

HARM REDUCTION TRAINING MANUAL

**A Manual for Frontline Staff Involved with Harm
Reduction Strategies and Services**

January 2011



i) Letter to Reader

This manual has been provided as a tool to assist you in your service to help reduce the harms associated with drug use to individuals, families and within your community. We encourage using and sharing these tools and information provided to promote growth in the knowledge and understanding of harm reduction within your communities. Harm reduction continuously changes and we encourage you to follow the web links provided to remain up to date on the changes, information, policies, and forms.

ii) Current/ updated information

The latest:

BC Harm Reduction Strategies and Services Policy and Guidelines

Harm Reduction Program: Supply Requisition Form

Can be found at:

<http://www.bccdc.ca/prevention/HarmReduction/default.htm>

Health link BC – Health files can be accessed at:

<http://www.healthlinkbc.ca/healthfiles/index.stm>

Note about footers and updates: Footer dates will only be changed on those pages that have been amended; all other footers will remain unchanged.

Pages to be removed and replaced along with date of modification will be recorded on the last page of the manual.

TABLE OF CONTENTS

INTRODUCTION	4
1. HARM REDUCTION	5
DEFINITIONS OF HARM REDUCTION.....	5
GUIDING PRINCIPLES OF HARM REDUCTION	5
HARM REDUCTION IN CANADA AND INTERNATIONALLY	4
2. INFECTIONS	7
HIV/AIDS	8
HEPATITIS	8
SEXUALLY TRANSMITTED INFECTIONS	9
<i>Chlamydia</i>	9
<i>Genital Herpes</i>	9
<i>Gonorrhoea</i>	9
<i>Human Papillomavirus (HPV)</i>	10
<i>Syphilis</i>	10
3. DRUG EFFECTS	12
4. SAFER SUBSTANCE USE	15
5. MENTAL HEALTH	18
6. WORKING WITH INDIVIDUALS	18
PERSONAL VALUES, ATTITUDES AND MISCONCEPTIONS	19
INDIVIDUAL ENGAGEMENT STRATEGIES.....	19
RESPONDING TO A HISTORY OF ABUSE	20
FAMILIES, INDIVIDUAL AND COMMUNITY.....	20
ABORIGINAL COMMUNITIES	22
REFERRING CLIENTS TO OTHER SERVICES	22
ADVOCATING FOR CLIENTS.....	23
YOUTH.....	23
LESBIAN, GAY, TRANSGENDERED, BISEXUAL, QUEER (LGTBQ)	23
7. APPENDICES	23
1. HARM REDUCTION	
Harm Reduction: History of Harm Reduction in British Columbia	
1A: Harm Reduction Definitions, Reducing Harm: Treatment and Beyond. Four Pillars Drug Strategy	
1B: Harm Reduction: A British Columbia Community Guide	
1C: Harm Reduction health files #102a	
#102b	
1D: BC Harm Reduction Strategies and Services Policy and Guidelines	
1E: BC Harm Reduction Strategy and Services (HRSS) Committee	
Primary, Secondary and One-off Distribution Site Policy	
1F: Strategies – Harm Reduction Strategies and Services newsletters	
2. INFECTIONS (BC health files #)	
2A: HIV/AIDS #08m	
2B: Hepatitis A vaccine #33; hepatitis B vaccine #25a; hepatitis C virus #40a; Living well with hepatitis C infection #40b	
2C: Chlamydia #08l	
2D: Genital Herpes #08d	

2E: Gonorrhea #08a
2F: Human Papillomavirus (HPV) #101a
2G: Syphilis #08e

3. DRUG EFFECTS

3A: Street Definitions

4. SAFER SUBSTANCE USE

4A: Harm Reduction Program: Supply Requisition Form

4B: Harm Reduction Supply Ordering at the BCCDC

4C: Rationale for crack pipe mouthpiece distribution

Questions and Answers:

- Female condoms
- Sterile water
- Cookers and Injection Drug Use
- Stericup® cooker: Cooker instructions
- Acidifier (Ascorbic acid) and Injection Drug Use
- Crack pipe push sticks
- Crack pipe mouthpieces

4D: More than just needles: an evidence –informed approach to enhancing harm reduction supply distribution in British Columbia

4E: Best Practices for British Columbia Harm Reduction Supply Distribution Program (September 2008)

4F: Harm Reduction Learning Series Pamphlets

6. WORKING WITH INDIVIDUALS

ABORIGINAL

6A: Walk With Me: Pathways to Health; Harm Reduction Service Delivery Model

6B: Community Readiness: A Handbook for Successful Change: Please download from website

LESBIAN, GAY, TRANSGENDER, BISEXUAL AND QUEER

6C: List of Suggested Readings

6D: Glossary of Terms

7. ACTIVITY AND ENGAGEMENT EXERCISES

7A: Client engagement / role play activity

7B: 5-min elevator pitch

7C: Peer engagement: benefits and challenges activity

8. RESOURCES

Introduction

The purpose of this manual is to build on the knowledge, skills, and attitudes necessary to maximize the distribution of products to reduce harms associated with substance use; and to engage, educate, and advocate for individuals. The manual outlines and encourages the use of best practice to colleagues and peers within their specific agencies and organizations. It provides a reference to what support and treatment resources are available to which they can refer individuals. Specifically frontline staff will be able to use the manual as a guide and reference tool for:

- Individual engagement
- Encourage and support needle collection and return (at the individual and community levels)
- Inform individuals about reducing risks of blood borne pathogen transmission, and safer drug using and sexual practices
- Engage with individuals to provide effective education regarding harm reduction practices associated with routes of use, substances used, and social use practices.
- Respond to individuals who report a history of past or recent trauma, abuse or violence
- Refer individuals (e.g. social services, housing, addiction and mental health treatment)
- Advocate for individuals
- Respond to community pressures and concerns.

1. Harm Reduction

At the end of this section, you will be able to explain:

- **Definition for harm reduction**
- **Everyday examples of harm reductions interventions.**
- **The guiding principles of harm reduction**
- **The history of harm reduction within Vancouver and globally**

It is important to acknowledge that harm reduction is not a new concept. Harm reduction principles have been applied for many decades in many areas outside the field of addiction. Day to day strategies such as using a seatbelt while driving a car, wearing sunglasses while outside, or using hand rails when walking down stairs are all examples of an intervention to help reduce harm.

→ *What are some examples of harm reduction strategies that you use in your everyday life?*

Definitions of Harm Reduction

Harm reduction has a variety of meanings to different people, which has made developing one general definition very difficult. Regardless of the definition, harm reduction is a philosophy, approach, and a set of principles that combined help achieve certain social and political goals. As per the BC Harm Reduction Strategies and Services Policy and Guidelines:

Harm reduction involves taking action through policy and programming to reduce the harmful effects of behaviour. It involves a range of non-judgmental approaches and strategies aimed at providing and enhancing the knowledge, skills resources and supports for individuals, their families and communities to make informed decisions to be safer and healthier.

For further definitions of Harm Reduction and Reducing Harms: Treatment and Beyond see Appendix 1A.

Guiding Principles of Harm Reduction

The principles of harm reduction as outlined in the Harm Reduction: British Columbia Community Guide (2005) (Appendix 1B) are summarized below.

PRAGMATISM - Harm reduction recognizes that drug use is a complex and multi-faceted phenomenon that encompasses a continuum of behaviors from abstinence to chronic dependence and produces varying degrees of social harm. Harm reduction accepts that the non-medical use of psychoactive or mood altering substances is a universal phenomenon. It acknowledges that, while carrying risks, drug use also provides the user and society with benefits that must be taken into account.

HUMAN RIGHTS - Harm reduction respects the basic human dignity and rights of people who use drugs. It accepts the drug user's decision to use drug and no judgment is made either to condemn or support the use of drugs. Harm reduction acknowledges an individual drug user's right to self-determination and supports informed decision making in the context of active drug use. Emphasis is placed on personal choice, responsibility and management.

FOCUS ON HARMS - The fact or extent of an individual's drug use is secondary to the harms from drug use. The priority is to decrease the negative consequences of drug use to the user and others, rather than decrease drug use itself. While harm reduction emphasizes a change to safer practices and patterns of drug use, it recognizes the need for strategies at all stages along the continuum of drug use.

MAXIMIZE INTERVENTION OPTIONS - Harm reduction recognizes that people who use drugs benefit from a variety of different approaches. There is no one prevention or treatment approach that works reliably for everyone. It is providing options and prompt access to a broad range of interventions that helps keep people alive and safe. Individuals and communities affected by drug use need to be involved in the creation of effective harm reduction strategies.

PRIORITY OF IMMEDIATE GOALS - Harm reduction starts with “where the person is” in their drug use, with the immediate focus on the most pressing needs. It establishes a hierarchy of achievable interventions that taken one at a time can lead to a fuller, healthier life for drug users and a safer, healthier community. Harm reduction is based on the importance of incremental gains that can be built on over time.

DRUG USER INVOLVEMENT - Harm reduction acknowledges that people who use drugs are the best source for information about their own drug use, and need to be empowered to join the service providers to determine the best interventions to reduce harms from drug use. Harm reduction recognizes the competency of drug users to make choices and change their lives. The active participation of drug users is at the heart of harm reduction.

For further information on harm reduction and its benefits refer to Appendix 1C: Harm Reduction Health File #102a Understanding Harm Reduction and File #102b Harm Reduction for Families and Caregivers.

Harm Reduction in Canada and Internationally

Harm reduction started in Merseyside, England in the mid-1980s. As a result of the increasingly obvious connection between injecting drug use and the rise of HIV and hepatitis C virus (HCV) infections, harm reduction initiatives started emerging in Canada in the late 1980's with the establishment of needle exchanges, methadone maintenance and sexual health education programs. Needle exchanges, supported by provincial policy, began in BC in 1988.

During the 1990s in Vancouver, the drug market underwent a significant shift. Cocaine became available in large amounts which coincided with the increase of individuals with low incomes and mental illness in the Downtown Eastside (Kerr, Woods, 2006). In 1997, the local health authority in Vancouver declared a public health emergency when the rate of HIV infections became the highest in the Western World along with the rise in HCV infections.

Today, the prevalence of drug use and persons who use drugs in Vancouver's downtown eastside puts harm reduction in the forefront of health related issues. As a result, BC is seen as a leader within the North American context but looks internationally to research outcomes of harm reduction where harm reduction strategies are more developed.

Since 2004 the BC Centre for Disease Control has tracked the distribution of products funded by the provincial government and subsidized by Provincial Health Service Authority to reduce drug-related harms. These products include needles and syringes, sterile water, alcohol swabs, male condoms: lubricated, non-lubricated and flavoured; female condoms, and lubricant. Supplies can be ordered directly by sites which have been approved by the health authority (primary sites); smaller quantities of supplies or supplies for special events may be collected from a primary site by prior arrangement.

In November 2008 BC switched to a single source distributor so that all supplies are available from one site. The supply requisition forms (Appendix 4A) should be faxed to BCCDC where they are processed weekly (on Fridays) and sent to the distributor. The distributor has committed to having 3-months supplies in stock. Where possible sites are requested to order in bulk every 3 months to avoid handling fees for small orders. For Supply order details see Appendix 4B.

The British Columbia Harm Reduction Strategies and Services (HRSS) Committee provides the structure to facilitate coordination of evidence based harm reduction strategies and services. The BC Harm Reduction Strategies and Services Policy and Guidelines (2009) is found in Appendix 1D. Further information on harm reduction practices can be found in the resource section of this manual.

"Harm Reduction" works in cooperation with prevention, treatment and enforcement. It does not exist in isolation nor exclude prevention, treatment and enforcement. Harm reduction acknowledges the importance of prevention, treatment and enforcement 'pillars' and the need to work together to reduce harms related to illegal drug use. Vancouver's harm reduction strategies are based on the Four Pillars Drug Strategy approach. For more information refer to Appendix 1A: Vancouver Four Pillars Drug Strategy, Appendix 1F: Harm Reduction Strategies and Services newsletter

→ What are some Harm Reduction strategies you have seen implemented in your area of work?

2. INFECTIONS

At the end of this section, you will be able to explain:

- **The link between harm reduction strategies and the transmission of infections**
- **Routes of transmission for infections**
- **How to talk about safer sex with clients**

Infections are microorganisms such as viruses or bacteria that can cause disease in people. There are many different pathogens but we will focus on hepatitis A, B and C, Human Immunodeficiency Virus (HIV) and other sexually transmitted infections (STI). Pathogens such as hepatitis B virus (HBV) and HIV can be transmitted through contact with infected human blood and other potentially infectious body fluids such as:

- Semen
- Vaginal secretions
- Cerebrospinal fluid
- Synovial fluid
- Pleural fluid
- Peritoneal fluid
- Amniotic fluid
- Saliva (in dental procedures), and
- Any body fluid that is visibly contaminated with blood.

The goal of harm reduction in the context of drug use is to reduce the harms, such as transmission of infections, associated with the behaviour. This may be achieved by prevention through education around safer sex practices and safer substance use, and by providing relevant supplies. There are various routes of transmission of infections therefore harm reduction approaches must be varied and at times used simultaneously.

HIV/AIDS

HIV is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). HIV attacks the immune system, resulting in a chronic, progressive illness which leaves infected people vulnerable to opportunistic infections and cancer. HIV can be transmitted by unprotected sexual intercourse (vaginal, anal, oral); shared needles or equipment for injecting drugs; unsterilized needles for tattooing, skin piercing; pregnancy, delivery and breast feeding (from an HIV-infected mother to her infant); and occupational exposure in health care settings. See Appendix 2A: HIV health file # 08m

Hepatitis

Hepatitis, is inflammation of the liver, and may be caused by a virus such as hepatitis A, hepatitis B and hepatitis C. Chronic hepatitis may cause permanent liver damage, scarring, cirrhosis of the liver, liver cancer and liver failure. Approximately 40,000 cases of chronic hepatitis B and 60,000 cases of hepatitis C have been identified in BC since early 1990's; rates of infection in BC are higher than the national average. Effective vaccines are available to prevent hepatitis A and B (See health files #33 and #25a). There is no vaccine for hepatitis C.

Hepatitis A virus (HAV) can be transmitted from the feces of an infected person through oral-anal sex. HAV causes an acute infection lasting from a few weeks to several months. It does not lead to chronic infection. Outbreaks of HAV have occurred amongst individuals who use intravenous drugs; transmission may be related to poor hygiene and sharing drugs, syringes, and drug preparation equipment. HAV also can be transmitted through poor food handling such as eating food or drinking water that has been contaminated with fecal matter containing the virus.

Hepatitis B virus (HBV) is transmitted through contact with blood or other body fluids (i.e. semen and vaginal fluid) of an infected person. Modes of transmission are sexual contact, unsafe injections practices; close interpersonal contact with infected household contacts, perinatal (from mother to baby at birth) and blood transfusions. HBV is not spread by casual contact. HBV chronic infection is inversely related to the age at infection; 90% infants and 5-10% adults remain chronically infected.

Hepatitis C virus (HCV) is transmitted mainly by blood-to-blood contact. Sharing needles, syringes and other drug-use equipment is the most common way of transmitting HCV. Some British Columbians were infected with HCV before 1990, through blood products received before reliable tests to identify the virus in blood donors were available. Most people have no symptoms and therefore are unaware when they are infected with HCV. About 10% of people have a brief illness with symptoms of hepatitis: fever, tiredness, loss of appetite, nausea, jaundice (yellow skin or eyes), abdominal pain, and dark urine 6 - 9 weeks after they have been infected. The majority of people infected (70-85%) do not clear the virus and become chronically infected with HCV. They may experience long-term health concerns, such as tiredness, lack of energy, or digestive problems and liver damage (cirrhosis). See appendix 2B: Hepatitis C health files #40a and 40b

Prevention Strategies

Hepatitis A and B vaccines are effective in preventing infection and are free for people who inject illegal drugs and those who have HCV.

HAV vaccine is given as a series of two shots with the second dose given at least 6 months after the first. The vaccine provides excellent protection against HAV in persons over six months of age.

People eligible to receive free HAV vaccine include:

- People who use illegal drugs by needle;
- People who have hepatitis C;
- Men who have sex with men

HBV vaccination series (usually 3 shots) is provided free at local health units for:

- Household members and sexual partners of someone who has hepatitis B;
- Sexually active homosexual or bisexual males;
- Individuals who inject illegal drugs by needle or a sexual partner of an individual who does;
- Individuals who have many sex partners or have a recent history of a sexually transmitted disease; or have hepatitis C.

Avoid sharing needles or other equipment used for injecting, snorting or smoking drugs; and avoid sharing household items which may be contaminated with blood such as razors and toothbrushes.

Sexually Transmitted Infections

The term Sexually Transmitted Infection (STI) is now commonly used in the place of STD (Sexually Transmitted Disease). STIs are generally transmitted through various forms of sexual contact or activity. Some of the most common STIs are chlamydia, genital herpes, gonorrhea, human papillomavirus (HPV) and syphilis.

Chlamydia - is a sexually transmitted bacterium that infects the urethra, the cervix and the rectum. The bacteria, Chlamydia Trachomatis (CT) is passed between people by direct contact with infected sexual fluids from the genitals. Actual penetration is not necessary for the bacteria to be transmitted. Close contact of a penis and vagina, prior to condom use, or masturbation with the sexual fluids may transmit the bacteria if one partner has the infection. If the bacteria is rubbed into the eye, it is possible to get an eye infection (conjunctivitis). See Appendix 2C: Chlamydia health file #08I

Genital Herpes - Herpes is the common name for two viruses - Herpes Simplex Type 1 and Herpes Simplex Type 2. Herpes can affect mouth/face, genital and/or rectal area. It used to be thought that Herpes Simplex Type 1 caused sores and blisters on the mouth or face whereas Herpes Simplex Type 2 caused these same symptoms in the genital and/or rectal area. It's now known that Herpes Simplex Type 1 can spread to the genital and rectal area and Herpes Simplex Type 2 to the face and mouth.

Herpes is incurable and once a person is infected with the virus they will have it for life and may periodically experience symptoms associated with it. The herpes virus is spread by skin-to-skin contact either genital to genital or face/mouth to genital (oral sex). Symptoms do not need to be present for the virus to be passed from one person to another. In fact, the herpes virus can be inactive or latent for long periods of time.

For this reason many people who have Herpes never realize it, and most people who pass it on to someone else are unaware of their infection at the time. This is called asymptomatic shedding. The good news is that over 95% of the time herpes can be detected when the virus is active allowing the person to avoid exposing a partner. For more information refer to Appendix 2D: Genital herpes health file #08d.

Gonorrhea - is a sexually transmitted infection that can infect the urethra, cervix, throat and rectum. A bacterium called Neisseria Gonorrhoeae causes these infections. Also known as: GC, "Clap", VD, "Drip." Gonorrhea is spread between people by direct contact with the infected sexual fluids from another person. These fluids are not always seen. Gonorrhea can be spread from an infected person's throat to a penis and vice versa, but not when oral sex is performed on a woman.

Penetration or ejaculation is not necessary for gonorrhea to be transmitted. Close contact, like touching before condom use, or masturbation with the sexual fluids of an infected person can transmit the bacteria from one person to another.

It is also possible, though not common, to transmit the bacteria by your hands or fingers. For example, touching infected sexual fluids then rubbing an eye could result in an eye infection known as conjunctivitis. For more information refer to Appendix 2E: Gonorrhea health file #08a

Human Papillomavirus (HPV) - is one of the most common causes of STIs in the world. Scientists have identified more than 100 types of HPV, most of which are harmless. About 30 types are spread through sexual contact. Some types of HPV cause genital warts and some can cause cervical cancer and other genital cancers. Any person who is sexually active can get genital warts. Genital warts can be transmitted by direct skin to skin contact during vaginal and anal sex. Oral transmission of this virus is extremely rare. Warts on other parts of the body, such as the hand and feet, are caused by a different type of wart virus. These warts cannot be spread can be spread to the genital area. For more information refer to Appendix 2F: Human Papillomavirus (HPV) health file #101a

Syphilis - is an infection with the bacterium *Treponema pallidum* from the spirochete family. Symptoms for syphilis come in stages and vary from person to person. It is also known as the great imitator since it appears to be like many other diseases and is difficult to diagnose. Syphilis is most commonly transmitted through sexual activity, including penis to vagina, penis to mouth, penis to rectum and mouth to vagina. For more information refer to Appendix 2G: Syphilis health file #08e.

How to talk about safer sex with clients

Talking about sex is often difficult, it is important for workers to find ways to discuss safer sex practices more openly with individuals. It is helpful to speak with individuals using terms they will understand and acknowledge that they may find the discussion difficult. When talking about sex it is essential to consider the individuals experience, understanding and beliefs about sex.

Safe sex practices

Safe sex means not allowing your partner's body fluids (blood, semen, vaginal fluids) into your body. It can also mean covering up or avoiding contact with parts of the body that might be infectious (e.g. herpes sores or warts). Condoms are most commonly used in safe sex practice to reduce the risk of transmission of infectious diseases such as HIV and various STI's. There are male and female condoms;

Male condoms - latex condoms are the most common barrier used for safe sex. Most condom failures is not due to the condom, but because people using the condom didn't put it on correctly. Please review the steps below.

- Open the condom wrapper carefully; keeping in mind condoms can be torn by fingernails and sharp objects such as jewelry, zips and buckles. Only put on condom after there is a partial or full erection.
- Air trapped inside a condom can cause it to break. Squeeze the tip of the condom with your fingertips to leave some extra space in the tip, and put on condom, rolling the entire condom down to the base of the penis, still pinching the top. Be sure that the roll is on the outside.
- Make sure the condom stays in place during sex; if it rolls up, roll it back into place immediately. If the condom comes off, withdraw the penis and put on a new condom.
- Soon after ejaculation - or when sex is finished - withdraw the penis while it is still erect, making sure to hold the condom firmly in place. Remove the condom only once the penis is fully

withdrawn. Dispose of the used condom hygienically. Wrap the condom in a tissue and place it in the trash. Don't flush it down the toilet.

Female condoms – are not as commonly used as the male condom but are just as effective. The female condom is a tube made of thin polyurethane plastic or rubber. It is closed at one end, and designed to form a loose lining to a woman's vagina with two flexible rings, one at each end, to keep it in place. The ring in the closed end fits inside the vagina, just behind the pubic bone. The ring at the open end stays outside the vagina, lying flat against the area around the entrance to the women's vagina



How to put on a female condom:

- Open the package carefully. Choose a position that is comfortable for insertion - squat, raise one leg, sit or lie down. Make sure the condom is lubricated enough.
- Make sure the inner ring is at the closed end of the sheath, and hold the sheath with the open end hanging down. Squeeze the inner ring with thumb and middle finger (so it becomes long and narrow), and then insert the inner ring and sheath into the vaginal opening. Gently insert the inner ring into the vagina and feel it go up. Place the index finger inside the condom and push the inner ring as far as it will go. Make sure the condom is inserted straight, and is not twisted inside the vagina. The outer ring should remain on the outside of the vagina.
- The penis should be guided into the condom in order to ensure that the penis does not slip into the vagina outside the condom. Use enough lubricant so that the condom stays in place during sex. The female condom should not be used at the same time as a male condom because the friction between the two condoms may cause the condoms to break.
- If the condom slips during intercourse, or if it enters the vagina, then you should stop immediately and take the female condom out. Then insert a new one and add extra lubricant to the opening of the sheath or on the penis.
- To remove the condom, twist the outer ring or frame gently and then pull the condom out keeping the sperm inside. Wrap the condom in the package or in tissue and throw it away. Do not put it into the toilet. It is generally recommended that the female condom should not be reused.

The female condom will feel unfamiliar at first and some people find it difficult to insert. It is important to clear instructions for use, diagrams are also found on the packet. Women may find that with time and practice using the female condom becomes easier. The female condom can be inserted prior to sexual intercourse and does not rely on the male partners willingness to use it, therefore it may provide women the opportunity to feel empowered and in control of their own sexual health and safety.

3. DRUG EFFECTS

At the end of this section, you will be able to explain:

- Psychological and physiological effect of depressant and stimulant drugs
- The signs of an overdose and what to do if one occurs

Psychoactive drugs are any chemical substance, natural or synthetic, which alters mood, and the level of perception or brain functioning. They may be classified by:

- Effects on the central nervous system (CNS)
- Legal status
- Therapeutic use
- Origin
- Chemical structure

The CNS drug effects can be further divided into the following:

Depressants – decrease the activity of the central nervous system (CNS) and/or autonomic nervous system (ANS) including depression of respirations. Examples: sedative hypnotics such as alcohol, benzodiazepine and barbiturates, cannabinoids at low doses and opiates have various effects on the body mentally and physically.

Stimulants – increase the activity of the CNS and/or ANS. Examples: caffeine, nicotine, and cocaine, amphetamine and methamphetamine, prescribed amphetamine-like drugs, designer drugs such as phenylethylamines and methcathinone.

Hallucinogens – alter the state of consciousness frequently producing disturbances in thought and perception. Examples: indolealkylamines [such as Lysergic acid diethylamide (LSD), Dimethyltryptamine (DMT), magic mushrooms and morning glory], phenylethylamines [such as mescaline, MDMA (ecstasy) and some derivatives], aricycloalkylamine [such as Phencyclidine (PCP), ketamine and cannabinoids at high dose].

Other substances include nutmeg, mace, catnip and locoweed, betel nut, nitrous oxide, amyl or butyl nitrite.

Refer to Appendix 3A: for a comprehensive listing of terminology or “street definitions”.

Psychiatric medications – for the treatment of acute and chronic psychiatric disorders. Examples: psychotropic medication including antidepressants such as monoamine oxidase inhibitors (MAOI), tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRI); antipsychotics (such as Phenothiazine, Thioxanthene, and Risperidal) and mood stabilizers (e.g. Lithium, Tegretol).

Psychological and Physiological Effects of Depressants

Benzodiazepines- short term use at low to moderate doses

Benzodiazepines alleviate anxiety and have sedative and anticonvulsant properties. Common side effects of benzodiazepines: mild to moderate impairment of motor coordination, thinking and memory functions drowsiness, lethargy or fatigue, confusion, depression, blurred vision, vertigo, tremors, slurred speech or stuttering, euphoria, nausea, constipation, dry mouth, loss of appetite, and less commonly, vomiting and diarrhea.

Benzodiazepines- short term use at high doses

Benzodiazepine taken at a higher dose will result in sedation. As a result, the person may either appear to be intoxicated or even fall asleep. Common side effects at taking higher doses of benzodiazepines include mood swings, paradoxical excitement, erratic and hostile behaviors.

Heroin use

Opioids such as heroin (also morphine) produce analgesia, euphoria and respiratory depression. Depending on use and tolerance the effects may vary from person to person. Other effects may include: respiratory depression, nausea, vomiting, urinary retention, pin point pupils and suppression of the cough reflex. A common side effect is the decrease of gastrointestinal motility causing constipation.

Methadone

Methadone is long acting synthetic opiate antagonist with a slow onset of action. Methadone maintenance therapy (MMT) has been shown to be effective in treatment of opiate substance dependence such as addiction to heroin and morphine. When taken orally it is readily absorbed, does not cause euphoric or sedating effects and does not result in continuing tolerance. Methadone can therefore be administered orally, once daily, at a relatively constant dose to reduce cravings for heroin and block the effects of opiate withdrawal symptoms.

Psychological and Physiological Effects of Stimulants

Cocaine - short term use in low doses

Cocaine acts on the CNS and sympathetic nervous system. It creates a sense of euphoria and can trigger a fight-or-flight response. The physiological effects are increased: alertness, heart rate, respiration, blood pressure and temperature. Other symptoms include dry mouth and a decrease in appetite and sleep. Behaviors from cocaine 'high' include: elation, euphoria, excitement, pressured speech or quiet contemplation and rapture, restlessness and grinding of teeth. When ingesting lower doses of cocaine, the person experiences an immediate "rush", euphoria followed by periods of dysphoria experienced as anxiety and agitation.

Cocaine - short term use in high doses

The person using higher doses of cocaine may develop feelings of grandiosity, paranoia and even drug psychosis. Additional effects are tremors and muscle twitching, seizures, hemorrhagic stroke and cerebral infarction, headaches, rapid weak pulse and heart attack, nausea, vomiting, pulmonary edema and lung damage, acute renal failure, and hyperthermia with cold sweat.

Methamphetamine

Methamphetamine is a stimulant which acts on the CNS. D-methamphetamine hydrochloride (crystal meth) is more potent and causes more dependency than other forms of methamphetamine. It can be taken orally or rectally, injected, smoked, or snorted. The intensity and timing of the effect varies depending on how it is taken. Crystal meth causes feelings of euphoria; the person may feel powerful, have endless energy, increased productivity, enhanced sexual performance and a reduced appetite. Once the initial feeling wears off the person may experience anxiety, depression, mental confusion, fatigue, and headaches. The effects of crystal meth last longer than cocaine and can keep the person "up" for longer. Long term use of crystal meth increases a person's tolerance causing them to require larger and more frequent doses for the desired effect. Prolonged use causes irritability, paranoia, violence, weight loss, psychosis known as "tweaking". Extreme paranoia and violence may occur and the psychosis may become permanent or continue as flashbacks.

Overdoses

Street drugs are not controlled substances; this contributes to the risk of overdose due to the uncertainty of quality and strength of the substance as well as the combination of these drugs. High dose of depressants can cause the body to shut down by affecting brain function. High doses of stimulant can

increase the affect of heart function by falsely causing the body to think it needs to work harder and faster to the point of exhaustion and collapse. If left untreated, it can be fatal.

Benzodiazepine overdose

Benzodiazepines are frequently involved in overdoses but are rarely the sole cause. They have a wide range in dose before they can become toxic which makes overdose difficult even if large quantities are ingested. However, an overdose of benzodiazepines is possible as it can cause respiratory depression.

Heroin overdose

Long term use of heroin decreases the effects felt by the user (tolerance) resulting in a need to increase the dose for the desired effect and the risk of overdose. A lethal dose of heroin affects level of consciousness and respiration so you will see the person lapsing in and out of consciousness (nodding) which may result in the person possibly aspirating on their own vomit or slowly going into respiratory arrest.

Cocaine overdose

Cocaine overdose has no known antidote so overdosing on cocaine is fatal. A lethal dose of cocaine depends on a person's tolerance, method of use and any underlying medical condition. The effects of a cocaine overdose are: cardiac arrhythmias, seizures, intracranial hemorrhage (bleeding in the brain), hyperthermia or respiratory arrest.

Poly drug overdose

A poly drug overdose involves a combination of drugs. Combinations of CNS depressants such as alcohol, opiates, benzodiazepines, methadone, barbiturates, psychotropic medications and/or antiepileptic together enhance each others depressant effect. Long acting substances like methadone, benzodiazepines and alcohol increase the risk of overdose when introducing heroin to the combination.

Recognizing an overdose

Often it is hard to identify when an overdose is happening. Being able to identify certain characteristic of an overdose will aid in providing the correct type of care required to assist someone in an overdose. Being able to recognize when someone is "on the nod" or "dropping" is essential. Nodding is recognized when someone appears to be falling asleep but can be roused when called by their name or by physical stimulation such as shaking them by their shoulders. Someone who has "dropped" cannot be woken up by any stimulation and are unresponsive (unconscious). Overdosing at times can be obvious. When someone has just taken a shot and immediately "drops", is unresponsive, experiencing slow shallow breaths or not breathing at all, and/or cyanotic (turning blue) they are overdosing. Unfortunately, poly drug overdose can be less apparent as it sometimes is a slower process. The person may slowly become unconscious but appear like they are sleeping while their breathing slowly stops.

What do I do if I find someone who has collapsed?

Assess the situation

Stay calm and examine the area for potential dangers to you, the victim and others. Look for needles, blood and any surrounding dangers. Ensure a safe environment for the victim and yourself by dealing with the dangers first.

Assess the victim

Check to see if they need your help by checking their level of consciousness. Call their name, if they do not respond or if they appear like they are in a deep sleep try waking them up by "shaking and shouting". Squeeze their earlobes, try to get them to open their eyes or squeeze your hand. If they do not respond, they are unconscious.

Airway and respiratory management

Check to see if the person is breathing. If the person is unconscious and lying on their back, check to see if they have anything in their mouth that may potentially be blocking their airway and remove it. Put them on their side to prevent their tongue from sliding back and blocking their airway. When putting them on their side, ensure their head is tilted back and slightly downward. If the victim is not breathing call 911 and start CPR.

Use of Narcan

Naloxone (Narcan) is a narcotic antagonist otherwise known as an antidote for opioid overdose. Narcan is administered by injection, trained medical professionals such as doctor's, nurses and paramedics. Narcan works by rapidly reversing the depressive affects of the opioid in the body but not of alcohol or barbiturates. Narcan is a temporary treatment to opioid overdose, as it only last between 1-4 hours in the body, and usually requires multiple doses. When Narcan begins to wear off the heroin in the body begins to take effect causing the victim to slowly become unconscious again.

Opportunities for prevention of overdose

Taking opportunities to engage with individuals regarding issues concerning overdosing is essential in overdose prevention. This consists of building individual relationships, discussing changes in the individuals' drug tolerance, and identifying safety concerns such as communicating safety plans when using which allows for the individual to contribute to their own care.

This section was adapted from Custodial Drug Guide: Medical Management of People in Custody with Alcohol and Drug Problems, 2nd ed.

4. Safer Substance Use

At the end of this section, you will be able to explain:

- **Why and how harm reduction distribution occurs**
- **What harm reduction supplies available and how they are distributed in BC**
- **The ordering process for harm reduction supplies.**
- **How to be maximize the distribution of harm reduction products**
- **Drug 'Using' practices and harms associated with some practices**
- **Harm reduction strategies in relation to substance use**

Harm reduction distribution in BC

Supporting safer practices of substance use is an essential element in harm reduction education; having adequate harm reduction supplies available is an integral part of putting harm reduction policies into practice. The *BC Harm Reduction Strategies and Services Policy and Guidelines* states "each of BC's five health authorities and their community partners will provide a full range of harm reduction services; and that the harm reduction products should be available to all who need them wherever they live". The following harm reduction supplies are available to health units and health authority approved community agencies:

- Condoms (male and female) & lubricants
- Needles & syringes

- Alcohol Swabs
- Sterile Water
- Plastic mouthpieces and wooden push sticks for crack pipes

For information on how to order these supplies and the Supply requisition form refer to Appendix 4A and 4B: Harm Reduction Supply Ordering at the BCCDC. The most recent form is available on line on the BCCDC website

An essential part of safer substance use behavior is having access to the correct, clean equipment but must also include effective communication surrounding safer substance use. Ideally there should be the time, place and space to effectively educate about supplies and proper techniques and safer substance use. A study was completed analyzing the distribution Harm reduction products throughout BC. For further information on this study see article in The Harm Reduction Journal More than just needles - Appendix 4D.

The BC Harm Reduction Strategies and Services Committee (BCHRSS) Committee is comprised of representatives from every regional health authority, BC Centre for Disease Control (BCCDC) and Provincial Health Services Authority, BC Ministry of Healthy Living and Sport, First Nation and Inuit Health. The committee has developed a provincial best practices document to provide guidance to BC harm reduction services, supply distribution, and collection programs. For more information refer to Appendix 4E: Best Practice for British Columbia's Harm Reduction supply Distribution Program.

“Using” practices and associated harms to these practices

Injection drug use

There are many dangers associated with injecting drug use including

- Frequency of injections (collapse of veins due to overuse)
- Type and potency of drug being injected (potential for overdose)
- Infections e.g.
 - Abscesses
 - Of the blood, (septicemia), untreated can lead to septic shock
 - Endocarditis (inflammation of the heart lining, muscle and valves)
 - Transmission of HCV and HIV by sharing contaminated needles and other paraphernalia
- Poor nutrition (decrease in appetite)

Crack use

Although crack can be injected, crack is most commonly smoked. Some of the dangers associated with smoking crack are:

- Transmission of various infectious diseases such as Hepatitis C, HIV, Tuberculosis (TB) and pneumonia due to sharing of drug paraphernalia.
- Participating in high risk behaviors due to decrease in inhibitions. These behaviors can increase the risk of transmission of sexually transmitted infections.
- For women specifically, there are additional dangers to crack use due to violence, social stigma and increased risk of disease.

Harm Reduction strategies related to substance use

Vein Care

Educating individuals on effective vein care is essential in reducing the risk of abscesses, infections and complications related to overuse of veins. The following are steps to effective vein care:

- Encourage intake of fluids.
- Apply a warm compress before injecting. This will help plump up the vein.

- Always use a tie. Pump up the vein by opening and closing fist
- Inject above the valve of the vein to prevent circulation problems, scar tissue and infection.
- Rotate injection sites. Reduce the risk of a collapsed vein
- Encourage using in a warm safe place to reduce harm associated to inject too quickly and not being careful.
- Start with veins closest to the wrist and work your way up. This way if the bottom part of the vein collapses the remaining part of the vein can be used.
- Inject in the direction of blood flow (towards the heart)

Refer to Appendix 4F: Harm reduction learning series pamphlets

Wound care

ABSCESSES are a pocket of pus; pus means you have an infection. Pus is in dead tissue, bacteria, and the white blood cells that gather to try and kill the infection. An abscess can start anywhere in the body where bacteria infect damaged tissue. Drug users often get abscess at injection sites. They are more likely to damage tissue and develop an abscess when they “skin pop”, “muscle it” or miss the vein. Both the cut and the drug can damage tissue. An abscess can even develop after the user stops injecting due to the impurities remaining in the body. People with weak immune systems (e.g. people with HIV/AIDS) are more likely to develop an abscess. If an abscess is identified, encourage and assist the person to seek medical attention.

Identifying an abscess:

- Hard, red bump which is tender to touch at site of injection
- Maybe warm to the touch
- Can be painful
- It is also possible for an abscess to appear somewhere other than the injection site

Soaking an abscess helps draw the abscess to the surface allowing for the pus to drain.

- Soak an abscess in clean hot water for at least 10-15 min 3-4 times a day. Use Epsom salts if available.
- If the abscess is in an area where it can not be easily submerged, then apply a hot and wet compress (washcloth). Soak compress in Epsom salts, if available.
- If the abscess appears to be getting larger or becoming more painful, seek medical attention as antibiotics may be required.

Mouth care

People who smoke crack may develop oral lesions and sores due to burns from the hot crack pipe or cuts due to broken glass. Sharing pipes may lead to transmission of infections. Plastic mouthpieces are available through the BC harm reduction program to allow individuals to protect themselves from exposure to communicable diseases and developing mouth sores.

For mouthpiece rationale and questions and answer sheet refer to Appendix 4C.

Encouraging clients to use chapstick or Vaseline can also reduce cracking and burning of lips. This also helps decrease the transmission of diseases like HIV, hepatitis B and C, TB and herpes.

Safe drugs

Elements related to safe drug include encouraging individuals to become vigilant about identifying what they are taking. This practice reduces the risk of potentially ingesting drugs they did not intend to use.

Three steps for safer drug use:

- Same dealer
- Look, smell, taste the drug
- Do a test shot

5. MENTAL HEALTH

At the end of this section, you will be able to explain:

- **Define of co-occurring mental health and substance use problems**
- **Recognize the relationship between drug use and mental health disorders**

Substance use problems are commonly seen in mental health. Sometimes this is referred to as concurrent disorder, dual diagnosis, dual disorders, co-morbidity and co-occurring substance abuse disorders and mental disorders. To encourage sensitivity to the stigmas associated to these terms, co-occurring mental health and substance abuse problems has been developed. Co-occurring mental health and substance abuse problems can be described as one or more mental health diagnosis along with abuse of one or more substance.

The relationship between substance use and mental health disorders are multifaceted. As explained below:

- Substance use may be causing the psychopathology (a substance- induced mental disorder). Some of the most common substance induced disorders are alcohol-induced depressive disorders, cocaine-induced psychotic disorders and stimulant-induced anxiety disorders.
- Substance use may be secondary to the psychopathology in various ways: Patients may use substances to self-medicate the symptoms of their mental disorder (for example, alcohol may be used to alleviate the symptoms of an anxiety disorder, such as social phobias).
- Patients may use substances to enhance symptoms of the mental disorder (as in the use of stimulants by manic patients).
- Patients may use substances in the attempt to counter side effects of medications that they are taking for a mental disorder (for example, a patient with schizophrenia may use cocaine in an attempt to counter neuroleptic side effects).
- The mental disorder and the substance use problems may be coincidental and not related to each other (Miele G, Trautman K, Hasin D: Assessing co-morbid mental and substance-use disorders: a guide for clinical practice, *J Pract Psychiatry Behav Health* 2:272, 1996).

6. WORKING WITH INDIVIDUALS

At the end of this section, you will be able to describe:

- **Personal values, attitudes and misconceptions towards harm reduction.**
- **How to refer individuals appropriately**
- **How to advocate for individuals and harm reduction**
- **The links between families, individual and community**
- **Harm reduction Strategies in relation to youth**
- **Harm reduction strategies in relation to lesbian, gay, transgender, bi-sexual, queer (LGTBQ).**

Personal values, attitudes and misconceptions

To put harm reduction into practice, it is important to convey acceptance and support individuals to become the experts in their own lives. The service provider, regardless of their beliefs should not show disapproval of active drug use as it can destroy the therapeutic relationship and the individual's sense of self worth. For service providers to keep their motivation and dedication in this area of work, we must feel like we are making a difference. If individuals don't change then we don't feel like we are doing our work and we are failing the individual. The more we enforce these expectations of ourselves, the harder our work becomes increasing our chance of burn out and disengagement

Stigma and discrimination issues that can affect harm reduction strategies

Stigma refers to negative attitudes (prejudice) and negative behaviour (discrimination). These attitudes and judgments can affect how we think about, behave and provide care to clients.

“people with substance use and mental health problems are not normal or not like us; that they caused their own problems; or that they can simply get over their problems if they want to”.

Individual Engagement Strategies

Harm reduction providers work to build relationships with people to deliver the best possible service to individuals and the community. Effective client engagement recognizes the diversity of consumers of harm reduction supplies and services. Services should understand why individuals are accessing harm reduction supplies and how best to support each person. This means knowing how and why supplies are being used, being aware of the specific issues different individuals may face and by providing education, referrals and support to each person.

It is important that service providers be able to educate about:

- Safer using practices
- Safer sex practices
- Addictions issues and supports
- Recreational drug use
- Culturally competent services and supports for marginalized peoples
- Transgender issues and hormone injection practices
- Identifying health issues
- Local programs and services to support your clients

Individuals come first:

- Always greet the person regardless of what else you are doing – make eye contact, smile, etc.
- Be friendly
- Thank people for coming in
- Understand if the client is in a rush

Meet an individuals needs: reducing the spread of infection:

- Always give out what is asked for without judgment
- Support secondary distribution
- Ask people if they know how to use harm reduction supplies

Caring for our communities:

- Always ask for or about returns
- Harm reduction consumers are part of the community- returning used needles re-enforces that feeling
- Thank people for returning needle

- Ask if they have information to share about their community

Our health is Important:

- Goal of the program—access to healthcare services
- Important for people to know what resources are available.
- Understand what illness looks like – specific cues
- Extremely sensitive issue
- Always try to follow up with client

Respect is a two way street:

- Consumers and service providers must be respectful to each other
- Both staff and consumer should respect each others privacy. Staff should not share confidential information with outside services unless given permission to do so by the consumer.

An excellent resource is Canadian HIV/AIDS Legal Network: Nothing About Us Without Us — Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative: <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=85>

Responding to a History of Abuse

Domestic violence (also referred to as intimate partner abuse) is a crime. It results from an imbalance of power and control over one's partner. Domestic violence is primarily committed by men against women but also occurs in same sex relationships and by women against men. Domestic violence does not necessarily mean the person is physically battered or beaten. Abuse comes in many forms and can include various forms of mistreatment and cruelty such as:

- Constant threatening
- Psychological/emotional abuse,
- Sexual abuse
- Financial/material abuse
- Spiritual and verbal abuse.

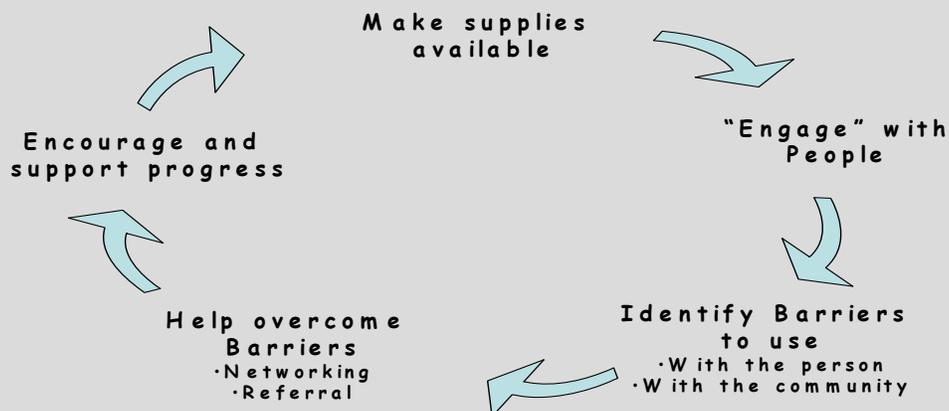
Goals in reducing harms associated with abuse:

- To increase the safety for women and men who are being abused
- To increase access to resources
- To assist in the collection of relevant medical evidence should the client choose to engage in the legal process
- Provide support and advocate for client safety

Families, Individual and Community

Harm reduction affects families, individuals and communities; building relationships at each level is essential, refer to Appendix 1C #102b: Harm Reduction for Families and Caregivers health file for additional information related to harm reduction, families and your community. Below is a diagrammatic representation of the Harm Reduction Continuum or cycle; it is a useful tool to consider the stages of harm reduction and the need for continuous engagement and relationship building.

Harm Reduction Continuum / Cycle



Various activities are included in the appendix of the manual to assist you in building these relationships. These activities include 7A, the Engagement Role Play and 7B, the 5min Elevator Pitch activity, which are exercises on how to engage with individuals regarding harm reduction. The Peer Engagement activity (7C), is a group activity to be used with colleagues, or community members to identify the benefits of peer involvement in harm reduction within your community and also to identify some challenges.

How to promote community involvement to harm reduction initiatives:

- Build rapport and trust within the community
- Establish relationships within the community
- Raise awareness about prevention, care and social services for HIV/AIDS, STD's drug use addictions and homelessness
- Educate the community about resources and current services within the community
- Support communities and build self esteem among targeted populations
- Respect the community and the people within it

Community barriers will always exist. Health care providers should take every opportunity possible to explain in clear culturally relevant terms the goals of their harm reduction strategies. Given the distrust that exists in various communities around drug related harm reduction initiatives, building community relations is an indispensable part of everyone's role. Listen and learn from what the clients and the communities tell you. The following are common barriers affecting harm reduction initiatives within communities:

- Stigmas, myths and misconceptions
- Drugs and behaviors
- Politics
- Lack of support
- Lack of trust
- Lack of funds

Building rapport and trust within the community is time consuming but is critical to the success of harm reductions initiatives. The following are individual barriers:

- Negative attitudes, prejudices, homophobia, racism and sexism
- Being judgmental toward target populations
- Lack of respect for individual choices, fear of change
- Health condition

Aboriginal communities

The burden of disease for HIV/AIDS has been greater for Aboriginal people in the province of British Columbia (BC). Although Aboriginal people comprise approximately 5% of the population of BC, in 2007 Aboriginal people made up 13% of new HIV infections. This over representation is even more pronounced for Aboriginal women who accounted for 36% of new HIV cases in women in BC. (Chee Mamuk 2008) Studies completed on HCV prevalence among Aboriginal populations are limited in their generalizability as most have been conducted in urban centers among those self-identifying as Aboriginal. Also, compared to the population at large, the prevalence of HCV infection is high amongst Aboriginal people (Hepatitis Services, BCCDC).

Rates of infection are shaped by a number of realities for Aboriginal communities such as poverty, unemployment, poor access to health care, discrimination, residential school effects/cycles, homelessness, and addictions. These realities are pathways for infections like HIV and hepatitis into the community. Communities are at different levels of readiness to deal with these infections and there still remains a lot of stigma, fear, and misinformation.

Many Aboriginal communities follow an abstinence-based approach to addiction and strategies to make clean drug equipment available, like needles, may lack support from community leaders. Even condom distribution is discouraged in some communities. Recognizing these challenges, all Aboriginal AIDS Organizations in BC are working on harm reduction programming and education. Leaders from these organizations have come together on Aboriginal HIV/AIDS programming in an initiative called *Renewing Our Response*. This work is to renew the BC Aboriginal HIV/AIDS strategy developed in 1998 by the *Red Road HIV/AIDS Network*. One of the five strategic areas *Renewing Our Response* has identified is building readiness in Aboriginal communities for harm reduction programming.

For those who have not worked in or with Aboriginal communities it is imperative to understand that each band belongs to a Nation, with languages, traditions, processes and attitudes that are individual and distinct from each other Nation in BC. For example talking to somebody in the Carrier Nation is different than speaking to a Sylix (Okanagan) Nation member. Since each nation has their own protocols to be followed, time spent on researching the individual nations is important. Take time to get to know your local nations.

Also, when presenting information in Aboriginal settings, it is imperative to give verbal thanks to the traditional stewards of the land (the Aboriginal Nation) where the presentation is taking place.

The Canadian Aboriginal AIDS Network (CAAN) has developed a manual called "Walk With Me: Pathways to Health; Harm Reduction Service Delivery Model". It is a culturally safe harm reduction model that shows a process a community or organization can go through to develop harm reduction programs. Refer to Appendix 6A: Walk with Me: Pathways to Health; Harm Reduction Services Delivery Model

Many Aboriginal AIDS Organizations in BC utilize the Community Readiness Model. This model was developed by the TriEthnic Centre at the University of Colorado. It is used to assess how ready a community is for a topic and suggests strategies that will match the communities' level of readiness. This model can assist communities to build readiness for harm reduction programs. The following website has more information on the Community Readiness Model: <http://www.triethniccenter.colostate.edu/>.

Referring Clients to Other Services

- Housing
- Social Services
- Mental Health

Advocating for Clients

Advocacy is the pursuit of influencing opinions, individual behaviors, and organizational conduct to achieve social change. Desired outcomes include influence on public policy, law, and resource allocation. Advocacy often occurs in the context of activities intended to educate and inform, while at other times may involve non-partisan political dialogue.

Youth

Harm reduction measures do not only apply to adult but youth as well.. On many occasions they are stereotyped into categories such as difficult, unmotivated and unreliable which hinders their involvement in their own care. The attitude of “we know best” frequently denies youth from the same care provided to adults.

Confidentiality is continuously a dilemma that arises when providing care for youth. Understanding the limitations to confidentiality, for many, is a challenge due to parents feeling they have the right to request information and/or withhold information from them and youth wanting to withhold information such as sexual activity or substance abuse from their parents.

Confidentiality is a right for all competent persons; therefore, all competent teens have the right to keep their health status private from family members, including parents (Canadian Paediatric Society, 2008).

The challenges at times are both ethical and legal. Many times we are inclined to tell the parents without taking into context the potential harms such physical or mental abuse that may result in disclosing information. In such case the obligation is to promote client safety and advocating for the client right to privacy.

