchange programs.</p>	<p>s material that could result in an infection.</p> <ul style="list-style-type: none"> • If you choose not to use an official biohazard container, please dispose of your paraphernalia in a puncture proof container such as a bleach or soda bottle. Please do not place these containers in garbage receptacles as it may pose a risk to some people, particularly sanitation workers. We will accept alternative containers at syringe exchange. 	<p>time to review why we do what we do and how it is going</p>	
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<p>Condoms</p>	<p>When used consistently and correctly, male latex condoms are effective in preventing the sexual transmission of HIV infection and can reduce the risk for other STDs (i.e., gonorrhea, Chlamydia, and trichomonas).</p>	<ul style="list-style-type: none"> • The only way to be completely safe is to not have sex at all, however, when used consistently and correctly, male latex condoms are effective in preventing the sexual transmission of HIV infection and can reduce the risk for other STDs (i.e., gonorrhea, Chlamydia, and trichomonas). • Because condoms do not cover all exposed 	<ul style="list-style-type: none"> • Local training videos • On site training with more experience staff • Selected readings-program agreements/procedures, research articles • Staff meeting standing agenda item-time to review why we do what we do and how it is going 	<p>CDC. Fact sheet for public health personnel: Male latex condoms and sexually transmitted diseases. http://www.cdc.gov/hiv/PUBS/facts/condoms.htm</p> <p>National Institute of Allergy and Infectious Diseases, National Institutes of Health, DHHS. Workshop summary: Scientific evidence on condom effectiveness for sexually transmitted disease (STD) prevention. July 20, 2001. http://www.niaid.nih.gov/dmid/stds/condomreport.pdf</p> <p>CDC. MMWR. Update: barrier protection against HIV infection and other sexually transmitted diseases. August 6, 1993,42(30).</p> <p>CDC. Sexually Transmitted Diseases Treatment Guidelines 2002. MMRW 2002; 51 (No. RR 6) http://www.cdc.gov/STD/treatment/12002TG.htm#PreventionMessages http://www.cdc.gov/ncidod/diseases/hepatitis/c/faq.htm#3b</p> <p>Management of Hepatitis C; 2002. National Institutes of Health Consensus Development Conference Statement. September 12th, 2002. Pages27-28.</p> <p>Sexual Transmission of Hepatitis A, B, and C Thirteenth Meeting of the International Society for Sexually Transmitted Diseases Research - July 11-14, 1999 - Denver, Colorado</p> <p>Terrault NA. Sexual transmission of hepatitis C virus in heterosexual monogamous couples-the HCV partners.</p> <p>The Liver Meeting, 54th annual meeting of the American Association for the Study of Liver Diseases. October 24-28, 2003. Boston, Massachusetts.</p>
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		<p>areas, they are likely to be more effective in preventing infections transmitted by fluids from mucosal surfaces (e.g., gonorrhea, Chlamydia, trichomoniasis, and HIV) than in preventing those transmitted by skin-to-skin contact (e.g., herpes simplex virus [HSV], HPV, syphilis, and chancroid).</p> <ul style="list-style-type: none"> • True 		<p>http://www.ashastd.org/stdfaqs/hepb.html</p> <p>CDC. MMWR. Incorporating HIV prevention into the medical care of persons living with HIV. July 18, 2003; 52(RR-12).</p> <p>Schriebman, T, Friedland, G. (2003). <u>Human immunodeficiency virus infection prevention: Strategies for clinicians. Clinical Infectious Diseases, 36:1171-6.</u></p>
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		efficacy of latex condoms in the prevention of HCV is unknown.		
Lubrication	Water based lubricant such as KY jelly or glycerin should be used with latex condoms to prevent breakage.	<ul style="list-style-type: none"> • Use plenty of lube with your condoms even if the condoms are already lubricated, it helps prevent breakage. 	<ul style="list-style-type: none"> • Local training videos • On site training with more experience staff • Selected readings-program agreements/pr ocedures, research articles • Staff meeting standing agenda item-time to review why we do what we do and how it is going 	CDC. MMWR. Update: barrier protection against HIV infection and other sexually transmitted diseases. August 6, 1993,42(30).