Age of consent - decision-making in these situations should be in accordance with the Health Care Consent Act, which clearly states that consent to medical treatment depends on the mental capacity, not the chronological age of the patient (17,18). Only the province of Quebec has a fixed age of consent of 14 years, below which the consent of a parent or guardian is required (17). In all other provinces, the capacity to accept or refuse treatment is dependent on the teen’s ability to understand his or her condition and the options available to him or her. To be capable, the teen must understand and appreciate the risks and benefits of accepting or refusing treatment. More complex illnesses and treatments are harder to understand and, therefore, require a higher degree of competency to consent to treatment

Lesbian, gay, transgendered, bisexual, queer (LGBTBQ)

As with many marginalized populations, many LGBTQ people experience substance use, mental health issues and trauma, discrimination and violence. Harm reduction service providers must be educated on how to create safe spaces and how to support LGBTQ consumers. This means understanding LGBTQ experiences and identities, identifying community resources and ensuring clients feel safe and supported in accessing your services. For more information including terms and additional reading refer to Appendix 6C: Suggested additional readings and Appendix 6D: Glossary of terms.

Adapted from Prism Alcohol & Drug Services: An Introduction to working with Lesbian, Gay, and Bisexual People, and Transgender people.

7. APPENDICES

1. HARM REDUCTION

1A: Harm Reduction Definitions. Reducing Harm; Treatment and Beyond
Four Pillars drug Strategy

1B: Harm Reduction: A British Columbia Community Guide
www.health.gov.bc.ca/prevent/pdf/hrcommunityguide.pdf

1C: Harm Reduction health files #102a & #102b
<http://www.healthlinkbc.ca/healthfiles/pdf/hfile102a.pdf>
<http://www.healthlinkbc.ca/healthfiles/pdf/hfile102b.pdf>

1D: BC Harm Reduction Strategies and Services Policy and Guidelines
http://www.bccdc.ca/NR/rdonlyres/4D0992FA-0972-465B-81DD-970AEF178FD0/Epi_HarmReduction_Guidelines_BCHRSSPolicyUpdateFeb2009_20090506.pdf

1E: BC Harm Reduction Strategy and Services (HRSS) Committee Primary, Secondary and One-off Distribution Site Policy
<http://www.bccdc.ca/prevention/HarmReduction/default.htm>

1F: Harm Reduction Strategies and Services newsletter
<http://www.bccdc.ca/prevention/HarmReduction/default.htm>

2. INFECTIONS (BC health files #)

2A: HIV/AIDS #08m
www.healthlinkbc.ca/healthfiles/pdf/hfile08m.pdf

2B: Hepatitis A vaccine #33; hepatitis B vaccine #25a; hepatitis C virus #40a; Living well with hepatitis C infection #40b
www.healthlinkbc.ca/healthfiles/pdf/hfile33.pdf
www.healthlinkbc.ca/healthfiles/pdf/hfile25a.pdf
www.healthlinkbc.ca/healthfiles/pdf/hfile40a.pdf
www.healthlinkbc.ca/healthfiles/pdf/hfile40b.pdf

2C: Chlamydia #08l
www.healthlinkbc.ca/healthfiles/pdf/hfile08l.pdf

2D: Genital Herpes #08d
www.healthlinkbc.ca/healthfiles/pdf/hfile08d.pdf

2E: Gonorrhoea #08a
www.healthlinkbc.ca/healthfiles/pdf/hfile08a.pdf

2F: Human Papillomavirus (HPV) #101a
www.healthlinkbc.ca/healthfiles/pdf/hfile101a.pdf

2G: Syphilis #08e
www.healthlinkbc.ca/healthfiles/pdf/hfile08e.pdf

3. DRUG EFFECTS

3A: Drug Terminology

4. SAFER SUBSTANCE USE

4A: Harm Reduction Program: Supply Requisition Form
<http://www.bccdc.ca/prevention/HarmReduction/default.htm>

4B: Harm Reduction Supply Ordering at the BCCDC

4C: Rationale for crack pipe mouthpiece distribution;
Q & A's:

- Female condoms
- Sterile water
- Cookers and Injection Drug Use
- Stericup® cooker: Cooker instructions
- Acidifier (Ascorbic acid) and Injection Drug Use
- Crack pipe push sticks
- Crack pipe mouthpieces

4D: More than just needles: an evidence –informed approach to enhancing harm reduction supply distribution in British Columbia

<http://www.harmreductionjournal.com/content/5/1/37>

4E: Best Practices for British Columbia Harm Reduction Supply Distribution Program (September 2008)

http://www.bccdc.ca/NR/rdonlyres/4E145403-D047-49CA-A592-768FEBF6025A/0/Epi_HarmReduction_Guidelines_HRSSBestPractices_20090508.pdf

4F: Harm Reduction Learning Series Pamphlets

6. WORKING WITH INDIVIDUALS

ABORIGINAL

6A: Walk With Me: Pathways to Health; Harm Reduction Service Delivery Model
http://www.caan.ca/pdf/WalkWithMe_en.pdf

6B: Community Readiness: A Handbook for Successful Change

Can be down loaded from:

<http://triethniccenter.colostate.edu/communityreadiness.shtml>

LESBIAN, GAY, TRANSGENDER, BISEXUAL AND QUEER

6C: List of Suggested Readings

6D: Glossary of Terms

7. ACTIVITY AND ENGAGEMENT EXERCISES

7A: Client engagement / role play activity

7B: 5-min elevator pitch

7C: Peer engagement: benefits and challenges activity

8. RESOURCES



History of Harm Reduction in British Columbia

1984 – First needle exchange in the world is launched (Amsterdam, Netherlands)

Mid-1980's – Mersey Model of harm reduction (Merseyside, UK): Multiple harm reduction strategies used systematically in a single location included a needle exchange, counseling, prescribing drugs (eg opiates) & employment/housing services.

1986 – First legal supervised injection site (SIS) opens (Bern, Switzerland). Another SIS operating in Netherlands but not with legal support from local authorities.

1988 BCCDC Street Nurse Program started in response to increasing HIV infections

1989 – First Needle Exchange Program in British Columbia: The City of Vancouver funds a pilot project for needle exchange delivered via the Downtown East-side Youth Activities Society and the North Health Unit.

1990 – 1st International Conference on the Reduction of Drug Related Harm (Liverpool, UK): Delegates from around the world went to learn re Mersey Harm Reduction strategy.

1994 (October) - Centralized bulk purchase of syringes for all 14 NEPS in BC by the provincial government to ensure sufficient numbers to meet client needs.

1996 Vancouver Injection Drug Users Study commenced longitudinal study of people who inject drugs 6 monthly interviews about drug use practices, health status, health and social service utilization, HIV and hepatitis C testing. BC centre for excellence HIV/AIDS

1997 – Public health emergency declared in Vancouver by Chief Medical Health Officer of the Vancouver Richmond Health Board in response to increasing overdose deaths, hepatitis A, B and C, syphilis and HIV infections.

1997 – [Vancouver Area Network of Drug Users formed](#) to increase the capacity of people who use illicit drugs to live healthy and productive lives through peer-based support and education

2001 – [City of Vancouver's four-pillar drug strategy](#) adopted by City Council: action across the four pillars of prevention, treatment, harm reduction, and enforcement.

2002 – Vancouver decentralization needle distribution incorporating into their regular service delivery models.

2002 – Provincial needle distribution policy replaces one-for-one needle exchange.

2002 – [Dr Peter Centre provides supervised injection](#) the College of Registered Nurses of British Columbia, ruled that it was in the scope of nursing practice to supervise injections for the purposes of preventing illness and promoting health.

2003 (April) - BC Harm Reduction Program transferred from Ministry of Health Services to the Vaccine and Pharmacy Services, BCCDC, Provincial Health Services Authority.

2003 (September) – First officially sanctioned [supervised injection site \(SIF\)](#) in North America opens in Vancouver’s Downtown Eastside: Health Canada grants Vancouver Coastal Health (VCH) a section 56 exemption under the CDSA.

2004 - World Health Organization concludes there is compelling scientific evidence to support the provision of sterile injecting equipment.

2004 (April) – City of Victoria unanimously approves a harm reduction policy framework: aimed at managing the harms to the community from substance use and providing the necessary supports for drug and alcohol users.

2004 – BCCDC tracks provincial harm reduction product distribution

2007 [Bevel up: Drugs, Users and Outreach Nursing](#) teaching DVD and manual

2007 (April) – “[Evidence and best practice for the employment of harm reduction activities in programs aimed at controlling communicable diseases](#)” Thomas Kerr and Evan Woods

2007 (May) – “[More than just Needles](#)” study to evaluate BC provincial product supply distribution and use of policy, to identify gaps and future demands.

2008 Harm Reduction Strategies and Services (BC HRSS) - new name endorsed.

2008 (May) [Strategies Newsletter](#) is launched to highlighting the latest information on harm reduction principles, policies and programs in BC.

2008 (September) – “[Best practices](#)” document published by BC HRSS Committee to provide guidance to BC’s harm reduction services supply distribution/collection programs.

2008 (October) – Provincial harm reduction product distribution is centralized: single site distributes harm reduction supplies for the province through orders received at BCCDC.

2008 – Supplies for safer smoking; plastic mouth pieces and wooden push sticks are added to provincial harm reduction supplies distribution list.

2009 (January) –2-day harm reduction workshop in Vancouver, hosted by BC HRSS and BCCDC outreach/street nurse program; Participants (n=88) included front-line staff, peers (people who use drugs) and Aboriginal agency/community representatives.

2009 (June) Pacific Summit on Drug User Health; active drug users from around BC and Yukon met in Vancouver. BC/Yukon Association of Drug War Survivors formed.

2009 (June) – [Harm Reduction Home webpage](#) developed on new BCCDC website.

2009 (August) –[BC Harm Reduction Manual](#) published, hard copies sent to all BC distribution sites and published on website

2010 (March) – [Cookers and acidifiers](#) are added to provincial harm reduction supplies distribution list.

2009/10 – 5m syringes/needles, 2.7m water vials and 3.9m condoms distributed in BC

Definitions of Harm Reduction

Harm Reduction has a variety of meanings to different people. There is no “original” definition of harm reduction but what is definite is harm reduction is a philosophy, approach, and a set of principles which together help achieve certain social and political goals. Several organizations highlight different aspects as seen in the definitions below:

1. The International Harm Reduction Association (2002) has a comprehensive definition of substance use related to harm reduction:
Policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use.
2. The Harm Reduction coalition describes harm reduction as “a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use, to abstinence. Harm reduction strategies meet people who use drugs “where they’re at”, addressing conditions of use along with the use itself (Harm reduction Coalition, 2008)
3. The Drug Policy Alliance (2008) describes harm reduction as a “public philosophy that seeks to lessen the dangers that drug abuse and our drug policies cause to society. A harm reduction strategy is a comprehensive approach to drug abuse and drug policy.”
4. The Vancouver Area Network Drug Users (VANDU) is “committed to increasing the capacity of people who use drugs to live healthy productive lives. We do this by affirming and strengthening people who use drugs to reduce harms to themselves and their communities (Vancouver Area network of Drug Users, 2008)

Reducing Harm: Treatment and Beyond

The Drug Policy Alliance Network (DPA Network)

<http://www.drugpolicy.org/reducingharm/>

Harm reduction is a public health philosophy that seeks to lessen the dangers that drug abuse and our drug policies cause to society. A harm reduction strategy is a comprehensive approach to drug abuse and drug policy. Harm reduction's complexity lends to its misperception as a drug legalization tool.

- Harm reduction rests on several basic assumptions. A basic tenet of harm reduction is that there has never been, is not now, and never will be a drug-free society.
- A harm reduction strategy seeks pragmatic solutions to the harms that drugs and drug policies cause. It has been said that harm reduction is not what's nice, it's what works.
- A harm reduction approach acknowledges that there is no ultimate solution to the problem of drugs in a free society, and that many different interventions may work. Those interventions should be based on science, compassion, health and human rights.
- A harm reduction strategy demands new outcome measurements. Whereas the success of current drug policies is primarily measured by the change in use rates, the success of a harm reduction strategy is measured by the change in rates of death, disease, crime and suffering.
- Because incarceration does little to reduce the harms that ever-present drugs cause to our society, a harm reduction approach favors treatment of drug addiction by health care professionals over incarceration in the penal system.
- Because some drugs, such as marijuana, have proven medicinal uses, a harm reduction strategy not only seeks to reduce the harm that drugs cause, but also to maximize their potential benefits.
- A harm reduction strategy recognizes that some drugs, such as marijuana, are less harmful than others, such as cocaine and alcohol. Harm reduction mandates that the emphasis on intervention should be based on the relative harmfulness of the drug to society.

- A harm reduction approach advocates lessening the harms of drugs through education, prevention, and treatment.
- Harm reduction seeks to reduce the harms of drug policies dependent on an over-emphasis on interdiction, such as arrest, incarceration, establishment of a felony record, lack of treatment, lack of adequate information about drugs, the expansion of military source control intervention efforts in other countries, and intrusion on personal freedoms.
- Harm reduction also seeks to reduce the harms caused by an over-emphasis on prohibition, such as increased purity, black market adulterants, black market sale to minors, and black market crime.
- A harm reduction strategy seeks to protect youth from the dangers of drugs by offering factual, science-based drug education and eliminating youth's black market exposure to drugs.
- Finally, harm reduction seeks to restore basic human dignity to dealing with the disease of addiction.

Vancouver Four Pillars Drug Strategy

The Four Pillars drug approach was initially established and implemented in Europe to reduce the harms associated to addictions in order to create healthier, safer communities. In Vancouver, the four pillars approach is considered a “cooperative project” that relies on the efforts of many such as Vancouver Coastal Health, the BC government, Health Canada, the Vancouver Police Department, Vancouver Agreement, the City of Vancouver Four Pillars Coalition members and the community, within their areas of responsibility.

PREVENTION- Entails promoting healthy families and communities by improving public health, safety and order. Prevents or delays the start of substance use among young people and reducing the harm associated with substance use. Successful prevention efforts aim to improve the health of the general population and reduce differences in health between groups of people by addressing the incidence rate (rate of new cases) and prevalence (number of current cases).

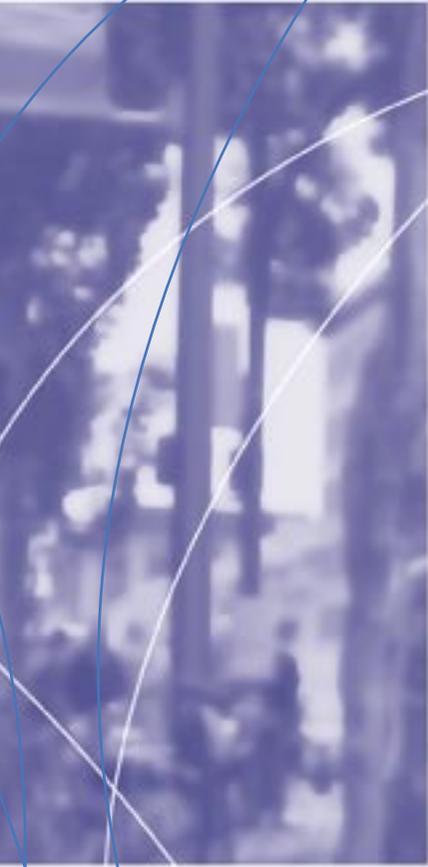
TREATMENT- Provides various levels of interventions and support programs for individuals with addiction. Treatment alternatives encourages to meet individuals “where there at” in their addiction and giving them options to choose healthier lives. Interventions and support programs include outpatient and peer-based counseling, methadone programs, daytime and residential treatment, housing support and ongoing medical care.

HARM REDUCTION - To reduce harms associated to the use and sale of legal and illegal drugs to communities and to individuals. The main principle focuses on the problematic effects of substance use on an individual and not necessarily on the individual them self. It focuses on setting achievable realistic goals for an individual which may not always be abstinence based. In achieving this, harm reduction can reduce the spread of deadly communicable diseases, decrease if not prevent drug overdose deaths, increase contact with health care services and drug treatment programs and reducing consumption of drugs in the street.

ENFORCEMENT – involves recognizing the necessity for peace and quiet, public order and safety in the Downtown Eastside and other Vancouver neighborhoods. By targeting organized crime, drug dealing, drug houses and problem businesses involved in the drug trade, this helps to reduce crime, reduce fear associated to crime and restore order to otherwise volatile situations. Enforcement can also build and improve coordination with health services and other agencies that link drug users to withdrawal management (detox), treatment, counseling and prevention services.

Harm Reduction

A BRITISH COLUMBIA COMMUNITY GUIDE



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Harm Reduction

A BRITISH COLUMBIA COMMUNITY GUIDE

Introduction.....	2
Background.....	3
What is Harm Reduction?.....	4
Principles of Harm Reduction.....	5
Common Concerns About Harm Reduction.....	6
Evidence Based Harm Reduction.....	7
Education and outreach.....	7
Referral to health and social services.....	7
Low threshold support services.....	7
Law enforcement policies and protocols.....	8
Needle exchange programs.....	9
Methadone maintenance treatment.....	10
Supervised consumption facilities.....	10
Street drug testing and early warning systems.....	11
Heroin prescription.....	12
Development of a Municipal Harm Reduction Response.....	13
Community Examples.....	18
Comprehensive Drug Strategies in B.C.....	22
Resource List.....	22
References.....	24

Introduction

This guide has been written to assist municipalities in British Columbia in taking a leadership and a facilitative role in reducing the level of drug related harm in their communities. In particular, it contains information about an approach to these problems that has become known as harm reduction. It sets out the evidence and potential benefits of using a harm reduction approach to address the harms associated with problematic substance use.

The use of drugs and alcohol is a complex and sensitive area of public policy. Municipalities are already on the front line. They bear the brunt of mounting costs for policing and enforcement. Public order and safety may be put at risk by open drug use in communities. Without coordinated action, public health systems can become overburdened with problems arising from the spread of HIV, hepatitis and other diseases related to drug use, particularly injection drug use.

Municipalities, however, are also repositories of knowledge, skills, and innovative problem solving ideas. These are the key to successful mobilization of community resources. Municipalities can exert influence on policy in areas such as public and community health, housing, social services, community safety, recreational services, development and zoning, licensing and by-laws.

The central task is to encourage a constructive dialogue that leads to agreement and action among key stakeholders, including drug users, service providers, residents, businesses, educators, police, health authorities, local governments and Aboriginal communities. This process is greatly assisted by the dissemination of evidence-based information about harm reduction and how it supports policies and programs aimed at improving the health and well being of the entire population.

This guide provides an overview of harm reduction and various actions that can be taken at the municipal level to develop a strategy for mobilizing communities around harm reduction. It focuses on supporting the development of a community response using the traditional authority of municipal jurisdictions.

Background

The health of every community in Canada is affected by drug use.¹ Solutions must come from all levels of society. Informed public discourse is critical to developing effective responses to address the harms from drug use. One of the central tasks of government is to provide clear, credible information and encourage constructive dialogue on the nature of drug use in our society, its risks and benefits, and the policies and programs needed to reduce the harms to individuals, families and communities from problematic substance use.

People who use drugs are not expendable—they are human beings who come from families who love them. They are someone's son, daughter, brother, sister or parent. Drug use, particularly injection drug use, puts people at risk of overdose death, relapsing dependence, and medical conditions which are difficult and costly to treat.² The risk for problems with drugs often goes hand in hand with risks for other social problems. A 2001 report by the McCreary Centre Society showed that street youth in B.C. are more likely to have injected drugs and to have histories of unhappy family backgrounds, abuse and neglect, sexual exploitation, unstable housing, low school connectedness and suicide attempts.³

The risks from drug use also affect families and communities, not just the people who use drugs. People who inject drugs may be having unprotected sex that puts others at risk for diseases such as HIV and hepatitis B and C.⁴ Community health is put at risk when diseases spread beyond injection drug users into the general population.

The social harms associated with injection drug use range from the loss of public space due to open drug use, discarded needles and other drug paraphernalia, to drug-related criminal activity and decreases in real and perceived public safety. Families experience breakdown, child neglect or abuse, job loss, financial and legal problems, risk of homelessness and social isolation.

It is clear that problematic substance use generates high social and fiscal costs. The best results can be achieved by managing it as a health issue that requires a full range of evidence-based interventions. While it is important to have a variety of treatment options available, not all drug users can or will access treatment. There is no magic bullet – not all treatment options are effective for all people suffering from a substance use disorder.⁵ Therefore, it is important to provide effective interventions to minimize the negative consequences of active drug use and dependence. Dead people cannot recover from addiction. Harm reduction is an essential part of a comprehensive response to problematic substance use that complements prevention, treatment and enforcement.

What is Harm Reduction?

The International Harm Reduction Association (2002) describes harm reduction as:

Policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use.

Harm reduction is a pragmatic response that focuses on keeping people safe and minimizing death, disease and injury associated with higher risk behaviour, while recognizing that the behaviour may continue despite the risks. At the conceptual level, harm reduction maintains a value neutral and humanistic view of drug use and the drug user. It focuses on the harms from drug use rather than on the use itself. It does not insist on or object to abstinence and acknowledges the active role of the drug user in harm reduction programs.

At the practical level, the aim of harm reduction is to reduce the more immediate harmful consequences of drug use through pragmatic, realistic and low threshold programs. Examples of the more widely known harm reduction strategies are needle exchange programs, methadone maintenance treatment, outreach and education programs for high risk populations, law enforcement cooperation, medical prescription of heroin and other drugs, and supervised consumption facilities.⁶

There are many reasons why people engage in higher risk behaviour and not all people are able to make the immediate changes necessary to refrain from such behaviours. Harm reduction is a set of non-judgmental policies and programs which aims to provide and/or enhance skills, knowledge, resources and support that people need to live safer, healthier lives. It encourages people to build strengths and to gain a sense of confidence.

Harm reduction can help move a person from a state of chaos to a state of control over their own life and health. For some people, abstinence is the most feasible way to reduce harm. Interventions that aim for abstinence and for safer drug use both have a place within harm reduction. The key is to balance abstinence-based programs with those that reduce harm for people who continue to use drugs.

Harm reduction saves lives and improves quality of life by allowing drug users to remain integrated in society. The alienation and marginalization of people who use drugs often compound the reasons why they engage in unsafe drug use. Harm reduction also reduces health care costs by reducing drug-related overdose, disease transmission, injury and illness, as well as hospital utilization.

Harm reduction benefits the community through substantial reductions in open drug use, discarded drug paraphernalia, drug-related crime, and associated health, enforcement and criminal justice costs. It lessens the negative impact of an open drug scene on local business and improves the climate for tourism and economic development.

Principles of Harm Reduction⁷

PRAGMATISM

Harm reduction accepts that the non-medical use of psychoactive or mood altering substances is a near-universal human cultural phenomenon. It acknowledges that, while carrying risks, drug use also provides the user and society with benefits that must be taken into account. Harm reduction recognizes that drug use is a complex and multifaceted phenomenon that encompasses a continuum of behaviours from abstinence to chronic dependence, and produces varying degrees of personal and social harm.

HUMAN RIGHTS

Harm reduction respects the basic human dignity and rights of people who use drugs. It accepts the drug user's decision to use drugs as fact and no judgment is made either to condemn or support the use of drugs. Harm reduction acknowledges the individual drug user's right to self determination and supports informed decision making in the context of active drug use. Emphasis is placed on personal choice, responsibility and self-management.

FOCUS ON HARMS

The fact or extent of an individual's drug use is secondary to the harms from drug use. The priority is to decrease the negative consequences of drug use to the user and others, rather than decrease drug use itself. While harm reduction emphasizes a change to safer practices and patterns of drug use, it does not rule out the longer-term goal of abstinence. In this way, harm reduction is complementary to the abstinence model of addiction treatment.

MAXIMIZE INTERVENTION OPTIONS

Harm reduction recognizes that people with drug use problems benefit from a variety of different approaches. There is no one prevention or treatment approach that works reliably for everyone. It is choice and prompt access to a broad range of interventions that helps keep people alive and safe. Individuals and communities affected by drug use need to be involved in the co-creation of effective harm reduction strategies.

PRIORITY OF IMMEDIATE GOALS

Harm reduction establishes a hierarchy of achievable steps that taken one at a time can lead to a fuller, healthier life for drug users and a safer, healthier community. It starts with "where the person is" in their drug use, with the immediate focus on the most pressing needs. Harm reduction is based on the importance of incremental gains that can be built on over time.

DRUG USER INVOLVEMENT

The active participation of drug users is at the heart of harm reduction. Drug users are seen as the best source of information about their own drug use, and are empowered to join with service providers to determine the best interventions to reduce harm from drug use. Harm reduction recognizes the competency of drug users to make choices and change their lives.

Common Concerns

About Harm Reduction

Concern: Harm reduction enables drug use and entrenches addictive behaviour.

This is rooted in the belief that drug users have to hit “rock bottom” before they are able to escape from a pattern of addiction and that harm reduction protects them from this experience. For those who do not want to quit, cannot quit, or relapse into drug use, harm reduction can effectively prevent HIV, hepatitis C and other drug-related harms. Harm reduction is often the first or only link that drug users have to the health and social service system and, as such, it is a gateway to addiction treatment. Harm reduction services increase the possibility that drug users will re-engage in broader society, lead productive lives and quit using drugs, instead of contracting and transmitting infectious diseases and/or succumbing to drug overdose death.⁸

Concern: Harm reduction encourages drug use among non-drug users.

This is based on the notion that harm reduction “sends out the wrong signal” and undermines primary prevention efforts. Some feel that helping drug users stay alive, reduce their exposure to risk and become healthier may encourage non-users to regard drug use as safe and to want to start using drugs. This view underestimates the complexity of factors that shape people’s decisions whether to use drugs. It also ignores numerous scientific studies that have found no evidence that the introduction of needle exchange or other harm reduction programs increases drug use.⁹

Concern: Harm reduction drains resources from treatment services.

Harm reduction interventions are relatively inexpensive and cost effective. They increase social and financial efficiency by interrupting the transmission of infectious disease at a lower cost, rather than waiting to treat complications of advanced illness at a much higher cost.¹⁰

Concern: Harm reduction is a *Trojan Horse* for decriminalization & legalization.

Harm reduction attempts to deal with the harms from drug use as it occurs within the current global regulatory regime. Some advocates of harm reduction want to see changes in the way governments have been attempting to control the trade and use of currently illegal drugs; others do not. Harm reduction itself is neutral regarding the question of legalization.¹¹ The philosophy of harm reduction applies equally to alcohol and tobacco use, which is legal in most countries.

Concern: Harm reduction increases disorder & threatens public safety & health.

Often referred to as the “honey pot effect”, this concern assumes that harm reduction programs will attract drug dealers and compromise the safety and well being of the surrounding community. Evidence has conclusively demonstrated that harm reduction programs do the opposite.¹² They have a positive impact on public health by reducing the prevalence of blood borne viruses such as HIV and hepatitis C. Needle exchange programs often recover more needles than they distribute, which means fewer used needles discarded publicly in the community. Supervised injection facilities reduce the number of public injections by providing a safe, indoor alternative to open drug use. Protocols between police and harm reduction service providers ensure drug trafficking laws are enforced – open drug dealing is discouraged, while drug users are encouraged to access needed services.

Evidence Based Harm Reduction

The following harm reduction strategies have strong evidence of effectiveness in the scientific literature and in practice. They are an integral part of a comprehensive response to problematic substance use.

EDUCATION AND OUTREACH

Drug education materials with a harm reduction focus are a cost effective way to target drug users. These materials do not promote drug use, but rather tell users how to reduce the risks associated with drug use, especially the transmission of HIV and hepatitis C. Harm reduction education materials can teach safer injecting techniques, overdose prevention and proper condom use. The materials frequently attain high levels of cultural acceptability and approval among target populations, with impacts on knowledge, attitudes and self-reported or planned behaviour.¹²

Outreach programs seek face-to-face contact with drug users. They deliver information, resources and services to hard to reach populations of drug users and establish links between isolated drug users and critical health services. Outreach programs provide literature about HIV and hepatitis C risk reduction, promote teaching and modelling of risk reduction by leaders of drug user networks, distribute condoms and bleach kits, make referrals to services, provide counselling and support community development. The involvement of drug users is an important component of effective outreach as peers help change group norms by demonstrating changes in their own behaviour.¹³

Outreach programs have been found to achieve the following outcomes: cessation of injecting, reduced injecting frequency, reduced sharing of needles and other injection equipment, increased disinfecting of needles, increased referrals and entry into drug treatment, and increased condom use.¹⁴

REFERRAL TO HEALTH AND SOCIAL SERVICES

Drug users often do not seek health care because they fear legal consequences, face stigma from service providers, or are disenfranchised from society. Harm reduction encourages drug users to seek adequate care and encourages service providers to provide that care without discrimination. It facilitates access to medical and social services for people who are isolated and would not normally access mainstream services. One of the basic tenets of harm reduction is the right to comprehensive, non-judgmental medical and social services and the fulfillment of basic needs for all individuals and communities affected by drug use.

LOW THRESHOLD SUPPORT SERVICES

A key attribute of harm reduction practice is the concept of *low threshold* service delivery. Low threshold services have minimum requirements for participation and normally address basic health and social needs of the drug user. For many people it is impossible to address drug dependence or deal with the multitude of related health problems without first having a safe, stable place to live and nutritious food to eat.

Low threshold addiction services do not require abstinence. Instead, they work towards engaging participants who actively use drugs while reducing drug-related harm. These services help to stabilize participants and direct them to treatment services when they are ready. Ongoing contact with service providers allows for the development of trust while the minimal requirements provide opportunity for building a history of successes rather than reinforcing the experience of failure.

Evidence from Switzerland indicates that comprehensive and highly integrated low threshold services are effective in engaging drug users and reducing drug-related harm, such as HIV and hepatitis C infection. In the mid 1980s, the Swiss had a system of primarily abstinence-based drug treatment, similar to what Canada has now. These services attracted no more than 20% of all active drug users. In the early 1990s, Switzerland implemented a broad harm reduction approach and developed a range of low threshold addiction, health, housing and employment services. Today, over 65% of active drug users are in some form of drug treatment and the remainder are in contact with harm reduction services, such as needle exchanges and supervised consumption sites.¹⁵

LAW ENFORCEMENT POLICIES AND PROTOCOLS

Health and law enforcement are both concerned with reducing drug-related harm. While the emphases differ, there is considerable overlap and mutual benefit in working together. Police activities can influence health harms such as overdose and the spread of blood borne diseases, and health activities can influence crime and public amenity.

Policing practices in some jurisdictions have changed over the past few decades. They have become less reactive and more proactive, intelligence driven, and more concerned with implementing best practice. This has required a greater understanding and use of crime prevention strategies which can be viewed as similar to health promotion strategies.¹⁶

Harm reduction based approaches to law enforcement complement public health efforts by seeking to reduce the net harm experienced by drug users and the community. Examples of these enforcement practices include greater use of discretion by police, provision of harm reduction training for police, direct involvement of police in harm reduction activities, and partnerships between police and health agencies.¹⁷

The use of discretion in attending overdoses (e.g. police not attending non-fatal overdoses) is well established and has reduced the reluctance of drug users to call ambulances, resulting in fewer deaths.¹⁸ Other accepted discretionary practices are the use of warnings or cautioning and the use of referrals to appropriate health and social services as alternatives to arrest and confiscation of injection equipment.¹⁹ There is also evidence that police can reduce harm by maintaining adequate distance from health services used by drug users, so as not to deter access, and by not interacting with drug users during the injection process.²⁰

Partnerships between police and health agencies ensure that police practices are, as much as is possible, complementary to public health efforts. Among the earliest approaches is “problem oriented’ policing which involves establishing partnerships with local communities that focus on identifying the root causes of community problems and the most effective actions for addressing them.²¹

Drug Action Teams (DATs), which were first developed in the United Kingdom and are based on partnerships between police, social service and health agencies.²² Common outputs of DATs include the development of health-focused trainings for police and the development of referral cards that are handed out by police that list available health and social services. DATs have been associated with increased awareness of health issues and harm reduction among police and greater collaboration among partners.²³

The major challenges to cultivating healthy working partnerships are the different objectives, values and service philosophies of police and health agencies. This is most evident when the partnerships are implemented in a top-down fashion. It has been recommended that particular attention be paid to involving non-specialist lower ranking police officers in the design and implementation of these types of partnerships.²⁴

NEEDLE EXCHANGE PROGRAMS

Needle exchange programs (NEPs) distribute sterile syringes and collect used syringes. They operate on the principle that every injection should be performed with sterile equipment. The use of non-sterile injection equipment increases the risk of HIV, hepatitis C and bacterial infections which are difficult and costly to treat. In Canada, injection drug use is currently the single most important route of hepatitis C transmission.²⁵ Blood borne pathogens are also a public health threat to others, including spouses, partners and unborn children of injection drug users.

NEPs have been scientifically demonstrated to reduce risks of contracting HIV and hepatitis C.²⁶ Studies have shown that they can decrease the risk of contracting HIV by as much as 50 to 80%.²⁷ NEPs serve as a collection point for used needles and can minimize the number of publicly discarded needles that can be found in parks, playgrounds and school yards.²⁸ NEPs also serve as an entry point for drug users to access critical health and social services, including referrals to detoxification and treatment services when desired.²⁹ NEPs have not been associated with increases in crime.³⁰ The best results are achieved by creating good access to sterile needles and other injection equipment.³¹

NEPs are an established international best practice in health. In B.C., the Ministry of Health and the B.C. Centre for Disease Control have direct responsibility for NEP policies and guidelines related to effective and safe implementation. In 2004/05, approximately 6.38 million needles and syringes were exchanged across the province.

METHADONE MAINTENANCE TREATMENT

Methadone maintenance therapy (MMT) is the current gold standard for treating heroin dependence.³² It may be thought of as a long term treatment for heroin addiction just as insulin is a long term treatment for diabetes. Methadone is a legal opioid medication prescribed by physicians and dispensed by community pharmacists. Each dose is consumed orally, in most cases in the presence of a pharmacist. Methadone works by binding with receptors in the brain that also bind with heroin, resulting in reduced cravings for heroin. There is no “high” or changes in behaviour associated with taking methadone. It is relatively safe and has few side effects.

MMT reduces the use of other opioids, injection related health risks, mortality and drug-related criminal activity.³³ It improves physical and mental health, social functioning, quality of life, pregnancy outcomes and client connections to other critical medical and social services. MMT is also highly cost effective.³⁴

In the past, MMT was often prescribed and dispensed with many restrictions. Evidence now supports low threshold MMT, which has reduced or fewer barriers to service, but not less regulation.³⁵ Low threshold MMT provides alternatives for clients to access methadone, such as through mobile dispensaries, which increases retention. Other characteristics of low threshold MMT are: client centred service, user friendly opening hours, tolerance for other drug use, greater opportunities for take-home doses, fewer mandatory requirements for regular urine testing or counselling, and higher, more effective dosing levels.

MMT is an established international best practice. In B.C., MMT is administered by the *College of Physicians and Surgeons of B.C.* The B.C. Methadone program has expanded significantly in the past decade to improve its reach among heroin dependent British Columbians and is very successful in retaining clients.³⁶ In 2004, there were approximately 8221 registrants in the program, up from 1221 in 1991. It is expected that new registrants will match population growth over the next decade. The B.C. Methadone program has received two international awards recognizing the comprehensive nature and quality of the program.

SUPERVISED CONSUMPTION FACILITIES

Supervised consumption facilities (SCFs) are generally defined as legally sanctioned and medically supervised facilities where drug users can inject or inhale pre-obtained illegal drugs. In Canada, SCFs are experimental, science-based and research-focused initiatives. The federal *Controlled Drugs and Substances Act* (CDSA) closely regulates the scope, operation and scientific evaluation of these initiatives. The operation of SCFs reflects a highly formalized partnership between Health Canada, the Province, regional health authorities and local municipalities.

In 2003, Health Canada granted Vancouver Coastal Health (VCH) an exemption under Section 56 of the CDSA to establish a supervised injection facility in Vancouver’s Downtown Eastside (DTES). The site was created as a scientific research pilot project. Establishing the facility required written agreement from stakeholders, including the B.C. Ministry of Health, VCH, City of Vancouver and Vancouver Police. Any new SCF would be subject to the same scrutiny and exemptions and would require municipal approval.

SCFs serve an important function by providing immediate response to overdoses, increasing use of health and social services, and reducing the problems associated with public consumption of drugs. Early results from the Vancouver site indicate no overdose deaths among participants and a reduction in the number of public injections in the DTES.³⁷ SCFs also offer direct and sustained contact with injection drug users. Staff can encourage clients to seek help, discuss health concerns and provide immediate medical care, counselling and referrals. The Vancouver site regularly connects clients to services such as detox, addiction counselling, recovery support, mental health services and methadone treatment.³⁸

The majority of SCF users tend to be the most marginalized and socially disadvantaged injection drug users. Studies have found that those who use SCFs are more likely to be long term injection drug users with unstable living conditions, low income and a history of incarceration. The Vancouver site has also been found to attract younger drug users who have an elevated risk of HIV infection and overdose.³⁹ This provides an important opportunity to link this hard to reach group with health care and addiction treatment services.

STREET DRUG TESTING AND EARLY WARNING SYSTEMS

Illegal drugs are not subject to government controls for safe manufacture, storage and distribution. As a result, illicit markets have long been associated with harms arising from poor product safety, including contamination, adulteration and dosing or purity factors. Contamination refers to residues from the production process or contaminants that are unintentionally incorporated into the drug that can cause poisoning. Adulteration refers to substances that are deliberately added to the drug (e.g. bulking or cutting agents) that can also result in unintended adverse reactions. In recent years, particular attention has focused on the range of substances often found in samples of “ecstasy” (a slang term for what is purported to be *methylenedioxymethamphetamine* or MDMA), which include a wide variety of other, often more potentially harmful drugs, such as crystal methamphetamine. Dosing or purity factors refer to uncertainty about the strength or purity of the drug which makes it difficult to calculate doses, resulting in unintentional overdose. Heroin overdose, for example, can sometimes be attributed to the circulation of batches with higher than expected purity.

Harm reduction responses to these hazards include street drug testing and early warning systems.⁴⁰ Street drug testing is increasingly used in clubs and festivals where ecstasy is consumed. It is available to some degree in various European countries, including Austria, Belgium, France, Germany, Netherlands, Spain and Switzerland. Early warning systems alert health and other authorities to changes in drug market and/or consumption patterns. When necessary, these systems can be linked to targeted information campaigns to alert drug users to the hazards of contaminated or adulterated drugs. Examples of early warning systems are the US Center for Disease Control warning system for contaminated heroin and the European Infection warning systems for clostridium infections (e.g. botulism and tetanus) and new synthetic drugs.⁴¹ Street drug testing can be used to disseminate information about hazardous substances directly to drug users and can alert early warning systems to the circulation of high strength or contaminated batches of drugs.

HEROIN PRESCRIPTION

Despite the success of methadone maintenance, a substantial proportion of heroin users remain resistant to this mode of treatment. These individuals tend to be long-term heroin users who have experienced several treatment failures. Heroin prescription provides diacetylmorphine to a narrowly defined target population through on-site, controlled injections or inhalations in settings with comprehensive and integrated health and social services. Both program experience and clinical studies from the Netherlands, Switzerland and the United Kingdom suggest that the medical prescription of heroin to chronic heroin users who have not responded to treatment can result in positive health and social outcomes.⁴²

In 2002, the results of clinical trials in the Netherlands established a direct link between the prescription of heroin and positive health and social outcomes. The Dutch study, a scientifically rigorous investigation, found that supervised co-prescription of heroin to chronic, treatment resistance heroin addicts led to improvements in all health outcome domains: physical health, mental status and social functioning.⁴³

In early 2005, a similar clinical trial began in Vancouver and Montreal. Known as the North American Opiate Medication Initiative, or NAOMI, this study will examine whether prescribed heroin is a better treatment than methadone for individuals who have not been successful with other treatment approaches. Researchers are also examining whether distributing heroin at no cost to these treatment-resistant users will reduce the homelessness and crime associated with drug use.

Development of a Municipal Harm Reduction Response

Municipalities are uniquely placed to respond to public concerns about harms from substance use. Although they are not the main providers of such services, they are nevertheless concerned about the allocation and delivery of these services as they affect the health, safety, and welfare of their community. It is important, therefore, that municipalities provide leadership to support, or at least not impede, local responses to harm reduction, and emphasize its importance to policy makers at all levels of government.

In some areas of B.C., initiatives are already well developed, and there are clear plans in place to guide the implementation of harm reduction strategies. In other areas, harm reduction planning may not have gathered sufficient momentum and the integration of harm reduction into municipal planning has not yet been achieved. In such a situation, the following approach may form a suitable plan of action.

STAGE ONE

Bring Key Stakeholders Together

Municipal officials convene a meeting to identify preventable drug-related harm and how they are linked with other initiatives to address substance use, particularly those for treatment. The meeting should be kept quite small, with a municipal lead and representation from law enforcement, community relations/education, and public health services.

STAGE TWO

Create a Leadership and Organizational Structure

The core group then forms an organizational structure, potentially involving several agencies. This will drive forward the development process by providing accurate information, facilitating community discussion and encouraging community support and understanding for the issue.

Municipal leadership of this group is highly recommended. The structure can be in the form of a committee of council, a mayor's task group, or a local harm reduction initiative. Leadership roles and responsibilities should be specified for participants. Access to administrative support is crucial to sustain ongoing community mobilization and to co-ordinate the development and implementation of the municipal harm reduction strategy.

A communication plan should also be developed and put in place. It is important that the public and potential stakeholders are kept informed of the progress of work. Close involvement with members of the local media is important to ensure the public receives accurate information.

STAGE THREE

Identify Key Community Partners

The core group then makes a list of potential participants to widen the initiative and organize a co-ordinated response. People with credibility in the community can be strong champions of this work. Many harm reduction initiatives are greatly strengthened by the participation of people who work directly with drug users to improve their lives, and who therefore have their trust. Examples are street nurses and outreach workers who directly assist drug users dealing with problems.

Every effort should also be made to include individuals with personal experience of problematic substance use. Such individuals may be current users who want to help the community and former users who have now stopped. It is also helpful to have representation from health, social services, education and law enforcement. Potential places to find such partners might include addiction treatment facilities, the police force, pharmacies, social workers, drop-in centres, churches, public health agencies, mental health organizations and other community agencies.

Here are some suggestions to enhance the collective process at this stage

- Develop a vision and mission statement. A vision statement describes what the community will look like if the initiative is successful. A mission statement expresses how the work will be done to achieve the vision.
- Clarify expectations. Develop roles and responsibilities for members of the group. Decide what criteria might exist for any future membership.
- Do not assume everyone understands the relevant issues. Ensure that all members are able to obtain high quality guidance and information.
- Discuss your proposals with existing organizations in the community to see if they are interested in taking forward some of the work.

STAGE FOUR

Conduct Needs Assessment and Inventory of Local Services

Conduct a detailed needs assessment to determine the level of unmet need for harm reduction services. Communities should take advantage of existing data sources, such as health, education and police sources, and encourage the data holders to help collect the data necessary to support the development, implementation, assessment and evaluation of a comprehensive harm reduction strategy.

Do an audit of existing prevention, treatment, support and enforcement services in the community. What are the gaps in services? Is there a mismatch between current and emerging demand for service and what is available? Are there any barriers that impede users obtaining these services?

It is important that the municipal harm reduction strategy be based on solid information and monitored and evaluated on an ongoing basis.

STAGE FIVE

Develop a Locally-Driven Harm Reduction Strategy

Draft a comprehensive municipal harm reduction strategy using information from the needs assessment, audit of local services, existing organizational plans for responding to problematic substance use, and the advice of key stakeholders. The harm reduction strategy should have the following components:

SMART Goals and Objectives

- Specific
- Measurable
- Achievable
- Results oriented
- Time limited

Strategic Approach

Minimize the burden of harm with evidence-based interventions

These are evidence-based harm reduction measures that specifically target members of the community experiencing unacceptably high levels of drug-related harm. They aim to significantly reduce levels of harm. Communities are encouraged to specify the types of substances and user groups that require attention and to seek out evidence-based interventions to address their particular concerns. Please refer to the section in this guide on evidence-based harm reduction for suggestions.

Strengthen existing services and infrastructure

The aim is to strengthen existing harm reduction efforts and promote integrated, multi-sectoral approaches to reduce the harms from substance use. For example, municipalities, in consultation with their regional health board and community service providers, are encouraged to identify and attempt to remove existing obstacles to the establishment of harm reduction programs and develop clear guidelines to support the co-operation and integration of local services.

Municipalities are also encouraged to identify opportunities for collaboration with neighbouring communities and other municipalities in the region. Care should be taken to avoid displacing problems from one community to another in the development of a comprehensive harm reduction strategy.

Key Elements

Develop a comprehensive, integrated and balanced strategy with the following components:

Prevention

Harm reduction starts with prevention. Effective prevention strategies create opportunities and supportive environments for people to make informed and healthy life choices. Outreach services and integrated community and school-based harm reduction education are good examples of prevention strategies. Prevention of harm can also help reduce the health consequences of substance use, such as HIV or hepatitis C infection, through overdose prevention and management, needle exchange and supervised consumption facilities.

Treatment

Treatment is a critical component of harm reduction, supporting substance-dependant individuals to manage their substance use and move towards abstinence and recovery. Treatment services include detoxification, supportive recovery, residential care, pharmacotherapy and primary health care. Treatment services are particularly important for people who are isolated by their dependence and may also have concurrent mental health issues.

Community Supports

Housing is critical to harm reduction. Without stable living arrangements, many people are simply unable to access or maintain their engagement in prevention and treatment programs. Emergency, transitional and supportive housing must be available for people who continue to use drugs, as well as those who are in recovery. Other supports needed to help people reintegrate into the community include low threshold mental health and addictions services, assertive community outreach, life and work skills training and supportive employment.

Enforcement

Police have direct contact with people who use illegal drugs on a regular basis. They are well placed to help reduce the harm to individuals and communities from problematic substance use. Police can do this by working closely with health care professionals to develop protocols for harm reduction services, such as sobering centres and needle exchanges. Police can also partner with municipal licensing and enforcement staff to enforce building code and other by-law violations at problem premises known to support the illegal drug trade.

Roles and Responsibilities

The challenges of implementing a municipal harm reduction strategy will require careful delineation of roles and responsibilities of community partners, as well as the establishment of clear protocols and guidelines for inter-agency collaboration. For example, municipalities could agree to develop a harm reduction policy to explicitly guide future planning and service delivery, review their own planning and decision-making mechanisms to ensure they take into account the strategy's objectives and make full use of their regulatory authority and existing services to support those objectives.

STAGE SIX

Mobilize the Community and Implement the Strategy

The purpose of community mobilization is to:

- inform and listen to the community
- reduce barriers to acceptance of harm reduction
- overcome denial of community issues and problems
- ensure each point of view is listened to with respect
- promote local ownership of the project
- develop collaboration between individuals and organizations

It is best to employ community mobilization tactics that have been successful in the past to make the community aware of the municipal harm reduction strategy.

Effective public education increases awareness of the issues and increases community support for the harm reduction strategy. Community consultations are valuable opportunities to inform members of the public, identify issues that are causing concern and to identify potential proponents and critics of a harm reduction strategy.

Public information events are particularly helpful when dealing with a controversial issue like harm reduction. They provide opportunities to share objective, credible information and address misconceptions. The community may be undecided on the issues, but will likely give serious consideration to a strategy that has good evidence and desirable objectives.

Open meetings are an important way in which a community is able to express its concerns and listen to information and advice. An effective meeting can be organized in many ways: panel discussions, presentations by informed speakers, showing films and videos, and question and answer sessions between the community, municipal officials, and local harm reduction service providers.

It is also necessary to use other ways of reaching the public with the information. Written information can be given to the press, officials driving the process can provide interviews to local news outlet, and written information and questionnaires can be distributed to citizens.

STAGE SEVEN

Monitor Implementation and Adjust Course if Needed

It is important to monitor the implementation of the strategy on a regular basis in consultation with community partners. If there are changes in the community or in the larger policy, funding or service delivery context, course corrections may be needed to ensure the strategy remains relevant and responsive to local concerns. In monitoring implementation, key questions to ask include: Is the strategy being implemented in a timely manner? Are resources being deployed efficiently and effectively? Are community partners and public satisfied with the progress? Are the goals and objectives being met?

STAGE EIGHT

Communicate Results

It is important to keep community partners informed on a regular basis to maintain interest and support. The communication plan should be utilized to emphasize progress and successes. Specific communication tactics include the development of media advisories, reports, websites, community meetings and inserts in local papers.

Community Examples

A MADE IN VICTORIA APPROACH

In April 2004, the City of Victoria unanimously approved a harm reduction policy framework for managing the harms to the community from substance use and the necessary supports for drug and alcohol users.

Victoria's harm reduction approach addresses the complex inter-relationship between prevention, treatment, enforcement, housing and other supports. It promotes public and professional dialogue on substance use in the community, and it supports collaborative action to address the adverse health, social and economic consequences of substance use.

There were a number of precipitating factors that led the City of Victoria to adopt its harm reduction policy, including public concern, public health, public interest, and public pressure.

Public Concern

- Open drug and alcohol use
- Public after effects of excessive drug and alcohol consumption
- Discarded drug paraphernalia

Public Health

- Rising rates of HIV and hepatitis C
- Overdose deaths

Public Interest

- Unprecedented turnout to screenings of the documentary *Fix: The Story of an Addicted City* in 2002 and participation in post-show discussion forums
- Public discussions in churches, community centres and neighbourhood associations on alternative approaches to dealing with substance use

Public Pressure

- High demand for information on what other cities are doing, what is working and what might be appropriate for Victoria
- Immense pressure from the business community and public to do something about substance use in the downtown core

In response to these factors, the City of Victoria, Vancouver Island Health Authority & the Victoria Police developed the Downtown Health Action Plan, with a range of short and longer term initiatives.

Projects accomplished include enhanced needle pick up, a sobering and assessment centre, a psychiatric emergency centre, expanded youth detox, an emergency mental health services team, downtown support workers, targeted police enforcement and the formation of the multi-stakeholder Inner City Health Coalition.

The City has gone through a tremendous learning curve in the past three years, which has fundamentally changed the way it looks at resolving some of its toughest social problems. The biggest challenge has been to grasp the complexity of substance use and its potential impact on people and communities. In doing so, the City has embraced harm reduction as a pragmatic, cost effective and socially responsible approach to reducing the personal and social harms associated with substance use.

HARM REDUCTION IN B.C.'S INTERIOR - CREATIVE APPROACHES TO UNIQUE SETTINGS

Handling the distribution and collection of syringes to reduce harms from injection drug use presents unique challenges in settings with few dedicated resources and vast geographic scope. In the Thompson, Cariboo, and Shuswap Health Service Delivery Area of the Interior Health Authority, initiatives spearheaded by public health nurses have resulted in creative and cost-effective approaches within this challenging context.

Needle exchange services in the region are coordinated by public health, but only in terms of providing required supplies and tracking the program's outcomes. Actual provision of needle exchange services is entrusted to local pharmacies and outreach workers who are already engaged with vulnerable populations associated with a high prevalence of injection drug use. This integrated approach makes good use of limited existing resources, and ensures that needle exchange is available in settings that are familiar and already accessed by the targeted populations.

In the denser, more urban setting of Kamloops, the collection of discarded syringes has become a community concern. The Liver Information and Treatment Clinic (LITC), a project of the Kamloops Health Unit, has employed a community development model and partnered with local business, community, enforcement, and municipal government in order to develop a response. A "sharps container" (receptacle for used syringes) program has been initiated, and containers have been installed in areas that are accessible to the community.

In addition, a public education campaign was launched to promote better understanding in the community regarding problematic substance use, and specifically safer ways to pick up a used syringe for disposal. One of the primary targets of the campaign is families in the community.

To reach this audience, and help educate children about the issue, the campaign employs a mascot, a knight named "Sir Ringe," who has been so successfully received that his use has stepped beyond the role of mascot for safe needle disposal; he was recently used to encourage children and parents to seek out immunization for influenza.

B.C. Ministry of Health, 2005. "Priorities for Action in Managing the Epidemics: HIV/AIDS (2003-2007): 2004 Progress Report"

FEDERATION OF CANADIAN MUNICIPALITIES: MODEL MUNICIPAL DRUG STRATEGY PROJECT

The Federation of Canadian Municipalities, in partnership with the National Crime Prevention Centre, the Canadian Centre on Substance Abuse and the Health, Education and Enforcement in Partnership, developed and piloted the Model Municipal Drug Strategy (MMDS), a municipally focused, community-based approach to substance abuse issues. The strategy addresses prevention, including public awareness and education, rehabilitation, with an emphasis on harm reduction, treatment and support, and law enforcement. Nine communities across Canada were funded to pilot test the MMDS approach, including Courtenay, Richmond and Prince Rupert. The pilot projects were evaluated to identify accomplishments, challenges and lessons learned in developing a municipal drug strategy.

Accomplishments

- Raising awareness about drug problems in the community
- Securing endorsement from municipal officials
- Coordinating action plans
- Executing needs assessments and resource inventories
- Establishing quality community partnerships

Challenges

- Mobilizing the community, especially specific groups such as seniors citizens, youth, business leaders and Aboriginal communities
- Maintaining focus among a broad range of stakeholders
- Obtaining accurate information on substance use in the community
- Securing adequate resources to accomplish goals and sustain the drug strategy

Lessons Learned

Municipal governments can provide critical leadership, lend legitimacy, facilitate partnerships and generate political will to encourage institutional partners and service providers to re-visit existing practices and redeploy existing resources to better meet community needs.

The strategy development process should be simple, with clearly defined goals and objectives, organizational roles and responsibilities and working protocols. It should build on incremental but visible successes.

Update: In 2002, Richmond City Council appointed the Richmond Substance Abuse Task Force to develop and implement a drug strategy tailored specifically to meet the needs of the Richmond community. The Richmond Substance Abuse Strategy has five goal areas: prevention and education, treatment, harm reduction, inter-agency co-operation and enforcement. This “umbrella” strategy provides direction to local agencies for their substance abuse initiatives. The success of Richmond’s drug strategy can be attributed to a broad group of stakeholders in the community who take responsibility for solving the problems of substance abuse, work together on programs and initiatives and advocate for funding and services from other levels of government.

WORKING WITH PEOPLE WHO USE

A key aim of any harm reduction strategy is to engage the co-operation and collaboration of people who are at personal risk of substance-related harm. Harm reduction services speak a language of hope to active drug users, and are a clear and demonstrable sign that the community cares about them and their lives.

Some people need significant help to come to grips with their illness and start a process of recovery. These are the people who most need to know about the location and availability of harm reduction services in their local area.

Others have reached a stage in their lives where they recognize the importance of such issues, and want to help the community to respond to this complex and multi-faceted issue. Research consistently shows that such people have greatly enhanced credibility when communicating information about health risks to their peers.

There have been several successful initiatives taken in B.C. that have originated with users and have become an integral part of the collective response. Several have gone on to become formal organizations giving a voice to people at risk of substance-related harm.

Peer2Peer is an outreach-based syringe exchange started by three drug users in Vancouver who wanted to help their peers. Two years ago, Vancouver Coastal Health recognized their value by providing funds to broaden this work. They now work 7 evenings a week in their area in Vancouver.

VANDU (Vancouver Area Network of Drug Users) was established more than 7 years ago by users to act as a community resource and source of education. The organization encourages users to become community volunteers. Their members assist the overall city strategy in many ways: encouraging disease awareness, promoting harm reduction, and picking up injection-related litter.

SOLID (Society of Living Intravenous Drug-Users) has played an important part in the discussion that has been taking place in Victoria. Members assist with the Network X mobile syringe exchange, and they provide a range of education initiatives about treatment opportunities as part of their on-going work.

KANDU (Kelowna Area Network of Drug Users) was established in response to interest expressed by several members of the city's drug-using population. KANDU joined forces with The Four Pillars Coalition in Kelowna to help address the city's drug problem. The KANDU Project began a needs assessment in the summer of 2004 involving street interviews, one-on-one interviews and focus group meetings. The results of the data collected offer insight and ideas from the drug users themselves. Their areas of concern addressed all four pillars of the city's strategy (harm reduction, enforcement, treatment and prevention).

Comprehensive Drug Strategies in British Columbia

Central Okanagan Framework for Action

http://4pillars.livingpositive.ca/framework/CO4PC_Final_Report.pdf

City of Vancouver: *Four Pillars Drug Strategy*

<http://www.city.vancouver.bc.ca/fourpillars/>

Preventing Harm from Psychoactive Substance Use

http://www.city.vancouver.bc.ca/fourpillars/pdf/preventingharm_report.pdf

Lower Mainland Municipal Association: *Regional Action Plan to Reduce the Harmful Effects of Alcohol and Drug Misuse*

http://www.lmma.bc.ca/pdf/LMMA_Action_Plan.pdf

Resource List

Here is a list of publications and web sites with further information on harm reduction:

Alberta Non-Prescription Needle Use (NPNU) Consortium – *Harm Reduction Information Kit*

<http://www.hivedmonton.com/home.html>

Alberta Drug Strategy – *Discussion Draft*

http://corp.aadac.com/content/corporate/about_aadac/ab_drug_strategy_discussion_draft.pdf

Alcohol Policy Network – *Best Practices*

<http://www.apolnet.ca/resources/education/bestpractices.html>

B.C. Ministry of Health – *Problematic Substance Use Prevention*

<http://www.healthservices.gov.bc.ca/prevent/substance.html>

Every Door is the Right Door: *A British Columbia Planning Framework to Address Problematic Substance Use and Addiction*

http://www.healthservices.gov.bc.ca/mhd/pdf/framework_for_substance_use_and_addiction.pdf

B.C. Centre for Excellence in HIV/AIDS

<http://www.cfenet.ubc.ca>

BC Partners for Mental Health and Addictions

<http://www.heretohelp.bc.ca>

Canadian Centre on Substance Abuse

<http://www.ccsa.ca/ccsa>

Centre for Addictions Research of British Columbia

<http://www.carbc.uvic.ca>

Centre for Substance Abuse Prevention – *Building a Successful Prevention Program*

<http://casat.unr.edu/bestpractices>

Centre for Addiction and Mental Health

http://www.camh.net/public_policy/harmreductionposition.html

European Monitoring Centre for Drugs and Drug Addiction

<http://www.emcdda.eu.int>

Federation of Canadian Municipalities: *A Framework for Developing a Model Municipal Drug Strategy and related documents*

<http://www.fcm.ca/english/documents/hs.html>

Health Canada – *Canada's Drug Strategy*

http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/index_e.html

International Harm Reduction Association

<http://www.ihra.net>

Regina and Area Drug Strategy Report

http://www.rqhealth.ca/programs/drug_strategy/pdf_files/report_june03.pdf

Substance Information Link (*a CARBC public information website*)

<http://www.silink.ca>

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Ministry of Health



Understanding Harm Reduction

What is harm reduction?

“Harm reduction” aims to keep people safe and minimize death, disease, and injury from high risk behaviour.

Harm reduction involves a range of support services and strategies to enhance the knowledge, skills, resources, and supports for individuals, families and communities to be safer and healthier.

A range of services is available to prevent harms from substance use. Some examples include:

Impaired driving prevention campaigns

Create awareness of the risks of driving under the influence of alcohol and other legal or illegal substances

Peer support programs

Groups for people who use substances - to improve their quality of life and to address gaps in services

Needle distribution programs

Distribute clean needles and other harm reduction supplies and educate on their safe disposal

Outreach and education

Make contact with people who use substances to encourage safer behaviour

Substitution therapies

Substitute illegal heroin with legal, non-injection methadone or prescription heroin

Supervised consumption facilities

Prevent overdose deaths and other harms by providing a safer, supervised environment for people using substances

What are the benefits of harm reduction?

Harm reduction has many benefits for people who use substances, their families, and communities. Research shows harm reduction activities can:

- Reduce HIV infection and hepatitis
- Reduce overdose deaths and other early deaths among people who use substances
- Reduce injection substance use in public places, and reduce the number of used needles in public
- Reduce the sharing of needles and other substance use equipment
- Educate about safer injecting and reduce injecting frequency
- Educate about safer sex and sexual health and increase condom use
- Reduce crime and increase employment among people who use substances
- Increase referrals to treatment programs and health and social services

What does harm reduction mean for people who use substances?

Harm reduction makes it as easy as possible for people who use substances to get help.



Harm Reduction for Families and Caregivers

What is harm reduction?

“Harm reduction” aims to keep people safe and to reduce deaths, disease and injuries from high-risk behaviour.

Harm reduction involves a range of support services and strategies to help keep individuals, families and communities safer and healthier.

How can I reduce harm?

There are many ways that you can reduce harm.

- Wash your hands to reduce the spread of germs and disease.
- Brush your teeth to reduce dental decay.
- Use seat belts and child car seats to reduce serious injury or death.
- Use a helmet and knee, elbow, and wrist pads during sports activities to reduce serious head and body injuries.
- If you smoke, do so outside of your home to prevent exposing your family to second-hand smoke.
- If you plan to drink alcohol, designate a driver to prevent accidents and injuries.

How can parents, caregivers and communities reduce harm?

A strong community is the result of healthy individuals and families. Together we can all make a difference.

- Support school-based education programs on tobacco, alcohol and other drugs that offer children information and skills to make safe, healthy choices throughout their lives.

- Support and assist with programs that engage children in activities such as sports, art, dance, music, special interest clubs and hobbies. These activities help children develop self-respect, confidence and positive relationships with their families, culture and community, and a sense of belonging, pride and tradition.
- Provide children with the information and skills to stay safe, including teaching them what to do when they cross the street, if they are approached by a stranger, or if they find a needle.

What are the benefits of harm reduction related to substance use?

Harm reduction can have many benefits for people who use substances, their families and their communities. Research shows harm reduction activities can help in a number of ways:

- Reduce HIV infection and hepatitis
- Reduce overdose deaths and other early deaths among people who use substances
- Reduce injection substance use, the frequency of injecting and the number of used needles in public
- Reduce the sharing of needles and other substance use equipment
- Educate about safer injecting
- Educate about sexual health, sexually transmitted infections and safer sex
- Increase condom use
- Reduce crime and increase employment among people who use substances
- Increase referrals to treatment programs and health and social services

What services are available for people who use drugs?

A range of services is available to prevent harms from substance use.

Needle distribution/recovery programs

Distribute clean and recover used needles and other harm reduction supplies, and provide information on their safe disposal

Substitution therapies

Substitute illegal heroin with legal, non-injection methadone or prescription heroin

Outreach and education

Make contact with people who use substances to encourage safer behaviour

Supervised consumption facilities

Prevent overdose deaths and other harms by providing a safer, supervised environment

For More Information

- Harm Reduction: A British Columbia Community Guide
www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf
- [HealthLink BC File #102a Understanding Harm Reduction](#)
- [HealthLink BC File #29 Steps for Protection against Germs and Disease](#)
- [HealthLink BC File #85 Hand Washing for Parents and Kids](#)
- [HealthLink BC File BC #30c Protecting your Family from Second-hand Smoke](#)
- [HealthLink BC File # 38d Pregnancy and Alcohol Use](#)
- [HealthLink BC File #97 Contact with Blood or Body Fluids: What You Need to Know](#)



BC Centre for Disease Control
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For more BC HealthFile topics, visit www.HealthLinkBC.ca/healthfiles/index.stm or your local public health unit.

Click on www.HealthLinkBC.ca or call **8-1-1** for non-emergency health information and services in B.C.

For deaf and hearing-impaired assistance, call 7-1-1 in B.C.

Translation services are available in more than 130 languages on request.

Harm reduction services are open to all people who use substances, at any stage of their substance use. This way, help is available when someone using substances wants to move in a new direction, for example switching from injecting, or using heroin to using methadone, or accessing treatment.

People who use substances are encouraged to participate in harm reduction activities. These services aim to involve people in their own health by keeping them connected to the health system. Harm reduction can empower people to improve the quality of their lives.

I have concerns about harm reduction...

Many people express concerns about harm reduction. Some of the more common concerns are addressed here.

Q: Could harm reduction make it easier for people to use substances and prevent them from quitting?

A: In society, there are people who use substances. Dependent users may not want or be able to quit, or may continue to relapse into substance use. Harm reduction reduces the risk and spread of infections like hepatitis and HIV. Harm reduction creates opportunities for people to lead healthier lives.

Q: Could harm reduction activities encourage people to use substances?

A: Research shows that harm reduction activities do not encourage substance use.

Q: Does harm reduction drain funding from treatment programs?

A: Treatment programs are part of harm reduction. Specific harm reduction activities are cost-effective, and prevent costly outcomes like hepatitis and HIV.

Q: Does harm reduction mean trying to legalize substances?

A: Legalization is not part of harm reduction. Harm reduction applies to both legal and illegal substance use. A high school organizing safe rides home after graduation because parents realize their teenagers may be drinking, is an example of harm reduction.

For More Information

Harm Reduction: A British Columbia Community Guide

www.housing.gov.bc.ca/ptf/hrcommunityguide.pdf



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BC Harm Reduction Strategies and Services Policy and Guidelines

TABLE OF CONTENTS

1	Harm Reduction Definition.....	1
2	Scope.....	2
3	Policy Statement	2
4	Goals of BC Harm Reduction Strategies and Services Policy	2
5	Monitoring Framework.....	3
6	Objectives.....	4
7	Distribution Procedures for Syringes and Other Supplies	4
8	Safe Disposal of Syringes.....	5
9	Facilitating Access to Other Services	5
10	Education.....	5
11	References.....	6
12	Suggested Readings.....	6

1.0 Harm Reduction Definition

Harm reduction involves taking action through policy and programming to reduce the harmful effects of behaviour. It involves a range of non-judgmental approaches and strategies aimed at providing and enhancing the knowledge, skills, resources and supports for individuals, their families and communities to make informed decisions to be safer and healthier.

2.0 Scope

These guidelines support harm reduction strategies and services pertaining to problematic substance use and sexual health.

3.0 Policy Statement

Harm reduction is an integral component of the prevention, treatment and care continuum. Effective harm reduction policy and programming rests on guiding principles that reflect a client-centered and ethical focus. The populations who are served by harm reduction activities are diverse and often already marginalized—drug use compounds the stigma they face. Individuals and systems involved in providing harm reduction supplies and services must respect human rights and the dignity of their clients by adhering to basic ethical principles such as fairness, to do good and respect for autonomy.

Each Health Authority and its community partners must work together to provide a full range of harm reduction services within their respective jurisdictions. Core components include, but are not limited to: referrals, advocacy, education, and supplies distribution. These services are aimed at reducing harms from injection and other drug use.

Best evidence supports implementation of harm reduction supply and distribution programs (HRSDPs) to decrease blood borne pathogen transmission among those who use drugs and their partners. HRSDPs also increase engagement of vulnerable and marginalized populations into the health and social service system to reduce transmission of other communicable diseases such as sexually transmitted infections, Tuberculosis and Pneumococcal infections and support other concurrent mental health conditions and/or addictions such as alcohol dependency.

4.0 Goals of BC Harm Reduction Supply Services (HRSS) Policy

- 1) Reduce incidence of drug-related health and social harms, including transmission of blood-borne pathogens through equipment sharing
- 2) Promote and facilitate referral to primary health care and addiction and mental health services
- 3) Increase public awareness of harm reduction principles, policies and programs
- 4) Improve access to HRSDPs for all British Columbians to empower them to reduce harms associated with problematic substance use and unsafe sex

5.0 Monitoring Framework

The following framework provides a guide for monitoring outcomes associated with the implementation of the HRSS policy:

Goal 1: Reduce incidence of drug-related health and social harms, including transmission of blood-borne pathogens	
Indicators	Data Sources
<ul style="list-style-type: none"> ▪ Health Authorities report implementation of best practice strategies and services ▪ Number and rate of new cases of HIV and HCV among people who use drugs ▪ Persons prescribed methadone ▪ Number of illegal opioid/stimulant-induced deaths and PYLL from such deaths. 	<ul style="list-style-type: none"> ▪ Ministry of Health Services <ul style="list-style-type: none"> ○ Vital Stats; Medical Services Plan ▪ Health Authorities ▪ BC Centre for Disease Control ▪ Health Canada Enhanced Surveillance (BCCDC & Vancouver Coastal Health) ▪ Centre for Addictions Research BC ▪ Centre for Applied Research in Mental Health and Addictions ▪ BC Centre for Excellence HIV/AIDS ▪ BC Coroners office
Goal 2: Promote and facilitate referral to primary health care and addiction/mental health services	
Indicators	Data Sources
<ul style="list-style-type: none"> ▪ Harm reduction strategies and service agencies have in place referral mechanisms to treat primary health care and addiction/mental health ▪ Number of clients accessing HRSDPs that receive a health and social service referral 	<ul style="list-style-type: none"> ▪ Health Authorities
Goal 3: Increase public awareness of harm reduction principles, policies and programs	
Indicators	Data Sources
<ul style="list-style-type: none"> ▪ Health Authorities and community partners are aware of harm reduction philosophy as it pertains to illegal drugs and legal drugs such as alcohol ▪ Health Authorities have communications strategies developed and implemented to disseminate accurate information to the public. 	<ul style="list-style-type: none"> ▪ Health Authorities ▪ BC Centre for Disease Control ▪ BC Ministry of Health
Goal 4: Improve access to HRSDPs for all British Columbians to empower those to reduce harms associated with problematic substance use	
Indicators	Data Sources
<ul style="list-style-type: none"> ▪ Supply distribution and recovery numbers by HSDA ▪ Number of HRSDP clients/encounters associated with primary and secondary distribution sites 	<ul style="list-style-type: none"> ▪ Health Authorities

6.0 Objectives

Objective 1: Health Authorities will establish and maintain partnerships with community agencies and stakeholders in the delivery of HRSS.

Objective 2: Health Authorities, contracted agencies and community partners will maximize access to HRSS.

Objective 3: Health Authorities, contracted agencies and community partners will take appropriate steps to protect the public from inappropriately discarded injection equipment and drug paraphernalia.

Objective 4: Health Authorities, contracted agencies and community partners will strive to eliminate syringe sharing and promote the use of a sterile syringe for each injection.

Objective 5: Health Authorities, contracted agencies and community partners will provide individuals with harm reduction information (including information on combining alcohol and drugs), access to supplies and referrals to health care, mental health and addictions, and other relevant community services.

Objective 6: Health Authorities, contracted agencies and community partners will consider a full range of harm reduction service delivery options including supervised injection sites and distribution of supplies such as plastic mouthpieces for crack pipes and condoms to reduce harms among those who use drugs, their families and communities.

Objective 7: Dissemination of HRSS policy and best practices across and within health Authorities

Note: *Harm reduction programs can range from those which meet just a few objectives—to more robust ones that meet several. Areas with environments of relatively concentrated drug use should have programs which, together with community partners, meet all six objectives.*

7.0 Exchange Procedures for Syringes and Other Supplies

Access to HRSS should extend to whoever needs them regardless of the person's age, drug-using status, drug of choice, or residence for example, a health facility or correctional centre.

All programs should strive to provide maximum access to harm reduction-related medical supplies according to best practices.

All programs should strive to distribute as many supplies as the individual client requires to meet that client's particular needs. For instance, the individual should receive enough syringes to be able to use a new one for each injection.

It is possible that the person seeking HRSS is not seeking supplies for him or herself. In these situations it is acceptable to provide supplies for the purpose of secondary distribution.

All HRSDPs should endeavour to partner with key stakeholders in retrieving as many used distributed supplies as possible, particularly used syringes and educate the community about how to dispose of used syringes safely. The program should strive for 100% appropriate disposal. There should be a strong emphasis placed on encouraging people to either return their syringes or to dispose of them properly.

For a complete review of evidenced based harm reduction supply distribution and recovery programming please refer to the HRSS Best Practices document.

8.0 Safe Disposal of Syringes

HRSS agencies and community partners will formulate the community plan for harm reduction supply disposal. The plan may address for example, community education, the provision of sharps containers in supervised settings, the pick up of discarded supplies from streets, schoolyards, parks and alleys, the provision of small sharps containers to clients.

Each agency that receives supplies from HRSS will implement a plan for the safe handling, transport, and disposal of supplies, as well as a plan for staff, clients and volunteers to prevent occupational exposure and respond to a blood and/or body fluid exposure (e.g. needle stick injury).

Monitoring of the program by Health Authority and HRSS agencies will include an account of syringes provided, returned and reports of syringes inappropriately discarded.

The Health Authority and the HRSS agency within its boundaries will be responsible for making information available to the community about the plan for the safe disposal of syringes and the numbers distributed and returned.

9.0 Facilitating Access to Other Services

As an integral part of its needle exchange and harm reduction supply distribution practice each HRSDP that does not provide communicable disease testing, vaccination, counseling and screening services for mental health conditions or alcoholism will develop client referral pathways that are user friendly and perceived by clients as accessible.

Examples of service referrals are; housing, financial assistance, food services, alcohol and drug counselling and/or treatment, reproductive care, parenting assistance, youth services, public health, primary care, mental health services, legal services/victim services, disease testing/management/treatment, and other related services.

10.0 Education

As an integral part of its needle exchange practice each HRSDP will include, but is not limited to, educational programming for clients regarding:

- Safer injection practices including discussion about vein maintenance and the limited effectiveness of bleach;
- Safe needle disposal;
- Safer sex practices;
- Harm reduction information;
- Principles of general health and well being;
- Information on poly drug use including legal and illegal drugs
- Specific populations, *special efforts should be made to counsel women, aboriginaltwo spirited people and lesbian, gay, bisexual, transgendered and queer (LGBTQ) about unique vulnerabilities. The evidence suggests that women are more likely to be expected to use used equipment and there is significant overlap between women's drug and sexual networks...*¹⁻⁵

11.0 References

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5. Paone, D., Cooper, H., Alperen, J., et al., **“HIV risk behaviours of current sex workers attending syringe exchange: the experiences of women in five US cities,”** *AIDS Care*, (1999) v. 11, n. 3, pp. 269-280.

12.0 Suggested Readings (available on BCCDC website)

Best Practices for British Columbia's harm reduction supply distribution program. (2009)

Kerr T, Wood E. Evidence and best practice for the employment of harm reduction activities in programs aimed at controlling communicable diseases. (2006)



BC Harm Reduction Strategy and Services (HRSS) Committee Primary, Secondary and One-off Distribution Site Policy

Purpose

The purpose of this document is to define distribution sites that receive publicly funded safer sex and drug use supplies, to provide guidance on establishing these sites, and to explain the process to be completed in order for a distribution site or one-off event to receive supplies.

Primary/Secondary Distribution Sites

Definitions

- **Primary distribution site** - a site such as a Health Unit that orders supplies directly from BCCDC and receives those supplies directly from the central distributor
- **Secondary distribution site** – a site that receives or picks up supplies from a primary distribution site (as defined above)

Decision to designate a primary distribution site is made by:

- Health-Authority (HA) HRSS Representative in collaboration with BCCDC Harm Reduction lead(s)

Decision to designate a secondary distribution site is made by:

- Primary distribution site manager in consultation with the HA HRSS Representative
 - Note: it is important that HRSS reps and BCCDC know where supplies are going in order to send out important/time sensitive information/alerts and for tracking supply distribution

Primary/secondary site designation criteria

	Primary distribution site	Secondary distribution site
Independency: decisional factor	Can operate independently because : <ul style="list-style-type: none"> • proved accountability • trained staff • ensuring ongoing compliance with policies/best practices of the Regional Health Authority and of the Harm Reduction Strategies and Services Committee 	Cannot operate independently because Primary site needs : <ul style="list-style-type: none"> • Regular contact/follow up with secondary distribution site • Verify accountability and training of staff
Quantity of supply	Large supply quantity for each requisition * : <ul style="list-style-type: none"> • shipping cost is justified 	Small supply quantity for each requisition: <ul style="list-style-type: none"> • shipping cost is not justified
Remoteness	Remote access : <ul style="list-style-type: none"> • Regular pick-up trip to primary distribution site is not economically (time/distance) justifiable/feasible 	Close to a primary distribution site <ul style="list-style-type: none"> • Regular pick-up trip to primary distribution site is feasible • Other types supplies sent/picked up from primary site • Increase in shipping cost is not justified

* Please see the notes on minimum order size on the Harm Reduction Program: Supplies Requisition Form located on the web at www.bccdc.ca under harm reduction.



Duties of primary site (with regards to secondary site)

- Performs due diligence before authorizing secondary site, and initiates processes to ensure ongoing compliance with policies/best practices of the HRSS Committee and of the Regional Health Authority where they operate
- Forwards/ updates secondary site contact information to BCCDC - biologicals@bccdc.ca
- Keeps close contact, aligns strategies, and trains secondary site staff
- Communicates/trains secondary site regarding change in Harm Reduction policies and new products
- Regularly reviews annual usage with secondary site
- Receive requisitions from secondary site in a timely manner to enable inclusion of quantity in 3 monthly primary site requisitions
- For information only, regularly forwards secondary distribution requisition to BCCDC (attached)

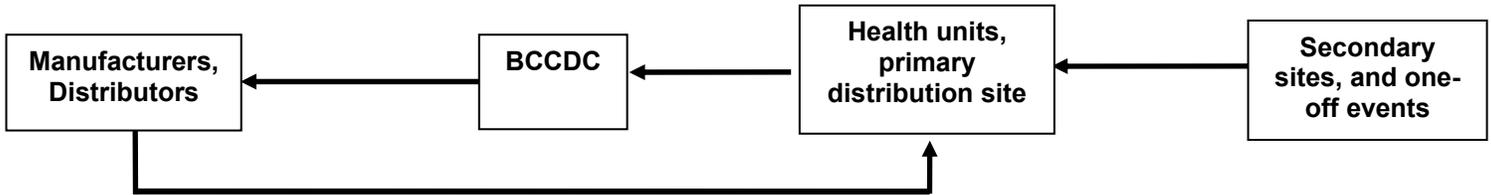
Duties of secondary site

- Complies with Harm Reduction policies and aligns strategy with primary site and Regional Health Authority
- Informs primary site about supply needs in a timely manner
- Stores supplies appropriately, manages inventory
- Ongoing supply quality assurance processes in place (i.e., checks condition and expiration dates of supplies)

Required Information Needed by Primary Site to Establish a Secondary Site

CLIENT Name	
HSDA	
Street-Address	
Street-City	
Street-Postal Code	
Mailing-Address	
Mailing-City	
Mailing-Postal Code	
Operating Hours	
Contact Person	
Contact2	
Phone	
Phone2	
Fax	
Email	
Email2	

Harm Reduction Supplies: Distribution Process Algorithm



Manufacturers, Distributors	BCCDC Health unit, Primary distribution site	Health unit, Primary distribution site
<p>9) Receives Purchase Orders (POs) by fax 10) Processes POs Thursday AM/PM 11) Ships products to health units/primary site or authorized sites Thursday PM and Friday AM</p>	<p>4) Receives requisition by fax 5) Processes requisition once a week, on Wednesday 6) Send Purchase Orders to central distributor 7) Receives and pays invoices 8) Controls price and quantity</p> <p>19) Investigates any concerns re supply quality. Informs sites and distributors re concerns and initiates recalls etc.</p>	<p>1) Evaluates quantity needed for next 3 months* (including needs of secondary sites and one-off event it provides for) 2) Completes harm reduction supply requisition form (including secondary sites and one-off event needs) contacts BC CDC for advice as necessary 3) Faxes Harm Reduction Program Supply requisition form to BC CDC; includes secondary distribution/one-off requisition forms for information only CUT OFF TIME is Tuesday 04:00 PM PST</p> <p>12) Receives shipments from central distributor Thursday/Friday 13) Controls quantity against requisition (contacts BC CDC in case of discrepancy) 14) Stores supplies according to the expiration dates (Next Expired First Out) 15) Distributes to secondary sites and other customers when needed 16) Keeps a log of quantities used by secondary sites and one-off events 17) Checks regularly stock and expiration dates 18) Informs BCCDC of any concerns re supply quality</p>

HARM REDUCTION PROGRAM: SECONDARY DISTRIBUTION SITE SUPPLY REQUISITION FORM

For sites previously authorized by Health Authority Harm Reduction representative or Primary Site.

Primary distribution site name: _____ Contact person: _____

Email: _____ Tel#: _____ Fax#: _____

Secondary Site Name:	
Date Submitted:	
Requested Date of pick up:	
Site Operating Hours:	
Address, City & Postcode:	
Contact Person:	
Phone:	
Fax:	
E-mail	
Alternate Contact:	
Alternate Phone / E mail:	

	Unit Of Issue	Quantity Ordered
Lubricated Condoms (Durex)	(144/Box)	Boxes
Non-Lubricated Condoms (Durex)	(144/Box)	Boxes
Assorted Flavours - Scented Condoms (Durex)	(144/Box)	Boxes
Female Condoms	Individual	Each
Aqua Lube (3 ml per packet):	(144/Bag)	Bags
Syringes with needle attached (1/2 cc insulin syringe & needle)	(100/Box)	Boxes
Syringes with needle attached (1 cc insulin syringe & needle)	(100/Box)	Boxes
Syringes without needles: 3 cc	(100/Box)	Boxes
Syringes without needles: 5 cc	(100/Box)	Boxes
Needle, disposable 18g x 1 1/2"	(100/Box)	Boxes
Needle, disposable 22g x 1"	(100/Box)	Boxes
Needle, disposable 22g x 1 1/2"	(100/Box)	Boxes
Needle, disposable 25g x 5/8"	(100/Box)	Boxes
Needle, disposable 25g x 1"	(100/Box)	Boxes
Needle, disposable 26g x 1/2"	(100/Box)	Boxes
Needle, disposable 27g x 1/2"	(100/Box)	Boxes
Alcohol Swabs	(200/Box)	Boxes
Water Vials - 3 ml	(1000/Case)	Cases
Wooden Push Sticks	(100/Bag)	Bags
Cutter	Individual	Each
Disposable Cookers (Stericups)	(1000/Box)	Boxes
Citric Acid H00mg sachets	(1000/Box)	Boxes
Plastic mouth piece Vinyl Tubing 1/4" x 3/8"	(100 feet/roll)	Rolls
Plastic mouth piece Vinyl Tubing 5/16" x 7/16"	(100 feet/roll)	Rolls
Plastic mouth piece Vinyl Tubing 3/8" x 1/2"	(100 feet/roll)	Rolls

Please fax order forms to: Your Regional Health Authority Harm Reduction Contact



One Off Event(s) – Ordering Safer Sex Products

The British Columbia Centre for Disease Control (BCCDC), with oversight of the Harm Reduction Strategies and Services (HRSS) committee provides condoms and lubricant without charge to an authorized community or public health organization in BC. New sites may request regular or temporary approval for condom and lubricant distribution.

Sites seeking temporary approval e.g. festivals and other events, must request approval through the Health Authority (HA) Primary Distribution Site Manager or HA HRSS Representative. In some cases, sponsorship decisions are made in collaboration with the BCCDC Harm Reduction Lead. The temporary site will receive supplies through existing primary and secondary sites where possible; the HA contact will facilitate connections between existing and temporary sites.

Sponsorship

Events where < 100 boxes of male condoms **OR** < 50 bags of female condoms in total are requested; decisions to sponsor and provide supplies are made by:

- Primary distribution site manager and/or HA HRSS Representative

Events where > 100 boxes of male condoms **OR** > 50 bags of female condoms in total are requested; decisions to sponsor and provide supplies are made by:

- HA HRSS Representative and BCCDC Harm Reduction Lead

Duties of one-off event organizers

- Comply with HRSS policies and aligns strategy with primary site
- Informs provider site of supply needs **at least 8 weeks before the event**
- Store supplies appropriately, manages inventory
- Have supply quality assurance process in place (i.e., to check condition and expiration date of supplies)
- Accurately forecasts usage and need
- Return surplus quantity to same provider site, report exact # supplies distributed

Duties of sponsoring site

Performs due diligence before sponsoring. Assess:

- Ability of event staff to comply with HRSS policies and best practices
- Forecasted usage/need
- Forwards contact information of one-off event to BCCDC with the replenishment requisition, checks “one-off event”
- Assess true need for supplies and if necessary controls usage during event (if quantity being distributed is significant above forecasted amount)
- Ensures that surplus supplies from event are returned to provider site
- Documents usage, successes and challenges for future events and reports learning’s to HA Harm Reduction contact

Order form for one-off events

The “One-off event Request Form” (see over) must be completed and faxed to the Health Authority contact for approval. Once site/event approved supplies will shipped either directly to the requesting agency or picked up from the primary site with no delivery charge as agreed.

To ensure timely delivery, this request must be completed 8 weeks prior to the event.

One-off Event Harm Reduction Supply Request Form

(To be completed by non-governmental agency requesting one off supplies from a health authority)

Sponsoring Health-Unit/Primary distribution site name: _____

Contact person: _____ Email: _____

Tel#: _____ Fax#: _____

Note: Where your site is not the event organizer, please include a letter authorizing your agency to distribute condoms and lubricant at the event described below. This letter must be received prior to shipping of supplies.

Event Details

• Name and type of event : _____

Contact person: _____ Email: _____

Position: _____ Phone: _____

Address: _____ Fax: _____

• Sponsoring agency and partners: _____

• Location of the event: _____

• Date of Event: ___/___/_____ Length of event: _____ day(s)

• Will the event include overnight camping ? (Y/N) _____

• Expected number of event attendees: _____

• Please describe event attendees (age groups, etc.): _____

• Non-profit event For profit event

How do you plan to distribute education messages on proper condom and lubricant use and disposal?

How do you plan to distribute condoms and lubricant?

In most cases, supplies will be limited to a maximum order of 5,000 (35 boxes @ 144/box) insertive (male) condoms; 1,000 (10 bags @ 100/bag) receptive (female) condoms and 5,000 (5 boxes@1,152/box) packages of lubricant. Condoms are to be distributed free of cost, only for individual distribution and only for this event.

• Number of condoms requested: _____ male _____ female

• Packages of lubricant requested: _____ individual packages

How will you ensure condom and lubricant materials are removed from the area around the event site:

To avoid wastage, you must inform the Health Authority contact of any undistributed supplies and return them to your primary contact. **A report of how many supplies were distributed and returned to the primary site will be required.**

Name of HA Approver: _____

Signature of HA Approver: _____

Please fax or email this form to your health authority harm reduction contact

STRATEGIES

In this issue



Discover BC's harm reduction product distribution practices page 2

Ethics Opinion: Water for Injection vs. Water for Inhalation page 3

And more....

Welcome to the

Inaugural Issue of Strategies!



The BC Harm Reduction Strategies and Services (HRSS) committee is pleased to launch the inaugural issue of Strategies, its semiannual newsletter which highlights the latest information on harm reduction principles, policies and programs in British Columbia. The Harm Reduction Supplies Program purchases and distributes harm reduction supplies to more than 170 sites across the province to support regional health authorities in delivering and expanding harm reduction services for people who use illegal drugs.

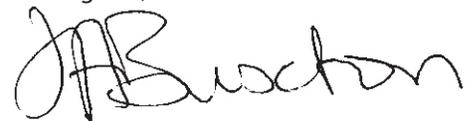
The HRSS committee is comprised of representatives from all 5 BC regional Health Authorities, the BC Centre for Disease Control (BCCDC), and the BC Ministry of Health. This group is dedicated to reducing the incidence of drug-related death, disease, and injury, including transmission of blood-borne pathogens through the sharing of drug paraphernalia.

This newsletter is intended to keep our stakeholders, health authorities and community

partners connected and informed of what is happening in BC with respect to harm reduction. It is imperative that our partners have the resources needed to provide the range of supply services and strategies required to enhance the knowledge, skills, resources, and supports for individuals, families and communities to be safer and healthier.

Future issues will feature local experiences, if you have something you wish to share, or have any questions, please contact your local representative. I hope you find this issue informative, and encourage you to send us your feedback.

Warm regards,



Dr. Jane Buxton
Physician Epidemiologist and Harm Reduction Lead, BCCDC

Contact Information:

British Columbia Centre for Disease Control (BCCDC)
655 West 12th Avenue, Vancouver, BC V5Z 4R4 Canada
Website: www.bccdc.org
Phone: 604.660.0584

More than just needles:

Exploring harm reduction product distribution practices across BC through qualitative interviews and geographic mapping

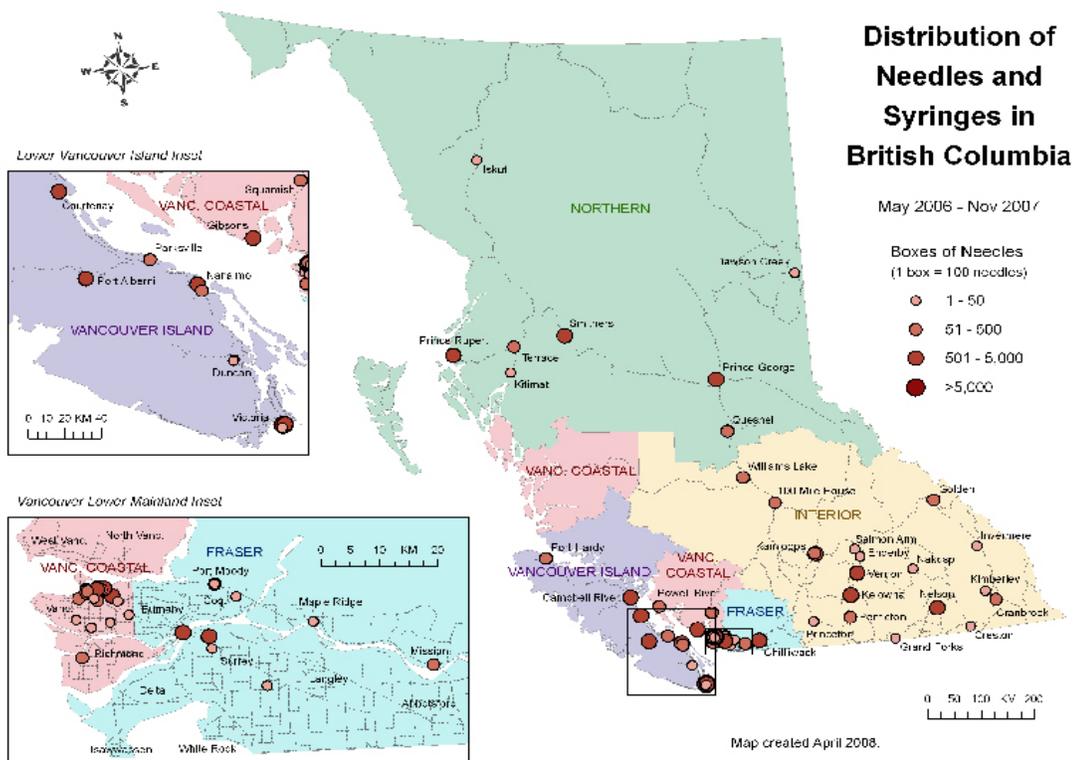


Each of BC's five health authorities and their community partners are committed to the provincial Harm Reduction Supply Services policy which states that they will provide a full range of harm reduction (HR) services to their jurisdictions, and ensure that HR products are available to all who need them, regardless of where they live or which drug they use. These products include condoms and lubricants, needles and syringes, alcohol swabs and sterile water.

These items are funded by the BC Ministry of Health and subsidized by the Provincial Health Services Authority (PHSA). They are distributed by the BC Centre for Disease Control (BCCDC), which also tracks the harm reduction products that are sent to health units and community agencies that distribute the supplies.

After initial analysis of BCCDC's tracking data, wide variations between health service delivery areas were noted. As a result of these discrepancies, the HRSS committee agreed that there was a need to investigate the range and adequacy of HR product distribution using qualitative interviews, and to analyze HR product distribution by site using geographic information systems. The "More than just Needles" study was launched in May 2007 to evaluate current product supply distribution, and explore future demands to identify gaps, cost-saving measures and potential cost pressures.

The study identified a lack of standardized policy and practice between distribution sites. For example, we found that processes varied from "self-serve" to provider-mediated. As well, some sites only provided condoms or very limited injection supplies, and one site utilized a 1-for-1 needle exchange. We also noticed little demand for female condoms, except in sites where education was provided. Secondary distribution of supplies (where an agency obtains supplies from a direct ordering site) was common but was



not systematically recorded. Furthermore, our study uncovered variations in training, with routine training of distributors occurring in few regions; other health authorities employed community engagement and development approaches. Although a new needle, syringe and sterile water should be used for every injection, we found considerable discrepancies, with one site supplying no water. Many sites also reported a demand for crack pipe mouthpieces. Geographic mapping also identified large rural areas without access to a primary distribution site (see map above).

As a result of the study, a consultant has been hired to develop a best practice document, to build on and share available resources, and to enable a more standardized approach to HRSS in BC. The guidelines may include criteria for new distribution sites, a secondary distribution data collection instrument and training resources.

Please note, the map above excludes secondary distribution sites.



Mouth pieces and push sticks to reduce harms for crack cocaine users

The HRSS Committee examined the evidence for disease transmission, benefits, risks and costs of providing rubber tubing and recommended that mouthpieces should be available. The tubing is available in 2 different widths to fit most glass stems, in 100-foot lengths which can be cut at the distribution site with special cutters.

Push sticks are used to pack and position the filter or screen (often Brillo) inside the crack pipe. Once the crack has been smoked the push stick is used to move the filter back and

forth to partially recover the crack that has hardened on the inside wall of the pipe as the pipe cools. We became aware that plungers from syringes supplied for HR purposes were being used to push the crack inside the pipe, while the rest of the syringe and needle was discarded. HRSS service providers in Vancouver estimated that 1 in 5 syringes distributed may be used for the plunger only.

The HRSS committee examined the risks and benefits of providing wooden push sticks, noting that this would avoid discarded needles and potentially toxic melted plastic related to using syringe plungers, and they also anticipated a cost savings as craft sticks are cheaper than needles and syringes. Some people used metal such as broken car aerials which could potentially crack and break the glass and cause cuts to fingers and lips. Wooden sticks were determined to be preferable to metal.

In the 1990s in Canada, street drug use patterns changed, with crack cocaine becoming much more prevalent. Crack cocaine smoking presents different public health risks from injection drug use, and poly-drug use may occur. Populations who engage in both activities are often highly vulnerable and marginalized, and may suffer from concurrent mental illness, physical ill-health and homelessness. People who smoke crack cocaine sometimes develop oral lesions, burns and cuts from hot or broken pipes or cracked lips. If glass pipes for crack smoking are shared, evidence suggests that individuals may be at increased risk of exposure to hepatitis C and other communicable diseases.^{1,5,6,7,8}

Using rubber mouthpieces on the ends of crack pipes allows individuals to protect themselves from burns and exposure to communicable diseases; a person can have their own mouthpiece which they alone use. Providing supplies for people who do not inject drugs also creates a further point of engagement for otherwise hard-to-reach populations of marginalized and vulnerable individuals.

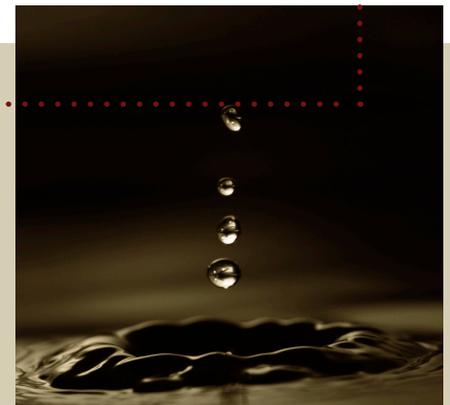
Ethics Opinion:

Water for Injection vs. Water for Inhalation

Sterile water is distributed to avoid harm from using contaminated sources (e.g. puddle water). Two types of sterile water are available: Sterile Water for Inhalation in 3ml vials; and Sterile water for Injection in 10ml vials. The HRSS policy has been to distribute the smaller Sterile Water for Inhalation vials to reduce the risk for cross contamination through re-using or sharing the larger vials.

In 2007, due to a temporary lack of availability of smaller vials, the BCCDC provided 10ml Sterile Water for Injection vials. Late last year, we met with members of the BC

Children's and Women's Ethics Committee to discuss ethical issues related to providing Sterile Water for Inhalation compared to Sterile Water for Injection. The committee discussed these issues at length and felt that Sterile Water for Injection in 3ml vials would be the preferred product to use. However, since water for injection is not currently commercially available in this volume, the committee applied the ethics framework of least harms. A consensus was reached supporting the provision of 3ml vials of Sterile Water for Inhalation in preference to 10ml vials for injection.



Sterile Water for Injection	Sterile Water for Inhalation
<ul style="list-style-type: none"> • Lower bacterial endotoxins & particulate matter • Available in 10ml vials only 	<ul style="list-style-type: none"> • Packaged in 3ml vials for single use



New supplies and Warehousing

The HRSS committee considers the evidence (benefits, risks and costs) for each new HR supply item requested, and members may seek feedback from their health authority. Once the committee recommends a new harm reduction supply item be added to the list, each health authority decides if and how to distribute the products, often through stakeholder and community engagement.

be used in the future to monitor distribution, reduce transportation costs, ensure accountability, determine minimum orders and identify gaps. A Request for Proposal (RFP) process to find a vendor who can warehouse and distribute all the harm reduction supplies will be undertaken. Prior to the tendering process BCCDC will work with Vancouver Coastal Health Authority at the Supervised Injection Site to evaluate the acceptability of various types of needles and syringes.

A centralized warehousing system for supply distribution of all HR products will

Harm Reduction Health Files

A health file has been developed to improve the understanding of the principles of harm reduction for professionals and the general public. The "Understanding Harm Reduction" health file #102 can be accessed at <http://www.bchealthguide.org/healthfiles/pdf/hfile102.pdf>. Further health files are being developed.

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10. Sheena Campbell, Coordinator, Harm reduction programs, Vancouver Coastal Health, Personal communication.

Harm Reduction Strategies and Services Committee Members

Ministry of Health

Kenneth Tupper, Manager, Problematic Substance Use Prevention
 Stephen Smith, Blood Borne Pathogen, Communicable Disease & Addictions Prevention

Provincial Health Services Authority (PHSA), BC Centre for Disease Control (BCCDC)

Jane Buxton, Harm Reduction Lead, Physician Epidemiologist
 Juanita Maginley, Program Manager, STI Outreach
 Rodney Taylor, Director of Pharmacy Warehouse & Operations

Interior Health Authority (IHA)

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 Nora Walker, Communicable Disease Consultant

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Mary Margaret Proudfoot, Regional Coordinator, Communicable Disease Program
 Jennifer Dunn, Public Health Nurse

Health Officers Council of BC

Reka Gustafson, Medical Health Officer, Vancouver Coastal Health

First Nations & Inuit Health - Health Canada

Dennis Wardman, Community Medicine Specialist with a Special Interest in Addiction Medicine

Fraser Health Authority (FHA)

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 Amrit Rai, HIV/AIDS, Hep C & BBP Leader, Health Promotion and Prevention

Vancouver Island Health Authority (VIHA)

Audrey Shaw, Manager, Communicable Disease Program

Vancouver Coastal Health (VCH)

Sara Young, Community Developer, Harm Reduction Programs
 Miranda Compton, Manager of HIV/AIDS HR programs

STRATEGIES

Issue: No.2 Date: January 2009

In this issue



Standardizing Harm Reduction: A guidance for BC's harm reduction practices page 2

Follow the evidence, harm reduction works
Health Authority Updates page 3

And more....

Welcome to the Second Issue of Strategies!



Welcome to the second issue of Strategies, a semi-annual newsletter brought to you by the BC Harm Reduction Strategies and Services (HRSS) committee.

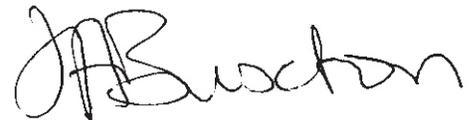
The HRSS committee is comprised of representatives from all five BC regional Health Authorities, First Nations and Inuit Health, the BC Centre for Disease Control (BCCDC), and the BC Ministry of Health. We are dedicated to reducing drug related harms such as death, disease, and injury, including transmission of blood-borne pathogens through the sharing of drug paraphernalia.

I'm delighted to share this second issue with you, to keep you connected and informed of recent news and happenings in BC with respect to harm reduction. In this issue, you can read about updates on projects the HRSS committee has been working on since the last issue. We have made several achievements in the past 6

months, including completing the Best Practices document, determining a single distributor of harm reduction supplies, planning the first training workshop for frontline distributors, and developing a training manual.

Many thanks to those who provided feedback and suggestions after reading the inaugural issue of Strategies. I hope you find this issue informative, and encourage you to send us your feedback.

If you have ideas, thoughts, or comments regarding the newsletter, please contact your local representatives. Your feedback will be much appreciated.



Dr. Jane Buxton
Physician Epidemiologist and Harm Reduction Lead, BCCDC

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Standardizing Harm Reduction:

A guidance for BC's harm reduction practices

In May 2007, the HRSS committee launched the "More than just Needles" study to evaluate HR product supply distribution and to identify gaps, cost-saving measures and potential cost pressures in British Columbia.

From the study, the HRSS committee saw a need for a comprehensive and coordinated response to the widespread social issue in BC caused by illegal psychoactive substances. As a result, a provincial best practices document to provide guidance to BC's harm reduction services, supply distribution, and collection programs was developed.

Because BC is a large and diverse province, it is vital that interventions are based on a regular assessment of the nature and magnitude of drug use, as well as trends and patterns of infection. Services should be tailored in regard to specific locations and populations, drug choices and modes of administration.

The best practices policy guide draws on current local, national and international documents related to harm reduction supply distribution and services. It also incorporates feedback from BC service providers,

health authority staff and organizations of people who use injection drugs. The guide makes evidence-based best practice recommendations for Harm Reduction Supply Distribution Programs (HRSDPs), and provides local examples of best practices in BC and elsewhere.

The document highlights the importance of involving people who use drugs in planning and service delivery; community engagement; impact of and relationships with law enforcement; and the role of health authorities and governments in the establishment of and support for HR strategies and services.