APPENDIX H

Program Development Templates

Template for Public Health Program Development Process

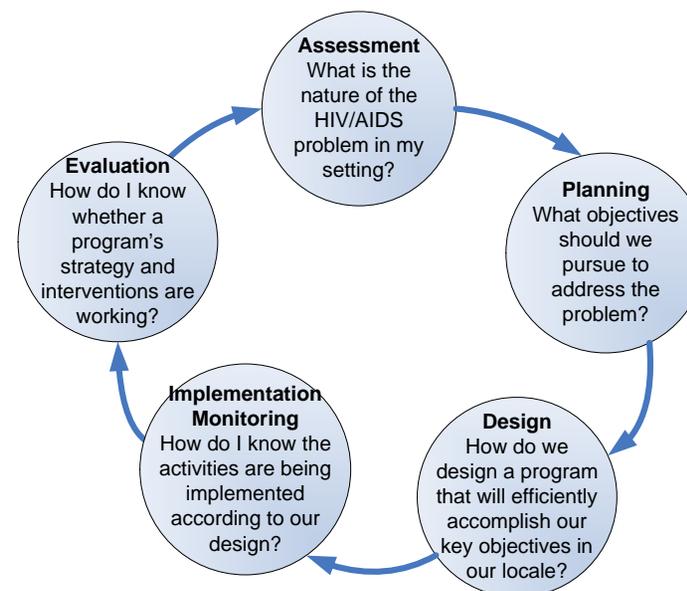
Step 1: Assessment, is a process for better understanding the status of the HIV/AIDS epidemic and response in a specific time and place. Generally, it involves gathering, synthesizing and analyzing information with enough objectivity and detail to support programming. An assessment should result in a comprehensive profile of the HIV/AIDS situation in a country, province, district, or community. It helps us understand the people at risk for HIV, the gender differences in vulnerability, and those affected by it.

Step 2: Strategic Planning is a process where you define and prioritize the objectives the organization will pursue, and define the target audiences and geographical focus of activities. You also develop SMART objectives and an evaluation framework, to identify some of the measures that can document progress and success.

Step 3: Program Design Now it is time to get more specific by identifying the resources and activities or interventions needed to accomplish your objectives, and to tailor and organize them into an implementation plan. Program design is the process that determines how to manage the interventions.

Step 4: Implementation Monitoring is the process of putting a plan into action. This is the phase at which words on paper become an actual prevention or care and support program. Implementation monitoring is the process of keeping track of how a project or program is being implemented, and how closely the project or program matches the plan.

Step 5: Evaluation A systematic method for collecting, analyzing, and using information to answer basic questions about your program. It helps to identify effective and ineffective services, practices, and approaches and assess progress toward program objectives



Adapted from data available from:
http://www.synergyaids.com/apdime/mod_3_design/stage_3/step_4.htm
 Per HIV Prevention Program Evaluation Materials
 Modified by Wendi Johnson, MPH
 Oregon Public Health

Logic Model Template

PROBLEM OR ISSUE:

TARGET POPULATION	THEORY OF CHANGE	ACTIVITIES	OUTPUTS	SHORT & LONG TERM OUTCOMES	IMPACT
<i>Who are you targeting?</i>	<i>Why do you think this will work: If...then...</i>	<i>In order to address the problem or asset you will accomplish the following activities:</i>	<i>We expect that once accomplished these activities will produce the following <u>evidence</u> or <u>product</u>.</i>	<i>We expect that if accomplished these activities will lead to the following changes within 1-year:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 2-5 years:</i>
<i>Who are you targeting</i>	<i>Why do you think this will work: If...then...</i>	<i>In order to address the problem or asset you will accomplish the following activities:</i>	<i>We expect that once accomplished these activities will produce the following <u>evidence</u> or <u>product</u>.</i>	<i>We expect that if accomplished these activities will lead to the following changes within 1-year:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 2-5 years:</i>

BARRIERS, CONSIDERATIONS & INFRASTRUCTURE DEVELOPMENT NEEDS:

GRAPHIC WORKSHEET FOR PUBLIC HEALTH PLANNING

INPUTS
Resources and Infrastructure
Capacity

OUTPUTS
Activities or Strategies
Linked to Outcomes

OUTCOMES
Intermediate and High Level Outcomes