All HRSDPs should have policies and procedures that use evidence-based best practices, are realistic, and reflect local resources. This guide provides guidelines and examples of best practices for policies and procedures that can be utilized and adapted in rural and urban settings around the province.

The "More than just Needles" report is available at <http://www.harmreductionjournal.com/content/5/1/37>. The best practices policy guide is available on BCCDC's website.



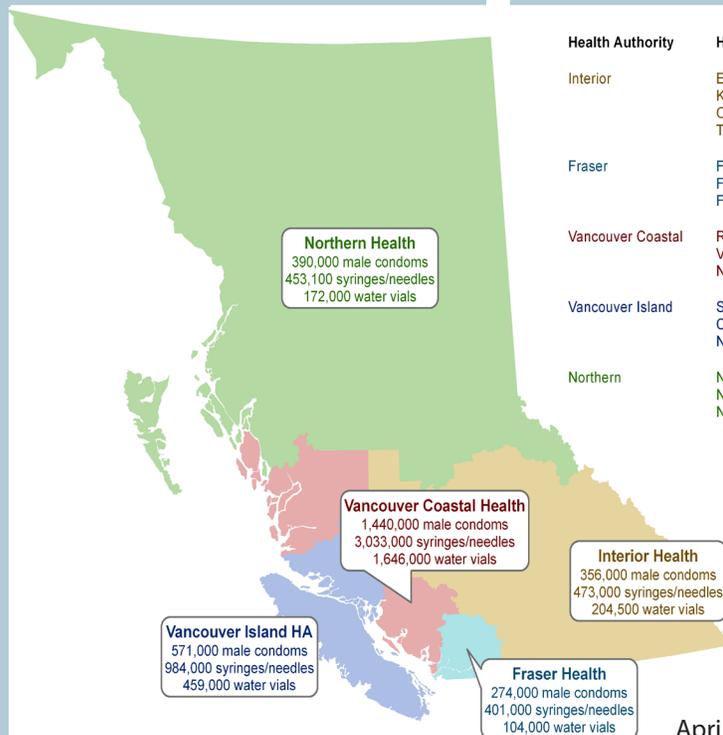
HR Product Distribution Update

Since October 2008, HR product distribution in BC has been centralized to a unique distributor located in the Greater Vancouver area.

Due to concerns with reusing or sharing of needles, 10 ml syringes are no longer provided. It is important to note again that a new needle and sterile water should be used for each injection. HRSS is exploring sterile water for injection in 1 or 3 ml plastic ampules with manufacturers.

Our condom supplier, after going through a RFP process, will be changing to Durex this year.

The most updated supply request form can be found on the BCCDC website. All forms should be sent to BCCDC and supplies will be shipped together to each site.



April 1, 2007-March 31, 2008

Follow the evidence, harm reduction works

Illegal drug use affects all Canadians and poses a threat to community and public health. Injection drug use results in a large financial burden as well as social and human costs that stem from crime, disease, and death.

In the past, the majority of resources to address the illegal drug problem have been directed to interventions whose effectiveness is most in doubt. Although policy makers are becoming increasingly interested in harm reduction as evidence showing that harm reduction programs can reduce the human and fiscal costs grows, the concept of harm reduction remains widely misunderstood by policy-makers and the public at large.

The "Evidence for harm reduction activities for communicable disease control" paper outlined the evidence and best practice for the employment of harm reduction activities in programs aimed at controlling communicable diseases. The paper reviewed several harm reduction strategies, including needle exchange programs, safer crack kit distribution programs, supervised injection facilities, supervised smoking facilities, methadone maintenance therapy, heroin prescription, educational approaches, and outreach-based interventions. It also considered the evidence supporting selected prison-based harm reduction strategies.

Each harm reduction strategy reviewed was graded based on grading scheme developed by the Health Development Agency of the National Health Service in the United Kingdom. The programs were graded from Class A (strong evidence) to Class D (weak evidence), with respect to their ability to control communicable disease

incidence as well as their ability to reduce risk behaviours and to modify environments where risk behaviours are elevated.

The review, based on evidence and reports, rated needle exchange programs (NEP), prison-based NEP, methadone maintenance therapy, heroin prescription, and outreach programs as Class A strategies. Supervised injection Facilities (SIF) were graded as Class B because despite the evidence that SIF reduce syringe sharing and reduce injection drug use in risky environments, there have been no studies of the impact of SIF on the incidence of HIV or other blood-borne diseases. Safer crack kit distribution, supervised smoking facilities, and educational programs were graded as Class D not because they are ineffective programs, but because of the lack of evidence and evaluation of these programs.

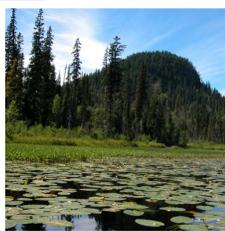
The review also looked at a number of factors that can positively or negatively affect the efficacy of any harm reduction program. Factors such as early intervention, responsiveness, coverage, comprehensiveness, and involvement of current/ former drug users in program delivery were discussed in the paper.

Given the ongoing drug-related harm throughout British Columbia, there was an urgent need to significantly expand and evaluate harm reduction programs. The review looked at the scientific evidence of various harm reduction programs. These programs can complement the other three pillars of enforcement, treatment, and prevention initiatives to reduce drug-related harms. The full report is available on the BC Centre for Disease Control website.



Vancouver Island Health Authority

In June, the Public Health and Mental Health & Addiction Programs of the Vancouver Island Health Authority co-hosted an Interactive Harm Reduction Event for those whose work involves service delivery to populations who use illicit drugs. The goals of the event were to increase knowledge and skill in i) integrating harm reduction into all health services, ii) developing a consistent harm reduction message, iii) working with user groups and iv) assigning responsibility to both governments and users. Approximately 55 people from the Health Authority, the agencies contracted to provide comprehensive needle exchange services and prevention and support services, as well as other inner city agencies, participated in an interactive presentation by Mark Haden, Vancouver Coastal Health Addiction Services, and small and large group discussions.



Northern Health Authority

A day long working session held in Fort St John on October 9, 2008 brought together a wide range of community stakeholders from around the north east to hear presentations on research and evidence regarding harm reduction. Over 60 people attended from both community based and government agencies and from a diversity of perspectives and disciplines such as the faith community, law enforcement and front line service providers. The intention of the session was to provide an opportunity for diverse views on harm reduction to meet hard facts and begin the task of finding a shared ground to address the issues of substance abuse in the region.



Vancouver Coastal Health

Vancouver Coastal Health's (VCH) HIV/AIDS and Harm Reduction program presented its second annual HIV Education Day on November 6th. This free event brought over 130 service providers, clinical staff, and community members to Vancouver's Roundhouse Community Centre to discuss the innovative and culturally appropriate HIV prevention, support, treatment and care services offered in our communities. The day's discussions centred around the successes and challenges of existing services. Dr. Gabor Maté's powerful closing presentation, "The Four Compassions: HIV Care in an Addicted Population", entreated attendees to continue to support harm reduction initiatives which ensure those affected by HIV have opportunities and appropriate supports to improve their overall health and wellness.

Rural Strategies: *Lending a Helping Hand*

For the past three years, Marilyn and Dan Tolmie of the Merritt Helping Hands Society have been passionately involved in the Needle Distribution project in the downtown core of Merritt, BC. Society co-founders Dan, Marilyn and Brian Hopkins, along with 10 other volunteers, came together with one goal in mind: to improve the health and well being of people addicted to drugs, prescription drugs, and alcohol in their community.

Dan and Marilyn, both recovering addicts themselves, have devoted the past three years of their lives to providing support and love for those in need in their community. Because of their past, they quickly gained legitimacy and trust within the community.

"We are here to make our community a better, safer place," said Marilyn. "It takes people who have experienced or are experiencing the issue to find strategies and solutions and to implement them." The group realized a pressing issue when Interior Health's needle exchange program moved up the hill to the Nicola Valley Health Care Centre. With no available transportation and a long uphill walk to a new location, most drug users stopped accessing the harm reduction services.

"People refused to go up the hill to the health centre for their supplies," explained Marilyn. "They feel humiliated and looked down on when walking up the hill and going to the hospital to get their needles." Instead of waiting for people to come to them, the Helping Hands Society decided to take the initiative to bring harm reduction products to those who need them. With the support of a

local church, public health and other partners, they began operating a weekly needle exchange site at the United Trinity Church, distributing condoms, clean syringes, water, alcohol swabs, and literature on HIV, Hepatitis B/C, and other blood borne diseases.

Gayle Carrière, Blood Borne Pathogen Outreach Nurse Educator with Interior



Dan and Marilyn Tolmie, and Brian Hopkins, co-founders of the Merritt Helping Hands Society

Health, is absolutely amazed at the group's accomplishments in such a short time frame. "The outreach nurse who used to come in was only getting to the first level of drug users in the community and the program was more of a silent service," she said. "This group was able to break that barrier and deliver the program to more people than we've ever been able to." Dan and Marilyn attributed their accomplishments to something they believe most professionals fail to establish and that is trust. "We've known some of these people for years, some are friends and some are just people we knew when we were addicts ourselves," Marilyn said.

To Dan and Marilyn, harm reduction goes

beyond providing clean needles and syringes. "You need to realize that those who still suffer from their addiction, like you and I, have needs and feelings too. Sometimes all they need is just a hug, someone to talk to, or just a bottle of shampoo," said Marilyn. She recalled the grateful smiles on the faces of the people when the group gave them brand new, clean hygiene products donated by a store in the community. "We often take simple things like this for granted. To them, things like a bar of soap are all it takes to make them feel like they are 'normal' again," Marilyn explained. The Helping Hands Society believes that empowering the people who use substances and making them feel like they belong is an important factor in the harm reduction equation.

Another crucial factor Dan and Marilyn pointed out is community support. The Helping Hands Society already has the support of the City of Merritt, the RCMP, and many other organizations in the community. "The RCMP sees us as a resource," said Marilyn. "We have educated them on what harm reduction supplies are so that they don't take them if a house gets busted." The group also does drug awareness workshops with local schools, teaching them about the consequences of drug use and the importance of harm reduction.

With trust from the drug using community and support from the Merritt community, the Helping Hands Society will continue to distribute harm reduction supplies and provide ongoing support and education to their clients.

News & Events

- The HRSS committee and BCCDC's STI/HIV Prevention and Control Division proudly supported the first Canadian Prison-Academic-Community Health and Education Conference held at UBC on Dec. 4-5, 2008.
- The International Harm Reduction Association's 20th International Conference will be held in Bangkok, Thailand from April 20 -23, 2009.
- The Canadian Public Health Association 2009 Annual Conference will be held in Winnipeg, Manitoba from June 7-10.

BC Harm Reduction Strategies and Services Committee Members

Ministry of Healthy Living and Sport

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Ciro Panessa, Manager, Harm Reduction and Blood Borne Pathogens

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Bev Grunert, Communicable Disease Program Coordinator

Nora Walker, Communicable Disease Consultant
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Mary Margaret Proudfoot, Regional Coordinator, Communicable Disease Program

Jennifer Dunn, Public Health Nurse

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First Nations & Inuit Health - Health Canada

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Fraser Health Authority (FHA)

Amrit Rai, HIV/AIDS, Hep C & BBP Leader, Health Promotion and Prevention

Vancouver Island Health Authority (VIHA)

Audrey Shaw, Manager, Communicable Disease Program

Vancouver Coastal Health (VCH)

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STRATEGIES

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In this issue

- Harm Reduction Product Distribution..... p 2
- Health Authority Updates..... p 3
- Harm Reduction Strategy in Vernon..... p 4
- Street Youth Job Action..... p4

Welcome to the Third Issue of Strategies!



Welcome to the third issue of Strategies, a newsletter brought to you by the BC Harm Reduction Strategies and Services (HRSS) committee.

The HRSS committee is comprised of representatives from all five BC regional Health Authorities, First Nations and Inuit Health, the BC Centre for Disease Control (BCCDC), and the BC Ministry of Healthy Living and Sport. We are dedicated to reducing drug related harms such as death, disease, and injury, including transmission of blood-borne pathogens through the sharing of drug paraphernalia.

I'm delighted to share this third issue with you, to keep you connected and informed of recent news and happenings in BC with respect to harm reduction. In this issue, you can read about updates on projects the HRSS committee has been working on. We have continued to improve harm reduction distribution and accountability by reviewing the ordering by each site over the past 3 years.

In response to feedback, we are distributing new harm reduction supplies. To make access to BC harm reduction policy, order forms and information easier, we have consolidated the information in one place on the BCCDC website. We had a successful training session from which a training manual was developed. There are ongoing initiatives all around the province.

Many thanks to those who provided feedback and suggestions after reading the last issue of Strategies. I hope you find this issue informative, and encourage you to send us your feedback. If you have ideas, thoughts, or comments regarding the newsletter, please contact your local representatives. Your feedback is much appreciated

Dr. Jane Buxton
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Harm Reduction Product Distribution

May 2010 UPDATE

In 2008/09, HR product distribution in BC was centralized to a unique distributor located in Greater Vancouver.

Supplies can be ordered by harm reduction distribution sites which are approved by the appropriate regional health authority. The harm reduction supply requisition form is available on line at www.bccdc.ca and should be faxed to BCCDC.

In response to input from the field we have introduced new products to facilitate harm reduction. Such items include cookers, acidifiers and a larger sized mouthpiece. Cookers are used for mixing and heating the drugs before injection, alternatively people use teaspoons or drinks cans which are commonly shared. By providing sterile, disposable cookers, we can decrease sharing and subsequently reduce the transmission of hepatitis B, hepatitis C and HIV, and reduce other infectious diseases.

Acidifiers, such as citric acid, are used to dissolve crack cocaine so it can be injected. Harsher acids such as lemon juice or vinegar are often used and cause more pain and damage to the veins.

The single-use packets we provide are medical-grade powder; to cause the least amount of damage, the smallest amount of citric acid which dissolves the rock should be used.

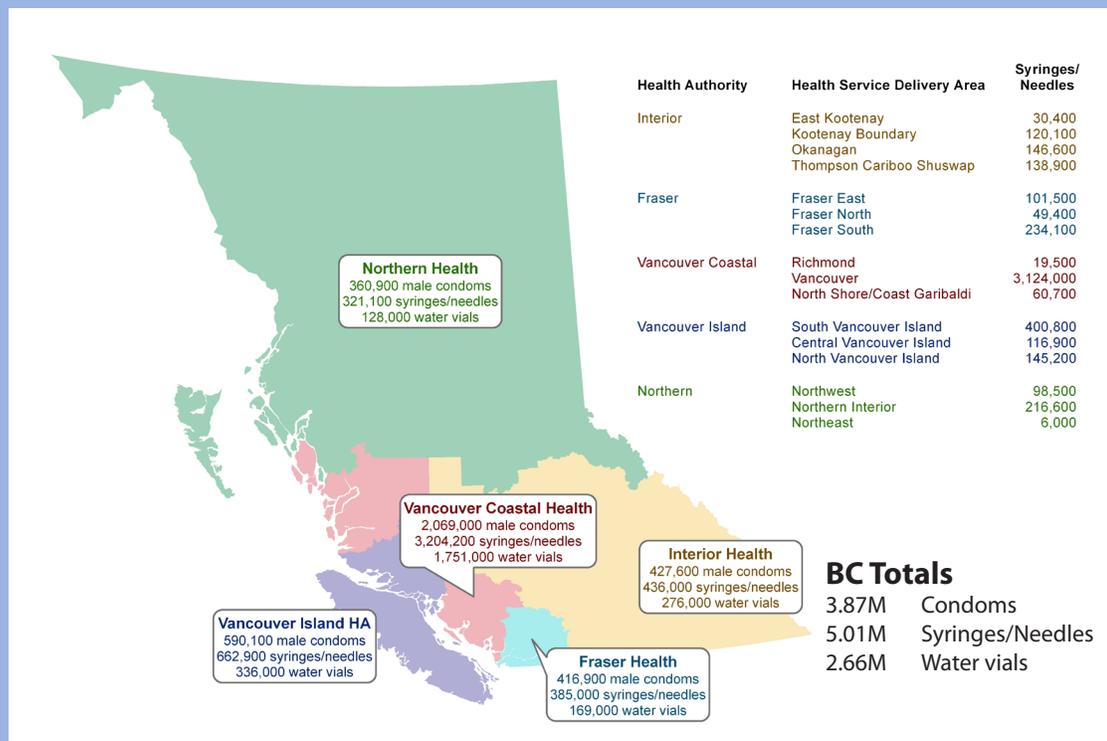
Mouthpieces which are put on the glass stems used for smoking crack can reduce the risk of oral lesions, as the tubing avoids direct contact of the mouth and lips with hot and broken glass stems. It also allows individuals to use their own mouthpiece and so protect themselves from the transmission of communicable diseases through sharing pipes. We found our original 2 sizes of mouthpieces did not fit stems used in some areas of the province so a larger size was introduced.

Also, a recent research article found hepatitis C (HCV) was diagnosed first in over half of persons identified as coinfecting with HIV and HCV in BC. The median time to subsequent HIV diagnosis was 3.5 years, which highlights the importance of client engagement, referral and harm reduction in order to prevent HIV. For more information, visit: <http://www.biomedcentral.com/1471-2458/10/225>

HR Product Distribution Update 2009/10

Transportation of Supplies

Upon a review of our 2009/10 distribution statistics, we identified that 30% of current sites in the province order below the threshold of \$600, so that transportation costs are incurred. Working with regional health authorities we have established a primary and secondary site policy to maximize efficiency of distribution. This enables a primary site (a larger centre) to order supplies that can then be collected by, or transferred to, the secondary site (a smaller centre), subsequently reaching order thresholds and encouraging communication and training of the staff at the smaller sites.



British Columbia Harm Reduction News & Notes

Provincial

In June 2009, BCCDC launched its new website – www.bccdc.ca, which includes a Harm Reduction homepage. This page will include all Q&A documents, archived editions of Strategies, manuals and guidelines, and some local research. Please bookmark this page for future use.

In 2009, the BCCDC hosted a two-day Harm Reduction Workshop in Vancouver, BC. It focused on collaboration and sharing successes to implement harm reduction programs in BC. This workshop attracted 88 participants from all over the province, and included front-line workers, peers (people who use drugs), and representatives from Aboriginal agencies and communities. A manual was drafted for the workshop and updated with input from the field. In 2009, a hard copy manual was printed for each distribution site and is posted online at: www.bccdc.ca/prevention/HarmReduction/default.htm.

The contact information of all primary distribution sites has been updated and the new primary/secondary site policy (by including secondary site contact information) will enable rapid dissemination of information to all those who need to know. Communication may be necessary regarding potential concerns with items supplied, new items available and other alerts, for example regarding the risk of severe infections (due to low white cells) associated with cocaine contaminated with levamisole. Details of the alert can be found on BCCDC web site under Alerts 2009.

Vancouver Island Health

VIHA is focusing on implementing an island-wide, secondary distribution and collection of harm reduction supplies through VIHA community offices and VIHA funded services. A logo is being developed to post at all distribution sites to signify to clients that supplies are available at the location. A mobile service delivery model, including foot, bike and vehicle service, delivered by contracted service providers, peers and secondary sites has been developed in the Greater Victoria area in response to the closure of the fixed site.

Vancouver Coastal Health

The VCH Harm Reduction Program is pleased to partner with over 80 programs to provide harm reduction supplies and education in Vancouver and along the South Coast. These sites had nearly 250,000 visits in 2009 and provided over 13,000 referrals to health services, addictions and other supports. VCH continues to improve supply distribution by engaging with new primary harm reduction supply distributors and encouraging secondary distribution. In 2009, VCH also saw some of its highest syringe return rates at harm reduction sites, as well as improved syringe recovery rates by needle sweeps crews and in outdoor disposal boxes.

The 2010 Olympic and Paralympic games offered the opportunity to showcase local harm reduction initiatives on the international stage. A great deal of media attention was focused on drug use in Vancouver and on examining the four pillars of prevention, treatment, harm reduction and enforcement. The BCCDC STI/HIV Prevention and Control Division, Harm Reduction Strategies and Services and VCH partnered successfully over the course of the Olympics to improve HIV awareness by distributing over 200,000 condoms to residents and visitors.

Interior Health

In 2009, Living Positive Resource Centre, Okanagan became a primary distribution site for harm reduction materials. In an effort to provide low-barrier access to individuals seeking the equipment, they have created a 'Harm Reduction Menu', designed for use by individuals with varying degrees of literacy or language skills. The menus contain pictures of each of the items available, and make ordering as easy as filling in the number of items required next to their pictures. It also provides added confidentiality, as the menu can be handed to any staff member without the need to verbalize what it is that's needed. If interested in utilizing and adapting this menu in your facility please contact Sheila Kerr at skerr@lprc.ca.

Northern Health

The Northern Harm Reduction Committee was formed following the 2009 Vancouver training workshop. This group is creating a 2010 work plan which includes planning an annual education event in each of the 3 HSDA's to support harm reduction education among health authority partners and other community stakeholders and mapping the baseline harm reduction distribution and recovery sites with a goal to increase distribution in 2010.

Substance use is often hidden in smaller communities because of confidentiality concerns. NH and UNBC are collaborating on a research project to identify substances used, access to harm reduction education and supplies, and how best to engage clients. The research is being conducted by peers who use substances, and who are thus better situated to reach these hidden users of illicit substances. The study will be concluded in spring of 2011 and will provide a template for other northern communities to implement relevant harm reduction approaches in smaller communities.

Frontline workers in NH report an increase in crack pipe use. Since initiating crack pipe distribution 5 months ago, the needle exchange in Quesnel is experiencing a steady increase in crack pipe demand with a corresponding decrease in injection supply requests. A similar pattern is emerging in Prince George at the AIDS Prevention site and on the mobile wellness van where some of the clients being served have never injected. Staff report providing crack harm reduction supplies creates an avenue and opportunity to reach this group for health service support.

Fraser Health

FH Mental Health & Addiction Services continue to utilize a harm reduction (HR) framework in the delivery of addiction services, extending the traditional application of HR beyond supply distribution and education. FH promotes HR supplies distribution within the region, and needle distribution sites report that they have moved from one-to-one exchange to distribution. Harm reduction leaders work towards increasing awareness and common understanding with the police and community stakeholders in certain areas. Increasing access to harm reduction supplies continues to be one of the priority objectives. A couple of new needle distribution sites have been established which allows for the hard to reach population to access harm reduction services.

FH Health Promotion and Prevention and Mental Health and Addictions are partnering to implement a series of workshops for front line staff, leadership and key decision makers to increase awareness about harm reduction and create an opportunity to partner with not only community organizations but also other departments within the Health Authority.

Harm Reduction Strategy in Vernon, B.C.

It is clear that in Greater Vernon, there is a huge concern over the impact of addiction on the wider community. Media coverage and letters to the editor indicate that the social and economic fallout from addictions is one of the biggest issues facing the community. A number of sectors have been calling for action, concerned about loss of customers due to fears about the street population, and residents upset about the level of crime in their neighbourhoods.

In spring 2008, the Partners in Action Committee created a Harm Reduction Action Team to assist the Street Clinic, run by North Okanagan Youth and Family Services (NOYFSS), in its transition from a clinic model to an outreach model. The action team assisted NOYFSS in developing a needs assessment and community readiness report. Given the community concern regarding addictions, it became clear that a wider community harm reduction strategy was also needed to address the issues.

In the fall of 2008, the Action Team embarked on creating a community based strategy for harm reduction in the Vernon area. This included hosting a series of community meetings including an initial consultation, a series of focus groups and a final strategy session.

Although many groups and individuals were feeling the impact of addictions in the community, it was unclear how people viewed harm reduction. Through the Needs Assessment and Community Readiness Report, the Action Team was able to organize and facilitate the strategy session that ultimately set the community priorities.

The final result is a detailed Harm Reduction Strategy that was created with input from a broad spectrum of the community. Over 150 individuals took part, including people currently addicted and/or recovering from addictions. The Harm Reduction Team launched the strategy on April 29, 2010, with results being reported from the recommendations.

The City of Vernon agreed to put needle drop boxes in public washrooms ensuring a safe place to dispose of needles and lessening the chance of the public and/or maintenance staff encountering a used needle. Hospital staff and front line workers created a protocol to better serve homeless individuals (often struggling with addictions) who are released from the hospital without a place to safely recover. The By-laws department joined forces with front line workers to visit homeless campers and drop off tips on how to keep themselves and the community safer while tenting on public space.

These are just a few examples of concrete actions taking place in Greater Vernon. The Harm Reduction Action Team is excited by the community's willingness to get involved to more effectively address addiction issues in Greater Vernon. For more information, please contact info@socialplanning.ca.

Submitted on behalf of the Harm Reduction Action Team by: Annette Sharkey, Executive Director, Social Planning for the North Okanagan.

BC Harm Reduction Strategies & Services Committee Members

Ministry of Healthy Living and Sport

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Ciro Panessa, Manager, Harm Reduction and Blood Borne Pathogens

River Chandler, Policy Analyst, Problematic Substance Abuse

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Street Youth Job Action

Street Youth Job Action (SYJA) is a social enterprise initiative of Directions Youth Services Centre that provides mentoring and development opportunities for homeless youth in Vancouver. The project gives these youth a chance to learn a set of skills and behaviours to prepare them for the workforce—skills like teamwork, punctuality, communication, a strong work ethic, and what it means to be part of a community.

This innovative program provides employment opportunities for youth aged 15-24 years. The jobs include street cleaning, needle sweep, janitorial work, and other labour services. In order to qualify for work, the youth are required to arrive at the Directions Centre clean, sober, and on time. Staff assigns them jobs and duties that are available for the day. After the youth have completed their tasks, they are paid that same day for services delivered.

Community Partners with this initiative include: City of Vancouver, Downtown Vancouver Business Improvement Association, CP Rail, Vancouver Coastal Health Authority, and Waste Management. Age

If you are interested in becoming a community partner or for more information, please contact:

Anne Costello at 604.633.1472 ext. 3552 or Ange Myers at 778.898.7354 or amyers@fsgv.ca.



HIV/AIDS

What is HIV/AIDS?

Acquired Immunodeficiency Syndrome (AIDS) is a very serious disease. You can get it from the Human Immunodeficiency Virus (HIV). HIV harms your immune system, compromising its ability to protect you against infections. Since people with AIDS do not have this protection, they can get many different infections and cancers.

How can I get HIV/AIDS?

You can get AIDS only if the HIV virus gets into your body. The virus can be carried into your body in semen, fluid from the vagina, or blood. People can get the HIV infection when they have sex or when they share drug-use equipment such as needles or syringes. An infected mother can pass HIV on to her baby during pregnancy, delivery, or breastfeeding.

How can I prevent HIV/AIDS?

You can get HIV/AIDS from other infected people through contact with their blood or body fluids. Most HIV infections happen when you have sex or share injection needles with someone who is infected. It is also possible to get HIV from dirty tattoo equipment, or by sharing a razor or a toothbrush with someone who has HIV. You can **not** get HIV from touching, shaking hands, or hugging a person who has HIV or AIDS. You can **not** get HIV from pets or biting insects such as mosquitoes.

Some people think they may get HIV if they donate blood. This is not true. The nurse who takes your blood uses a new needle for each person. There is no contact with anyone else's blood when you give blood.

The blood that people give is always checked for HIV, so there is a very low risk of getting HIV from the blood given in a hospital.

Is kissing safe?

You can not get HIV or AIDS from kissing. Deep kissing or "French kissing" is safe.

How can I tell if I have HIV infection?

There is a blood test for HIV called the HIV antibody test. Persons testing for HIV can choose whether to use their names or initials for the test.

If your HIV test result is positive, it means that you are infected with HIV.

If your HIV test result is negative, it probably means that you do not have HIV antibodies. Most people who are infected with HIV develop antibodies between 4 and 6 weeks after becoming infected with the virus, and almost all people will develop antibodies by three months. If this amount of time has not passed prior to your test, your test can be negative but you could still have the virus. If there is a chance you have been infected recently, the only way to be sure you do not have HIV is to have a second test three months after your first test.

AIDS is the last stage of the HIV infection. People who have AIDS may become very ill and die from the disease or its complications. But you can protect yourself against HIV and AIDS.

How can I protect myself against HIV/AIDS?

- Use a new condom every time you have sex, even oral sex.
- Having many sex partners increases your risk.
- Do **not** share injection needles, syringes or other injection equipment.
- Do **not** share razors or toothbrushes.
- Make sure that all tattoo equipment is sterile.

If you take risks having sex, you can get infections, and you can pass on the infections to people who have sex with you *and* to their unborn babies. Protect yourself and others by having safe sex.

What should I do if you think I may have HIV or AIDS?

If you think you have symptoms, or if you took a risk having sex or using drugs, see your doctor or go to a STI (sexually transmitted infection) clinic. You may need to have a blood test. If your blood test is positive, it means you have been infected with HIV, and you could pass it on to others. It does not mean that you have AIDS or that you will get it.

What is the treatment for HIV/AIDS?

There is no cure for HIV infection or AIDS. The virus stays in your body. However, doctors have effective medicines to treat HIV and its complications. Getting early treatment can slow down the virus and help you stay healthy.

Inform your partner(s)

Since HIV is a reportable disease in British Columbia, it is important that your sex partner(s) and anyone you have shared needles with be notified if you have HIV. They will have to decide if they want to be tested for HIV infection.

You may want to tell them yourself. If you cannot tell them, then talk to the doctor or nurse. They can help to notify partners in a confidential manner, so you do not need to reveal your test results to others.



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For more HealthLink BC File topics, visit www.HealthLinkBC.ca/healthfiles/index.stm or your local public health unit.

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Translation services are available in more than 130 languages on request.



Hepatitis A Vaccine

Immunization has saved more lives in Canada in the last 50 years than any other health measure.

What is hepatitis A vaccine?

Hepatitis A vaccine protects against infection from the hepatitis A virus. The vaccine is approved by Health Canada.

Hepatitis A vaccine is not part of the routine schedule of childhood immunizations. However, hepatitis B vaccine is provided free as part of the routine childhood immunizations. For more information, see HealthLink BC File [#25c Hepatitis B Infant Vaccine](#) and [#25a Hepatitis B Vaccine](#).

Who should get the hepatitis A vaccine?

If you have been potentially exposed to hepatitis A, you should get one shot of vaccine within 14 days of the exposure to prevent disease.

The vaccine is given in two doses or shots to those 6 months of age and older. The second dose is given at least 6 months after the first.

The hepatitis A vaccine is provided free to people at high risk of infection, including:

- Those who have hemophilia or receive repeated infusions of blood or blood products
- Those who inject drugs or share drug snorting, smoking, or injecting equipment
- Males who have sex with other males
- Those with HIV, hepatitis B or hepatitis C infection, or chronic liver disease

- Those who have had a bone marrow or stem cell transplant
- Those who will have or have had a liver transplant
- Inmates of a correctional facility
- Close contacts of a person with hepatitis A infection. These include people living in the same house, close friends, children in the same daycare, drug-sharing people, and sexual partners
- Those who have eaten food prepared by a food handler with hepatitis A infection.

If you are in the last two categories, you should get the vaccine within 14 days of your potential exposure to hepatitis A.

The vaccine is also recommended, but not provided free, for people likely to come in contact with or spread the hepatitis A virus, including:

- Those living, working or travelling in developing countries, particularly in rural areas
- Food handlers
- Those with multiple sex partners
- Residents and staff of institutions for the developmentally challenged with an ongoing problem with hepatitis A infection
- Zoo-keepers, veterinarians and researchers who handle primates
- Those involved in research on hepatitis A virus, or the production of hepatitis A vaccine.

It is important to keep a record of all immunizations received.

Benefits of Hepatitis A Vaccine

The vaccine is the best way to protect against hepatitis A infection.

When you get vaccinated, you help protect others as well.

Possible Reactions after the Vaccine

Vaccines are very safe. It is much safer to get the vaccine than to get hepatitis A.

Common reactions to the vaccine may include soreness, redness and swelling where the shot was given. Headache, fatigue, fever, and stomach upset may also occur after getting the vaccine. These reactions are mild and generally last 1 to 2 days.

Acetaminophen or Tylenol® can be given for fever or soreness. ASA or Aspirin® should NOT be given to anyone under 20 years of age due to the risk of Reye Syndrome.

It is important to stay in the clinic for 15 minutes after getting any vaccine because there is an extremely rare possibility of a life-threatening allergic reaction called anaphylaxis. This may include hives, difficulty breathing, or swelling of the throat, tongue or lips. If this happens after you leave the clinic, call 911 or the local emergency number. This reaction can be treated, and occurs in less than one in a million people who get the vaccine.

Report serious or unexpected reactions to your public health nurse or doctor.

Who should not get the vaccine?

Speak with a public health nurse or doctor if you have had a life-threatening reaction to a previous dose of hepatitis A vaccine, or any component of the vaccine including neomycin, or to latex.

What is hepatitis A?

Hepatitis A is a virus that attacks the liver. For every 1000 people infected, 1 to 3 will die. The death rate is higher in people 50 years of age and older.

The hepatitis A virus is found in the bowel movements (stool) of infected persons. People with hepatitis A infection who use the bathroom without proper hand washing can pass the virus on to others through food preparation or other hand-to-mouth contact. The disease can also be spread by sexual contact, or sharing of equipment used in drug use, such as needles or pipes.

Hepatitis A can also be spread by drinking contaminated water, or by eating raw or undercooked shellfish, such as crabs, clams, oysters or mussels, that have been contaminated with sewage.

Mature Minor Consent

Effort is made to seek parental or guardian consent prior to immunization. Children under the age of 19 who are able to understand the risks and benefits may consent to or refuse immunizations, regardless of the parent's or guardian's wishes. It is recommended that parents/guardians and their minor children discuss immunizations beforehand, and ask the nurse or doctor any questions.

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Hepatitis B Vaccine

**Keep your child safe.
Get all shots on time.**

By getting all shots on time, your child can be protected from many diseases over a lifetime.

Immunization has saved more lives in Canada in the last 50 years than any other health measure.

What is hepatitis B vaccine?

Hepatitis B vaccine protects against the hepatitis B virus. The vaccine is approved by Health Canada.

Who should get the vaccine?

Hepatitis B vaccine is provided free as part of your child's routine immunizations. The vaccine is given in Grade 6 as two doses or shots, four to six months apart.

The hepatitis B vaccine is also provided free to infants as part of their routine immunization. See [HealthLink BC File #25c Hepatitis B Infant Vaccine](#) for more information.

Adults and those 16 years of age and older require three doses of the vaccine.

The vaccine is also provided free to children and adults at high risk of hepatitis B infection, including:

- Children under 7 years of age living with people at high risk of hepatitis B, such as intravenous drug users, men who have sex with men, or sex trade workers
- Children under 12 years of age whose families have emigrated from areas with high rates of hepatitis B

- Children who live with a person with hepatitis B
- Sexual partners of someone with hepatitis B
- Males who have sexual contact with other males
- Injection drug users and their sexual partners
- Those who share drug snorting, smoking, or injecting equipment
- Those with many sexual partners or a recent sexually transmitted infection
- Those with chronic liver disease, hepatitis C, or a liver transplant
- Those with chronic kidney disease including predialysis, hemodialysis, or peritoneal dialysis patients
- Those who have received a kidney or stem cell transplant
- Those who have hemophilia or are receiving repeated infusions of blood or blood products
- Inmates of a correctional facility
- Students training in a health care profession who may have contact with blood and body fluids
- Teachers, staff and students in a childcare setting attended by a child with hepatitis B, whose behaviour or medical condition increases the chances of exposure to that child's blood or body fluids
- Staff or residents in a community group home for the developmentally challenged.

If you are not eligible for a free vaccine, speak with your doctor or public health unit about buying the vaccine. It is important to keep a record of all immunizations received.

Benefits of the Vaccine

The hepatitis B vaccine is the best way to protect against hepatitis B infection and its complications, including permanent liver

damage, which can lead to liver cancer and death. When you get vaccinated, you help protect others as well.

Possible Reactions after the Vaccine

Vaccines are very safe. It is much safer to get the vaccine than to get hepatitis B.

Common reactions to the vaccine may include soreness, redness and swelling where the shot was given. Some may experience a mild fever.

Acetaminophen or Tylenol® can be given for fever or soreness. ASA or Aspirin® should NOT be given to anyone under 20 years of age due to the risk of Reye Syndrome.

It is important to stay in the clinic for 15 minutes after getting any vaccine because there is an extremely rare possibility of a life-threatening allergic reaction called anaphylaxis. This may include hives, difficulty breathing, or swelling of the throat, tongue or lips. If this happens after you leave the clinic, call 911 or the local emergency number. This reaction can be treated, and occurs in less than one in a million people who get the vaccine.

Report serious or unexpected reactions to your public health nurse or doctor.

Who should not get the vaccine?

Speak with a public health nurse or doctor if you have had a life-threatening reaction to a previous dose of hepatitis B vaccine, or any component of the vaccine including yeast, or to latex.

What is hepatitis B infection?

Hepatitis B is a virus that attacks the liver. It can cause serious health concerns including permanent liver damage (cirrhosis). Hepatitis B is also the main cause of liver cancer, which can be fatal. Hepatitis B virus is spread from one infected person to another by contact with blood or body fluids, such as an accidental poke with a used needle, intimate sexual

contact, being splashed in the mouth, nose, or eyes with infected blood, being bitten by an infected person or by sharing blood-contaminated items such as a toothbrush, dental floss or razor. Mothers infected with hepatitis B virus can pass the virus to their newborn babies during delivery.

After the virus enters your body, it usually takes two to three months to develop signs of illness. Many people who get hepatitis B show no symptoms and may not know they have the disease. Whether there are signs of illness or not, you can pass the virus on to others.

Mature Minor Consent

Effort is made to seek parental or guardian consent prior to immunization. Children under the age of 19 who are able to understand the risks and benefits may consent to or refuse immunizations, regardless of the parent's or guardian's wishes. It is recommended that parents/guardians and their minor children discuss immunizations beforehand, and ask the nurse or doctor any questions.

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Hepatitis C Virus Infection

What is hepatitis C virus infection and what are the symptoms?

Hepatitis C is a disease of the liver caused by the hepatitis C virus (HCV).

Most people feel well, have no symptoms and don't know they have hepatitis C infection.

Some people may have a brief illness with symptoms usually appearing six to twelve weeks after being infected with the virus.

Symptoms of acute hepatitis C infection may include fever, tiredness, jaundice (yellow skin or eyes), abdominal pain, dark urine, loss of appetite, and nausea (sick to your stomach).

Others may experience long-term health concerns such as tiredness, lack of energy, or digestive problems.

How common is hepatitis C virus infection?

The total number of people in Canada who have hepatitis C is believed to be about 300,000. This means that about one in every one hundred people in Canada have hepatitis C.

Many have not been tested and do not know they have the disease. There are about 4,000 new cases of hepatitis C virus infection in Canada each year.

People at higher risk of having hepatitis C infection include:

- People who have used injection drugs, or shared drug use equipment;
- People who received a blood transfusion or blood product before May 1992;

- People who received blood-derived coagulation products before July 1988, or intravenous immunoglobulin products prior to 1997;
- People who received an organ or tissue transplant before 1990.

All blood products and donors in Canada are now screened for hepatitis C virus. The risk of infection from a blood transfusion or blood products is now very low, estimated at less than 1 in 500,000 units of blood donated.

There is a risk for hepatitis C virus infection in countries where the blood supply is not tested or where infection can occur through unclean medical equipment.

How can you tell if you have hepatitis C?

After the hepatitis C virus infects your body, antibodies appear in your blood. There are blood tests available to detect the presence of the virus itself, and the antibodies to the virus.

While a few people will recover from the infection and clear the virus from their body, most people will be chronically infected. This means that the person is capable of spreading the infection to others.

How is the hepatitis C virus spread?

At this time, there is no vaccine to prevent people from getting hepatitis C infection.

Hepatitis C virus infection is usually spread by blood-to-blood contact with infected blood. Infection can occur through:

- Illicit drug use including sharing drug snorting, smoking or injection equipment such as needles and syringes, straws and pipes;
- Exposure to blood and blood products including receiving a transfusion of blood or a blood product in a country where the blood supply is not tested for hepatitis C. In Canada, this applies to blood and blood products received before 1992;
- An accidental needle poke with a used needle or syringe;
- An infected mother passing it to her newborn infant (risk of about 5 – 6%);
- Sexual intercourse, especially for those who have multiple sexual partners;
- Sharing toothbrushes, dental floss, razors, nail files, or other items which could have tiny amounts of blood on them;
- Skin-piercing events such as tattoos, body piercing, acupuncture or electrolysis, if the equipment is not clean.

There is a very low but real risk of passing on the virus through other body fluids such as saliva, semen, vaginal secretions or breast milk.

How is hepatitis C *not* spread?

Hepatitis C is *not* known to be spread by:

- Coughing or sneezing;
- Contact such as hugging and kissing;
- Using the same dishes or cutlery;
- Swimming in a chlorinated pool when you have cuts, scrapes or are menstruating;
- Being bitten or stung by an insect which then bites or stings someone else;
- Contact of healthy intact skin of others by your body fluids such as saliva, urine, feces or vomit.

How do you get treatment?

People who test positive for hepatitis C should see their family doctor regularly and have their blood tested to see how their liver is functioning. They may also be referred to a specialist for further testing and assessment.

Some people with hepatitis C virus infection will be eligible for treatment that may clear the virus from their body. Some people with severe liver damage will require a liver transplant.

What should you do if you prick yourself with a dirty needle?

- If possible, put the wounded area lower than the heart, to promote bleeding.
- Wash the area well with soap and water
- Go to the nearest hospital Emergency Department immediately for care.

If you have hepatitis C, can you be protected against other diseases?

Yes. Vaccines that will protect you from hepatitis A, hepatitis B, pneumococcal disease and influenza are provided free to people infected with hepatitis C. You can get these shots from your local health unit or family doctor.

For more HealthLink BC File topics, visit www.HealthLinkBC.ca/healthfiles/index.stm or your local public health unit.

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Living Well with Hepatitis C Virus Infection

How can you prevent the spread of Hepatitis C virus (HCV)?

The hepatitis C virus (HCV) is usually spread by contact with infected blood. There is a very low but real risk of passing on the HCV through other body fluids, such as breast milk, saliva, semen or vaginal secretions.

If you are infected with HCV, you can reduce the chance of spreading this virus to others as follows:

- Never donate your blood, semen, body organs or tissues.
- Discuss with your partner(s) the fact that you are infected with HCV.
- Use a condom every time you have sex, especially if you have more than one partner. This also helps to reduce the risk of other sexually transmitted diseases.
- Discuss issues about pregnancy and breastfeeding with your doctor.
- Tell your doctor if you have ever donated or received blood products or tissue transplants.
- Do not share razors, toothbrushes, dental floss, nail files, or other items that could have tiny amounts of blood on them.
- Do not share drug snorting, smoking or injection equipment, such as straws, pipes, cookers, filters, water, needles or syringes.
- Use bleach to clean areas that could have blood on them – and use nine parts water to one part bleach.
- Keep all open cuts and sores bandaged until healed.
- Put articles stained with blood in a separate plastic bag before disposing into household garbage – for example, bandages, tissues, tampons, razors, dental floss.

- Advise your doctor, dentist and anyone else who might come in contact with your blood, such as those who do tattoos, body-piercing, electrolysis, or acupuncture, that you are infected with HCV.
- Advise anyone who has had direct blood-to-blood contact with your blood to see a doctor.

How is Hepatitis C virus *not* spread?

HCV has been shown to *not* spread by:

- Casual contact, such as in an office setting;
- Coughing or sneezing;
- Contact such as hugging and kissing;
- Using the same dishes or cutlery;
- Swimming in a chlorinated pool when you have cuts or scrapes or when you are menstruating;
- Being bitten or stung by an insect which then bites or stings someone else;
- Contact of healthy skin of others with your body fluids such as saliva, urine, feces or vomit.

How does Hepatitis C virus affect people?

Most people feel well and have no symptoms, so they do not know that they have HCV infection. Some people may have a brief illness with symptoms of hepatitis usually appearing six to twelve weeks after they have been infected with the virus. Symptoms of acute hepatitis C infection may include: fever, tiredness, jaundice (yellow skin or eyes), abdominal pain, dark urine, loss of appetite, nausea (sick to your stomach).

A few people may experience long-term health concerns, such as tiredness, lethargy or digestive problems.

About seven out of ten people who become infected with HCV carry the virus throughout their lives. These people remain infectious and run the risk of becoming ill sometime in the future.

This long-term or chronic HCV infection may lead to scarring of the liver, called cirrhosis. The chance of developing cirrhosis increases with the length of infection. After twenty years, about two out of ten people with hepatitis C will have cirrhosis. People who drink alcohol are at greater risk of damaging their liver. Cirrhosis can lead to liver failure or liver cancer in a small number of people.

What about treatment and care for Hepatitis C?

At this time, there is no vaccine to prevent HCV infection.

You should see your family doctor regularly and have your blood tested to determine how your liver is functioning. You may be referred to a specialist for further testing and assessment. Some people with hepatitis C are eligible for treatment, which may cure the viral infection. Some people with severe liver damage from hepatitis C will need a liver transplant.

What can you do to stay as healthy as possible?

To promote good health while living with HCV infection, learn about the disease and consider the following:

- Get more information about hepatitis C from your doctor, local health unit, support groups, or the Canadian Liver Foundation at www.liver.ca.
- Use over-the-counter and prescribed medications only as advised by your doctor.

- Do not take megavitamin therapy or herbal products without consulting your doctor.
- Eat healthy, nutritious food as outlined by the Canada Food Guide.
- Get regular exercise.
- Avoid alcohol as it increases the liver damage caused by HCV.
- Avoid smoking and illicit drugs.
- Get vaccinated for hepatitis A and B, if you are not already immune. These vaccines are provided free to people infected with hepatitis C. Hepatitis A and hepatitis B infections may cause further liver damage. For more information, see [HealthLink BC Files #25a Hepatitis B Vaccine](#) and [#33 Hepatitis A Vaccine](#).
- Get vaccinated for influenza every year during influenza or flu season.
- Get vaccinated for pneumococcal disease too. This vaccine and a booster dose after five years are also free for people infected with hepatitis C.
- It is important to manage the HCV infection and take good care of your health. HCV should not be a barrier to employment.

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Chlamydia

What is chlamydia?

Chlamydia is an infection caused by a germ or bacteria.

How is it spread?

It is spread by having unprotected sex – not using a condom – with someone who is infected with chlamydia. An infected person can transmit chlamydia any time, whether or not symptoms are present. An infected person is contagious until he or she has been treated. Most people with chlamydia do not know they have it as they have no changes with their body.

To find out if you have chlamydia, you must be examined by a doctor or nurse and have tests taken.

What are the symptoms?

If symptoms appear, it is usually one to three weeks after exposure to an infected person.

Chlamydia may not cause symptoms until the infection has spread to other areas of the body.

For women, symptoms can include:

- A burning feeling when urinating;
- A change in periods or more painful periods;
- Bleeding or blood spotting from the vagina;
- Pain during sexual intercourse;
- Pain in the lower stomach area;
- Conjunctivitis or pink eye;
- The need to urinate more often; or
- A slight fever.

For men, symptoms can include:

- Abnormal fluid from the penis;
- An itching feeling inside the penis;
- Pain while urinating or a need to urinate more often; or
- Conjunctivitis or pink eye.

What are the complications?

Chlamydia causes no long-term problems if treated early during the infection. Untreated chlamydia can lead to complications.

In women, it can spread and cause infection in reproductive organs and other parts of the body. It can also cause pelvic inflammatory disease or PID in women. See HealthLink BC File [#08c PID](#) for more information. Pregnant women may pass the infection to their baby's eyes during childbirth. This can cause irritation in the baby's eyes, and may need to be treated.

In men, complications can include infection in the urethra or the testicles or an inflammation of the prostate.

What is the treatment?

The treatment for chlamydia is antibiotic pills. Any person(s) you have had sex with within the previous two months must also be treated, whether they have symptoms or not. Follow up tests are recommended six months after treatment.

Important: Do not have sex until you and your partner(s) have finished taking the prescribed pills. Take all of the medication exactly as instructed.

Should I be tested for other sexually transmitted infections (STIs)?

If you have different sexual partners, or if your partner has different partners, you should also be tested for other STIs including gonorrhea, syphilis and HIV (the virus linked to AIDS). You should also consider getting vaccine shots to prevent hepatitis B virus infection.

Please remember: The more sexual partners you have, the higher your risk of getting a STI.

Birth control pills

Birth control pills may not work very well when you are taking some antibiotic medicines. Keep taking your birth control pills while taking any medication, and also use a second form of birth control, such as a condom, until your next period after completing the antibiotics.

Ways to reduce your risk of getting a sexually transmitted infection

- Have sex with only one partner who has been tested for sexually transmitted infections (STIs), who has been treated if necessary and who is having sex only with you. The more partners you have, the higher your risk of getting an STI.
- Use a female or male condom every time you have sex. Condoms offer protection against STIs, but they must be used properly.
- Have regular check-ups for STIs.
- Decide not to have sex.

Important facts about condoms

- A condom acts like a barrier that helps prevent the exchange of body fluids, the transmission of sexually transmitted infections, and pregnancy.
- A new condom should be used each time you have sexual intercourse (anal, vaginal, or oral sex).
- Check the expiry date on the condom package.
- Use only water-based lubricants with the male latex condom. Oil-based lubricants, such as petroleum jelly, lotion or baby oil, can weaken and destroy latex.
- Female condoms are made of polyurethane. This material can be used with any type of lubricant, water-based or oil-based.
- Some lubricants contain chemicals called spermicides to help protect against unwanted pregnancy. If they irritate your genitals, don't use them.
- Do not use a male condom together with a female condom as the friction created may cause tearing of either product.
- If a condom breaks during sex remove it immediately and apply a new condom.
- Remember! Condoms do not offer 100 per cent protection from STIs and unwanted pregnancy. It will not consistently prevent transmission of STIs passed through skin-to-skin contact – for example, syphilis, human papilloma virus (warts) and herpes. However, if used properly, they are very effective and can reduce the risk of transmission of these STIs.

Putting on a male condom

- Take the condom carefully out of the packet.
- Place the condom on the tip of the penis when it is hard and erect, but before it touches the partner's body. Make sure that the rolled-up condom rim faces outward.
- With the other hand, pinch the tip of the condom to remove any trapped air, and unroll the condom to the base of the erect penis.

- After intercourse and before the penis becomes soft, withdraw the penis carefully, holding the rim of the condom against the penis, so that semen does not spill out.
- Slide the condom gently off the penis, and knot the open end.
- After using the condom, throw it in the garbage.

Putting on a female condom

- A condom can be inserted up to eight hours before sexual intercourse.
- Open the package carefully. Hold the small ring at the closed end of the condom between the thumb and middle finger.
- Find a comfortable position, either lying down, sitting with your knees apart or standing with one foot raised on a stool, squeeze the small ring and insert it into the vagina as far as you can.
- Put a finger inside the condom and push the small ring inside as far as possible. It is also possible to insert the condom by putting it onto the erect penis before intercourse.
- Make sure that the part of the condom with the outer ring is outside the body. The outer ring will lie flat against the body when the penis is inside the condom.
- When the penis enters the vagina, make sure that the penis is inside the condom.
- Immediately after sexual intercourse, remove the condom by gently twisting the outer ring and pulling the condom out, making sure that no semen is spilt and throw it in the garbage.

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Genital Herpes

What is genital herpes?

Genital herpes is an infection caused by the herpes simplex virus. The virus can cause painful blisters and sores on the genitals (sexual organs) and/or on the mouth.

How is it spread?

Genital herpes is spread by having unprotected sex – not using a condom – with someone who is infected with the herpes virus, whether the person has sores or not. Herpes can be spread from the mouth to the genitals when one partner has cold sores and engages in oral-genital sex. Even very small breaks in the skin allow the virus to enter and start an infection.

What are the symptoms?

Most people with herpes do not recognize the symptoms. Sometimes, symptoms may not become visible for months or years. You can have herpes and not know it.

Symptoms of genital herpes can include painful red dots or tiny blisters on the genitals, swollen glands, fever, and body aches. Other warning signs include itching, burning, tingling, and leg pain.

If you have symptoms, you need to be examined by a doctor or nurse and have lab tests done.

Usually, symptoms begin 2-14 days after having sex with someone who has herpes. The first outbreak of blisters is usually longer and more severe than outbreaks that may occur later.

After the first outbreak, the virus withdraws into the nerves below the skin in the area where the sores first appeared. During this time, the virus does not cause symptoms and remains inactive. Once a person is infected with the virus, it remains in the body for life. In most people, the virus becomes active from time to time, causing repeated blisters and sores.

What are the complications?

Complications are generally rare and usually occur with the first genital herpes outbreak.

Women who are newly infected late in pregnancy can pass the infection to their baby during childbirth.

If the virus travels to another part of the body, it may cause disease in that part of the body.

What is the treatment?

Medication is prescribed when herpes first develops or if the blisters continue to appear. Treatment helps reduce discomfort from the symptoms, but there is no cure for herpes.

A healthy lifestyle, such as a good diet, rest and exercise, may help reduce the number of outbreaks.

To ease discomfort when you have symptoms, try the following:

- Wear loose-fitting clothing and cotton underwear;
- Soak in warm water baths;
- Keep the infected area dry;
- Do not use medicated or non-medicated ointments or creams.

Do not have sex until you and your partner(s) have finished all the medication. Take all of the medication exactly as instructed.

Should I be tested for other sexually transmitted infections (STIs)?

If you have different sexual partners, or if your partner has different partners, you should be tested for other STIs including gonorrhea, chlamydia, syphilis, and HIV (the virus linked to AIDS). You should also consider getting a vaccine to prevent hepatitis B infection.

The more sexual partners you have, the higher your risk of getting a STI.

Ways to reduce your risk of getting a sexually transmitted infection

- Have sex with only one partner who has been tested for sexually transmitted infections (STIs), who has been treated if necessary, and who is having sex only with you. The more partners you have, the higher your risk of getting a STI.
- Use a female or male condom every time you have sex. Condoms offer protection against STIs, but they must be used properly.
- Have regular check-ups for STIs.
- Decide not to have sex.

Important facts about condoms

- A condom acts like a barrier that helps prevent the exchange of body fluids, the transmission of sexually transmitted infections, and pregnancy.
- A new condom should be used each time you have sexual intercourse (anal, vaginal, or oral sex).
- Check the expiry date on the condom package.
- Use only water-based lubricants with the male latex condom. Oil-based lubricants, such as petroleum jelly, lotion or baby oil, can weaken and destroy latex.
- Female condoms are made of polyurethane. This material can be used with any type of lubricant, water-based or oil-based.
- Some lubricants contain chemicals called spermicides to help protect against unwanted pregnancy. If they irritate your genitals, don't use them.
- Do not use a male condom together with a female condom as the friction created may cause tearing of either product.
- If a condom breaks during sex remove it immediately and apply a new condom.
- Remember! Condoms do not offer 100 per cent protection from STIs and unwanted pregnancy. It will not consistently prevent transmission of STIs passed through skin-to-skin contact – for example, syphilis, human papilloma virus (warts) and herpes. However, if used properly, they are very effective and can reduce the risk of transmission of these STIs.

Putting on a male condom

- Take the condom carefully out of the packet.
- Place the condom on the tip of the penis when it is hard and erect, but before it touches the partner's body. Make sure that the rolled-up condom rim faces outward.
- With the other hand, pinch the tip of the condom to remove any trapped air, and unroll the condom to the base of the erect penis.

- After intercourse and before the penis becomes soft, withdraw the penis carefully, holding the rim of the condom against the penis so the semen does not spill out.
- Slide the condom gently off the penis, and knot the open end.
- After using the condom, throw it in the garbage.

Putting on a female condom

- A condom can be inserted up to eight hours before sexual intercourse.
- Open the package carefully. Hold the small ring at the closed end of the condom between the thumb and middle finger.
- Find a comfortable position, either lying down, sitting with your knees apart or standing with one foot raised on a stool, squeeze the small ring and insert it into the vagina as far as you can.
- Put a finger inside the condom and push the small ring inside as far as possible. It is also possible to insert the condom by putting it onto the erect penis before intercourse.
- Make sure that the part of the condom with the outer ring is outside the body. The outer ring will lie flat against the body when the penis is inside the condom.
- When the penis enters the vagina, make sure that the penis is inside the condom.
- Immediately after sexual intercourse, remove the condom by gently twisting the outer ring and pulling the condom out, making sure that no semen is spilt and throw it in the garbage.



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Gonorrhoea

What is gonorrhoea?

Gonorrhoea is a disease caused by germs or bacteria. The infection is usually found at the opening of the uterus, or in the tube that carries urine from the bladder. It can also infect the rectum, throat, and pelvic organs. To find out if you have gonorrhoea, you must be examined by a doctor or nurse and have tests taken.

How is it spread?

Gonorrhoea can be spread easily from one infected person to another by having unprotected sex - not using a condom - with someone who has this disease. Gonorrhoea can be spread at any time while a person is infected, whether or not he or she has symptoms. A person can still become infected again in the future even if the person and infection are treated.

What are the symptoms?

In some cases there are no symptoms, and a person can have gonorrhoea and not know it. When symptoms develop, they usually occur two to five days after the person becomes infected, but may not appear for up to thirty days.

Women may notice a change in the amount and colour of fluid from the vagina, pain while urinating, and/or unusual menstrual bleeding. Men may notice a creamy white or yellow fluid from the penis and a burning feeling while urinating. In both men and women, a gonorrhoea infection in the rectum may cause itching, pain, bleeding, or a stringy white fluid when having a bowel movement. Gonorrhoea infections in the throat may cause a sore throat.

What are the complications?

If treated early before any complications begin, gonorrhoea causes no lasting problems. Untreated gonorrhoea can lead to many complications. If this infection is left untreated, it can spread and damage organs in the body.

Women may have difficulty getting pregnant. Men may develop an infection in the testicles, which can make it difficult to make a woman pregnant. Pregnant women may pass the infection to their baby's eyes during childbirth. This may lead to blindness if the baby is untreated. In both men and women, untreated gonorrhoea can cause joint, skin and eye problems.

What is the treatment?

Both the person diagnosed with gonorrhoea, and their sexual partner(s) within the last sixty days, must take antibiotic pills. Any sexual partner(s) of the person diagnosed with gonorrhoea must be treated, regardless of their test results. Follow up tests are recommended six months after treatment.

Important: Do not have sex until you and your sexual partner(s) have finished all the medication. Take all of the medication exactly as instructed.

Should I be tested for other sexually transmitted infections (STIs)?

If you have different sexual partners, or if your partner has different partners, you should also be tested for other STIs including chlamydia, syphilis and HIV (the virus linked to AIDS). You should also consider getting vaccine shots to prevent hepatitis B infection.

Please remember: The more sexual partners you have, the higher your risk of getting a STI.

Birth control pills

Birth control pills may not work very well when you are taking some antibiotic medicines. Keep taking your birth control pills while taking any medication, and also use a second form of birth control, such as a condom, until your next period after completing the antibiotics.

Ways to reduce your risk of getting a sexually transmitted infection

- Have sex with only one partner who has been tested for sexually transmitted infections (STIs), who has been treated if necessary and who is having sex only with you. The more partners you have, the higher your risk of getting an STI.
- Use a female or male condom every time you have sex. Condoms offer protection against STIs, but they must be used properly.
- Have regular check-ups for STIs.
- Decide not to have sex.

Important facts about condoms

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- A new condom should be used each time you have sexual intercourse (anal, vaginal, or oral sex).
- Check the expiry date on the condom package.
- Use only water-based lubricants with the male latex condom. Oil-based lubricants, such as petroleum jelly, lotion or baby oil, can weaken and destroy latex.
- Female condoms are made of polyurethane. This material can be used with any type of lubricant, water-based or oil-based.
- Some lubricants contain chemicals called spermicides to help protect against unwanted pregnancy. If they irritate your genitals, don't use them.
- Do not use a male condom together with a female condom as the friction created may cause tearing of either product.
- If a condom breaks during sex remove it immediately and apply a new condom.
- Remember! Condoms do not offer 100 per cent protection from STIs and unwanted pregnancy. It will not consistently prevent transmission of STIs passed through skin-to-skin contact – for example, syphilis, human papilloma virus (warts) and herpes. However, if used properly, they are very effective and can reduce the risk of transmission of these STIs.

Putting on a male condom

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- With the other hand, pinch the tip of the condom to remove any trapped air, and unroll the condom to the base of the erect penis.

- After intercourse and before the penis becomes soft, withdraw the penis carefully, holding the rim of the condom against the penis, so that semen does not spill out.
- Slide the condom gently off the penis, and knot the open end.
- After using the condom, throw it in the garbage.

Putting on a female condom

- A condom can be inserted up to eight hours before sexual intercourse.
- Open the package carefully. Hold the small ring at the closed end of the condom between the thumb and middle finger.
- Find a comfortable position, either lying down, sitting with your knees apart or standing with one foot raised on a stool, squeeze the small ring and insert it into the vagina as far as you can.
- Put a finger inside the condom and push the small ring inside as far as possible. It is also possible to insert the condom by putting it onto the erect penis before intercourse.
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- Immediately after sexual intercourse, remove the condom by gently twisting the outer ring and pulling the condom out, making sure that no semen is spilt and throw it in the garbage.



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Human Papillomavirus (HPV) Infection

What is HPV Infection?

HPV is one of the most common sexually transmitted infections (STIs). There are more than 100 types of HPV. Two types cause 70 per cent of cancer of the cervix in women. Another 2 types cause 90 per cent of genital warts in women and men.

How is HPV spread?

HPV is spread by skin-to-skin contact from one person to another during oral, vaginal or anal sexual activity. Sexual intercourse is not necessary to get infected with HPV.

HPV can infect all of the genital area and surrounding skin. This includes the vagina, cervix, rectum, penis, vulva, and anus. It is possible to have more than one type of HPV infection at the same time.

What are the symptoms of HPV?

Most people do not show any signs or symptoms of an HPV infection, and they can pass HPV onto others without knowing it.

How common is HPV infection?

Three out of 4 sexually active women will get at least 1 HPV infection at some time in their lives. The more sexual partners you have, the higher your risk of spreading the virus and getting an HPV infection.

What are the risks of HPV infection?

Most women who have an infection of HPV in the cervix clear the infection within 2 years. But when it does not clear, cells in the cervix that are infected with HPV can become cancerous within 1 to 20 years.

Every year in BC:

- 150 women will get cervical cancer.
- 40 women will die from the disease.
- 6,000 women will develop high-risk changes to the cervix, which are precancerous.
- 10,000 invasive procedures will be done to stop cancer of the cervix from developing.

What is the treatment for HPV?

There is no treatment, but specific types of HPV infection can be prevented using the HPV vaccine. Girls and women are best protected when they get the HPV vaccine before they become sexually active.

The HPV vaccine is recommended for girls and women between the ages of 9 and 26 years before they come in contact with HPV. The vaccine prevents HPV infection but it does not get rid of it once the infection occurs.

It is important for women to get regular Pap tests once they become sexually active because the HPV vaccine does not protect against all cancers of the cervix.

Who should get the HPV vaccine?

Starting in the 2008-2009 school year, HPV vaccine will be provided free to girls in grades 6 and 9 in BC.

The vaccine may also benefit women who are sexually active and have not been infected with HPV.

For women not covered by the school-based program, please talk to your doctor.

How can I reduce the risk of HPV?

- Get the HPV vaccine.
- Always use a condom with sexual activity.
- Delay the start of sexual activity.

For more information

For more information, see the following HealthLink BC Files:

[#101b Human Papillomavirus \(HPV\) Vaccine Grade 6 and 9 Program](#)

[#08k Genital Warts](#)

[#08C Pelvic Inflammatory Disease \(PID\)](#)



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Syphilis

What is syphilis?

Syphilis is an infection caused by a germ, such as bacteria. Syphilis is described in terms of its stages: primary, secondary, early latent and tertiary. Each stage has a different set of symptoms. Many people may not notice any symptoms, and a person can have syphilis and not know it.

To find out if you have syphilis, you must be examined by a doctor or nurse. Lab tests must also be done, including tests on the sore(s) and a blood test.

How is it spread?

Syphilis can be spread by having sex with someone who is infected with syphilis.

What are the symptoms?

During the primary stage, a sore can develop where the bacteria entered the body. The sore usually occurs 3 days to 3 months after having sex with someone infected with syphilis. The sore may appear on any part of the body in contact with the sexual fluids of an infected person. Sometimes, the sore will not be noticeable. In both men and women, the sore will go away on its own within 1 month, but the disease will continue to spread.

About 4 to 6 weeks after being infected, a rash may develop during the secondary stage of the infection. It may look like other rashes, such as measles. The rash can appear anywhere on the body, but it is most often found on the belly, the genitals, palms of the hands, and soles of the feet. You may not notice the rash, but you can still spread the disease to other people.

After the rash goes away, and if you do not receive treatment, the disease will progress to the latent or hidden stage of syphilis. You may not have any symptoms for a period of time. The latent period can last from 3 years to 30 years.

What are the complications?

During the late or tertiary stage of the disease, untreated syphilis can cause damage to the brain, heart and other organs in the body. Severe cases of the disease can cause death. Pregnant women can also pass syphilis to an unborn child resulting in stillbirth, pre-term birth, and abnormalities in the baby.

What is the treatment?

During any stage, syphilis can be treated with antibiotics. Antibiotic treatment can not undo the damage caused by syphilis in the late or tertiary stage, but it can prevent further damage. After treatment, you must have blood tests to make sure the treatment worked.

Do not have sex until 2 weeks after you and your partner(s) have finished the treatment.

Should I be tested for other sexually transmitted infections?

If you have different sexual partners, or if your partner has different partners, you should also be tested for other sexually transmitted infections (STIs) including gonorrhea, chlamydia, and HIV virus linked to AIDS. The more sexual partners you have, the higher your risk of getting a STI. You should also consider getting vaccinations to prevent hepatitis B infection.

Birth control pills

Birth control pills may not work very well when you are taking some antibiotics. Keep taking your birth control pills while taking any medication. Use also a second form of birth control, such as a condom, until your next period after completing the antibiotics.

Ways to reduce your risk of getting a sexually transmitted infection

- Have sex with only one partner who has been tested for sexually transmitted infections (STIs), who has been treated if necessary, and who has sex only with you. The more partners you have, the higher your risk of getting an STI.
- Use a female or male condom every time you have sex. Condoms offer protection against STIs, but they must be used properly.
- Have regular check-ups for STIs.
- Decide not to have sex.

Important facts about condoms

- A condom acts like a barrier that helps prevent the exchange of body fluids, the transmission of sexually transmitted infections, and pregnancy.
- A new condom should be used each time you have sexual intercourse (anal, vaginal, or oral sex).
- Check the expiry date on the condom package.
- Use only water-based lubricants with the male latex condom. Oil-based lubricants, such as petroleum jelly, lotion or baby oil, can weaken and destroy latex.
- Female condoms are made of polyurethane. This material can be used with any type of lubricant, water-based or oil-based.
- Some lubricants contain chemicals called spermicides to help protect against unwanted pregnancy. If they irritate your genitals, don't use them.
- Do not use a male condom together with a female condom as the friction created may cause tearing of either product.
- If a condom breaks during sex remove it immediately and apply a new condom.
- Remember! Condoms do not offer 100 per cent protection from STIs and unwanted pregnancy. It will not consistently prevent transmission of STIs passed through skin-to-skin contact – for example, syphilis, human papilloma virus (warts) and herpes. However, if used properly, they are very effective and can reduce the risk of transmission of these STIs.

Putting on a male condom

- Take the condom carefully out of the packet.
- Place the condom on the tip of the penis when it is hard and erect, but before it touches the partner's body. Make sure that the rolled-up condom rim faces outward.
- With the other hand, pinch the tip of the condom to remove any trapped air, and unroll the condom to the base of the erect penis.

- After intercourse and before the penis becomes soft, withdraw the penis carefully, holding the rim of the condom against the penis, so that semen does not spill out.
- Slide the condom gently off the penis, and knot the open end.
- After using the condom, throw it in the garbage.

Putting on a female condom

- A condom can be inserted up to eight hours before sexual intercourse.
- Open the package carefully. Hold the small ring at the closed end of the condom between the thumb and middle finger.
- Find a comfortable position, either lying down, sitting with your knees apart or standing with one foot raised on a stool, squeeze the small ring and insert it into the vagina as far as you can.
- Put a finger inside the condom and push the small ring inside as far as possible. It is also possible to insert the condom by putting it onto the erect penis before intercourse.
- Make sure that the part of the condom with the outer ring is outside the body. The outer ring will lie flat against the body when the penis is inside the condom.
- When the penis enters the vagina, make sure that the penis is inside the condom.

Immediately after sexual intercourse, remove the condom by gently twisting the outer ring and pulling the condom out, making sure that no semen is spilt and throw it in the garbage.



BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

For more HealthLink BC File topics, visit www.HealthLinkBC.ca/healthfiles/index.stm or your local public health unit.

Click on www.HealthLinkBC.ca or call **8-1-1** for non-emergency health information and services in B.C.

For deaf and hearing-impaired assistance, call 7-1-1 in B.C.

Translation services are available in more than 130 languages on request.

Street Definitions

ASCORBIC ACID	also known as “vitamin-C” for breaking down rock
BREAKING DOWN ROCK	dissolving crack-cocaine/rock to make it injectable
COMING DOWN	after the “half-life” of your dosage has worn away
COOKER	aluminum steri-cup to prepare drugs in & filter into a (rig)
DILLYS	dilaudid, a prescription pain killer (an opiate, like heroin)
DOING THE CHICKEN	seizure-like swinging and flailing of arms, legs, fast-pacing
DOWN	heroin (an opiate)
HIT	an intravenous injection
JIB	crystal-methamphetamine (a stimulant)
JONESING	the thirst or desire for more drugs during “coming down”
LEGS	refers to duration of your dosage, also “half-life”
ON THE NOD	sleeplike-state of consciousness caused during opiate-use
POINT	needle
POWDER	“up”, cocaine powder, ready for prep to injection or snorting
RIG	syringe, tool, spike, works
ROCK	crack-cocaine, for smoking

SICK	opiate withdrawal symptoms
SKETCHING	psychosis-induced behaviour, like nervous walking, eye movements, etc
SMASH	a “hit”, any injected drug
SPEEDBALL	injecting a mixture of “up” & “down”
SPITBALL	plastic-wrap packaged powder cocaine (often stored in dealer’s mouths)
T&R’S	Talwin & Ritalyn, a pharmaceutical “speedball” (often injected)
TECHING	crystal-meth inspired construction, hobby, or idle pass-times
TWEAKING	sidewalk-digging, floor-scrounging, looking for dope while “high”
“X”	ecstasy, a “rave-club” drug

HARM REDUCTION PROGRAM : SUPPLY REQUISITION FORM

Please fax requisition forms to: Vaccine and Pharmacy Services
 BC Centre for Disease Control
 655 12th Ave W Suite 1100
 Vancouver BC V5Z 4R4
 Tel: (604) 707-2597



BC Centre for Disease Control
 AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Fax: (604) 707-2583

PRIMARY distribution site: _____	Date Submitted: _____
Contact Name: _____	
Shipping Address: _____	Delivery Days: _____
_____	Delivery Times: _____
Postal Code: _____	Email: _____
Phone Number: _____	Fax Number: _____

**This form is only for distribution sites previously authorized by Health Authority representative.
 If you are not an authorized site, please contact your Health Authority representative
 as shown on next page.**

**Order Enough for 3 MONTH Supply or
 try to meet the Minimum Order Quantity**

*Please allow max. 2 weeks delivery.
 Deliveries on Mondays or later*

		Unit Of Issue	Quantity Ordered
Lubricated Condoms (Durex)	ORDER IN MULTIPLES OF 5 BOXES	(144/Box)	Boxes
Non-Lubricated Condoms (Durex)	ORDER IN MULTIPLES OF 5 BOXES	(144/Box)	Boxes
Assorted Flavours - Scented Condoms (Durex)	ORDER IN MULTIPLES OF 5 BOXES	(144/Box)	Boxes
Female Condoms	if request is less than 100 (ea), please call us	(100/Bag)	Bags
Aqua Lube (3 mL per packet):	144/gross, 8 gross/box	(1,152/Box)	Boxes
Syringes with needle attached (1/2 cc insulin syringe & needle)		(100/Box)	Boxes
Syringes with needle attached (1 cc insulin syringe & needle)		(100/Box)	Boxes
Syringes without needles: 3 cc		(100/Box)	Boxes
Syringes without needles: 5 cc		(100/Box)	Boxes
Needle, disposable	18g x 1 1/2"	(100/Box)	Boxes
Needle, disposable	22g x 1"	(100/Box)	Boxes
Needle, disposable	22g x 1 1/2"	(100/Box)	Boxes
Needle, disposable	25g x 5/8"	(100/Box)	Boxes
Needle, disposable	25g x 1"	(100/Box)	Boxes
Needle, disposable	26g x 1/2"	(100/Box)	Boxes
Needle, disposable	27g x 1/2"	(100/Box)	Boxes
Alcohol Swabs		(200/Box)	Boxes
Water Vials - 3 ml		(1000/Case)	Cases
Disposable Cookers (Stericups)		(1000/Box)	Boxes
Ascorbic Acid	300mg sachets	(1000/Box)	Boxes
Wooden Push sticks		(100/Bag)	Bags
Cutter		(each)	Each
Plastic mouth piece	Vinyl Tubing 1/4" x 3/8"	(100 feet/roll)	Rolls
Plastic mouth piece	Vinyl Tubing 5/16" x 7/16"	(100 feet/roll)	Rolls
Plastic mouth piece	Vinyl Tubing 3/8" x 1/2"	(100 feet/roll)	Rolls

Harm Reduction Supply Ordering at the BCCDC

Health Authority contacts for site authorization

To receive harm reduction supplies, each distribution site must be pre-authorized by the health authority representative. The following are the current contacts;

Fraser health:	Amrit Rai Amrit.Rai@fraserhealth.ca	Tel 604 - 918-7605
Interior Health:	Jeanie Fraser Jeanie.Fraser@interiorhealth.ca	Tel 250 - 549-6342
Northern Health:	Susan Broomsgrove Susan.Broomsgrove@northernhealth.ca	Tel 250 - 565-2636
Vancouver Coastal Health:	Sara Young Sara.Young@vch.ca	Tel 604 - 714-3771 x2321
Vancouver Island Health:	Audrey Shaw Audrey.Shaw@viha.ca	Tel 250 - 519-7094

NEW Single Source Distributor

- In November 2008, (to improve availability and efficiency of shipping) the BCCDC switched to a single source distributor for all harm reduction supplies.
- The distributor has committed to have a minimum of 3 months stock of supplies at all times; therefore the supplies will be available when you need them.
- This will enable you to reduce your stockpiles/safety stock and save storage space.

Changes to Supplies (see supply requisition form for details)

- Following consultation with key stakeholders in the field, three (3) different sizes of mouthpieces are now available as well as disposable cookers and citric acid. Please see frequently asked questions on harm reduction page of BCCDC website for further information.

BCCDC Weekly Processing

- To order supplies, fill out the attached Harm Reduction Supply Requisition Form and fax it to the number on the form.
- BC CDC will **process requisitions in batches on Thursday AM only**, so we recommended submitting your order by Wednesday afternoon. All orders received after the cutoff time of 10am on Thursday will be processed the following week.
- The distributor will **ship the orders on Monday** or later for remote areas. Delivery time is expected to be up to two weeks.

Minimum Order Size

- Female condoms can now only be ordered in boxes of 100 from the distributor. For smaller quantities, please contact BCCDC directly.
- We recommend that you order in bulk every 3 months or longer to meet the Minimum Order Size; the distributor charges additional handling fees for small orders. For instance, the following orders would be large enough to avoid an additional handling fee:

1 box Aqua Lube – carton	(1,152 per box)	or	20 boxes of 1cc syringes	(100 per box)
5 boxes assorted flavors-scented male condoms	(144 per box)		1 case of water vials	(1000 per case)
5 boxes non-lubricated male condoms	(144 per box)		20 boxes of male condoms	(144 per box)
5 boxes lubricated male condoms	(144 per box)		1 box of Aqua Lube	(1152 per box)
2 bags female condoms	(100 per bag)		10 boxes of alcohol swabs	(200 per box)

- If you failed to meet the Minimum Order Size, BCCDC might not process your order and will fax back the Requisition Form with mention "increase your order". Your requisition might not be processed until the next Thursday and your delivery delayed.

Receiving Supplies and Questions

Please check your order. Ensure that you receive the correct quantity and that the supplies reach you in good condition. If you notice any discrepancy, or have any questions or concerns about the distribution of harm reduction supplies please call **(604) 707 - 2597**.

Rationale for Crack Pipe Mouthpiece Distribution

- **In the 1990s, street drug use patterns changed, with crack (i.e. an easily marketable form of freebase cocaine) smoking in Canada becoming much more prevalent than in the past.(1)**
- **Crack cocaine smoking presents different public health risks than injection drug use,(2) although the sub-populations who engage in both activities are often highly vulnerable and marginalized, and may suffer from concurrent mental illness, physical ill-health and homelessness.(3)**
- **Prevalence of hepatitis C virus is highest among people who inject drugs, but is also higher in the population of non-injectors (i.e. people who use, but do not inject, illegal drugs such as heroin or cocaine) than in the general population.(4)**
- **People who smoke crack cocaine sometimes develop oral lesions or cracked lips.(5,6)**
- **Pipes used by crack smokers infected with hepatitis C and with oral lesions sometimes test positive for hepatitis C virus.(7)**
- **Evidence suggests that if glass pipes for crack smoking are shared, individuals may be at increased risk of exposure to hepatitis C and other communicable diseases.(8,9,10,11)**
- **It is estimated that up to 70% of people infected with hepatitis C are unaware of their positive status.(12)**
- **Using plastic mouthpieces on the ends of crack pipes allows individuals to protect themselves from exposure to communicable disease risks.**
- **Providing supplies for people who do not inject drugs reduces risk behaviours associated with blood-borne pathogen transmission and provides opportunities for engagement with otherwise hard-to-reach populations of marginalized and vulnerable individuals.(13)**

References

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- ² Haydon, E., & Fischer, B. (2005). Crack use as a public health problem in Canada. *CJPH*, *96*(3), 185-188.
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Female Condoms: Questions and Answers

What is the female condom?

The female condom is a tube made up of a sheath and 2 flexible rings, which keep the condom in place. It is closed at one end, and designed to form a loose lining to a woman's vagina. The inner ring at the closed end fits inside the vagina, just behind the pubic bone. The outer ring at the open end stays outside the vagina, lying flat against the area around the entrance of the vagina. The BC Harm Reduction Strategies and Services provides the new female condom 2 (FC2) which is thinner and less squeaky than the previously available female condom. It is latex-free. The sheath and outer ring are made of nitrile polymer and the inner ring is made of polyurethane.



When do you use a female condom?

The condom can be inserted up to 8 hours before sex. It should be removed after sex and thrown into the garbage. It should not be reused.

It should not be used with a male condom because the friction between the two condoms may cause them to break.

How do you put on a female condom?

- Choose a position that is comfortable for insertion – squatting, raise one leg, lie or sit down
- Make sure the condom is well lubricated; this will help the condom stay in place.
- Squeeze the inner ring with your thumb and middle finger, and insert the inner ring and the sheath into the vaginal opening. Using your index finger push the inner ring as far as it will go. The outer ring should remain outside the vagina.
- When having sex, the penis should be guided into the condom in order to ensure that it does not slip into the vagina outside the condom.

What type of protection does a female condom provide?

- It prevents the spread of sexually transmitted infections, including HIV and AIDS.
- It is as effective as the male condom at preventing pregnancy. (75-99% effective)

What are the advantages of a female condom?

- Prevents the spread of sexually transmitted infections, including HIV and AIDS.
- Does not reduce the male partner's stimulation.
- Provides women with control and choice about their sexual health
- Is available without a prescription and has no hormonal side effects.
- Can be used by people with latex sensitivities.
- Is prelubricated and can be used with oil-based and water-based lubricants.
- Can be inserted before sex play begins (up to 8 hours before).
- Erection is not necessary to keep condom in place.
- Does not affect future fertility.

Why does the BC Harm Reduction* Strategies and Services provide female condoms?

Female condoms are a safe and effective way to prevent the spread of sexually transmitted infections as well as pregnancy. We provide female condoms to decrease transmission of infection and prevent unwanted pregnancy. Female condoms also provide women with control and choice about their sexual health (1, 2). It also allows both partners to be protected even if the man refuses to wear a condom. Studies show that if women are taught how to use female condoms then the uptake is higher (3). Therefore, when offering and distributing female condoms it is important to explain how to use them.

How can female condoms be ordered?

Female condoms can be ordered by harm reduction distribution sites which are approved by the appropriate regional health authority. The harm reduction supply requisition form available on-line at <http://www.bccdc.ca/default.htm> should be used, and the female condoms ordered at the same time as other harm reduction supplies. The completed form is faxed to BCCDC. Female condoms can be ordered in bags of 100; if less than 100 are required, it should be discussed with BCCDC Vaccine and Pharmacy Services.

References:

*For a definition of harm reduction please see Health file #102, Understanding Harm Reduction <http://www.healthlinkbc.ca/healthfiles/hfile102a.stm>

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Sterile Water for injection drug use: Questions and Answers

What is Sterile Water?

Drugs may be sold as powder, crystals (rocks), or tablets. To reduce the risk of vein damage and developing infections the drugs should be fully dissolved in sterile water when injected. The use of sterile water over unclean (e.g. puddle water) or non-sterilized water avoids harm from contaminated sources when injected.

Why should people who inject drugs use sterile water?

Because the water is sterile, users will be less likely to develop harmful bacterial infections like cellulitis and abscesses, septicemia (infection in the bloodstream) and endocarditis (infection of the heart valves).

What type of sterile water does BC Harm Reduction* Strategies and Services provide?

In BC, Sterile Water for Inhalation is provided. It comes in a 3 ml plastic ampoule with a snap off top. Because of its small volume it encourages single use. Sterile Water for Injection currently only comes in 10 ml ampoules which may encourage re-use or sharing and therefore cause transmission of infections.

Why does BC Harm Reduction Strategies and Services provide sterile water?

Water is commonly shared or obtained from non-sterile sources when sterile supplies are not readily available. We provide single use ampoules of sterile water to reduce sharing. Once the sterile water ampoule is opened any left-over should be thrown away, so that it does not become contaminated and cause an infection if re-used or is used by someone else. By reducing the sharing of equipment, the transmission of hepatitis B, hepatitis C, HIV, and other infectious diseases will be reduced. Since the water is sterile, users will also be less likely to develop other bacterial infections.¹

Best practice recommends one sterile water ampoule should be used with a sterile needle for each injection.^{2,3} In BC only half as many sterile water ampoules as syringes were distributed in 2009/10. Programs should strive to distribute as many water ampoules as required so the individual client can use a new water ampoule and new needle for every injection. Providing supplies to enable safer drug use to people who inject drugs creates a way to engage hard-to-reach and under-served populations in health care and social services. No studies have found that providing safe supplies makes people more likely to engage in harmful drug use.

How can Sterile Water be ordered?

Sterile water can be ordered by harm reduction distribution sites which are approved by the appropriate regional health authority. The harm reduction supply requisition form available on-line at <http://www.bccdc.ca/default.htm> should be used and the water for inhalation ordered at the same time as other harm reduction supplies. The completed form is faxed to BCCDC.



References:

*For a definition of harm reduction please see Health file #102, Understanding Harm Reduction <http://www.healthlinkbc.ca/healthfiles/hfile102a.stm>

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2. Strike C, Watson TM, Lavigne P, Hopkins S, Shore R, Young D, Leonard L, Millson P. Guidelines for better harm reduction: Evaluating implementation of best practice recommendations for needle and syringe programs. (NSPs) Int J Drug Policy 2010; Apr 20.
3. Best Practices for British Columbia's Harm Reduction Supply Distribution Program (2008) available at <http://www.bccdc.ca/prevention/HarmReduction/default.htm>

Cookers and Injection Drug Use: Questions and Answers

What is a cooker?

A **cooker** is the container used for mixing and heating a drug. Some drugs are sold as powder, crystals (rocks), or tablets. To be injected, they should be fully dissolved in sterile water and cooking the drug facilitates this process. People often use non-sterile cookers such as spoons, bottle caps, the bottom of drink cans, or syringe barrels¹.

What are the risks of shared or non-sterile cookers?

Cookers are one of the most commonly shared items used in drug injections; they are more commonly shared than needles². They may be shared directly, as when several users draw up their injections from the same cooker, or indirectly/accidentally, for example when a user finds a discarded spoon that they do not know has been previously used as a cooker.

Shared cookers, like shared needles and other equipment used with injections, have been shown to transmit serious blood-borne infections such as hepatitis B³, hepatitis C⁴ and HIV^{5,6} between users. Any non-sterile cooker, even if it is not shared, may be contaminated by bacteria, which can lead to life-threatening bacterial infections, including abscesses, cellulitis, bone and joint infections, or heart infections⁷.

What type of cooker does BC Harm Reduction* Strategies and Services provide?

Sterile, disposable cookers known as Stericups®⁸ are provided. A Stericup® is a small, lightweight aluminum cooker with a flat-bottom bowl and a heat-resistant plastic-covered handle. It is designed to be used only once. After being heated for the first time, the aluminum becomes fragile and the handle falls off easily.



What drugs can be prepared using the cooker?

Cookers can be used to prepare any drug for injection, including pills, heroin, crack cocaine, cocaine, and crystal meth. Cocaine and methamphetamines dissolve well in water. White heroin (heroin hydrochloride) dissolves when heated but heroin base (brown heroin) requires the addition of a mild acid, such as ascorbic or citric acid and may need some heat to properly dissolve. Crack also requires the addition of a mild acid and heat to properly dissolve. Cookers should always be used in conjunction with sterile water and filters to prevent infections.

How are cookers used?

Cookers should be assembled following the “Instructions for use of Stericup® cooker” to minimize the chance of contamination and subsequent infection. Once assembled, each Stericup® cooker can be used once over an open flame to mix and dissolve drugs. Uncapped needle tips can be damaged if used to mix or grind drugs in a cooker. A clean, capped needle can be used for this purpose. Users should be aware that this lightweight cooker may be easily knocked over, and should be careful to avoid spills. The cooker should be disposed of after single use.

Why does BC Harm Reduction Strategies and Services provide sterile, disposable cookers?

Cookers are commonly shared when supplies are limited or not readily available⁹. We provide single-use cookers to reduce sharing. All programs should strive to distribute as many supplies as required for the individual client to be able to use a new one for each injection. By reducing the sharing of equipment, the transmission of hepatitis B, hepatitis C, HIV, and other infectious diseases will be reduced. Since the equipment is sterile, users will also be less likely to develop other bacterial infections.

Providing safe supplies to people who inject drugs creates a way to engage hard-to-reach and under-serviced populations in health care and social services. No studies have found that providing safe supplies makes people more likely to engage in harmful drug use.

How can cookers be ordered?

Cookers can be ordered by harm reduction distribution sites which are approved by the appropriate regional health authority. The harm reduction supply requisition form available on line at <http://www.bccdc.ca/default.htm> should be used and the cookers ordered at the same time as other harm reduction supplies. The completed form is faxed to BCCDC.

References

*See *Health File #102a: Understanding Harm Reduction* in the BC Health Guide for a definition of harm reduction: <http://www.healthlinkbc.ca/healthfiles/hfile102a.stm>

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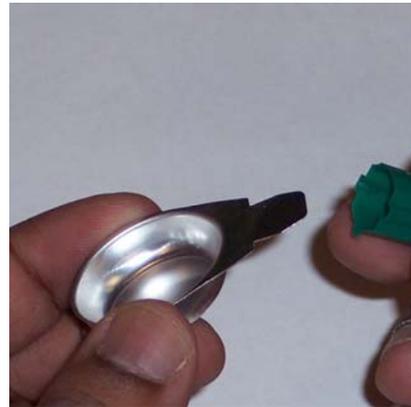
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⁸ Apothicom. Stericup. 2009. <http://www.apothicom.org/stericup.php?lang=en>

⁹ Scottish Drugs Forum and Glasgow Involvement Group. Views from the street: Needle exchange users in Glasgow. 2004.

Instructions for use of Stericup[®] cooker:

- Do not touch the inside of the bowl!
- Peel open the package carefully, keep the bowl up
- Hold the outside of bowl with one hand
- Make sure the small bump on the green plastic handle is down (when attached it will help prevent the cooker tipping over if is placed on a flat surface)
- Slip the metal handle inside grooves of green plastic handle
- When heating the bowl, hold the handle from the sides
- The cooker is single use only
- Do not share
- DISPOSE OF THE COOKER CAREFULLY WITH YOUR NEEDLE



References

Apothicom. Stericup. 2009. <http://www.apothicom.org/stericup.php?lang=en>.

Acidifier (Vitamin C – Ascorbic Acid) and Injection Drug Use: Questions and Answers

What is vitamin C?

Vitamin C (ascorbic acid) is a weak organic acid which is used as an acidifier. It comes as a white powder that can be dissolved in water to form a mild acidic solution. It is available in waterproof sachets of 300mg.

Why do injection drug users use acidifiers?

Crack cocaine and 'black tar' (or 'brown') heroin are usually sold as solid crystals (rock) or powder; to inject them, the user must dissolve them in an acidic solution. Most powdered, 'white', heroin does not require an acidifier to dissolve it in water. Common acidifiers include vitamin C, citric acid, lemon juice, and vinegar^{x, xi, xii}.

What are the problems with lemon juice and vinegar?

Lemon juice and vinegar are commonly used because they are widely available^x. However, they are much harsher acids, causing more pain, irritation, and damage to the veins. Repeated damage causes veins to collapse^{xi}. A drug user may then start using more dangerous veins^{xiii}, such as veins in the neck or groin, that are near major arteries. If a major artery is pierced accidentally with a needle, life-threatening blood loss can occur^{xii}. Vinegar and lemon juice may also be contaminated with bacteria or fungus. These may lead to life-threatening infections including abscesses, cellulitis and heart infections^{xiv}, or eye infections causing blindness^{xv, xvi}.

How is vitamin C used?

The smallest amount of ascorbic acid is used to dissolve the drug in order to keep vein damage to a minimum. In a stericup or 'cooker' (see Cookers Q and A), the drug is combined with sterile water. Small amounts of vitamin C are added until the drug is fully dissolved. For crack, the amount of vitamin C required is about ¼ the size of the rock; however for crack and brown or black tar heroin, the amount of vitamin C needed to fully dissolve the drug varies with the purity of the drug. Heroin may be heated until the drug is fully dissolved. Crack may also be heated, but should not be boiled. Once the packet of vitamin C is opened, any left over should be thrown away, so that it does not become contaminated and cause an infection.

Why does BC Harm Reduction* Strategies and Services provide ascorbic acid?

Medical-grade vitamin C is the safest acidifier. It causes the least damage to the veins, is non-toxic, and is sterile, reducing or eliminating the harms associated with other acids^{xi}. Acidifiers are commonly shared when supplies are limited or difficult to access^{xvii}. Shared acidifiers, like shared needles and other injecting paraphernalia, may transmit infections such as hepatitis C or HIV between users^{xviii, xix}. Single-use vitamin C packs should be available to all who need it and in a quantity to ensure sufficiency for each injection. Providing safe supplies to people who inject drugs creates a way to engage hard-to-reach and under-served populations in health care and social services. No studies have found that providing safe supplies makes people more likely to engage in harmful drug use.

How can vitamin C packets be ordered?

Vitamin C packets can be ordered by harm reduction distribution sites which are approved by the appropriate regional health authority. The harm reduction supply requisition form available on-line at <http://www.bccdc.ca/default.htm> should be used and the vitamin C ordered at the same time as other harm reduction supplies. The completed form is faxed to BCCDC.

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Crack Pipe Push Sticks: Questions and Answers

Question: What is a push stick?

Push sticks are used to pack and position the filter or screen (often Brillo) inside the crack pipe. Once the crack has been smoked the push stick is used to move the filter back and forth to partially recover the crack that has hardened on the inside wall of the pipe as the pipe cools.

Question: What are push sticks made of?

- Metal- (e.g. coat hangers, broken off car aerials, small screwdriver); these may chip the glass inside the pipe and cause the ends of the pipe to break
- Wood (e.g. chop sticks or kebob sticks) or
- Plastic (ball point pens or the plunger from a syringe)

Question: Why is using syringe plungers a problem?

- When the syringe plunger is used the rest of the syringe including the attached needle is discarded.
- The plunger is plastic and can melt inside the hot pipe.
- Syringes are relatively expensive and this wastes harm reduction resources that could be used elsewhere.

Question: How frequently are syringe plungers used as push sticks?

- Service providers in Vancouver estimate 1 in 5 syringes distributed may be used for the plunger only.¹
- In a survey of male crack users over 50% said they had used syringe plungers.²

Question: Why does the BC Harm Reduction* Strategies and Services provide wooden push sticks?

- To avoid discarded needles and potentially toxic melted plastic related to use of the syringe plunger
- Wooden craft sticks are cheaper than syringes
- The wooden push sticks are less likely than metal to crack the glass pipes and therefore may avoid cuts to fingers and lips
- Providing supplies for people who do not inject drugs creates a further point of engagement for otherwise hard-to-reach / under serviced populations.

Question: How can wooden push sticks be ordered?

The push sticks can be ordered using the harm reduction supply requisition form available on line at <http://www.bccdc.ca/default.htm>, which is then faxed to BCCDC. The sticks come in packets of 100.



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*For a definition of harm reduction please see Health file #102, Understanding Harm Reduction
<http://www.healthlinkbc.ca/healthfiles/hfile102a.stm>

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² Preliminary results from Safer Crack-use Outreach Research and Evaluation survey.

Crack Pipe Mouthpieces: Questions and Answers

Question: What is a crack pipe mouthpiece?

Crack is a crystal form of cocaine. The solid crack (rock) is placed into a glass pipe or stem (straight shooter) or metal pipe, which is heated by a flame (usually from a cigarette lighter) to melt the crack and the vapour inhaled. The crack pipe mouthpiece is a length of clear vinyl tubing, which is attached to the glass pipe and put into the mouth. The mouthpiece can be taken off the glass pipe as necessary and used by an individual to avoid sharing.

Question: Why do crack users get mouth sores and cuts?

Glass and metal pipes conduct heat from the flame. Oral lesions (blisters or sores) and cracked or burnt lips occur due to contact with the hot glass or metal. A glass crack pipe can fracture and break at the tip due to repeated overheating or scraping the resin inside the pipe. The jagged edges may be removed and the shorter pipe continued to be used. The sharp edges of a broken pipe may cause cuts, and without a mouthpiece the shorter pipe may be more likely to cause burns to the lips and fingers.¹⁻³

Question: What diseases can sharing crack pipes spread?

- Sharing of equipment (e.g. glass pipes) especially when oral lesions are present can provide a route of transmission for hepatitis C, hepatitis B, HIV and other communicable diseases.⁴⁻⁸
- The spread of **TB** has been found in a crack using populations.^{9,10} and sharing of crack cocaine paraphernalia may have been an efficient means of spreading **pneumococcal pneumonia** in an outbreak in Vancouver in 2006.¹¹

Question: Why does the BC Harm Reduction* Strategies & Services provide mouthpieces?

- The core components of harm reduction strategies & services include referrals, advocacy, education and supply distribution. These services are aimed at reducing harms from injection and other drug use. Harms include oral lesions and cuts and communicable disease transmission.
- Mouthpieces can reduce the risk of oral lesions as the tubing avoids direct contact of the mouth with hot crack pipes and broken glass stems.
- Having one's own rubber mouthpiece allows individuals to protect themselves from the transmission of communicable diseases through sharing pipes.
- Providing supplies for people who do not inject drugs creates a further point of engagement for otherwise hard-to-reach / under serviced populations.

Question: How can mouthpieces be ordered?

The harm reduction supply requisition form available on line <http://www.bccdc.ca/default.htm> can be used to order the tubing, the form is then faxed to the BCCDC. The tubing comes in 3 different widths to fit most glass stems; each plastic bag contains 100-foot of tubing which can be cut at the distribution site with special cutters also provided by the harm reduction supply services.

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*For a definition of harm reduction please see Health file #102, Understanding Harm Reduction <http://www.healthlinkbc.ca/healthfiles/hfile102a.stm>

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Research

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More than just needles: An evidence-informed approach to enhancing harm reduction supply distribution in British Columbia

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Abstract

Background: The BC Harm Reduction Strategies and Services (HRSS) policy states that each health authority (HA) and their community partners will provide a full range of harm reduction (HR) services to their jurisdictions and these HR products should be available to all who need them regardless of where they live and choice of drug. Preliminary analysis revealed wide variations between and within HAs.

Methods: The objective of this study is to analyze distribution of HR products by site using Geographic Information Systems (GIS) and to investigate the range, adequacy and methods of HR product distribution using qualitative interviews. The BC Centre for Disease Control pharmacy database tracks HR supplies distributed to health units and community agencies. Additionally, eleven face-to-face interviews were conducted in eight mainland BC communities using an open-ended questionnaire.

Results: There is evidence in BC that HR supplies are not equally available throughout the province. There are variations within jurisdictions in how HR supplies are distributed, adequacy of current HR products, collection of used needles, alternative uses of supplies and community attitudes towards HR. GIS illustrates where HR supplies are ordered but with secondary distribution, true reach and availability of supplies cannot be determined.

Conclusion: Currently, a consultant is employed to develop a 'best practice' document; relevant health files, standard training and protocols within HAs are also being developed. There is a need to enhance the profile and availability of culturally appropriate HR services for Aboriginal populations. Distribution of crackpipe mouthpieces is being investigated.

Background

The British Columbia (BC) Harm Reduction Strategies and Services (HRSS) committee has representation from

each of the 5 regional health authorities, the BC Ministry of Health and the BC Centre for Disease Control (BCCDC). The BC HRSS policy states that each health

authority and their community partners will provide a full range of harm reduction (HR) services to their jurisdictions and that the HR products should be available to all who need them regardless of where they live and choice of drug [1]. The HR products distributed include condoms and lubricants, needles and syringes, alcohol swabs and sterile water and are funded by the BC Ministry of Health and subsidized by the Provincial Health Services Authority.

The HR product distribution is coordinated by BCCDC; the BCCDC pharmacy database tracks HR products ordered by health units and community agencies (approved by the health authorities) that distribute the supplies. Over 20 products are currently available for distribution to the more than 150 ordering sites in BC. Preliminary analysis of the data revealed wide variations between and within health authorities. As a result of these discrepancies we identified a need to evaluate current product supply distribution, identify gaps, cost-saving measures and potential future demands.

The objective of this study is to:

- 1) Analyze distribution of HR products by site using geographic information systems
- 2) Investigate the range, adequacy and methods of HR product distribution using qualitative interviews.

Much of the current information and knowledge surrounding HR in BC is derived from Vancouver; therefore we sought to include the perspectives of distribution sites outside Vancouver.

Methods

Product distribution by site was obtained from the BCCDC pharmacy database. We used a period of 19 months (May 2006-November 2007) to ensure inclusion of sites that placed infrequent orders i.e. less than annually. All needles with syringes attached (0.5 and 1 cc) and individual needles (but not individual syringes) were collated to produce the total volume of needles distributed and were analyzed using geographic information systems.

Interview sites were selected purposively from BCCDC pharmacy database to ensure a range of geographic factors and volume of supplies distributed. An invitation letter was sent to the contact at each selected site. A research assistant contacted potential participants to arrange an approximately one-hour in-person interview.

The semi-structured interviews consisted of open-ended questions developed by the research team. The questions were modified to explore emerging concepts as data col-

lection progressed [2]. Interviews were audio-taped and the research assistants made field notes of their observations.

Questionnaire domains included:

- 1) How HR supplies are distributed
- 2) Perspectives on the adequacy of current harm reduction products
- 3) Collection of used needles
- 4) Alternative uses of supplies
- 5) Perceived community buy-in

The interviews were transcribed verbatim and analysed using standard qualitative methods. Members of the research team reviewed the transcripts and independently identified themes within the pre-determined domains and from open-ended comments. Transcripts and field notes were reviewed in an iterative manner to ensure all emergent themes were captured. Representative quotes were selected from the transcripts to illustrate the main themes identified.

To inform the findings, the mapping and qualitative analysis were presented to HRSS committee members for further input; notes of the discussions were taken. Ethical approval was received from the University of British Columbia Behavioural Research Ethics Board.

Results

Supply distribution

Supply orders were tabulated into reports to illustrate date and quantity of each category of products ordered by each individual site, collated into 5 regional health authorities and the 16 health service delivery areas in BC. Input was received from HRSS committee regarding the report format and utility. Committee members agreed to use the information to provide feedback to their health authorities and distribution sites with regard to appropriate ordering frequency and product quantity to improve fiscal responsibility. Some sites supplied only condoms; others provided a full range of products. Single use water vials ordered varied from 0% – 70% of quantity of needles supplied.

Figure 1 shows the results of geographic information system mapping of the distribution of needles and syringes in the province of British Columbia between May 2006 and November 2007. Each dot represents a site where harm reduction supplies are ordered and distributed through public health nursing and other community

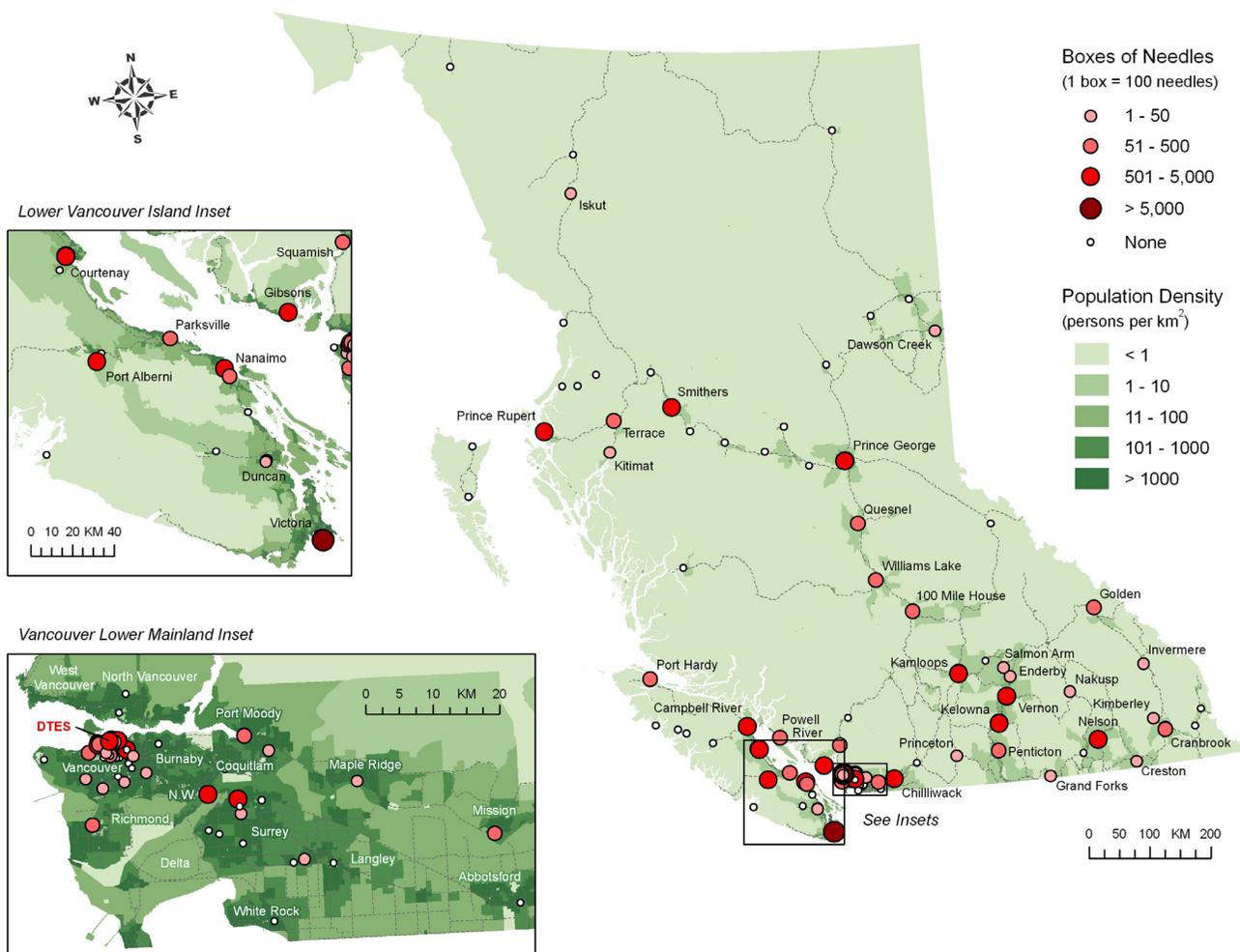


Figure 1
Distribution of needles and syringes in British Columbia May 2006–November 2007.

health organizations. The smaller white dots represent communities where harm reduction supplies are distributed but not needles and syringes (i.e. condoms only).

Qualitative interviews

Eleven face-to-face interviews were conducted in eight mainland BC communities. All selected interview sites agreed to participate. Interviews occurred with providers at health units, community health centers, Aboriginal Youth and Friendship Centers, and HIV/AIDS agencies and organizations; three of the interview sites did not distribute needles.

1) How HR supplies are distributed

The themes that emerged included: a) variations in how the supplies were made available to the clients and the degree of client engagement; b) one-for-one needle

'exchange' versus a needs basis distribution; c) data collection and d) trends in demand. Availability of supplies was item and site dependent. Some health units reported distributing sex products only, as injection supplies were available from a nearby agency. Some sites have condoms in a basket at the reception desk and in washrooms so clients can help themselves; other sites required clients to ask for all supplies, which were provided by the receptionist or the nurse on call. One site requested the client to call ahead to place their order in advance. A few sites provided harm reduction items in brown bags; clients selected bag A or B from a list or picture, which showed number of items in each, depending on their needs. A number of the health units had designated rooms in which supplies were stored and where the client met privately with the provider to obtain supplies and return used needle.

The degree of client engagement was highly variable. Some providers routinely engaged clients and reported regular referrals to 'detox' or clinics for sexually transmitted infections and blood borne pathogen testing. No standard protocols or training of the HR supplies providers were reported to be available in the rural sites.

All but one respondent reported giving supplies to individuals or agencies for distribution at that site i.e. "*secondary distribution*." Although individuals from First Nations communities obtain their supplies from the provider sites, no supplies were reported to be obtained for secondary distribution on reserve by nurses or other representatives. One site reported a female who came in for supplies to take to the working girls and at other sites clients took supplies in large quantities to share.

We have a regular exchange user who is male. And he's been coming for years and he exchanges for his group as well

All sites encouraged needle *exchange*; but only one site reported trying to ensure one-for-one exchange. However, even this site supplied a single clean needle and sometimes 4 or 5, even if no needles were returned. This was perceived to prevent people from 'tossing' needles and encouraged people to collect discarded needles found on the ground to exchange for clean ones.

Data collection also varied considerably from site to site. No systematic data collection of supplies obtained for "secondary distribution" was reported. One site registered individual clients by birthday; this site also tracked demographic information, drug of choice, HIV testing etc. Other sites collected no client information and had no tracking system.

We don't collect any demographic information from clients in any way. It is supposed to be anonymous

The demand for supplies fluctuated. For example, the demand for needles was reported to be highest around the time welfare checks were issued. A large lower mainland site reported a considerable decrease in needle distribution over time; it was estimated the number of needles distributed per month had almost halved to 15,000–18,000 a few years ago when smoking crack cocaine became the drug of choice. Although some rural sites reported a decline in needle distribution others noted a steady increase in demand as '*word got around*'.

2) Perspectives on the adequacy of harm reduction products

This section discusses input regarding current supplies, by item category, and then will explore what is perceived to be missing from the list. Male condoms were available at

each site; lubricated condoms were generally preferred to non-lubricated and one distributor reported providing in a ratio of about 5:1. Clients usually did not specify a preference of condom type although younger clients preferred flavoured condoms.

Female condoms were not widely used, some sites required women to ask specifically for them, as they believed this ensured provision of adequate education regarding use. The two sites with the greatest distribution reported actively engaging the women and teaching about female condom use. One site sent the female clients to a clinic next door as

..... this is a good way to get the girls 'checked over' [tested for sexually transmitted infections]

Most clients use 0.5 or 1 cc syringes with needles attached. Larger syringes and needles were reportedly used for injecting steroids. There was general consensus that clients were not using sterile water for every injection, though some sites thought the demand for water was increasing.

The demand of water is not comparable, in terms of, people will take more needles than they will take water, in fact we ask them specifically every time they... ask for needles, do you want water?

One site reported distributing no sterile water

We don't ever get asked for water... It's just the needles

Requests for additional supplies include those used for injecting drugs e.g. cookers, filters, tourniquets and sharps containers; miscellaneous e.g. paper bags in which to hand out supplies and drinking water for clients, and finally those related to crack use e.g. crack pipes, mouth-pieces and screens. Crack was perceived as the most commonly used drug in many of the areas, and that an increasing number of clients were asking for crack smoking paraphernalia. Some sites reported purchasing their own additional items for injection or crack use.

3) Collection of used needles

All sites reported encouraging clients to return used needles.

Users bring in used needles and...we have a large sharps container that they put them into

Some sites provided clients with individual sharp containers, which varied between official yellow biohazard containers to empty rigid shampoo bottles. Sites distributing sharps containers requested that they be returned to the provider site when full. Others stated that clients reported

concern about collecting and keeping needles in the home when there were children in the household.

4) Alternate uses of HR supplies

Condoms had a number of different alternate uses. Non-lubricated condoms were reported to be used as tourniquets for injection drug use, and also by crack smokers who hold exhaled smoke in the condom to share or inhale it 'for a second take'. One site removed the condom basket from the front desk and washrooms in the summer as teenagers were using them as water balloons, leaving broken condoms on the sidewalk outside the office.

Providers in Vancouver revealed that the plungers of syringes were being used as a pusher for crack pipes to recover the crack resin dried on the inside of the pipe as it cools. When this was explored further with Vancouver front line staff it was estimated about 1 in 5 syringes were being used for this purpose, and the needle and barrel of the syringe discarded.

5) Community buy in/readiness

Participants reported few community development initiatives regarding HR or pick-up of discarded needles. There was a perception that HR philosophy was new to many health care workers and the general public.

The community with professionals and the public the flavour is currently stop the drug use. If we stop the drug use we could clean up the mess kind of thing... we all know... that doesn't work.

However some interviewees felt their community was ripe to hear the messages because 'there's been a few drug related tragedies [recently]'.

Discussion

Availability of clean needles (via needle exchange programs) has been shown to decrease the rates of transmission of HIV and hepatitis C (HCV) [3]. A recent study found that full participation in HR programs, including methadone, could decrease the risk for HIV and hepatitis C [4]. Therefore it is important, as stated by HRSS policy, that HR supplies are available to all who need them. However, there is evidence in BC that supplies are not equally available throughout the province. Spittal et al found Aboriginal youth in Northern BC had more difficulty accessing clean syringes than Vancouver youth [5]. No official harm reduction distribution on First Nations reserves was reported. Several barriers to comprehensive harm reduction services for First Nations persons have been identified by Wardman et al. These include cultural differences, stigma, limited service infrastructure and financial resources, and community size [6] While the abstinence model for the treatment of addictive disorders

is considered the norm in many First Nations communities, it is acknowledged that it is possible to enhance the profile and availability of culturally appropriate HR services in this context. This may include incorporating traditional Aboriginal practices, providing additional services such as education and counseling in conjunction with HR programs, and integrating into existing reserve public health programs [6,7]

Geographic information systems illustrated sites and the volume of HR supply distribution in BC, and by inference where availability may be lacking. However without secondary distribution information, the true reach and availability of supplies cannot be determined. Product distribution by population can be calculated for each health authority, but the variations within each jurisdiction are vast. It is interesting to note that Fraser Health with the largest health authority population in BC has only eight communities where supplies are delivered. Harvard et al found regional variations of BC harm reduction product distribution. However using reported HCV cases, as a proxy for injection drug use, variation in product distribution could not be attributed to variations of estimated prevalence of injection drug use [8].

Qualitative research seeks to explore process, opinions, attitudes and actions. It is the best method to answer questions about a topic, which may be sensitive and/or about which little is known. Sampling in qualitative studies is purposeful; so we explored the perspectives of HR distributors in sites outside Vancouver including rural areas. Qualitative interviews do not aim to be representative or generalizable; however we found recurrent common themes from different sites.

To improve the understanding of HR for health care providers and the public a generic 'Understanding Harm Reduction' health file [9] has been recently published. Despite the provincial policy of HR distribution on a needs basis, one site interviewed maintains one-for-one exchange. A health file discussing 'needle distribution vs. exchange and community engagement' is therefore in development.

Training of volunteers and staff to give HR advice and referrals for services and testing can increase client engagement. Sites where women received instruction on the use of female condoms distributed more of these items. Best practice guidelines suggest that distribution of needles and syringes should be comparable to the rates of sterile water, as both products should be used for every injection. However there is a wide variation in the request and offering of water for injection; some sites encouraged the use of water vials for each injection whereas others distributed no water because they were not asked for it.

Although flavored condoms were not in great demand it was felt important to continue, as these were popular with the younger population who should be encouraged to use safer sex products. Many sites requested sharps containers. However advice re safe collection of needles using rigid plastic containers such as shampoo bottles could improve the safety in the household and transportation and enhance needle return to the sites.

The use of syringe plungers to push the resin through the hot crack pipe, may lead to melting the plastic plunger and discarding of the needle and syringe barrel. The distribution of wooden push sticks through the HR supplies is currently being investigated. Clients at many sites requested crack pipes and mouthpieces. Two infectious disease outbreaks have been reported in BC associated with crack use. In 2006 an outbreak of *Streptococcus pneumoniae* in the DTES of Vancouver was identified, [10] and a Tuberculosis outbreak in a crack using population was reported elsewhere in BC [11]. A recent study detected hepatitis C virus on a crack pipe from an infected host, and therefore supports the possibility of transmission through sharing crack paraphernalia [12]. Crack users may have open mouth sores due to burns and cuts from hot and broken pipes therefore sharing crack pipes can transmit respiratory infections and blood-borne pathogens, including HCV and HIV [13]. Crack pipe mouthpieces are now available through the provincial BC HR supplies and each HA is undergoing consultation to determine if, and how, to provide these.

One HA has developed a training module; all urban site providers must participate in the training before they can distribute supplies, and is willing to share with other regions. Standard training and protocols within health authorities can lead to improved client engagement and awareness of the client needs. It may also encourage peers to be involved in distribution and needle collection. Community engagement is uncommon in rural areas, regions that have developed the process can share their experiences and lessons learned to enhance public understanding of harm reduction.

The mapping of needle distribution sites provides a highly visual way to show the limitations of primary distribution sites and enables health authorities to assess the reach of supplies in their regions. The qualitative research highlighted the lack of standardization between and within each health authority in BC. Therefore a consultant has been employed to develop a 'best practice' document to assist regions in employing standardized evidence-based process and protocols to improve access of supplies and client and community engagement. Development of a secondary distribution data collection tool and sharing of training modules will be explored. Additionally, as this

work is continued it is critical that the risk environment is taken into account in order to address issues at the community level and create 'enabling environments' for harm reduction [14].

Conclusion

This study has contributed to the evidence that HR supplies are not equally available throughout the province of British Columbia. The use of GIS in this study illustrates where availability of HR supplies may be lacking. However; with secondary distribution, true reach and availability of supplies cannot be determined. Variations within jurisdictions must also be taken into consideration. Development of standard training and protocols within HAs will play a important role in ensuring optimal utilization of HR supplies through BC and will lead to increased client awareness and engagement. Additionally, further research is needed to gain a better understanding of HR supply distribution, to enhance the profile and availability of culturally appropriate HR services for Aboriginal populations, and to create enabling environments for harm reduction across the province.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

JBu is the primary investigator for this study and was involved in the interview analysis and manuscript writing. Emma Preston contributed to the qualitative interviews and manuscript writing. SM was responsible for the GIS analysis. SH performed qualitative interviews and aided in manuscript writing. JBa reviewed qualitative interviews and assisted in manuscript writing. All have read and approved the final manuscript.

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Best Practices for British Columbia's Harm Reduction Supply Distribution Program

A provincial best practices document published by the BC Harm Reduction Strategies and Services (BCHRSS) Committee to provide guidance to BC's harm reduction services, supply distribution, and collection programs.

SEPTEMBER 2008

The BC Harm Reduction Strategies and Services (BCHRSS) Committee is comprised of representatives from BC's Regional Health Authorities, BC Centre for Disease Control and Provincial Health Services Authority, the BC Ministry of Healthy Living and Sport, and First Nations and Inuit Health. The BCHRSS is dedicated to reducing drug-related harms such as death, disease, and injury, including transmission of blood-borne pathogens through the sharing of drug paraphernalia.

This document was prepared by River Chandler.

Table of Contents

Introduction	3
Program Delivery Models	3
Fixed Site	
Mobile Services	
Outreach	
Pharmacy	
Vending Machines	
Peer Distribution	
Policies and Procedures	5
Assessment, Monitoring and Evaluation	5
Staffing	6
Safer Injecting Supplies	6
Safer Crack Cocaine Smoking Supplies	7
Additional Services	7
Education and Health Promotion	8
Needle Recovery and Disposal	8
Population Specific Considerations	9
Women	
Aboriginal People	
Involvement of People who use Illegal Drugs	9
Community Engagement	10
Law Enforcement and Public Order	10
Responsibilities	11
BC Health Authorities	
Provincial Health Services Authority/British Columbia Centre for Disease Control	
BC Ministries of Healthy Living and Sport and Health Services	
Provincial Government	
Federal Departments and Agencies	
Glossary of Acronyms used	11
APPENDICES	12
A: Examples Of Mobile Services In British Columbia	
B: Example of Outreach Services	
C: Examples Of Pharmacy Injecting Equipment Provision	
D: New South Wales Health Data Collection List	
E: WHO Service Evaluation Categories	
F: VCH Needle Exchange Data Collection	
G: Staff Core Skills and Knowledge	
H: Safer Crack Use Supply Initiatives	
I: Service Delivery in Prince George	
J: Peer Education	
K: Safe Disposal	
Reference List	14

Introduction

The use of illegal psychoactive substances (or drugs) in our communities is a widespread social issue in British Columbia. Problematic substance use negatively affects individuals, communities and societies as a whole. A comprehensive and coordinated response to this issue is important to the well being of all citizens of British Columbia.

The BC Harm Reduction Strategies and Services (BCHRSS) Committee, comprised of representatives from every Regional Health Authority, BC Centre for Disease Control (BCCDC) and Provincial Health Services Authority, the BC Ministry of Healthy Living and Sport, and First Nations and Inuit Health, have developed a provincial best practices document to provide guidance to BC's harm reduction services, supply distribution, and collection programs.

In British Columbia, harm reduction services have expanded beyond a 1:1 needle/syringe exchange model and the provision of sterile needles, to provide a wider range of injection and non-injection harm reduction supplies and services. For instance, present service delivery models include the provision of health and social services for people who use illegal drugs. While much of the literature cited in this policy guide refers to Needle and/or Syringe Exchange Programs, the recommendations contained in this guide will address provision of the wider range of supplies, and services for people who use injecting and non-injecting drugs. Programs providing supplies and services will be referred to as Harm Reduction Supply Distribution Programs (HRSDPs). Needles and syringes are usually provided as a single unit and here after referred to as 'needles'. Collection and safe disposal of harm reduction equipment is an integral part of the program.

In 2004, the World Health Organization concluded that there is compelling scientific evidence to support the provision of sterile injecting equipment. [1]

The Joint United Nations Programme on HIV/AIDS and the United Nations General Assembly also endorse Needle Exchange Programs.[2] The need for Needle Exchange Programs` and evidence for their effectiveness are documented in several recent major documents. [3-5]

HRSDPs reduce transmission of blood borne disease; reduce unsafe drug use and unsafe sexual behaviours associated with transmission of Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV); reduce the number of discarded needles; do not encourage initiation of drug use; do not increase duration and frequency of drug use; do not decrease motivation to reduce drug use among people who use injection drugs; and increase access to drug treatment. [3]

No cure or vaccine exists for HIV. The lifetime costs of providing treatment for people who use injection drugs who are living with HIV greatly exceed the costs of providing harm reduction services.[6] Additionally, clients receiving harm reduction services benefit from an improved quality of life.[6]

The highest rates of HCV infection are observed among people who use injection drugs and report sharing drug preparation or injection equipment. Sources of blood borne infection include shared drug-mixing containers; shared cotton filters and rinse water, as well as shared needles. A recent study suggests a positive association between

HCV seroconversion and drug equipment sharing, and recommends the use of sterile injecting equipment for all episodes of drug injecting.[7]

The BC Harm Reduction Strategies and Services Policy includes the following goals:

1. Reduce incidence of drug-related health harms, including transmission of blood-borne pathogens through needle sharing.
2. Promote and facilitate referral to primary health care and addiction/mental health services.
3. Increase public awareness of harm reduction principles, policies and programs.[8]

The policy includes provision of injecting and other equipment to prevent blood borne disease (HIV, HCV) and sexually transmitted infections (STI); needle disposal; HIV, HCV, STI and TB testing; vaccinations; and active referral to services including primary health care, housing, income assistance, food support, family support, and legal services.

This policy guide draws on current local, national and international documents related to needle and syringe exchange programs, harm reduction supply distribution, and the provision of harm reduction services. It also incorporates feedback from British Columbia service providers, health authority staff and organizations of people who use injection drugs. The guide makes evidence-based best practice recommendations for HRSDPs, and will provide highlights of best practices in BC and elsewhere.

The guide reviews program delivery models; provision of injecting and other harm reduction supplies; retrieval of used supplies; provision of and referral to health and social services; and client education. In a larger context, the document addresses involvement of people who use drugs in planning and service delivery; community engagement; impact of and relationships with law enforcement; and the role of health authorities and governments in the establishment of and support for harm reduction strategies and services.

BC is a large and diverse province, therefore it is vital that interventions are based on a regular assessment of the nature and magnitude of drug use, as well as trends and patterns of infection.[9] Services should be tailored in regard to specific sites, include other modes of drug administration, drug use populations and drug choices.

Program Delivery Models

The services offered at a particular site should reflect available resources in the community, characteristics specific to that area, and the best ways to reach and work effectively with local people who inject illegal drugs. [10] A mix of service delivery models should take into account the level of injecting use, types of drug use, polydrug use, the needs and demographic characteristics of people who inject drugs, and the levels of community support for harm reduction

initiatives.[11] The design and implementation of programs should be tailored to local needs; multiple sites for syringe distribution, for example, are often necessary to maximize access to clean injection equipment.[2] Providing services at multiple locations with varied hours of operation makes it easy for people to access sterile injecting equipment and other services. [9]

Internationally, many of the most effective HRSDPs provide a range of delivery modes, including fixed site, mobile and outreach services, syringe vending machines and pharmacies. [9] HRSDPs can collaborate with other service agencies to provide additional needle provision services outside the fixed site schedule. HRSDPs should provide a comprehensive range of services aimed at improving the health and well being of drug users. HRSDPs and their staff should use all available opportunities to educate people who use injection drugs about both the risks of injection and other modes of drug use, and ways to mitigate those risks.

Fixed Site

A fixed needle exchange site effectively responds to the existence of drug use scenes, where drugs are bought, sold, and used openly, or where large numbers of people who inject illegal drugs gather in one urban location. A convenient, accessible location and a good neighbor agreement, are important features of a fixed site.[9] A good neighbour agreement usually includes guidelines for communication generally worked out between needle exchange sites and surrounding neighbours in advance of opening a needle exchange. Agreements may include police, municipal government and the health authorities and should be reviewed and updated on a regular basis.

Comprehensive fixed sites should provide a range of injecting and harm reduction supplies, and capacity for equipment collection and disposal. In addition, fixed sites should include basic services such as education about harm reduction, safer drug use, and brief counseling. Further, fixed sites should provide referral to a wide range of health, community and addictions services, or directly offer primary health care services such as blood borne pathogen (HIV, HCV, hepatitis B virus (HBV)), STI and TB testing, vaccinations, and wound care on site. Some fixed site HRSDPs co-locate with these health services. As well, sites should collect comprehensive and anonymous client demographic and drug use data on a periodic basis. These topics are addressed in detail in later sections.

Offering needle exchange through Health Units can enhance the effectiveness of services. Vancouver Coastal Health, for example, offers needle exchange at its eight Community Health Centres. Community service providers, including specialized agencies offering services to youth, Aboriginal people, or sex workers, can also conduct needle exchange. Safeworks in Calgary, for example, runs two fixed sites in homeless shelters, and one in a community health centre.[12] Vancouver Island Health Authority provides harm reduction supplies at health units and through their street nurses in Victoria.

Comprehensive fixed site needle exchanges can also offer mobile exchange and street outreach services. These mobile services are necessary because significant barriers to accessing fixed sites exist, including fear of public exposure, stigma and shame, mobility issues associated with physical

disability, differing cultural and other values, policing practices, and availability of public transportation services.

Harm reduction supplies are generally distributed in much greater numbers at fixed sites. While mobile services are useful in reaching people who do not access fixed sites, it is not a substitute for fixed site service provision. Regular hours and a permanent site mean that people know when and where to access harm reduction supplies. Further, fixed sites have the capacity to provide additional services such as primary health care and addiction counseling services.

Mobile Services

Mobile services should provide a full range of injecting supply, collection and disposal services. In addition to providing and disposing of harm reduction supplies, mobile services should aim to engage marginalized populations, providing education, brief intervention and referral services. Mobile services operate most often from a van, usually with a driver in the front and at least one worker providing and collecting harm reduction supplies from the back. Mobile services extend geographic and service coverage, provide services in locations where people often inject illegal drugs, and reach clients who do may not access fixed sites.

As with fixed sites, demonstrated outcomes for effective mobile services include cessation of injecting; reduced injecting frequency; reduced sharing of injecting equipment; increased referral and entry into treatment, and increased condom use. [13] See Appendix A for examples of mobile services in British Columbia.

Outreach

Outreach services, also called pedestrian or backpacking services, can increase access to people who may not otherwise come into contact with HRSDPs through other modes of service delivery. Workers may travel on foot, carrying harm reduction supplies to areas where people who use injection drugs can be found. The street nurse program in Vancouver, for example, conducts needle and crack pipe mouthpiece distribution as part of a broader service delivery model. Some drug user advocacy groups also conduct peer based outreach services. See Appendix B for one example of outreach service.

Pharmacy

The Canadian HIV/AIDS Legal Network recommends that both pharmacists' associations and licensing bodies should encourage pharmacists to distribute sterile syringes.[14] Provision of injecting equipment by pharmacies increases the availability and the utilization of sterile injecting equipment because pharmacies already exist in most areas. In rural areas, pharmacies are often one of the few locations where individuals can easily obtain supplies. As well, access to safe injecting equipment is increased because pharmacies can draw a different population from those attending other HRSDPs.[2] Pharmacists in Canada continue to be reluctant to provide syringes to people who use injection drugs.[2] See Appendix C for examples of international and local pharmacy initiatives. Queensland Health, for example, provides harm reduction training and resources for pharmacists and encourages pharmacy based needle exchange.[15] A number of pharmacies in Interior Health dispense methadone and distribute needles see Appendix C.

Vending Machines

Several countries, for example Netherlands, Germany, Italy and Australia, now use syringe vending machines to supplement the services of fixed site HRSDPs. [9] The experience of vending machines in Australia has been described in several studies.[16] Vending machines increase geographic coverage, provide anonymous services, and can be made available on a 24 hour, 7 days a week basis. Typically, these machines dispense a harm-reduction pack that includes several needles and syringes, alcohol swabs, cotton wool, sterile water and a spoon. The packs also contain harm reduction educational materials. Machines are often installed on the outside walls at fixed site HRSDPs, and can also be installed where no other sources of safe injecting supplies exist. The disadvantage of this approach is that machines do not offer client specific information, counseling or referral services. [3] There is a cost to purchase and maintain them. Currently, there are no vending machines that distribute injecting equipment in Canada.[2]

Peer Distribution

Peer distribution increases access to harm reduction supplies for people who use illegal drugs. HRSDPs usually offer bulk harm reduction supplies to peer groups through fixed sites or other distribution points. Peers then distribute supplies to their networks. In urban settings, these forms of secondary distribution provide supplies to people who are reluctant to attend fixed sites, or have other barriers to accessing fixed site HRSDPs. In rural areas, peer based secondary distribution services can provide supplies when no fixed site programs exist, and/or where coverage by mobile services is limited.

An external evaluation of a peer-run HRSDP in Vancouver, BC, indicated that people who are current and former injection users of drugs can play a major role in harm reduction by reaching groups of people at the highest risk of infection. [17]

These forms of additional services can provide a broad range of harm reduction information and education. For instance, planning is underway for a peer-based program in the East Kootenays that will provide needle exchange and education about harm reduction, and training to address overdoses.(Alex Sherstobitoff, personal communication, March 18, 2008) In Victoria, the Society for Living Intravenous Drug Users (SOLID) has created a Safe Injection Manual for peer education that supplements the training it provides to current and former injection drug users. The manual addresses a number of topics including prevention of HIV, HCV, TB and STI transmission, safer injecting practices, health care access, and self-advocacy.[18]

Policies and Procedures

All HRSDPs should have policies and procedures that are based on evidence-based best practices, are realistic, and that reflect local resources. This guide provides guidelines and examples of best practices for policies and procedures that can be utilized and adapted in rural and urban settings around the province. Policies outline guiding principles, goals and objectives for service provision. Procedures, in contrast, are the distinct activities and interventions needed to meet policy objectives. The characteristics of effective programs can provide a substantial basis for the development of

policies and procedures. These characteristics may include:

- Provision of a comprehensive range of well-coordinated and flexible services.
- Involvement of the community in planning and implementation of services.
- Implementation of thorough and continuing assessment of programs and services.
- Provision of services in a wide variety of locations and different operating schedules.
- Provision of community-based outreach, which is essential and must be provided to marginalized populations in their own communities.

While the preparation of clear written policies is time consuming, it is a useful investment of resources. Policy documents can inform practice, be utilized for staff training, and establish credibility with outside agencies such as the police, local businesses and other neighbours. The goals articulated in these policies can set clear standards against which HRSDPs may measure their programs results and determine future initiatives.[19] Policy suggestions and examples can be found throughout this document.



Assessment, Monitoring and Evaluation

Assessment, monitoring and evaluation help to ensure that program goals and objectives are being met, and provide information to assist with future program and policy development.[11]

Before establishing an HRSDP, an assessment should be conducted to measure the following: types of drug use and modes of administration, injecting trends, needle sharing, extent and type of poly drug use, adverse health consequences of drug use, gender, age, ethnicity, Aboriginal status, sexual orientation and gender identity of drug users, other community resources, policing practices and policies, and community support for harm reduction.

These assessments should also be conducted on an on-going basis to assist HRSDPs to understand the nature and extent of emerging or rapidly developing drug use issues, health consequences of injection drug use, and the incidence and prevalence of blood borne and Sexually Transmitted Infections. Often referred to as a “rapid situation and response assessment (RAR),” these evaluations are fast, cost-effective, relevant and pragmatic and draw on local, as well as both quantitative and qualitative data sources. A full description of how to apply the RAR assessment tool can be found on the World Health Organization website.[20] A description of this method applied specifically to HRSDPs is also available from the Open Society Institute.[19] A study was performed using RARE (Rapid Assessment Response & Evaluation) methodology in Victoria in 2002. [21]

Staff activity reports and regular reviews of these reports can provide program monitoring and a basis for program development. Reports can include the collection of information such as dates, times and locations of client

contacts; supplies provided; and provision of other health services or referrals. In addition, staff can utilize log books to note issues such as problems, difficult questions from clients or staff, comments by clients about the service or the external environment, characteristics of drug use, including drug types, needle sharing, and needle disposal issues. Both of these forms of record keeping can be used for the purposes of information sharing, and service review and planning.[9]

These activities can be supplemented by staff meetings that provide opportunities to identify changes to services and programs that better meet the needs of clients. Managers are strongly encouraged to respond to issues and ideas identified by staff and to support timely changes to services and programs. Managers are also encouraged to engage staff in the development and assessment of the effectiveness of programs, particularly given that over time staff members are likely to develop on-going relationships with service users.

HRSDPs are encouraged to develop advisory groups comprised of stakeholders including neighbours, police, municipal staff, community service programs, needle exchange management and staff, and clients. These groups can play a key role in evaluating the effectiveness of services, particularly when supplemented by the input of client advisory groups comprised of people who use drugs. Regularly administered client surveys or focus groups are also a valuable tool for measuring the adequacy of service provision, impact of educational materials, and reduction of risk behaviours.

See Appendix D for New South Wales chart of health outcomes and service objectives for evaluating program delivery. See Appendix E for the World Health Organization's service evaluation categories.

Secondary distribution of harm reduction supplies is discussed in two ways: as peer distribution of supplies accessed from primary sites such as fixed and mobile sites, and as distribution of supplies at community organizations and agencies, sometimes called satellites. The literature primarily addresses the first form, not the second.

Currently data is not collected at organizational secondary sites, or satellites. It is important to know whether the BC Harm Reduction Policy Goal of providing supplies for every person who needs them regardless of where they live is being met. Accountability requires a clear understanding of local and regional needs and gaps in provision in order to meet the goal. See Appendix F for Vancouver Coastal Health Authority's data collection form.

■ ■ ■ Staffing

Internationally, nationally and provincially, a need for adequate and ongoing staff training and development has been identified. At the same time, standard training does not exist provincially, with the exception of Vancouver Coastal Health Authority, and minimal resources and limited opportunities are available for staff training. [2, 22-24] A need for standardized protocols for client engagement, harm reduction and health promotion service provision and referral clearly exists. Recommendations from a recent survey

by the Canadian Centre on Substance Abuse, for example, calls for the design of education and training curriculum responsive to workforce needs, that will translate into best practices across core competencies.[23] The BCHRSS in collaboration with STI outreach, Chee Mamuk Aboriginal program and other front line health authority staff is currently developing a program and delivery plan for training province wide in order to ensure consistent service delivery.

Staff policies, procedures and rules should be developed for effective program management. These should include the following:

- Staff recruitment procedures for job postings, interviews, final selection and training.
- Policies that demonstrate how information will be gathered and shared through program monitoring processes, log books, and meeting minutes.
- Policies and procedures for staff supervision and discipline.
- Policies to address staff health and safety.[11]

Queensland Health, Australia provides a complete and thorough description of needle exchange staff core skills and knowledge. For details, see Appendix G for more information.

A comprehensive set of training programs for project planners, managers and staff have been developed by WHO specifically for outreach projects for injection drug users. These materials can be utilized to develop locally specific training materials. [22]

Training for staff in HRSDPs and in community agencies in Vancouver Coastal Health Authority has been developed and is delivered by the Harm Reduction Program Coordinator, a nurse, and a volunteer from Vancouver Area Network of Drug Users (VANDU). Training includes client engagement, delivered by VANDU; safer shooting and smoking and health-related issues offered by a nurse; and data collection and ordering, by the Harm Reduction Coordinator.

■ ■ ■ Safer Injecting Supplies

Needle exchange programs should provide a full range of injection equipment. One-for-one needle exchange is considered to be unsatisfactory. HRSDPs should distribute sufficient equipment to allow clients to achieve an ideal public health objective of using a new sterile syringe for each injection.[25]

In addition to the transmission of HIV, evidence suggests a positive association between HCV seroconversion and drug equipment sharing. Syringes are only one source of blood borne infection: drug-mixing containers such as spoons and steri cups, filters, and rinse water are additional sources of infection.[7] The following chart illustrated the relationship between equipment provisions and health outcomes:

Injecting Equipment	Outcome
Needles and syringes: a sterile needle or syringe for each injection. HRSDPs currently provide a range of needle and syringe sizes. Vancouver Coastal Health, with input from distribution sites, provides 7 sizes plus the 2 standard needle and syringe units.	Reduces transmission of blood borne pathogens. (BBP)
Water: One 2ml sterile water ampoule for each injection	Reduces BBP transmission and bacterial infection
Alcohol swabs: one for each needle	Reduces BBP transmission, protects against abscesses and other bacterial infections
Cookers: single use steri-cups, or spoons	Reduces BBP transmission
Tourniquets or Ties: thin, pliable, non-porous	Reduces bacterial contaminants, trauma to veins and blood circulation impairment
Filters: small pore, one for each needle	Reduces BBP transmission, prevents deep vein thrombosis
Acidifiers: provide single use sachets of citric or ascorbic acid*	Can prevent endocarditis and candidal endophthalmitis.
Individual sharps disposal containers	Reduces needle littering in community
Male Condoms	Reduces BBP transmission and STIs
Female Condoms	Reduces BBP transmission and STIs. Female condom use is a woman-initiated intervention that is also a contraceptive, so can be easier to negotiate with a male partner.

*In order to inject insoluble drugs such as brown heroin or crack, users must first convert the drug into water-soluble form by adding an acid to create a salt. When acidifiers are not available people utilize lemon juice, vinegar and liquid acids, which can be a growth medium for bacteria and fungi that affect the heart and eyes.

■ ■ ■ Safer Crack Cocaine Smoking Supplies

HRSDPs should provide safer crack cocaine smoking supplies. The Public Health Agency of Canada (2006) I-Track report

found that 63% of people who use injection drugs reported smoking crack cocaine. However, not all crack smokers inject drugs; 44% of female crack users in one study reported having never injected drugs[26] and in another survey in BC, more than 60% of crack users reported not currently injecting drugs. Therefore, individuals who smoke crack may not be reached by other harm reduction initiatives such as needle exchange.[27] People who smoke crack experience chronic cuts, burns, blisters and open sores inside their mouths and on their lips and gums.[28, 29] Pipes used by crack smokers infected with hepatitis C and with oral lesions sometimes test positive for hepatitis C virus.[30] Evidence suggests that if glass pipes for crack smoking are shared, individuals may be at increased risk of exposure to hepatitis C and other communicable diseases.[31, 32] Providing harm reduction supplies such as plastic mouthpieces or safer crack use kits that can contain new or unused crack pipes for people who smoke crack allows them to protect themselves from exposure to communicable disease risks. Furthermore, mouthpiece and/or safer crack use kit distribution for safer crack use creates opportunities for engagement with otherwise hard-to-reach populations of marginalized and vulnerable individuals.[33] Peer based outreach and mobile services need to include widespread provision of safer crack use kits and mouthpiece exchange.[34] For examples of crack supply initiatives, see Appendix H.

There has been recent dialogue about the legality of distributing safer crack cocaine smoking supplies.

The position of the Province in this regard is that new or unused crack pipes are “devices” as defined in the Food and Drugs Act, and not instruments for illicit drug use, as prohibited by the Criminal Code; and, in consequence, new or unused crack pipes or safer crack use kits may be distributed for the purpose of preventing or mitigating the spread of disease. This is the same legal reasoning, which underpins the syringe distribution programs, which have operated in Canada for years.

A full discussion about distributing safer crack use kits in Canada can be found on the Canadian HIV legal network website at: www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1390

■ ■ ■ Additional Services

In addition to the provision of harm reduction supplies, HRSDPs are most effective if they provide, or are closely linked with, a wide range of primary health care services, as well as referral to additional health care, social services, and education programs.

The effectiveness of HRSDPs in engaging and helping people who inject drugs appears to rely on a combination of these components.[2] Additionally, HRSDPs are often the only contact people who inject drugs have with health or social

Promotion

Providing education materials that focus on harm reduction is a cost effective way to target people who use illegal drugs, and to reduce risks associated with drug use.

Harm Reduction: A British Columbia Community Guide suggests these educational materials should include information about safer injecting practices, prevention of transmission of blood borne diseases, overdose prevention, vein care and safer sex. Materials can be delivered through a variety of modes, including fixed, mobile, outreach and peer services.[13] Effective distribution of information must mean going to where drug users and networks congregate, at times when they are at greatest risk, and providing multiple ideas for behaviour change.[35]

Peer-based campaigns to increase the use of sterile injecting equipment, reduce needle sharing, and improve used equipment disposal have found to be highly effective, often because this information is explicit and direct.[3]

The involvement of people who use drugs in these initiatives is an important component of effective outreach because peers help change social norms through education, and by demonstrating changes in their own behaviour. [36]

For a description of a peer-based education model, see Appendix J.

Guidelines for developing these educational materials include:

- Use of language that is understandable, credible and familiar to people who use drugs.
- Materials that address sex and drug related concerns as well as those related to drug injection.
- Direct involvement of people who use drugs to ensure that messages are appropriate to potential audiences. [35]

HRSDPs should maintain a supply of appropriate written materials at all times. The provision of these materials often provides opportunities for client engagement, health promotion and other interventions. For examples of education materials that address a range of relevant topics see www.health.qld.gov.au/atods/programs/qnsp.asp. A training manual containing written materials is currently under development in BC to be introduced to the field at a training session early 2009.

Needle Recovery and Disposal

HRSDPs have an obligation to provide a robust recovery and disposal system because inappropriately discarded used injecting equipment undermines the credibility and sustainability of HRSDPs. While the risk of transmission of HIV or HCV infection from discarded needles is low, there tends to be a high level of public concern about this issue. Needle

service providers.[25] People who inject drugs and are also homeless, or marginalized in other ways, tend to have multiple health problems and thus often need primary health care services at a range of contact points including HRSDPs.

These additional services must be low-threshold in nature, which means minimum requirements for participation, no expectation of abstinence from drug use, and an emphasis on the basic health and social needs of people who use illegal drugs. The provision of multiple services will support the development of trust between HRSDPs and clients and will create opportunities for clients to build a history of successful interactions with service providers.[13]

Optimally, HRSDPs should provide primary health care services through partnership with public health staff or other health care providers in the community, or provide referral and advocacy to other supportive and safe health services in the community. Such services includes abscess treatment, wound care and other first aid; testing for HIV, HCV and TB; pre and post test counseling, and flu, tetanus, pneumococcal, and hepatitis A and B vaccines. Sexual and reproductive health services should be provided for women, including sex workers.

Vancouver Coastal Health currently provides comprehensive primary health services collocated with HRSDPs in eight Community Health Centres. For detailed information on their services, see www.vch.ca/community/community_health_centres.htm.

BCCDC provides outreach health care services for people who use injection and inhalation drugs through their Street Nurse Program. The program focuses on prevention, early detection and treatment, and assisting clients to connect with and negotiate the health care system. The program also helps to influence the health system and staff to respond to the needs of marginalized, hard to reach, high-risk injection drug using populations. BCCDC, in conjunction with the National Film Board of Canada and Canada Wild Productions, has produced an educational film about street nursing called Bevel Up. See www.nfb.ca/webextension/bevel-up.

People who inject drugs are often marginalized and live in poverty, and because HRSDPs are often the only contact with health and community services, it is essential that HRSDPs staff assist clients in accessing other related services. These services may include: treatment for substance dependence; mental health counseling services; housing; financial assistance; food services; parenting assistance; legal services; and victim services. Providing effective referrals requires that HRSDP staff have adequate training and resources in order to provide effective and timely referrals.

WHO recommends that community agencies develop referral databases of key services, and establish referral pathways and protocols with these key services.[9] Staff can determine client needs through conversations or through completion of a short questionnaire that asks services users about their needs. For an example of coordinated health and community services for injection drug users in Prince George, BC, see Appendix I.

Education and Health

stick injuries can be painful, as well as stressful, because of the waiting time for test results. In order to maximize community support for HRSDPs, these concerns and fears should be addressed in a constructive way.

Given that discarded drug use equipment may be found almost anywhere, effective recovery and disposal services require the participation of a variety of stakeholders including municipal governments, business associations, community agencies, and groups of people who use injection drugs. HRSDPs can play a key role in the development of such partnerships.[11] The promotion of safe disposal practices that supplement fixed needle exchange site disposal, along with community education initiatives, are key elements to an effective response to the issue of discarded drug use equipment.[11] Safe disposal practices include multiple approaches, such as provision of sharps containers to clients, partners and community members; public drop boxes in areas frequented by people who inject drugs; and pick up services through needle hot lines or community agency pick-up services (e.g. peer based “rig-digging” programs). For examples of community safe disposal initiatives, see Appendix K.



Population Specific Considerations

Women

Gender plays an integral role in vulnerability to infection, violence, ability to access care, availability of support and treatment, and the capacity to cope when infected or affected.[37]

For women, the stigma of illegal drug use is added to gendered discrimination, resulting in increased risk of HIV. HRSDPs must consider ways to engage women who use drugs in services, including gender sensitive harm reduction materials and approaches, sexual and reproductive health services, and gender sensitive referrals to other services such as drug treatment.

The Open Society Institute International Harm Reduction Development Program provides evidence-based recommendations for designing services for women who use drugs. The list of recommendations includes:

- Involving women who use drugs in service design and delivery.
- Creating a woman-friendly environment.
- Helping women become more independent, by addressing issues and intervening beyond the level of the individual. Examples include HRSDP based partnerships with women’s shelters, domestic violence programs, job training, provision of basic needs, and assistance dealing with social services.
- Providing low-threshold syringe access, mobile services, and secondary exchange.
- Incorporating sexual and reproductive health into harm reduction services.

- Addressing the prevalence of violence in women’s lives. [38]

Female condoms have been found to be highly acceptable [39, 40] and have an empowerment effect enabling women to control their own risk reduction. [41, 42] The use of female condoms is greatly improved with education and better understanding. [40] Therefore the female condom offered with education and support is an important tool in a woman’s harm reduction tool kit.

Aboriginal People

Aboriginal people experience higher rates of illegal drug use, including injection drug use, and lower access to healthcare and prevention services, than their non-Aboriginal counterparts. Culturally appropriate and specific programs and policies must be developed. The legacy of colonialism influences the current health of First Nations, Inuit and Métis people, and contribute to present-day issues with drug and alcohol use. There is an absence of funded harm reduction services in Aboriginal communities, specifically on reserves and in rural areas. There may be abstinence-based policies on reserve[43] which, combined with geographic diversity, means that Aboriginal people must overcome barriers such as transportation costs, family responsibilities, work commitments and lack of child care, to travel to harm reduction and other services.

The Canadian Centre on Substance Abuse (CCSA) noted that HIV infection rates for Aboriginal people are double those of other Canadians.[44, 45] A Vancouver, BC study found that Aboriginal persons in Vancouver had a significantly elevated burden of HIV infection.[46] The mortality rate of Aboriginal women injection drug users, mainly from overdose, homicide, and HIV/AIDS is nearly fifty times that of the general female population. To address these issues, the CCSA calls for the incorporation of aboriginal culture, beliefs, traditions and practices into current and emerging harm reduction services. The CCSA also calls for the development of policies and programs by Aboriginal communities, and the development of more flexible and responsive partnerships in the addictions field between various levels of government. [45] In particular, programs aimed at reducing the spread of HIV and HCV must include culturally sensitive and evidence-based programs. [46]

This is only a brief overview of the substantial literature on population considerations and issues, which face women, Aboriginal people, and visible minorities who use illegal drugs.



Involvement of People who use Illegal Drugs

People who use illegal drugs should be engaged in all aspects of HRSDP program development, implementation, and evaluation. Individuals who use drugs are the most familiar with drug use practices and patterns and are often able to help identify the most effective ways to reduce the spread of blood borne disease and to assist peers in other ways.[46] People who inject drugs have demonstrated capacity to organize peer groups and programs, and to

make valuable contributions to the community, including expanding the reach and effectiveness of prevention and harm reduction services by making contact with those at risk; providing services, support and referral; addressing public disorder issues and advocating for their rights and recognition of dignity of all citizens.[47]

Groups of people who use drugs (drug-user groups) should be adequately funded and resourced to represent users. User groups have been successful in influencing the response to HIV/AIDS, since the late 1980's. Research has concluded that the existence of groups has been a significant factor in HIV prevention.[47]

For a list of "Do's and Don'ts" for including people who use drugs, and a more extensive discussion of the inclusion of drug users, see "Nothing About Us Without Us" at www.aidslaw.ca.

Several groups are currently active in BC, including Vancouver Area Network of Drug Users (VAN DU) and DTES HIV/AIDS Consumer's Board in Vancouver; Society of Living Intravenous Drug Users (SOLID) in Victoria; KAN DU in Kelowna; and a new as yet unnamed group in Nelson.



Community Engagement

The development and utilization of an advisory committee with a broad representation of community stakeholders will support and sustain HRSDP services in the community. With the involvement of businesses and business associations, municipal governments, community service providers, and cultural and faith-based organizations, collaboration and shared responsibility will be encouraged, and social and economic resources will be mobilized.

Community-based HRSDP founding committees were established in Ontario to gather support for programs early. These committees often included cautiously supportive members and on occasion included vocal opponents such as police officers, members of religious groups or drug abstinence advocates. Many of those who initially opposed HRSDPs eventually came to support them through these interactions.[25]

The Ontario's best practices document suggests the following for engaging community's support for HRSDPs:

- Begin conversations from place of community concerns and create protocols to address these concerns.
- Provide education regarding harm reduction. A BC based review of the distribution of harm reduction supplies noted that little community development regarding harm reduction has taken place, and the philosophy of harm reduction is quite new in the general public. [48]
- Provide needle retrieval and disposal services.
- Create good neighbour agreements between HRSDPs and their key stakeholders.

The provision of ancillary services by HRSDPs, such as HIV testing and counselling, referrals to health and drug treatment, condom

distribution, and health education, can help generate community support for equipment exchange services.[2]

The BC Ministry of Health document, Harm Reduction: A British Columbia Community Guide, provides information and step-by-step guideline for the development of a municipally based harm reduction response. This document outlines a detailed approach to strategic planning and leadership for mobilizing communities and resources, and influencing policy. [13]



Law Enforcement and Public Order

Harm reduction based approaches to law enforcement complement public health harm reduction goals and services and local law enforcement can be a positive component to addressing the health and social needs of vulnerable populations. Examples of such approaches include greater use of discretion by police, harm reduction training for police officers, police involvement in harm reduction activities, and partnerships between police and health care and other service providers. HRSDPs should work with local police authorities to develop and maintain a collaborative relationship, and help officers to understand the activities of the HRSDP. HRSDPs can provide in-service training for police officers on a variety of topics including the general principles of harm reduction; the impact of HRSDPs on injection drug use, needle retrieval, and injury prevention, as well as the goals and the effectiveness of these services.[49]

Research suggests that some policing practices including increased enforcement that are used to try and create safe communities can be associated with unintended drug related harms such as such as rushed injections and needle sharing. Enhanced surveillance and police crackdowns have been shown to deter access to needle exchange programs. Enforcement-based policies can also result in unlawful harassment and confiscation of drug paraphernalia, particularly among women.[50]

Recommendations for police include the following:

- **Maintaining distance from needle and health services so that people who inject drugs are not deterred from accessing harm reduction services.**
- **Refraining from attending overdoses, which reduces the reluctance of drug users to call ambulances, resulting in fewer deaths.**
- **Refraining from interacting with users when injecting, as doing so will increase needle-sharing and rushed injecting**
- **Utilizing referrals to health and social services as alternatives to arrest and confiscation of equipment.**

Some HRSDPs have improved their relationship with

police by including officers as representatives on advisory committees. HRSDP-Police relations can also be improved through regular meetings, and development of protocols for dealing with problems and communication issues. Having a strong advisory committee with police representation is critical to developing neighborhood agreements and code of conduct agreements for HRSDPs, such as those developed for the AIDS Vancouver Island Mobile Needle Exchange Service. These agreements are useful in mitigating public disorder challenges that can sometimes be associated with service delivery



Responsibilities

BC Health Authorities

Health Authorities in British Columbia are responsible for ensuring planning, delivering and evaluating prevention and care services. This includes working with regional and local partners to identify and develop evidence-based responses to disease transmission. Health Authorities are responsible for ensuring services engage and serve vulnerable populations.

Provincial Health Services Authority/British Columbia Centre for Disease Control

The Provincial Health Services Authority (PHSA) is one of six health authorities – the other five health authorities serve geographic regions of B.C. PHSA's primary role is to ensure that B.C. residents have access to a coordinated network of high-quality specialized health care services

BC Centre for Disease Control (BCCDC) is an agency of the Provincial Health Services Authority that focuses on preventing and controlling communicable disease.

BC Ministries of Healthy Living and Sport and Health Services

These ministries lead and support health system partners. They set overall strategic direction for health services and the health system; provide legislative and regulatory frameworks; and plan for the future supply and use of health resources, including professionals, technology and facilities. These ministries monitor population health, and prepare for and coordinate responses to health risks and emergencies. They work to ensure consistent comprehensive service quality and approaches across regions, and evaluate health system performance.

Provincial Government

The provincial government works across a number of ministries, including Education, Children and Family Development, Housing and Social Development and Public Safety/ Solicitor General's Office to bring about improvements in the social determinants of health.

Office of the Provincial Health Officer

Under the Health Act, the Provincial Health Officer is the senior medical health officer for British Columbia and provides independent advice to the Minister of Health, the ministry and the public on public health issues and

population health. Each year, the Provincial Health Officer must report publicly, through the Minister of Health to the legislature, on the health of the population.

Federal Departments and Agencies

The Public Health Agency of Canada works with provinces and territories to promote and protect the health of Canadians, including decreasing transmission of infectious diseases and improving the health of those infected. The Centre for Infectious Disease Prevention collates data gathered at the local level.

Contracted Agencies

Work with Health Authorities to achieve their mandate of planning, delivering and evaluating prevention and care services. The specific content and local expertise that contracted agencies provide are crucial to effective health and social service delivery.

Community

Success of any harm reduction practices are dependent on the many other partners that make up a civil society such as municipal government, police, universities, schools, park boards, non governmental organizations, community leaders and other concerned citizens.



Acronyms used

BCCDC	BC Centre for Disease Control
BCHRSS	BC Harm Reduction Strategies and Services Committee
CCSA	Canadian Centre on Substance Abuse
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HRSDPs	Harm Reduction Supply Distribution Programs
KANDU	Kelowna Area Network of Drug Users
PHSA	Provincial Health Services Authority
RAR	Rapid situation and response assessment
RARE	Rapid Assessment Response and Evaluation
SOLID	Society for Living Intravenous Drug Users
STI	Sexually Transmitted Infections
VANDU	Vancouver Area Network of Drug Users
VCH	Vancouver Coastal Health Authority

APPENDICES

Appendix A	Examples of Mobile Services in British Columbia
Appendix B:	Example of Outreach Services
Appendix C:	Examples of Injecting Equipment Provision in Pharmacies
Appendix D:	New South Wales Health Data Collection List
Appendix E:	WHO Service Evaluation Categories
Appendix F:	Vancouver Coastal Health Data Collection Form
Appendix G:	Staff Core Skills and Knowledge, Queensland Health, Australia
Appendix H:	Safer Crack Use Initiatives
Appendix I:	Coordinated Service Delivery in Prince George
Appendix J:	Peer Education
Appendix K:	Safe Disposal Initiatives

Appendix A: Examples of Mobile Services In British Columbia

ANKORS, an HIV/AIDS education and prevention organization in the Interior Health Authority, provides harm reduction supplies and services in the East and West Kootenays. In addition to fixed sites at their Nelson and Cranbrook offices, ANKORS covers 25,000 square kilometers and provides services to sixteen plus communities through their mobile vehicle. The outreach worker takes calls from clients and delivers injection equipment to their homes, networks with clients, and provides for secondary provision and exchange through peer distribution.

A nurse travels with the mobile service in Prince George, in order to provide primary health care. The service refers people to additional community and health services, including referrals to the fixed site HRSDP.

In Port Hardy, AIDS Vancouver Island offers both fixed and mobile services for this small community on Northern Vancouver Island. For mobile services, clients call the fixed service to order injecting supplies, which are then delivered by mobile staff. In addition to injecting supplies, staff members provide educational material about safer injection and using clean needles. They also provide condom packs that include safe sex information and information about a range of health and community services. Peer distribution of supplies provides important additional coverage in this area.

Victoria's AIDS Resource and Community Service Society (VARCS) also offers mobile service. The van follows a fixed route through the city, and responds to calls from homes. The van is staffed with one paid staff person, and one volunteer on a full time basis, with the additional assistance of a street outreach nurse twice a week. Street nurse services provided on the mobile van route include wound care, vein management, adult immunizations, TB testing, harm reduction education, and referrals to a wide range of health

services; in clinic settings services also include HIV and HCV testing, STI testing and treatment, pregnancy tests, pap smears. The agency has established relationships with service providers in the city, and refer clients to a range of services including drug and alcohol counseling, detox, the methamphetamine clinic, and services for sex workers.

Appendix B: Example of Outreach Services

The Society of Living Intravenous Drug Users (SOLID) in Victoria offer outreach services in conjunction with their harm reduction distribution and Rig Dig needle pick-up program. Current and former People who use injection drugs begin by participating in peer training, addressing topics such as disease transmission prevention; mental health and addictions; HCV; safer injecting; and self-advocacy. They are paid an honorarium for training, and an hourly wage for outreach and needle retrieval. For their outreach work, the peer workers carry clean needles, water and crack cocaine-smoking kits in their backpacks. They engage with clients on the street in the early morning, between 7 and 9 am, before businesses are open and when no other needle distribution services are provided, and provide supplies, harm reduction information, brief counselling and referral services.

Appendix C: Examples of Pharmacy Injecting Equipment Provision

In Queensland, New South Wales, Australia, community pharmacies play a critical role in providing widespread access to sterile injecting equipment. Queensland Health, in a partnership with the Pharmacy Guild of Australia, provides harm reduction training and resources for pharmacists. As a result of the success of this project, Australia will develop a national framework for pharmacy provision of equipment. Additionally, Queensland Health is piloting a disposal project, with the provision of sharps containers in pharmacies.[15]

In the Interior Health Region of BC, in the Thompson, Caribou and Shushwap area, provision of harm reduction supplies is coordinated by public health, and delivered by pharmacies and outreach workers. Pharmacies which dispense methadone and distribute needles and other harm reduction supplies include Kipp Mallery Pharmacy and Manshadi Pharmacy in Kamloops, Pharmasave in Clearwater and Donex IDA Pharmacy and Department Store, 100 Mile House. Public health in this area believes that this system makes the best use of limited resources. (Nora Walker, personal communication, March 17, 2008) In Grand Forks, BC, a small community in Interior Health, one pharmacy provides 'care packages' containing syringes, alcohol wipes, and water, but do not have time to provide harm reduction education. (Alex Sherstobitoff, personal communication, March 18, 2008)

Appendix D: New South Wales Health Data Collection List

- Date of access
- Gender
- Number and type of needles issued
- Equipment safely disposed Y/N
- Postal Code
- Age
- Drug(s) injected

- Education and referral (information about/referral to services for health;
- HIV/AIDS, HBV, HCV)
- Addiction
- Safe(r) use
- Social needs (housing, food, income assistance)

Appendix E: WHO Service Evaluation Categories

- The World Health Organization service evaluation categories include:
- Range of equipment and services provided
- Convenience of access to equipment
- Friendliness of staff
- Involvement of people who use injection drugs in HRSDP activities
- Response of management and staff to complaints and to changes in behaviour and the environment
- Referral processes used

- use drugs
- Manage disposal of used needles and syringes
- Provide education and information on drug use and safe sex
- Conduct brief assessment and referral for people who inject drugs
- Provide client support and assistance where appropriate
- Promote the HRSDP within the community
- Conduct health promotion with clients and the community
- Educate new HRSDP staff and community groups
- Demonstrate professional development and update knowledge
- Attend to agency and staff issues
- Carry out administrative tasks (stock, collecting data, following organizational policy and procedure)[11]

Appendix F: VCH Harm Reduction Distribution and Recovery Data Collection



Date _____

Site _____

Sheet # _____

Visit	Number of Needles Returned	Number of Needles Provided	Number of Mouthpieces Provided	Referral			Initial	
				to Primary Health Care	to Addictions Services	to Other Services		
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
Sub Total	Visits	In	Out	Tubes	PHC	Addictions	Other	<< totals from this sheet
Fill in the boxes below on Sheet #1 - Add up the day's total and the month's running total								
Day's Total								<< totals from today
Yesterday								<< yesterday's running totals
Running								<< monthly running totals

Appendix G: Staff Core Skills and Knowledge

- Provide injecting and safe sex equipment to people who

Appendix H: Safer Crack Use Supply Initiatives

The Nursing and Health Behaviour Unit at the University of British Columbia conducted a safer crack use initiative called Safer Crack Use, Outreach, Research and Education (SCORE). The project provided safer crack use kits containing pipes, lighters, a harm reduction tip card, a resource card, push sticks, mouthpieces, alcohol swabs, bandages, condoms, and screens, in a black plastic bag. Women living in the Downtown East Side in Vancouver, BC assembled the kits. In a review of the program, eight recommendations were offered, including integration of provision of unlimited crack use supplies into existing harm reduction services. For the additional recommendations and further information about the project, see: Lessons Learned from the SCORE Project: A document to support outreach and education related to safer crack use. <http://nexus.ubc.ca/documents/Newsletters/SCORE%20Newsletter%20Vol%201.pdf>

Safer Crack Use Initiatives also exist in Toronto and Winnipeg. See http://www.toronto.ca/health/drugstrategy/pdf/tds_crack_kits.pdf

The AIDS Prevention Program in Prince George, supported by the Northern Health Authority, is an example of safer crack cocaine smoking supply distribution in BC.

Appendix I: Service Delivery in Prince George

In Prince George, coordinated, client-centred services are offered through integrated case management based on solid community and service partnerships. Since 1991, services have been primarily offered at a downtown storefront clinic location, provided by Northern Health, Preventative Public Health. Partners include mental health and addictions services, the RCMP, a mental health nurse, public health, the Friendship Centre, and community service providers. In addition to the above named partners, the clinic works closely with detox services, both in referring clients, and in providing weekly information sessions on blood borne pathogens.

HRSDP onsite services include HIV, HCV, and STI testing; STI treatment as per the BC Centre for Disease Control schedule; wound care; and flu and other vaccines. Provision of these services has proved to be an entry point for other services and referrals. Prince George has also adopted a BC

Women's initiative, providing PAP tests, the morning after pill and pregnancy tests. Women, who attend HRSDPs much less frequently than their male counterparts, are drawn to the HRSDPs for these services. (Linda Keefe, personal communication, March 14, 2008).

Appendix J: Peer Education

The Society for Living Intravenous Drug Users (SOLID) has developed peer education training with a goal of delivering accurate information and providing support for people who use drugs in the community. SOLID's definition of a peer educator is someone who has lived experience of previous or current drug use, or is a strong ally. Peer education training addresses transmission of HIV, HCV, TB and STI; safer injecting; improving and maintaining health; accessing health care in clinics and hospitals, and self-advocacy. In addition to delivering education through street outreach, peer educators provide this service in downtown service agencies.

Education and support groups in Interior Health include Merritt Helping Hands Society "providing education, providing support to the still suffering addict in the Nicola Valley" and Anything is Possible® which supports women reintegrating to Kamloops after incarceration "by sharing experiences, knowledge and skills, anything is possible".

Appendix K: Safe Disposal

The Safe Needle Disposal Toolkit is a project of Edmonton's Safedmonton Initiatives. Several public agencies, community organizations and citizens partnered to take action on community concerns about discarded needles in their city. The goals of the partnership include raising community awareness about needle safety; reducing the number of discarded needles on the streets; reducing risk and preventing injury to the public; and providing options for safe needle disposal. The choices for needle disposal in the city now include pharmacies, needle exchange services, and safe needle boxes in communities that request them. Extensive education material is provided for businesses, community members and children. For more information on this initiative, see www.edmonton.ca/safedmonton.

The City of Kamloops addressed a community-identified need for a plan to deal with discarded needles. The City, the RCMP, and Public Health partnered to design a campaign. They designed and delivered targeted education to residents, children and businesses in needle 'hot spots', and developed citywide awareness campaigns for businesses and citizens. They provided an educational pamphlet for residents, and "Sir Ringe" educational resources for children.

Victoria has installed and maintains 5 sharp disposal containers in drug 'hotspots'. In addition to providing needle pick up and disposal, and sharps containers, Victoria AIDS Resource and Community Service Society (VARCS) distributes pamphlets with information about their services. As a result, the Downtown Business Association, individual businesses and property managers contact VARCS on a regular basis for needle pick up and disposal.

Vancouver Coastal Health (VCH), community groups, contracted agencies, the City of Vancouver and Vancouver Board of Parks and Recreation have partnered to reduce

the number of inappropriately discarded needles in the community. The program coordinates regular sweeps of community spaces for needles, coordinates needle recovery from community groups and service agencies and offers mobile community needle recovery service 20 hours/day, 7 days/week through the needle pick-up hotline. VCH aims to recover all inappropriately discarded needles as soon as possible.

Through ongoing data collection and analysis, VCH's Harm Reduction Program is able to focus needle recovery efforts in the areas where they are most needed. In partnership with the City of Vancouver, VCH provides and maintains over 28 needle drop boxes in the Downtown Eastside. Needle exchange sites are provided with pocket cards and match books printed with a map of needle box locations in the Downtown Eastside.

VCH's Harm Reduction Program works closely with current and former drug using peers in shaping services and in the creation and distribution of marketing tools for the program, including those created for the Make it Your Gig to Return Your Rig campaign. Through this campaign, drug users have received acknowledgement and incentives such as lighters, matches and t-shirts for regularly returning used needles to needle exchange sites.

Appendix L: Safety –Engineered Needles

In order to reduce the number of occupational exposures, Work Safe BC is striving to ensure that when possible safety engineered needles be used instead of conventional needles. However, one exception is a situation where it is not clinically appropriate because of increased injury to the patient. At present it is not clear if distributing safety needles would lead an increase in, rather than reduction, of harm to people who use injection drugs, and ultimately, to public health. Therefore, before general guidance is issued advocating a change to safety needles further consultation with those who use injection drugs, professionals and researchers is needed. The full Work Safe Medical Practitioner FAQ can be found online at http://www2.worksafebc.com/PDFs/healthcare/faq_safety_engineered_needles.pdf



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British Columbia Centre for Disease Control (BCCDC)
655 West 12th Avenue
Vancouver, BC V5Z 4R4 Canada
604-660-1782
www.bccdc.org

abscesses

How can we reduce the risk of abscesses?

- Use a new rig every time you inject.
- Use in a safe place, where you do not have to rush!
- Before you use, wash your arms and hands with hot, soapy water. Hot water and rubbing also make the veins bigger and easier to hit.
- Use clean filters, cookers, and clean water every time.



• Clean the injection site with alcohol wipes.

- Don't skin pop or muscle the fix unless you can not find a vein in your arms. If you need to do this then always change the needle that you were using to try to get a vein to a clean one for the muscle

or skin injection. This will decrease your risk of abscesses. If drugs are not injected into a vein they can damage tissue.

- Choose good veins. Keep your veins big and fat by drinking lots of water. It's harder to miss when you have big veins. A miss can get infected and turn into an abscess.



- Use a tie. This increases blood volume in the veins and makes skinnier veins bigger and easier to see.

- Slow down. Relax. Take a deep breath to help keep your hand steady so you don't miss.
- Try not to inject into hands, feet and legs. The veins are too small and far from the heart.

- DON'T shoot into or near an abscess. DON'T squeeze or cut abscesses. This could push bacteria into your bloodstream and cause body-wide infections.

other common infections of injection drug use

An abscess can allow bacteria to get into the bloodstream, where it can travel around and cause other, more serious infections. These conditions can be life threatening and you must seek medical help immediately.

What is Septicemia?

Septicemia is a bacterial infection of the blood.

Signs and Symptoms:

Very high fever, feeling weak and very ill.

What is Endocarditis?

Endocarditis happens when bacteria in the blood stream infects the lining of the heart.

This infection can damage the heart valves.

Sometimes, it can travel to the lungs, brain or kidneys.

Signs and Symptoms:

Chest pains, high fever, tiredness, headaches, night sweats, shortness of breath.

What is Cellulitis?

Cellulitis is an infection and inflammation of the skin tissue. It is usually in an injection area.

Signs and Symptoms:

The skin looks very red, swollen, hot. It may be weepy and draining fluid. It is very painful.

The swelling may cause the skin to stretch tightly over the infected area and it may spread to cover a whole arm or leg. Go to a health care worker.

other brochures in the harm reduction learning series:

- crack (rock) cocaine
- safer injection information for drug users
- vein care
- coping with triggers
- o.d. overdose, crashing
- the safer fix

The Harm Reduction Learning Series is a joint project of the Dr. Peter Centre, Vancouver Coastal Health, and the prns. Supported in part by an unrestricted educational grant from Abbott Laboratories.

common

infections

{from injection drug use}



this brochure talks about

abscesses, septicemia, endocarditis and cellulitis

harm reduction learning series

abscesses

What are abscesses?

An abscess is a pocket of pus. Pus means you have an infection. Pus is dead tissue, bacteria, and the white blood cells that gather to try and kill the infection.

An abscess can start anywhere in the body where bacteria infect damaged tissue. Drug users often



get abscesses at injection sites. We

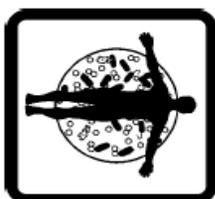
are more likely to damage tissue and develop an abscess when we skin pop, muscle it, or miss the vein. Both the cut and the drug itself can damage tissue. We can even get an abscess AFTER we stop injecting because impurities are still in our bodies.

People with weak immune systems (i.e. living with HIV and AIDS) are more likely to develop abscesses. If you have a weak immune system, you need to be even more careful.

Where does bacteria come from?

Bacteria is invisible. It can be on any used rig, cooker, filter, or tourniquet.

Bacteria is also on our skin, even when we think it's clean. This bacteria can get into our bodies through any opening in our skin.



How do we know we have an abscess?

A hard, reddish, tender lump will usually appear at the injection site, but it can also pop up in other places. The lump might feel warmer than the skin around it. It might even feel hot, and it might hurt. It might look pink and puffy. If the lump gets bigger, the infection is getting worse.

As the infection spreads, red streaks might spread out and away from the abscess. The infection might make us feel tired or cause fever or chills. We might have chest pain if the infection goes to our heart or lungs.

abscess treatments

About Hot Soaking:

Soaking helps draw out the infection. It helps the abscess come to a head and drain.

Here's how to do it:

Soak the abscess in a tub of clean hot water. Hot water with Epsom salts works better still. You can get these from health care clinics or the drug store.

If the abscess is in a spot you can't easily soak, then hold a hot, wet washcloth on it. You can use Epsom salts in this water too.

Soak at least 3 or 4 times a day, 10 to 15 minutes each time.

You may also need

Antibiotics:

If your infection is bad, your doctor may prescribe antibiotics. Be sure to finish them **ALL** – even if you feel better before they are used up.

If you don't take the whole prescription, the bacteria they are supposed to treat can develop resistance. This can make antibiotics less useful against future infections.

how to look after an abscess

Look after it YOURSELF with HOT

SOAKING if:

- It doesn't have any red streaks or hot puffy skin around it.
- You don't have chills or a fever.
- The lump is only a few days old.

Go to a CLINIC if:

- It has not improved after 3 to 5 days.
- The lump gets bigger.
- You see red streaks spreading out from the lump.
- The lump is hot, puffy and pink.

Go to the

EMERGENCY ROOM if:

- You have chest pains.
- You have chills or a fever.
- The infection looks like it is spreading really fast.



These conditions can be life-threatening and you must seek medical help immediately!

about injecting

What are the safest veins to use?

- The safer zone is between the elbow and the wrist. The veins below the elbow bend are larger and easier to use.

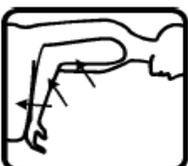


- Arm veins are the safest distance from your heart. Jugging is not safe. The jugular is close to your heart and could cause OD, blood clots to your lungs, heart attack or death. You could also hit the nerve which runs along the jugular and cause your face to become numb.

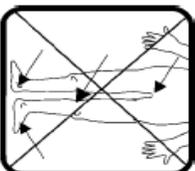
- Leg veins are too far from the heart. The body has to work harder to return blood from the lower limbs. The slower blood return means a greater risk for infections, blood clots and leg wounds.

Where should I inject in my body?

- Safer:
- Lower arm, upper arm, Avoid joints and hands.



- Less Safe:
- Legs.



Risky:

- Feet, ankles, groin, back of the legs.

Very Risky:

- Neck, breast, penis, eye, forehead.



What is the safest way for me to inject?

- **Never Use Alone.** Fix in a place you feel safe, where you don't have to rush and where someone can look after you.
- Know your dealer.
- Have enough light in the room in which you are fixing to better see your veins and prevent missing. Side-lights and mirrors can help.
- Wash your hands and injection area. This will greatly reduce the chance of bacteria getting into your body. Unbroken skin is the greatest protection against infection.



- Gather together all the equipment you will need for a safer fix. This includes a sterile rig, clean water, an alcohol swab, a filter and a tourniquet. Take a sharps container home.

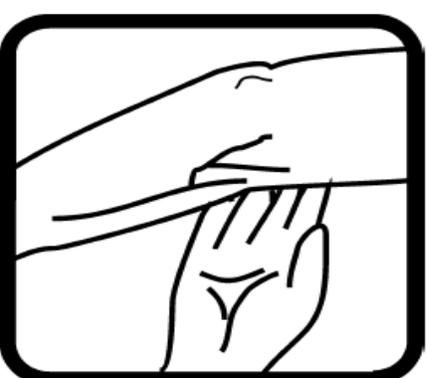


other brochures in the harm reduction learning series:

- crack (rock) cocaine
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vein care



for injection drug users

We want to help reduce the health risks of injecting drugs. Injecting drugs is always risky. We have written the following guide to help make injection safer.

harm reduction learning series

about veins and arteries

Veins have different sizes and shapes, but all serve the same purpose. They carry blood from your body back to your heart and lungs. In your lungs, blood is cleaned and collects oxygen. Clean blood is carried back out through our bodies by arteries.

The blood in our veins is thick and bluish-red in colour. In our arteries, the blood is thinner and bright red in colour. Blood from our veins clots

easily, and will stop bleeding with less direct pressure than our arteries.

Veins have lots of valves to help the blood flow back up into the heart.

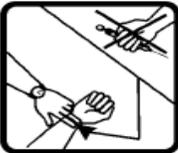
Arteries have a pulse. They carry blood quickly and at high pressure.



questions and answers

How can I tell whether I have hit a vein or an artery?

Veins are generally visible and near the surface of your skin. Arteries are deeper but when they come close to the skin surface, they have a pulse. When you hit a vein, dark blood will seep from your body. When you hit an artery, bright red blood will spurt. Never inject where you have a pulse!



Why is vein care important for injection drug users?

Injection drug use is hard on the veins. If you inject a lot, your veins could collapse or develop scar tissue and you won't be able to use them anymore. As well, when veins collapse, the risk of skin injuries and body-wide infections goes up.

How do I keep my veins healthy?

To keep veins healthy, drink lots of fluids. Water is good. Coffee and alcohol don't count. They will cause your veins to shrink and dehydrate your body.

Regular exercise will keep muscles strong. This helps keep veins big and healthy.

How about when I am using?

Take a warm bath or a shower. Wrap your arm in a warm towel or blanket for a few minutes. Heat will increase blood flow and the size of your veins.

Use in a warm, safe place so you don't have to hurry. Take a big breath before you inject.

Try to use a different part of the vein every time. Rotate your injection sites. Move an up the arm. This prevents loss of the vein forever from overuse in one area.

Start with the vein closest to the wrist and work up the arm. If part of the vein is collapsed or scarred, you lose the use of the vein below that spot.



Go with the flow! Inject in the direction of the bloodflow which in a vein is towards your heart. Never inject towards your fingers or toes!

Open and close your fist to pump up your veins before using. Always use a tie to expand the vein.

Feel your vein before injecting into it. Just because you can see it on the surface of your skin it doesn't mean the vein has enough blood in it.



Look for the valves in your veins and inject above them. To see a valve, look for bumps or fuller areas in the vein, or places where veins change direction.

Injecting above valves will pump the drug faster. It will also help prevent circulation problems, scar tissue and possible infections.

Always use clean supplies and inject with care.

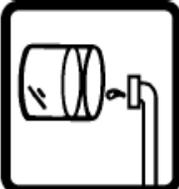
A word about Up.

Crystal meth, cocaine and other stimulants cause veins to shrink. The brain goes into 'action mode', which makes the heart beat faster and the veins shrink. Using up makes veins harder to find.

We want to help reduce health risks of injecting drugs. Injecting drugs is always risky. We have written this guide to help make injection safer.

staying healthy

Rock can be hard on your body, so try to do the following:

- Drink a lot of water to keep your mouth and lips moist. This helps prevent cracks and blisters. 
- Lube on your lips also helps prevent cracking.
- Gum will help keep your mouth moist, and helps prevent jaw-clenching and teeth-grinding.
- People using crack tend to have a lot of sex. Always protect yourself and others. Use condoms. 
- Eating is the last thing people want to do on a crack run. Don't let yourself become worn down. Take vitamins every day. 
- Covering up finger burns with band-aids helps prevent infections.

effects of crack

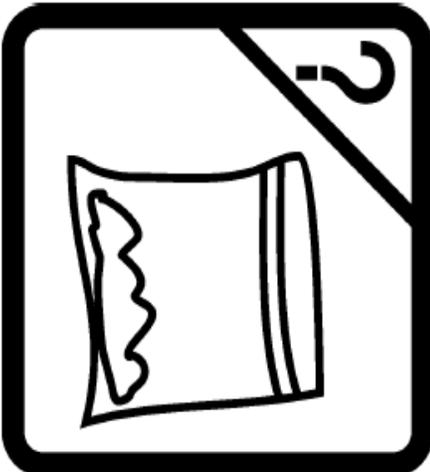
- Crack can produce a euphoria effect that lasts for five minutes to two hours. 
- Crack can damage the brain and affect memory and ability to think. It may also cause eating and sleeping disorders.
- People who have used crack can become psychotic. They may be confused and paranoid, or behave in an erratic or violent way. 
- Crack can cause hallucinations and muscle twitching.
- Using crack can lead to respiratory problems, seizures and cardiac arrest.

other brochures in the harm reduction learning series:

- coping with triggers
- safer injecting information for drug users
- vein care
- common infections from injection drug use
- o.d. overdose, crashing
- the safer fix

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crack
{rock}
cocaine



dos
and
don'ts

harm reduction learning series

safer using tips

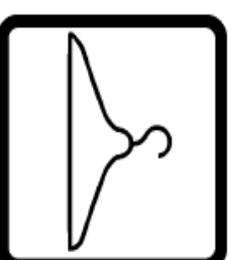
1. Smoke in a place where you feel safe with people you trust. It is important to have someone looking out for you.
2. Use a pyrex pipe. It absorbs heat better than regular glass and is less likely to shatter. Don't use pipes with jagged edges.
3. Always put a mouthpiece on the end of your pipe. This will help prevent burns from the hot end or cuts from jagged edges.
4. Never share mouthpieces or pipes! Infections are easily spread through sharing because of cuts and burns to your mouth.
5. Don't overheat one spot on the pipe. Moving the flame around will prevent hot spots that could break the pipe. Longer pipes will not overheat as easily.



6. Don't use gas-filled lighters. The fumes can cause bad headaches. Smoke rock in well-ventilated areas.
7. If you use matches, wait for the sulphur to burn off so you don't inhale it.
8. Use wire mesh to hold the rock in your pipe. Mesh is safer than brillo because it is not coated with toxins that are released when it is burnt. Inhaling toxins from brillo is damaging to your lungs.
9. If you have to use brillo, burn it first to remove the coating before smoking.
10. If you have to use brillo, use thick brillo. Fine brillo will break when burnt and you could inhale it into your throat and lungs.



11. Avoid copper brillo. It releases poisonous fumes when burnt.
12. Push the mesh through the pipe to avoid getting burnt. Coat hangers or umbrella spokes work well.
13. You must break down rock if you want to fix it. Avoid vinegar or lemon juice because they may contain a fungus that affects your vision. Ascorbic acid or Vitamin C powder are the best to use to do this. You can get them in some health clinics or buy them in drug stores.



what does overdosing *feel* like?

UP

- Your heart is pounding fast
- You are breathing fast and you may feel short of breath
- Your body feels hot, sweaty, shaky
- You may have pain in your chest
- You can't walk or talk

If at all possible, call for help.

DOWN

- You can't stay awake
- You have no energy or strength
- You can't walk or talk



Try to stay awake & call for help.



what does overdosing *look* like?

UP

- Fast pulse or no pulse
- Fast breathing or no breathing
- Skin hot, sweaty, red
- Confused, hallucinating or unconscious
- Unable to talk
- Vomiting
- Seizing

DOWN

- Slow pulse or no pulse
- Slow breathing or no breathing
- Skin pale, cold, blue
- Unable to wake up or to talk
- Pupils are pinned
- Vomiting
- Body limp



other brochures in the harm reduction learning series

- crack (rock) cocaine
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**o.d.
{overdose}
crashing**



**what to do
in case of o.d.**

harm reduction learning series

What to do in case of an o.d.

1. Do not leave the person who has OD'ed. Shout for help.
2. Stay calm.
3. Try to wake them up by "shaking and shouting" like this:
 - Shake them by their shoulders and talk to them.
 - Squeeze their earlobes.
 - Try to get them to open their eyes.



- Try to get them to talk to you.
4. If they don't wake up, call 911. Don't be afraid to call 911: Usually only the ambulance will respond to an OD, not the police!



- Are they taking a breath every once and a while?
6. If they are not breathing, you need to breathe for them until help arrives.
 7. If they are breathing only every once in a while, turn them on their side. Shake them to keep them awake. Tell them to keep breathing.



preventing o.d.

- Never use alone. Use with a buddy or in a supervised injection site.
- Know your dealer
- Know what drugs you are using
- Don't mix your drugs... especially with alcohol
- Prepare your own drugs
- Taste your drugs
- Know what an OD looks like



Before you use:

1. Know where the closest phone is.
2. Know where you are (what hotel, park, street, etc.)
3. Take an OD prevention program



8. Give the ambulance attendants as much information as you can:
 - what drugs were being used?
 - how long ago did they take them?
 - have they been on a run?
 - any medical problems that you know about?
 - what have you done to help the person?

What to expect

heroin

The high

- A high that lasts 20 minutes – 2 hours
- Feeling intense pleasure and reduced pain
- Warm skin, dry mouth, heavy feeling arms and legs
- Nausea, vomiting and severe itching
- Slow, shallow breathing

Coming down

- Feeling restless, sweaty, stomach cramps and diarrhea
- Muscle spasms and bone pain
- High blood pressure
- Strong cravings for more heroin

⚠ Note: combining substances can be dangerous. Proceed with caution.

crack/coke

The high

- A high that lasts 15–45 minutes
- Feeling an intense, euphoric rush
- Warm skin, dry mouth
- Feeling thirsty, not hungry
- Rapid heartbeat and breathing
- Auditory hallucinations, delusions

Coming down

- Feeling restless, sweaty and twitchy
- Sensitivity to noise and light
- Feelings of paranoia
- Strong cravings for more crack

Signs of overdose

heroin overdose

Feels like:

- You can't stay awake
- You don't have any energy or strength
- You can't walk, can't talk

Looks like:

- Slow pulse or no pulse
- Slow breathing or no breathing
- Skin looks pale and blue, feels cold
- Can't wake up or talk
- Pupils are pinned or eyes are rolled back
- Vomiting
- Body is limp

crack/coke overdose

Feels like:

- Your heart is pumping fast
- You're short of breath
- Your body is hot, sweaty and shaky
- You have chest pain
- You can't talk, can't walk

Looks like:

- Fast pulse or no pulse
- Fast or no breathing
- Hot and sweaty skin
- Confusion, hallucinations, unconscious
- Can't talk, can't walk
- Vomiting
- Seizures

What to do if someone ODS

- 1 Call out for help – do not leave the victim
- 2 If they've OD'd on heroin, try to get them awake and moving
If they've OD'd on crack/coke, try to get them to slow down and relax
- 3 Call 9-1-1 for an ambulance, send someone to seek help and report back
- 4 Tell paramedics as much as you can about what happened

Ready to detox?

Help is just a phone call away.

Call Access Central at 1-866-658-1221, seven days a week from 9am to 9pm for detox, residential addiction services and addiction housing.

1.866.658.1221

Your peers created this harm reduction pamphlet for you. Be safe.



Safer Injecting

heroin

crack/coke

What you need to inject safer:



Sterile needle



Sterile water



Alcohol swabs



Cotton filter or tampon (unscented)



Cooker or spoon



Rubber tie



Lighter or candle



Ascorbic acid/vitamin C (crack only)



Clean hands

the user-friendly series

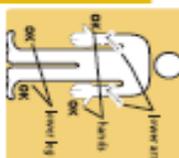
How to inject safer

Safer injection tips

1 Clean your hands with soap and water or alcohol swabs



2 Choose your injection site (lower arm is safest. If you have to inject elsewhere, lower leg than hand or 0F)



3 Prepare your drugs – crack/coke

crack Pour equal parts crack and ascorbic acid in cooker/ spoon

coke Pour coke into cooker/ spoon




3 Prepare your drugs – heroin

Pour drugs in cooker/ spoon

Pour sterile water in cooker/ spoon

Heat until drug becomes liquid

Take cotton filter/ piece of unscented tampon and place in drugs

Place needle in filter

Draw liquid into needle








Pour sterile water into cooker/ spoon

Using clean, capped needle, grind coke and ascorbic acid to mix

Using clean, capped needle, grind crack and ascorbic acid to mix

If crack mixture is cloudy or has sediment, heat as needed – DO NOT BOIL

Place a cotton filter/ piece of unscented tampon in drugs

Place needle in filter and draw liquid into needle








4 Clean your injection site with an alcohol swab



5 Tie off with a rubber tie using a quick release



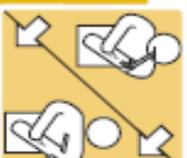
6 Insert your needle with the bevel up, at a 90 degree angle towards your head



7 Flag your needle: push needle in a little and pull back on plunger until you see blood in the needle



8 Loosen your tie



9 Inject your drug slowly



10 Pull out and with clean hands, apply pressure to injection site



11 Safely dispose of all equipment – make your rig to return



- Taste your drugs before you use
- Always use with a buddy
- Use a new needle for each injection
- Please don't break off the tip of your needle or re-cap it – it's not safe
- Remember: two holes in your arm are better than one in the ground. If you haven't used in a while, reduce your dose.
- **Protect yourself and your community – always dispose of your equipment safely**

- injecting**
- The most dangerous place to inject is your neck
 - To make your veins more visible, jog on the spot or do push-ups before tying off
 - If you can't see the bevel, look for the numbers on the side of your needle, they often line up with the bevel

- filters**
- Unscented tampons are safe to use as filters – do not use cigarette filters
 - Use a filter once only – using it more than once can lead to "cotton fever"

- ties**
- Ties should be on for two minutes maximum
 - If your hand falls asleep or arm turns red while tied off, the tie is too tight, or has been on too long

- abscesses and wounds**
- Keep injection sites clean and watch for abscesses – they can happen anywhere on the body, not just where you inject
 - If you have an abscess, do not pop it
 - Seek medical care for treatment of abscesses or wounds – they can lead to dangerous infections

doing it right, continued

4 after fixing

- Clean the area with gauze.
- Don't put other people at risk!

Dispose of your dirty rig and sharps works in a container or take capped, used rigs to a needle exchange.



Using responsibly will help to:

- Reduce the spread of infectious disease
- Prevent bacterial infections
- Reduce OD and OI deaths

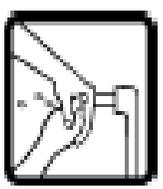
for more info or education

- Visit your local needle exchange or health clinic;
 - Complete a harm reduction course; or
 - Talk to a health care worker about the full range of harm reduction services.
- Visit a supervised injection site.

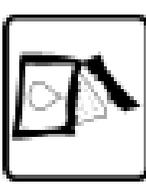
February 2010

injecting safely includes

- Not being alone.
- Washing your hands.



- Cleaning the injection site with alcohol.



- Always using a new sterile needle each time you inject.

- Using clean water.



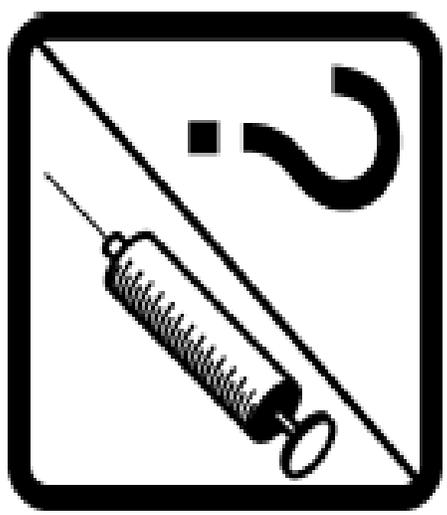
- Disposing of needles safely at a needle exchange.

other structural links to medical training series

- crash (pod) cocaine
- safer injection information for drug users
- vein care
- common infections from injection drug use
- OI, overdose, crashing
- coping with triggers

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{the safer} fix



quick tips

We want to help reduce the health risks of injecting drugs. Injecting drugs is always risky. We have written the following guide to help make injection safer.

harm reduction learning series

1 getting ready

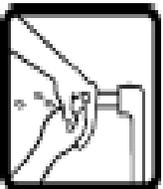
- **Never fix alone; always inject with someone you trust and in a place where you feel safe, like in a room with a friend or in a supervised injection site.**
- **Know your dealer.**
- **Always taste your hit to make sure of its strength.**



- **Gather together all the equipment you need: get clean rigs, sterile water, alcohol swabs, filters, and ties.**
- **Get a sharps container.**
- **Remember one fix=one rig.**

2 prepping

- **Relax.**
- **Wash your hand and the injection area.**
- **Use sterile water to mix your drug in a clean cooker or spoon.**
- **Draw your drug up with a sterile rig through a filter.**



- **Choose your injection site carefully. Some areas are safer than others.**
- **Use different veins each time.**

Safer

- Lower arm
- Upper arm

Avoid joints and hands

Less safe

- Legs

Very risky

- Neck
- Breast
- Penis
- Eye
- Forehead

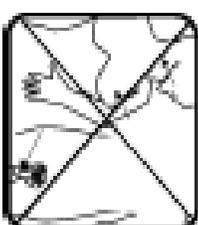


- **Flex your muscles to pump up your veins.**
- **Put a tie 2 inches above where you plan to inject.**



Risky

- Feet
- Ankles
- Groin
- Back of legs



3 fixing

- **Feel for the vein to make sure it is full enough to hit.**
- **Clean your injection area with an alcohol swab.**

- **Always have the eye of the needle facing up.**
- **Point the needle in the direction of your heart.**

- **Put the needle in on a slight angle.**
- **Avoid the bumps along the vein (they are fragile valves) and where the vein changes direction and branches off.**
- **Insert the needle gently until you get a tigg.**
- **Release the tie.**
- **Try to inject only half your fix. Pause and taste your hit. You can't take it back if you have injected too much.**



coping by using helpful images

Coping with helpful Images:

- A happy, proud me that didn't use
- Imagining myself 24hrs from now if I do use
- A wave passing
- Supportive friends
- A beautiful sunrise over mountains
- A goal I have in mind



Add your own:

-
-
-

getting ready for next time

Relapse happens, forgive yourself.

Relapse is a process that can start with very small things that grow and overwhelm us.

By recognizing triggers early on, you can slow down or stop the process.



Different things may work for you than for your friends - and it is worth finding out what helps you best!

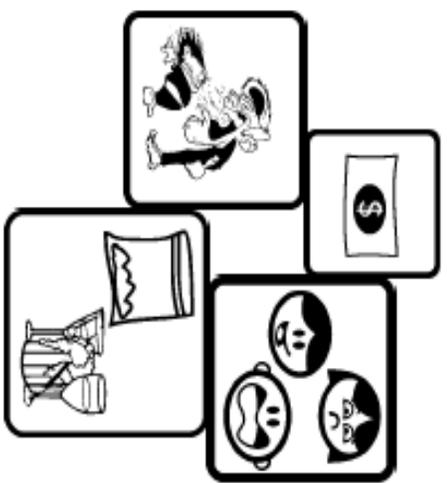
Further support is available - ask for help from health care workers and other people you can trust.

other brochures in the harm reduction learning series:

- crack (rock) cocaine
- safer injection information for drug users
- vein care
- common infections from injection drug use
- o.d. overdose, crashing
- the safer fix

The Harm Reduction Learning Series is a joint project of the Dr. Peter Centre, Vancouver Coastal Health, and the pbs. Supported in part by an unrestricted educational grant from Abbott Laboratories.

coping with {triggers}



what to do when you want to use

harm reduction learning series

the cause of triggers

Understanding the cause of triggers can help take their power away. The examples below give an idea about what to look out for. You might want to circle the top 3 that are triggers for you.

Things?

- Money in your pocket
- lighters
- pill bottles
- credit cards
- seeing drugs or alcohol.



Events?

- Cheque issue day
- pawnshops
- running into your dealer
- drug talk
- eviction.

coping with triggers

People?

- Missing friends
- a drug buddy
- your dealer
- your family.

Places?

- Your financial aid worker office
- hospital
- back alleys
- the neighbourhood
- the place where you usually get drugs.

Behaviours and activities?

- Shopping
- fights
- watching someone on the nod
- breaking up.



Feelings?

- Bored
- lonely
- frustrated
- relaxed
- insecure
- excited
- ashamed
- confident
- anxious
- left out
- depressed
- grieving
- normal
- "what's the use?"
- fear
- being in pain
- tired.



Add your own:

-
-
-

Coping by thinking or self-talk:

- This will pass.
- I am not going to use.
- I will get through this.
- I will be proud of not using.
- I can do something different.
- This won't take me where I want to go.
- Stop.
- I have other choices.

Add your own:

-
-
-

Coping by doing:

- Call non-using friend.
- Leave the area.
- Peel an apple.
- Sing a song.
- Meditate.
- Go to a meeting.
- Call a sponsor.
- Write a letter.
- Draw a picture.
- Close your eyes.
- Visit a place that holds good memories.
- Breathe deeply.

Add your own:

-
-
-

There are quite a few things we can do to cope. These ideas are just a start. We could all add to these lists. You may want to circle the top 3 that might be useful for you.

What to expect

crack

The high

- A high that lasts 5–30 minutes
- Feeling an intense, euphoric rush
- Warm skin, dry mouth
- Feeling thirsty, not hungry
- Rapid heartbeat and breathing
- Auditory hallucinations

Coming down

- Feeling restless, sweaty and twitchy
- Sensitivity to noise and light
- Feelings of paranoia
- Strong cravings for more crack

⚠ Note: combining substances can be dangerous – proceed with caution

crystal

The high

- A high that lasts 4–24+ hours
- Feeling alert and energetic
- Not feeling hungry or tired
- Dry mouth
- Faster breathing and heart rate
- Feeling restless, anxious or paranoid and unable to sleep

Coming down

- Feeling extremely tired, unable to sleep, anxious, hungry and thirsty
- Clenched jaw
- Strong cravings for more meth

Signs of overdose

feels like:

- Your heart is pumping fast
- You're short of breath
- Your body is hot, sweaty and shaky
- You have chest pain
- You can't talk, can't walk

looks like:

- Fast pulse or no pulse
- Fast or no breathing
- Hot and sweaty skin
- Confusion, hallucinations, unconscious
- Can't talk, can't walk
- Vomiting
- Seizures

⚠ Reminder: using condoms and lube during sex will reduce your risk for HIV and other infections.

Your peers created this harm reduction pamphlet for you. Be safe.

What to do if someone ODs

- 1 Call out for help – do not leave the victim
- 2 Try to get them to slow down and relax
- 3 Call 9-1-1 for an ambulance, send someone to seek help and report back
- 4 Tell paramedics as much as you can about what happened

Ready to detox?

Help is just a phone call away.

Call Access Central at 1-866-658-1221, seven days a week from 9am to 9pm for detox, residential addiction services and addiction housing.

1.866.658.1221



Safer Smoking



crack

crystal

What you need to smoke crack safer:

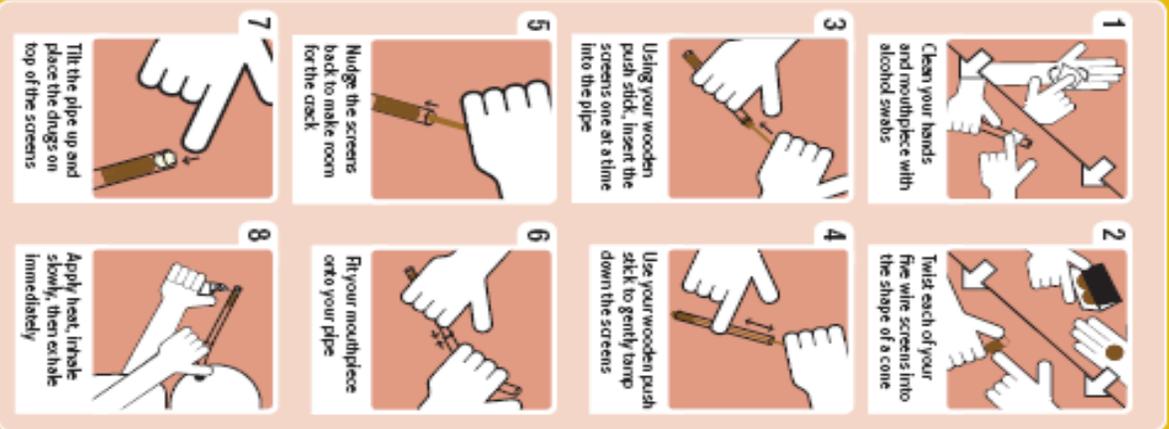
- | | | |
|-------------------------|----------------------|-------------------|
| | | |
| Shatterproof Pyrex Pipe | Re-usable mouthpiece | Five wire screens |
| | | |
| Wooden push stick | Lighter | Alcohol swabs |

What you need to smoke crystal safer:

- | | | |
|-------------------------|---------|---------------|
| | | |
| Shatterproof Pyrex Pipe | Lighter | Alcohol swabs |

the user-friendly series

Safer crack smoking



safer crack use tips

- Smoke in a safe place with people that you trust
- Take vitamins and eat something before you smoke – you won't feel like eating after
- Have condoms with you – you may want to have sex while high
- Pipe will be very hot once used – handle it with care
- Don't be alarmed by feelings of extreme depression once you're sober – it's your body reacting to the drug

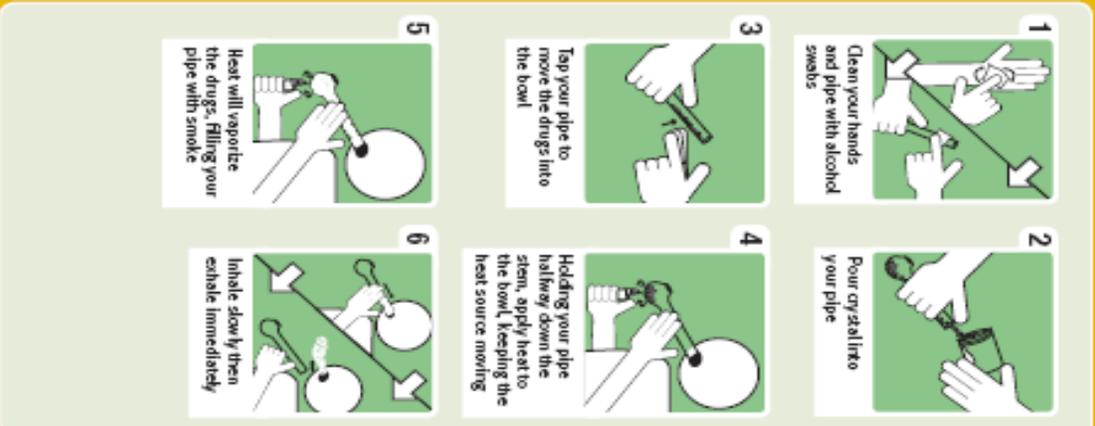
mouth care

- Don't share: use your own mouthpiece to avoid infection and mouth burns
- Drink water or fruit juice to keep your mouth moist and reduce cracks and blisters
- Moisten your lips with tube or lip balm
- Chew gum to keep your mouth moist and healthier

wire screens vs. brillo

- Wire screens are much safer than brillo
- Brillo's toxic coating can make you sick
- Brillo can break apart and be inhaled, burning your mouth and throat
- If wire screens aren't available and you can only use brillo, be sure to:
 - Burn the coating off and change it frequently

Safer crystal smoking



safer crystal use tips

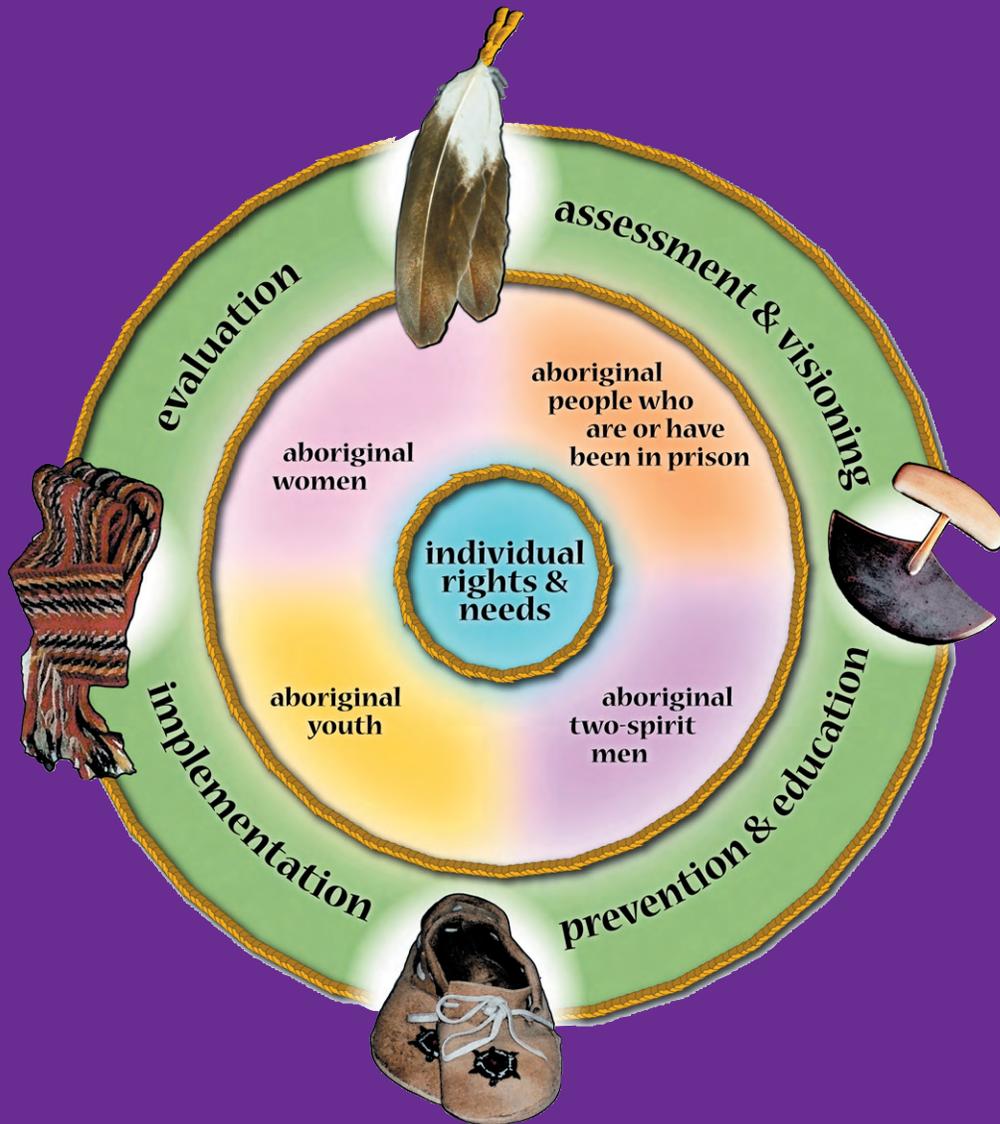
- Smoke in a safe place with people that you trust
- Inhale slowly and exhale immediately – don't hold it in
- Know your limits – once you're high, stop smoking
- Take vitamins and eat something before you smoke – you won't feel like eating after
- Have condoms with you – you may want to have sex while high
- Keep your pipe clean by burning off the residue and then scrubbing it with alcohol swabs
- When coming down, eating will help you sleep
- Don't be alarmed by feelings of extreme depression once you're sober – it's your body reacting to the drug

mouth care

- Avoid infection by using your own pipe – don't share
- Drink water or fruit juice to keep your mouth moist and reduce cracks and blisters
- Chew gum to keep your mouth moist and reduce clenching



Walk With Me Pathways to Health Harm Reduction Service Delivery Model



For Aboriginal Women, Aboriginal Youth, Aboriginal People
who are or have been in Prison and
Aboriginal Two-Spirit Men



THE CANADIAN ABORIGINAL AIDS NETWORK

Production of this document has been made possible through a financial contribution from the Public Health Agency of Canada under the Non-Reserve First Nations, Inuit and Métis Community HIV/AIDS Project Fund. The views expressed herein do not necessarily represent the views of the Government of Canada or the Public Health Agency of Canada. The Canadian Aboriginal AIDS Network thanks members of the National Steering Committee for direction, guidance and support in preparing this tool kit.

Brief Overview of the Canadian Aboriginal AIDS Network (CAAN)

- Established in 1997
- National, not-for-profit organization
- Represents over 340 member organizations and individuals
- Provides a national forum for members to express needs and concerns
- Provides relevant, accurate and up-to-date information on issues facing Aboriginal people living with and affected by HIV/AIDS in Canada
- Is governed by a thirteen member National Board of Directors and operated by a four member Executive

CAAN Mission Statement

As a key national voice of a collection of individuals, organizations and provincial/territorial associations, CAAN provides leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS. CAAN faces the challenges created by HIV/AIDS in a spirit of wholeness and healing that promotes empowerment, inclusion and honours the cultural traditions, uniqueness and diversity of First Nations, Inuit and Métis people regardless of where they reside.

CAAN Vision Statement

A Canada where First Nations, Inuit and Métis people, families and communities achieve and maintain strong, healthy and fulfilling lives free of HIV/AIDS and related issues where Aboriginal cultures, traditions, values and Indigenous knowledge are vibrant, alive, respected, valued and integrated into day-to-day life.

Acknowledgements

A special note of appreciation, to all participants of the focus groups, who have demonstrated courage and resiliency, as a model for living, and for the wisdom of the experiences they have shared from their daily lives. CAAN would like to give a special thank you to Bernice Downey for developing the original work used to frame this service delivery model.

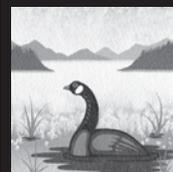
Vicky Laforge
Project Coordinator

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JUNE 2007

Table of Contents

Section One – Introduction	2
1.1 Introduction.....	2
1.2 About this Model.....	2
1.3 Development of the Model.....	3
1.4 Who can use this resource and how will it help?.....	4
1.5 Service Delivery Model.....	5
1.6 Barriers in developing Harm Reduction Approaches.....	6
1.7 HIV/AIDS, HCV and Harm Reduction.....	6
1.8 Harm Reduction Activities and Practices.....	7
Section Two – Service Delivery Model	10
2.1 Harm Reduction Task Force.....	10
2.2 Partnerships.....	10
2.3 Legal Issues.....	11
2.4 Service Delivery Model.....	11
2.5 How to use the Harm Reduction Service Delivery Model.....	12
Section Three – Four Target Groups	13
3.1 Target Groups.....	13
3.2 Women and Harm Reduction.....	13
3.3 Youth and Harm Reduction.....	14
3.4 Aboriginal people who are or who have been in Prison and Harm Reduction.....	16
3.5 Two Spirit Men and Harm Reduction.....	17
Section Four – Aboriginal People – Inuit, Métis, and First Nations	19
4.1 Culture – Holistic Healing.....	19
4.2 Aboriginal people in Canada – Inuit, Métis and First Nations.....	19
4.3 Aboriginal Culture – Inuit, Métis and First Nations.....	20
4.4 Determining Inuit, Métis and First Nations.....	21
Section Five – Implementation of the Harm Reduction Model	22
5.1 Assessment and Visioning.....	22
5.2 Prevention and Education.....	23
5.3 Implementation.....	25
5.4 Evaluation.....	27
5.5 Scenarios.....	27
Section Six – Moving Forward	30
6.1 Actions for Change.....	31
6.2 Closing.....	35
Section Seven – Bibliography	36
7.1 Bibliography.....	36
Section Eight – Appendices	43
8.1 Appendix One Harm Reduction National Steering Committee.....	43
8.2 Footnotes.....	X
8.3 Endnotes.....	X



Section One – Introduction

1.1 Introduction

The overall goal of this Harm Reduction project is to advance CAAN's previous work towards refining a culturally safe Harm Reduction service delivery model. The model is comprehensive, holistic and inclusive of the components of assessment, prevention, implementation and evaluation. This model has been designed to be diverse, and meets the needs of four target groups: Aboriginal Women, Aboriginal Youth, Aboriginal People who are or have been in Prison, and Aboriginal Two-Spirit men.

This culturally appropriate Harm Reduction model serves as a resource guide for service providers, communities, policy makers, and leaders. Groups may use the model to enhance their existing services or to learn more about Harm Reduction for Aboriginal people with respect to vulnerability to acquiring Human Immuno-Deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS). Four training modules have been developed to address the needs of each of the four target groups. The strategies used may be evaluated on a regular basis to ensure that client's needs are being met as the needs of the community/clients change. This document works together with the four training modules which provide a more practical hands-on version of information.

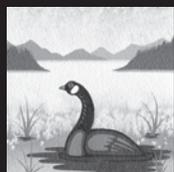
The development of this model has been conducted through focus groups that have provided the voice of experience. The work completed has been guided by a Harm Reduction National Steering Committee comprised of experts in HIV/AIDS and addictions.

1.2 About this Model

This model respects that all individuals reserve the right to be educated and receive health care services. They have the right to receive culturally appropriate services within the community designed for their basic needs. This project focuses on the needs of four target groups, Aboriginal Women, Aboriginal Youth, Aboriginal people who are or have been in Prison and Aboriginal Two-Spirit Men, while building on previous CAAN Harm Reduction initiatives such as Joining the Circle I and II, and the Circles of Knowledge Keepers Peer Education Module.

The targeted outcome is to improve and increase the Harm Reduction activities and policies within organizations and communities which provide culturally appropriate services to the Aboriginal target groups. This Harm Reduction service delivery model includes four comprehensive, flexible, holistic and culturally appropriate components that will meet the unique needs of the target groups. It is hoped that the work will influence the rapidly increasing rates of HIV/AIDS within the Aboriginal population and inform others about culturally appropriate Harm Reduction approaches.

Finally, this model will assist the spectrum of service providers including, community health representatives (CHR), addiction workers, mental health workers, nurses, doctors, and others in their day to day work with clients. This resource will provide First Nations, Inuit and Métis peoples who are or may be faced with the complex challenges related to chaotic substance use and issues related to HIV/AIDS.^A



Guiding Values

Wisdom, respect, humility, honesty, love, bravery and truth are the guiding values to this Harm Reduction strategy. These teachings provide this Model the basic values to associate with in order to provide a balanced and holistic approach to addressing Harm Reduction.

Wisdom

Traditional teachings, indigenous education, awareness sessions, use of Elders, generations of experience, and history combine to provide the capability of teaching others how to live a healthy balanced life.

Respect

This includes viewing people as equals, with their own gifts to share, practicing kindness towards others, regardless of their health status, sexual orientation, race, etc., while being appreciative of and caring for each other.

Humility

Recognizing that leadership, para-professionals, community, service organizations and clients understand and realize that all people have their own journey to follow in life.

Honesty

Providing a trusting environment for clients, with accurate, informative materials to advance the Harm Reduction approaches in Canada. It includes providing an atmosphere for clients where they may receive assistance regardless of risky behaviors that they may engage in, without judgement.

Bravery

Honouring the bravery of clients who come forward to mobilize against the continued spread of the HIV/AIDS and Hepatitis C (HCV) virus, by engaging in Harm Reduction initiatives. Promoting the bravery that is required for HIV and HCV testing. To have the courage and strength to make healthy choices that will influence your life, and the life of your family.

Love

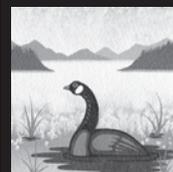
Using positive energy to provide a loving environment to help people who may not have been shown love in their lives. Showing affection, kindness, and caring to everyone that you greet throughout your day.

Truth

To be sincere, and to speak your truth, be who you are and be proud.

1.3 Development of Model

A culturally appropriate model is proposed as a way to frame a Harm Reduction approach to care, support and treatment. A number of information gathering activities contributed to informing the development of the model. A literature review to prepare for this project was undertaken by CAAN^B to synthesize information related to HIV/AIDS, Harm Reduction and Aboriginal populations; *Literature Review and Model Building in Harm Reduction for Selected Populations*.



A Harm Reduction National Steering Committee (HRNSC) was established and was representative of Aboriginal People Living with HIV/AIDS (APHA), various partner organizations, CAAN staff and CAAN Board of Directors (See Appendix I – Harm Reduction National Steering Committee) The HRNSC’s primary purpose was to guide the development of this service delivery model.

A focused review of other CAAN documents has been undertaken, including Aboriginal and non-Aboriginal AIDS service organizations (ASO) documents, select government sources, and other articles and documents. Internet searches included Pub Med Central, Google Scholar, CINAHL, with search words of Harm Reduction, service delivery models, best practices, HIV/AIDS, Aboriginal, models of intervention and culture assessment. Various HIV/AIDS related databases were also searched. Focus groups with target population representatives were held which further informed the development of the service delivery model and the development of the training modules.^C

Four specific training modules have been developed that use the ‘Walk with Me Pathways to Health’ model as the framework for training various service providers involved in HIV/AIDS work for First Nations, Inuit and Métis.

1.4 Who can use this resource and how will it help?

This document is targeted for use by a range of health care workers. These include community leaders, health directors, band councils and policy makers such as government representatives or AIDS service organizations.

Health care service providers

Through the development of policies, training, counseling with clients, community events, and collaborating with partners, the health care service providers may normalize, and incorporate this model into their programs and services.

Addiction Treatment Centres

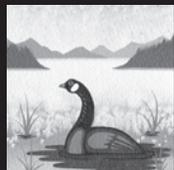
May utilize this Harm Reduction approach when addressing the needs of the communities that they are serving. Treatment Centres may educate the public on Harm Reduction approaches and are encouraged to produce new provisions for Harm Reduction services within the Centres.

Community members and leaders

Community members, families and leadership are also in need of support as they face this serious health issue. While there are community initiatives making headway in creating awareness about the HIV/AIDS epidemic, there are still others who don’t understand the vulnerability of their community members to this disease. There is often confusion or misinformation related to stigma and discrimination about the issue. There is also fear and anxiety and a sense of being overwhelmed as to how to address it. Community members and leaders need to understand what a Harm Reduction approach means. Often supportive approaches and programs are difficult to implement because of a lack of understanding, discrimination towards injection drug users, or a difference in values and beliefs.

Policy makers

Policy informs decision makers and provides a consistent structure within the organization, which



further provides a foundation for the management process of that organization. Policy makers at all levels of government and throughout the levels of organizations, both Aboriginal and non-Aboriginal, need to be informed of policies to ensure their influence will effectively achieve the goal of removing barriers, and of improving their organization's services.

AIDS service organizations (ASO) – are instrumental in the work they accomplish in addressing HIV/AIDS. Depending on their mandate, most are leaders in the fields of advocacy, policy development and research of HIV/AIDS and related issues. Aboriginal people need the expertise and leadership of these organizations to support their voices and convey the key message for change required.

1.5 Service Delivery Model

This service delivery model is comprehensive, holistic and inclusive of the components of Assessment and Vision, Prevention and Education, Implementation, and Evaluation.

Harm Reduction is an approach which focuses on the reality that an individual's readiness to change varies, and that individuals may not be ready, willing or able to completely change risk behaviors. Harm Reduction awareness sessions can be provided to educate the public on accepting Harm Reduction initiatives, to reduce the incidence of HIV/AIDS. Currently, Harm Reduction approaches are not fully accepted within communities. This is primarily because there is a discrimination against chaotic substance use and service providers believe that an abstinence approach is more effective in dealing with chaotic substance use. Applying a Harm Reduction approach within the community will ensure safe, holistic practices for all people, and will meet the differences in people's beliefs and values.

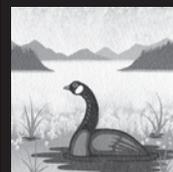
This model allows for flexibility and provides the tools necessary to provide for the implementation of Harm Reduction practices which are assessed by all partners within a community according to the needs, cultural requirements and level of community awareness of HIV/AIDS.

Many Aboriginal people who are or have been in prison are being diagnosed with HIV/AIDS and Hepatitis C (HCV). It is important that these individuals receive the appropriate health care, education and resources necessary to live as HIV/AIDS and HCV positive persons.

Tattooing, injection drug use (IDU), and unsafe sexual practices are some of the activities that are taking place within the prison system. One of the difficulties associated with introducing Harm Reduction initiatives within correctional facilities is the belief that providing clean needles and condoms means condoning or promoting injection drug use and inmate sexual intercourse.

Aboriginal Two-Spirit Men historically held a respected place within society where they were valued for the gifts which they possessed. Increasing services, support, care and treatment for Two-Spirit Men within communities/organizations, through the implementation of the Harm Reduction Model, will help to improve and address the individual rights and needs of this target group.

Strategies for Aboriginal Youth which keep their development in mind will assist Youth in being more accepting of Harm Reduction approaches later in life. As Aboriginal youth grow and experiment and learn their own ways, they will do so armed with the tools that will offer protection and wisdom that will reduce the chances of transmission of HIV/AIDS.



Aboriginal Women have HIV/AIDS at very high rates and a strategy must be put in place to reduce the incidence immediately. Communities, shelters, programs and services must provide these mothers, and daughters the tools necessary to have the strength to speak up, act and protect in order to reduce the incidence of HIV/AIDS and HCV within this target group. As with the other target groups, many women are engaging in risky behaviours. Through education and resources, and the acceptance of an effective Harm Reduction approach, more appropriate steps can be taken to address women's needs.

1.6 Barriers in Developing Harm Reduction Approaches

Critics of Harm Reduction believe this approach condones and even encourages behaviors they consider to be dangerous, socially de-stabilizing, and immoral. CAAN reports that the most common argument against needle exchange is that it will encourage drug use, even though this is not supported by scientific evidence.¹

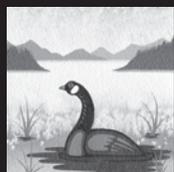
Today, while there are some encouraging examples of Harm Reduction initiatives emerging, overall there remains many challenges to implementing effective Harm Reduction programs and services in communities. Abstinence-based addictions treatment philosophies, limited access to services, and confidentiality concerns are a few of the barriers that individuals and communities are currently experiencing. Others may include (but are not limited to):

- Youth not attending school, and not participating in prevention and education activities.
- Women becoming too isolated within their homes to attend awareness activities about the high risk activities that they may be practicing.
- Two Spirit men may be within a community which is not accepting the existence of problems (i.e. high risk activities) occurring in the communities.
- Communication problems within a community, such as members not attending community meetings;
- Aboriginal people who are or have been in prison are faced with outdated policies that do not support Harm Reduction.
- Lack of Harm Reduction initiatives.
- Fear of providing Harm Reduction activities because it will be viewed as promoting the activity that they are trying to reduce.

1.7 HIV/AIDS, Hepatitis C Virus (HCV) and Harm Reduction

Current statistics indicate that Aboriginal populations remain over-represented in the HIV/AIDS epidemic in Canada with the overall infection rate 2.8 times higher than among non-Aboriginal persons. Almost two-thirds of new HIV infections are attributable to injection drug use (IDU), with HCV incidences in the Aboriginal population estimated at 8 times higher than in the general Canadian population.²

For First Nations; of all reported AIDS cases (2205) among First Nations people, 44.9% of cases can be attributed to IDU. Females represent 27.6% of cases, while youth (less than 30 years of age) account for 21.1% of all reported cases.³ For Métis, 30% of all reported AIDS cases are attributable to IDU, and



few cases (7.3%) indicated as being female; For Métis, youth account for nearly 31.7% of reported AIDS cases. Within the Inuit population, the IDU exposure category represents about a third of reported AIDS cases at 31.8%. Females represent 40% of the reported cases, while youth represent 31.8%.

The Public Health Agency of Canada (PHAC) reports that by the end of 2005, more people (in Canada) were living with HIV infection (including AIDS) at an estimated 58,000 (48,000 - 68,000). PHAC also reports 'a steady rise in the proportion of reported AIDS cases and positive HIV test reports among Aboriginal peoples in Canada in recent years';⁴ Aboriginal peoples account for 16.4% of the total reported AIDS cases for which ethnicity were known.^D

- Aboriginal persons represent 3.3% of the Canadian population and yet an estimated 3,600 to 5,100 Aboriginal people were living with HIV (including AIDS) in Canada in 2005. This represents about 7.5% of all prevalent HIV infections
- Aboriginal people are diagnosed with HIV at a younger age than non-Aboriginal peoples. A third (32.2%) of new positive HIV test reports among Aboriginal persons represent youth (aged < 30 years) as compared with 20.8% among non-Aboriginal persons.
- Aboriginal women represented 47.3% of all positive HIV test reports among women, as compared with 20.5% of reports among non-Aboriginal females.
- Among Aboriginal Canadians the proportion of new HIV infections in 2005 attributed to injection drug use (53%), was much higher than among all Canadians. (14%)

CAAN reports that the number of people with HCV in Canada is growing and increasing at a steady rate. The PHAC reports that currently, the major mode of contracting HCV is through the sharing of contaminated needles and other needle works among injection drug users. Other risk behaviors reported include the use of contaminated equipment for tattooing, body piercing, acupuncture, and intra-nasal (snorting) cocaine use.⁵ Health workers are also at risk due to accidental needle sticks. Infants born to HCV infected mothers, Aboriginal people who are or have been in prison, and injection drug users, are high risk groups relative to this project. IDU in the prison system is a significant factor in the transmission of HCV and both HIV/HCV rates of infection are thought to be much higher than reported.⁶

CAAN estimates that more than 1500 HIV positive Aboriginal people are co-infected with HCV^E. Further, people with HIV have a higher viral load and are more likely to transmit HCV to others.⁷ An important diagnostic factor is that the detection of HCV can be more difficult in people with HIV because a false negative may be obtained when individuals are HCV positive, even if they have not developed antibodies⁸.

Treatment protocols are complicated for people with HCV and lower success rates are cited.^F Liver toxicity is a concern; HIV positive women may pass on HCV to their unborn babies; there is a slowing of T-cell counts during HIV treatment; some people have difficulty detoxifying medications by the liver; and other drug related issues are all factors for consideration in co-infected individuals.



1.8 Harm Reduction Activities and Practices

Aboriginal groups, organizations and communities may establish creative ways to address Harm Reduction within their communities and/or organizations. Harm Reduction may be viewed as a continuum of services, which provides services to a target group where no services have previously existed. Prevention/education to reduce the risk of harm, testing for injection drug users to determine early diagnosis and facilitate treatment, and health promotion activities to minimize negative health outcomes, are all strategies towards effectively reducing the harm of chaotic substance use and decreasing the risk of HIV transmission.

Outreach services may address Harm Reduction by providing a glass of water, or a sandwich to someone who may not have eaten in days, gradually building trust in the process. At a future date, the same client may trust this individual enough to disclose abuse issues or to ask for further care. Within the continuum of care, this Model bridges an area that is not currently being addressed. In viewing the full spectrum you can see a person engaged in high risk behavior, who is not receiving any services or information, to the opposite end of seeing a person going to treatment and making life changes. Using a Harm Reduction approach means that within this continuum of services gaps are bridged, people educated, and a normalizing of service provision for the target groups.

Needle exchanges, condom distribution, counseling and the provision of methadone are all activities which mitigate the risks of becoming HIV positive. People will decide their own course and move forward when they are ready. Facilitating this process assists clients in moving forward on their healing journey with hopes of eventually choosing a less harmful life path for themselves.

Many people are aware of how HIV/AIDS and HCV are transmitted, yet they continue to engage in risky behaviors. With an increase in education, prevention, direct services and support, people will have increased awareness and will reduce incidences of HIV/AIDS and HCV.

A less challenging example of Harm Reduction could be the provision of pamphlets that provides information on anonymous testing for HIV/AIDS. A more challenging one could be the incorporation of a methadone clinic, or a needle exchange program.

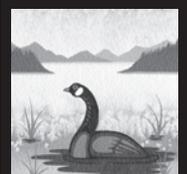
Throughout the various elements of the model, barriers will need to be identified and addressed. Barriers may vary according to community and/or organization and may include:

- Homophobia: This barrier has negative impacts on the entire community; it can affect entire organizations and can lead to hate crimes against people. In light of promoting a Harm Reduction Strategy or programs/services, homophobia can lead to the inaction within a community or service. Individual rights and needs of all people need to be promoted and requires education, support and services within a community or organization.
- Family relationships: Family may provide the basic foundation for an individual, yet, if there are problems within the family, problematic issues result. For example, in some extreme situations, individuals raised within an unhealthy family environment can lead to homelessness, suicidal ideation, chaotic substance use, incarceration, low self respect and low self-esteem. A woman may be disrespected by her husband, a young person may break the law and become imprisoned, a



youth may decide to run away from home, a Two-Spirit Man may become ostracized by his family. There are cases of entire families engaging in high risk behaviors together, such as IDU. This has catastrophic results and requires creative Harm Reduction approaches.

- The impact of colonization: Colonization, with the resultant racism, loss of language and sense of cultural identity among other negative outcomes, impacts an individual's self-esteem, care and support systems. There is often a connection between chaotic substance use and a negative sense of self, with deep rooted anger and a sense of powerlessness resulting.
- Chaotic Substance Use: When a person uses drugs it can often times result in the creation of chaos and havoc within their lives. Individuals who are using drugs and alcohol often remove themselves from difficult feelings and struggle to cope in their day to day lives. The challenges of living in a society that is unkind and un-accepting of people who engage in high risk activities compound the issue.
- Socio-economic factors- such as poverty and unemployment need to be part of a holistic approach for those attempting to recover from chaotic substance use and/or who may be at risk of HIV/AIDS. This applies to all stages of care, support and treatment. A state of poor health may be exasperated by the inability to eat healthy, purchase required medications, or to access reasonable housing, etc. A sense of powerlessness may be felt and this may lead to the individual's engaging in high risk activities, and experiencing a low sense of self-esteem.
- Confidentiality: Service Workers require appropriate training in confidentiality and HIV/AIDS disclosures and counselling to ensure that the strictest protocols and privacy are respected.
- Outreach and the need for cultural and emotional support: Aboriginal people who self identify as being lesbian, gay or Two-Spirit, trans-gendered, and bisexual have mobilized and established networks for themselves. For example, the 2-Spirited People of the First Nations is a non-profit social service organization providing care and support and treatment to its clients. Often, organizations such as this one are the only source of cultural support for many Aboriginal people who may have experienced isolation and ostracism from their families and communities.



Section Two – Service Delivery Model

2.1 Aboriginal Harm Reduction Task Force

CAAN has created a National Aboriginal Task Force on Injection Drug Use that will work to increase knowledge and awareness of issues of chaotic substance use and HIV/AIDS transmission/treatment, and will promote the creation of improved programs and services.

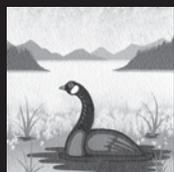
The Task Force will support, advise and provide coordination and actions on Harm Reduction issues. Population-specific approaches are being designed which will assist people who are at risk of infection, and those living with HIV/AIDS, to ‘directly shape policies and programs that affect them’⁹. The task force will provide input into projects, offering a voice on behalf of the people that CAAN serves and informs on a regular basis.

2.2 Partnerships

There is a wealth of HIV/AIDS and addictions expertise in Canada who can come together to collaborate and provide support to those developing and providing Harm Reduction programs and services. There are many HIV/AIDS and addictions agencies, programs and organizations at the local, Provincial, Territorial and National levels, Aboriginal AIDS Service Organizations, community health centres, researchers, social workers, hospice professionals, community workers, medical personnel and volunteers make up the profile of those in positions to provide informed support. The National Native Addictions Partnership Foundation (NNAPF) currently partners with CAAN for the purpose of sharing information on Harm Reduction. CAAN will be participating in NNAPF’s upcoming National training conference to provide training sessions for government, National Native Alcohol and Drug Abuse Program (NNADAP) workers, and other interested service organizations who will be participating in this conference (over 400 participants at the 2004 training conference). CAAN will provide training on the model, and exchange information with various organizations and engage in the networking and sharing of information at the NNAPF conference.

Collaborative efforts can help the community to gain an understanding and acceptance of Harm Reduction approaches. Providing communities with appropriate education and the training of front-line workers, the establishment of needle exchange programs, methadone maintenance, and outreach components, all represent a part of the journey towards safer drug use.

Various stakeholders addressing HIV/AIDS may include government, (Federal, Provincial and Territorial), non-profit groups, APHA’s, National networks, communities, Health Centres and any other groups who feel a need to advance the proposed Harm Reduction approach from an Aboriginal perspective. Partnership protocols will facilitate improved and efficient partner relationships which will increase the effectiveness of services for clients, increase adherence to the treatment approach and increase client support and satisfaction. Many communities, organizations and professionals have existing partnerships and do not work in isolation. Within the structures of this Harm Reduction Strategy, however, new partnerships may be developed which can lead to on-going collaboration in HIV/AIDS and HCV education, awareness and program development.



2.3 Legal Issues

When planning and/or implementing a Harm Reduction Strategy for an organization or community, various legal issues will need to be considered and explored. Planning and coordinating the Harm Reduction Strategy will require research and/or involvement with police services. Passing a band council resolution (BCR) may need to be considered and there may be a possibility that community by-laws need to be changed to support the Harm Reduction Strategy.

Various legal issues to consider can include (but are not limited to):

- HIV/AIDS testing and confidentiality
- Community approval, Band Council Resolutions, by-laws and protocols for crack kits and needle exchanges
- Safety issues for workers
- Confidentiality issues surrounding disclosures
- Privacy and confidentiality as essential elements of good practice
- Occupational safety needs of guards, counselors, workers at the needle exchange sites, etc
- Violations of human rights
- Working with organizations dealing with the law to ensure appropriate measures are taken to follow by-laws, procedures etc

2.4 Harm Reduction Model

The Harm Reduction model is a tool which can be used in collaboration with the training modules to enhance services within organizations or implement new Harm Reduction programming. The Model begins with an Individual's rights and needs, found at the centre of the circle. This model has been developed to fill a gap where particular target groups may not be receiving the care, support and treatment that they rightly deserve. The four phases that may be used by a service provider, organization or community has been broken down into four groups: Assessment and Visioning, Prevention and Education, Implementation and Evaluation.

All service agents will have the ability to apply this model regardless of where they are in providing Harm Reduction services. All organizations that receive training may or may not choose to apply the model within their agency, may or may not choose to provide needle exchange, for example, yet the training will provide examples of ways in which action may be taken. Whether an organization is at the planning stage, (with no current programming), or whether there is a need to enhance existing services, the model and training modules may be used to assist in the process. This service delivery model will provide the flexibility to apply creative, relevant, and diverse programs and services.



Harm Reduction Model



2.5 How to use the Harm Reduction Service Delivery Model

The Harm Reduction model has been developed to assist groups, communities and organizations in incorporating a Harm Reduction Program or Strategy which would include the needs of the community, while incorporating relevant cultural elements. To begin the process, an assessment or visioning exercise will be conducted which will review past, present and future goals of programming and needs of the community. Once the assessment has been completed, services, prevention activities, cultural elements and implementation procedures and issues will be outlined for the community and/or organization. The model will provide tools to assist in outlining appropriate cultural elements to a Harm Reduction Strategy. The goal is to lower incidences of HIV/AIDS and HCV within Aboriginal communities. This in turn will have a positive impact at both a national and international level.

The Model begins with its centre, being the individual, where services are created to respect their rights and needs through the development and implementation of appropriate services in Harm Reduction. This Harm Reduction Model is providing a service to a target population which has escalating rates of HIV/AIDS. An individual may not receive services when they are injecting drugs due to stigma and discrimination associated with their life on the streets. Or they may be struggling and not in a position considered as acceptable to service providers. Regardless of the actions of any person, each individual deserves the right to be educated on how to reduce the harm to themselves or to others, and to receive services that meet their individual needs.

The determination and application of Harm Reduction approaches will be provided to the four target groups. The services that may be provided for the target groups are 1) Assessment and Visioning, 2) Prevention and Education, 3) Implementation (of services and activities) and 4) Evaluation. Important aspects which need to be considered at all levels of planning and implementing of the programs and services include: accountability to all being served, partnerships (because you never plan a strategy alone), safe disclosure, evidence based practices, holistic health (physical, emotional, mental and spiritual health), and respect for the diversity of all three Aboriginal groups. Partnerships are encouraged within the framework of this model, although, Harm Reduction practices may be provided independently.



Section Three – Four Target Groups

3.1 Target Groups

Aboriginal Women, Aboriginal Youth, Aboriginal people who are or have been in Prison, and Aboriginal Two-Spirit Men are the four main target groups for this model. Four training modules will compliment this manual, with a focus on methods of providing care, support and treatment. The target groups have been identified as being at the highest risk and therefore, information will be applied to the four main target groups. The term Aboriginal refers to the Inuit, Métis and First Nations people, living on and off reserve, and in every part of Canada.

When considering Harm Reduction services, it is important to ensure that data is specific to the population served. Ethnicity data for positive HIV test reports are reported for 29.1% of records and are not available for all provinces and territories.¹⁰ This is an issue of concern in that even with limitations on surveillance, Aboriginal people remain over-represented. This situation coupled with the under-reporting of ethnicity data indicates that Aboriginal HIV cases are underestimated. It is reported that available statistics do not indicate the actual number of infected Aboriginal women, because many cases from this group go unreported. Variations in reporting ethnicity within and between provinces, delays in reporting, and misclassifications in ethnic status are other contributing factors¹¹.

3.2 Women and Harm Reduction

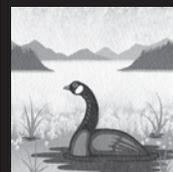
Aboriginal women within this target group include all women, heterosexual, bisexual, trans-gendered, Two Spirit women, and women who have sex with women.

Aboriginal women are becoming infected with HIV/AIDS at higher rates than other women in society. The high transmission rates have been reported through the medium of intravenous drug use and through having unprotected sex. Reported numbers of HIV/AIDS incidence among Aboriginal women reveal that this group is over-represented in the HIV positive classification.

In Canada, PHAC reports that a total of 1,786 AIDS cases and 8,849 HIV cases were reported in adult women up to December 31, 2005.¹² In addition, women represent ‘an increasing proportion of those with positive HIV test reports in Canada and in 2005 accounted for one quarter of such reports. Heterosexual contact and injection drug use are the two main risk factors for HIV infection in women.¹³

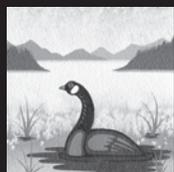
PHAC also reports that HIV/AIDS has had a significant impact on Aboriginal women.

- During 1998 - 2005, women represented 47.3% of all positive HIV test reports among Aboriginal peoples as compared with 20.5% of reports among non-Aboriginal peoples.¹⁴
- Before 1995, females represented 12.3% of reported AIDS cases among Aboriginal peoples, yet by 2005 the proportion had increased to 38.9%.



Various issues have led to Aboriginal women becoming a high risk for HIV/AIDS. Some of these include:

- Issues of power imbalance and violence: NWAC notes that socio-economic conditions, gendered discrimination and the lack of recognition of land and collective rights of Indigenous peoples have all had a negative impact on a woman's ability to live free from violence. In addition, NWAC reports that the unique needs and perspectives of Aboriginal women will not be met if the right and fundamental freedom to live free from violence is not respected, protected and fulfilled. ¹⁵
- Social determinants of health issues: Aboriginal women suffer from high rates of poverty and related ill-health, low education and low employment levels and homelessness. ¹⁶ Risk behaviors for Aboriginal women include those that often assist them in surviving the harsh socio-economic conditions that are strongly associated with a positive HIV test. These include rural to urban migration, homelessness, sex trade and/or sex work, injection drug use and alcohol abuse. ¹⁷ Aboriginal women are also considerably more likely to experience sexually transmitted infections. ¹⁸
- Survival: Women are more likely go to the streets and to the sex trade in order to receive money, drugs, lodging and food for their survival, to support their chaotic substance use, and to live, when they feel they have run out of other options. These drastic coping measures pose great harm to the women, children and their families.
- Relationship issues: having a partner who is an injection drug user may put a woman at higher risk for IDU herself, and of sharing needles or engaging in unprotected sex. ¹⁹ Addiction, the effects of residential schooling and family violence, among others, often contribute to a women's sense of low self-esteem. This makes it difficult for her to assert herself with her partner, and to demand he/she use condoms or have HIV testing.
- Maternal and reproductive health factors: Women are often the primary caregiver in Aboriginal families and will often put the needs of their children or family ahead of themselves, often compromising her health. Stigma and discrimination may be experienced by the HIV positive woman who chooses to give birth. Addressing the issues of mother-to-child transmission and breast feeding requires a more concerted effort. ^{20,G}
- Women who have sex with women (WSW) specific issues: WSW struggle for increased visibility and awareness about their issues and are beginning to organize and undertake advocacy and awareness activities.



3.3 Youth and Harm Reduction

Aboriginal youth vary in life experiences at all stages of their development. Prevention methods, education and awareness are important in teaching and thus normalizing Harm Reduction practices. Youth may learn about the various ways of reducing harm and will be able to incorporate practices into their lives and reduce the incidence of transmission of HIV/AIDS and HCV.

Many Aboriginal youth are experiencing chaotic substance use more frequently than their mainstream peers. But many are also seeking information on how substances may be used in a safe way, and how

to inject properly, and vein maintenance. It is important to understand their population-specific issues and ensure that they receive appropriate prevention and testing information.

Research shows that 33% of newly diagnosed Aboriginal people were under the age of 30 as compared with 20% of non-Aboriginal people. This means that Aboriginal youth are at high risk of HIV/AIDS. <http://www.harmreductionjournal.com/content/3/1/9>

PHAC reports that youth represent a 'small proportion of the total number of reported HIV/AIDS cases'.

- Individuals between the ages of 10 and 24 are reported as accounting for 3.5% of cumulative AIDS cases.
- For positive HIV test reports, youth between the ages of 15 and 19 accounted for 1.5% of all reports²¹.
- Aboriginal people receive a diagnosis of HIV at a younger age than non-Aboriginal people with a third (32.2 per cent) of new positive HIV test reports among youth. (<30 year) This figure is significantly higher than non-Aboriginal persons at 20.8 per cent.²²
- MSM and IDU each account for approximately a third of reported AIDS cases among Aboriginal youth. IDU is the largest factor at 33.9 per cent and MSM was at 30.6 per cent.^H

Foster Care: In Canada, Aboriginal children and youth are entering foster care at an alarming rate, with between 22,500 and 28,000 Aboriginal children in the child welfare system – three times the highest enrollment figures of residential school during the height of those operations²³.

Aboriginal youth are over-represented among criminalized young people. In 2000, 41.3% of all federally incarcerated Aboriginal people who were or had been in prison were 25 years of age or younger. Aboriginal people have much higher education and employment needs than do other incarcerated people. A high percentage (80%) of Aboriginal people who are or have been in prison report early drug/or alcohol use; physical abuse (45%); parental absence or neglect (41%); and poverty (35%) in their family backgrounds. 28% of Aboriginal people who are or have been in prison have been raised as wards of the community²⁴. These percentages are all indicators of young people being at high risk for contracting HIV/AIDS and HCV.

Youth at risk who are not being tested: Underserved Aboriginal adolescents and young adults, many of whom have involvement with the juvenile justice system or are in custody, are HIV positive or are at risk for HIV infection; many male and female teens are trading sex for survival or to purchase drugs; there are cases of chaotic substance use, young women are becoming pregnant, or two-spirit young people are runaways, street involved, homeless, or otherwise living on the edge of the community.

Unprotected sex: PHAC reports that the prevalence of sexually transmitted diseases (STD) and teen pregnancy may indicate the frequency of unprotected sex.²⁵

There is a lot of confusion and misinformation regarding HIV/AIDS: PHAC reports that studies indicated many youth believe that there is a vaccine to prevent HIV/AIDS and that the disease can be cured if treated early.

Addressing potential knowledge gaps: There are other contributing factors that are an area of concern. If a youth drops out of school, for example then he/she may not be privy to HIV/AIDS information.



Taking risks: Normal limit-testing is common place behaviour in adolescent development, however, vulnerable adolescent's ramp up the risks by taking sexual risks, being engaged in chaotic substance use and living on the streets²⁶.

Educational materials designed by and for youth: Youth designed materials, counseling for sexuality issues; access to health services, intervention and appropriate Harm Reduction approaches can help engage youth and address high risk behaviours.

Gateway Drugs: Youth require education and awareness of gateway drugs and the possibility that these could lead to harder drugs and more chaotic substance use. Various gateway drugs include tobacco, marijuana, alcohol, and ecstasy.

Aboriginal youth: Aboriginal youth need to be full participants in determining actions that will address their needs. CAAN has developed a youth link to its website which has been designed with and for youth which provides a means for communication regarding HIV/AIDS, while allowing for access to confidential information.

To view Canadian Aboriginal AIDS Network, Youth website go to: http://www.caan.ca/youth/html/index_e.html

3.4 Aboriginal People who are or have been in Prison and Harm Reduction

Aboriginal people comprise 2.7% of the adult Canadian population and women make up 50-55% of the Aboriginal population²⁷. The incarceration rate of Aboriginal people in Canada is high and Aboriginal people are over-represented. Approximately 18.5% of Aboriginal people who are now serving federal sentences are of First Nations (68%), Métis (28%) and Inuit (4%) ancestry. In the Prairies, where Aboriginal peoples comprise a larger portion of the general population, they account for a staggering 60% of Aboriginal people who are or have been in prison.

Aboriginal people who are or have been in prison experience longer periods of incarceration, are placed in maximum security, and are segregated more frequently than non Aboriginal people who are or have been in prison. These conditions reduce Aboriginal access to programming intended to prepare Aboriginal people who are or have been in prison for eventual release, and to increase their chances for successful integration into their communities²⁸.^J This situation has caused negative impacts in the areas of public health, civil rights and social justice.

While the federally incarcerated population in Canada declined by 12.5% from 1996 to 2004, the number of First Nations people in federal institutions has increased by 21.7%. The number of incarcerated First Nations women also increased by 74.2% over the same period.

It is important to understand the many reasons why Aboriginal people are over-represented in prisons.

- Many Aboriginal people end up on the streets for varying reasons, due to abusive home situations,



inability to afford housing, chaotic substance use, etc; Aboriginal people are struggling with the legacy of residential schooling, and are subjected to systemic racism and attitudes based on racial or cultural prejudice on a regular basis. Prejudice leads to living on the fringe of mainstream and in poverty.

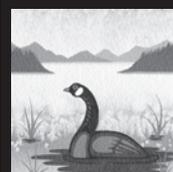
- Racism: Aboriginal people attract more police attention than non Aboriginal people as a general rule (i.e. they are more likely to be stopped and questioned)²⁹. They often end up in prison not because they are hardened criminals, but as a result of racism based on issues related to colonization and deterioration of their social, cultural, emotional, and spiritual well-being³⁰.
- Homophobia: Two-Spirit men and women are at particular risk of abuse, violence, racism, and sexual assault/rape; these issues increase their vulnerability to HIV/AIDS and HCV.

HIV/AIDS and HCV have become emergency issues in Canadian prisons. The rate of HIV seroprevalence is ten times higher in prisons than it is in the general population³¹. The rate of HCV in prison is approximately 39% of the population. The high incidence of HIV/AIDS and HCV is a result of IDU, unprotected sexual activities and tattooing. The rate of IDU by incarcerated Aboriginal men is between 43% to 54% and 8% of Aboriginal women who are or have been in prison. Aboriginal people who inject drugs in prison are at high risk of sero-conversion.

- High risk environment: Once someone becomes entrenched in the system they will face risks, especially if they use drugs and inject needles. Needles and other paraphernalia are considered contraband in prison (unless an inmate is diabetic) which leads to Aboriginal people who are or have been in prison to share needles with others. In this regard Aboriginal people who are or have been in prison are not permitted access to the very things that can prevent them from getting HIV/AIDS or HCV.
- Need for information: Significant energy and resources are required to ensure that accurate and timely information is being delivered³². If a person in conflict with the law has never been given information that they can relate to about HIV/AIDS and HCV, they may never ask to go for a test, and this potentially poses risks to sexual partners. There is a need to increase knowledge of sexually transmitted infection including symptom recognition and screening.
- Testing: If Aboriginal people who are or have been in prison have never been given information that they can relate to about HIV/AIDS and HCV, they may never ask or go for a test and as such pose risks to sexual partners out of ignorance. This also has implications on their health needs as they may go un-diagnosed and develop more serious health threats for themselves, their partner and their community.

3.5 Two-Spirit Men and Harm Reduction

Fact sheets regarding men-who-have-sex-with-men (MSM) have stated that the term “men who have sex with men” “describes a behavior rather than a specific group of people. It includes self-identified gay, bisexual, trans-gendered or heterosexual men. MSM are often in married [heterosexual] relationships, particularly where discriminatory laws or social stigma of male sexual relations exist.”^{33, K} MSM may



also include men who are not gay but who have sex with men in the sex trade in order to obtain food, drugs, and/or shelter. In terms of HIV/AIDS and HCV, sex between men is significant because it can involve unprotected anal sex, which is high risk behaviour.

The Public Health Agency of Canada reported in 2006 in Epi Update: HIV Infections among MSM in Canada:

- MSM account for 76.3 per cent of cumulative reported AIDS cases and 68.8 per cent of cumulative positive HIV test reports among adult males.
- Of all new HIV infections in Canada in 2005, MSM were estimated to make up 45 per cent of these cases.³⁴ PHAC reports that new infections among MSM has not decreased in 2005 and may have increased slightly compared to 2002.
- MSM account for 11 per cent of the prevalent infections and 10 per cent of incidence among Aboriginal peoples in Canada in 2005.³⁵ While there are only a few research studies on this sub-group of APHAs, some research is illuminating emerging trends. An example is found in the Vancouver Injection Drug Users Study (VIDUS) which is an open cohort study of IDU.
- In VIDUS surveys between 1995 and 2000, of 910 MSM who had injected drugs in the previous year; MSM/IDU 'were younger than MSM and more likely to be HIV sero-positive, Aboriginal, economically disadvantaged, engaged in the trade of sex for money and drugs and to report having female partners'.³⁶

Key prevention issues for Two-Spirit men include the following:

- Prevention and care programs are often neglected when there is a taboo on MSM behaviour:³⁷ Information and education and other prevention programs targeted specifically at MSM help save lives and curb the epidemic.
- Low self esteem, gay bashing and homophobia issues: These issues may lead to chaotic substance use, depression and various high risk behaviors.
- Transmission to female partners: This becomes an issue when MSM may also have sex with their female partners or wives.³⁸



Section Four – Aboriginal People – Inuit, Métis, and First Nations

4.1 Culture – Holistic Healing

The healing journey of Aboriginal people is more in-depth than seen in Western practices. The healing process includes information, prevention activities, crisis interventions, counseling and follow-up; all of which are typically included in a plan of care or treatment plan. The difference in practices for Aboriginal people will include the incorporation of community practices, customs, beliefs, ceremonies and use of Elders and Traditional medicine people. This holistic approach to the plan of care includes considering the physical, emotional, mental and spiritual aspects of a person's healing.

4.2 Aboriginal People in Canada – Inuit, Métis and First Nations

Inuit

The Inuit have determined a need to reduce harm within their communities, using creative and innovative strategies which differ from methods found in the south. Services are few and far between in many of the isolated and remote communities, and access to care, support and treatment may mean that many Inuit have to leave their community, family and homes in order to access such care. Many Inuit have been subjected to multi-generational trauma, coping through chaotic substance use, have high rates of suicide, and are affected by other determinants of health. Many northern communities have unsafe drinking water, poor housing and living conditions, and high rates of incarceration, with limited resources at their disposal. The Inuit live in isolated, northern communities where food security, a harsh environment, lack of access to quality health care and education, and lack of recreational activities often lead to negative social behavior.

Métis

The Métis in Canada have their own distinct culture, and service organizations, and deal with their own set of difficulties while combating HIV/AIDS and HCV. Lifestyle issues for the Métis range from dealing with the high costs of medications to receiving Métis specific services, to dealing with obtaining Métis specific data and research.

A Report by the National Aboriginal Health Organization 2001 Census Profile lists the Métis as:

- Being primarily young, and urban-based
- One in three, or 31% of the total Aboriginal population



- Median age of Métis is 27 years compared to 38 years for the non-aboriginal population
- 31% of Métis children live with a lone-parent

Métis leaders, communities and organizations may apply this culturally relevant Harm Reduction Model to their existing services. This service delivery model is designed to allow all Métis to address their own needs and to apply their own cultural elements while introducing relevant Harm Reduction approaches.

First Nations

Indian and Northern Affairs Canada (INAC) reports that there are 704,851 status Indians in Canada with 614 First Nation communities. However, there are many First Nations people who are not entitled to be registered as status Indians under the current Indian Act so the First Nations population is higher than is reported by INAC. Within all First Nation communities there are differences in languages, customs and culture.

Similarities amongst First Nations people in all of the communities across the country include the negative experiences of the residential school system, loss of culture and language, and the multi-generational impact that this has had on the people. Among many First Nations peoples there has been a high incidence of poverty, chaotic substance use, family violence, and high rates of incarceration, suicide, school drop outs, and HIV/AIDS infections.

4.3 Aboriginal Culture - Inuit, Métis and First Nations

Balance, holistic healing, and cultural programming are appropriate to the Inuit, Métis, and First Nations people and include these elements:

- Use of Elders
- Use of Medicines and Medicine people
- Circles
- Incorporation of dance and music which instill pride
- Council of Elders
- Language
- Healing ceremonies
- Connection with the land
- Camping and outdoor activities and services
- Incorporation of teachings
- Role clarification
- Extended family

The application of culturally appropriate services have been identified as a key element in increasing pride and self esteem as well as reducing suicide amongst First Nations, Inuit and Métis. The impact of instilling pride amongst Aboriginal people through cultural promotion is an evidence based practice which is crucial to the interventions for high risk Aboriginal people.



The Inuit, Métis, and First Nations people of Canada are diverse groups of people who engage in many different practices that vary according to the location of the people, their values and beliefs, the teachings that have been passed down from generation to generation, and the lifestyle they have practiced throughout the years. The different cultural practices inform this model, and tools are provided to outline beliefs, values and customs in order to apply these elements to their respective programs, policies and services.

4.4 Determining Inuit, Métis and First Nations cultural practices

The Harm Reduction Service Delivery Model has been developed within a holistic framework. Participants determine the appropriate cultural elements that fit their respective region, customs, values, beliefs and practices, through an assessment process. It has been determined that culture and a positive Aboriginal identity is important to healing and increased self esteem of Aboriginal people. Discovering or rediscovering pride in being Aboriginal leads to a healthy outlook on life and can move a person from feeling a low sense of self worth to a place where they experience pride in who they are, walk with their head high, experience happiness, freedom, and improved health. Through the application of this model and through accessing effective community services, a person will no longer walk alone and will feel proud as an Aboriginal person, walking with their head held high.

Various methods of incorporating cultural components to your organization, client, or community may involve the inclusion of:

- Input from community Elders
- Incorporation of an Elders Council within your community
- Individual questionnaires upon initial stages of assessment with a client
- Application of traditional teachings during prevention activities
- Review ceremonial practices, unique foods, and languages spoken
- Ensuring that the appropriate medicine people are assisting people within the community
- Visiting Aboriginal service organizations to determine appropriate protocols for each diverse group
- Discussing the cultural elements with the community at large and determining what other areas may need to be researched in order to meet the needs as determined by the clientele.



Section Five – Implementation of the Harm Reduction Model

5.1 Assessment and Visioning

When elected leaders, para-professionals/professionals, communities or service organizations feel the need to make changes within their respective departments or services, they begin with conducting a needs assessment, or visioning exercise. A community may require changes within service provisions (in order to apply Harm Reduction) and this change may be recognized through the assessment and/or visioning process. This exercise will provide an opportunity for all of the people who receive services to have input into how the change should occur, and to explore possible ways of reaching the desired outcome.

Individuals require information to assist them in making decisions about the levels of risk they are willing to accept, and the types of activities they are willing to engage in.³⁹ Service providers need resources to provide them with the information required to undertake effective health promotion with individuals they may see in their practice.^L

Reviewing where the organization has come from and looking at its growth over the years, and determining where it would like to go in the future, is an effective planning exercise. Planning a review of the adoption of Harm Reduction approaches which will be incorporated within the various areas of services or with the service providers will assist in the development of policy and program delivery. An assessment and visioning exercise may be used with a client to look at individual services, or it may be used with an entire service organization.

One of the objectives of establishing Harm Reduction approaches or practices is to address the need for change. Clients and/or community members may be engaging in harmful activities and the community may be seeking action and searching for methods that will reduce harm.

An assessment will determine the various program and community goals, interviewing/counseling and/or service goals. Short and long term goals of programs and policy changes will be discussed and reviewed within the assessment. The assessment tools used will include:

- Individual interviews
- Focus groups
- Public meetings with facilitated discussions
- Use of surveys/questionnaires
- Or through a combination of these methods.

A visioning exercise for communities will review the past, present and future of an organization or service. Questions that will be answered in the visioning exercise would include:

- Where we are
- Where are we going?



- Where do we want to be?
- How do we get there?

Things to consider when doing a community assessment or visioning exercise may include:

Cultural aspects of conducting a community assessment – Be sure to ask questions regarding how best to implement Harm Reduction approaches which incorporate culturally relevant aspects appropriate to the community or organization. Methods of conducting your assessment or visioning may include ceremonies, use of Elders, or it may be conducted orally, using focus groups, for example, rather than through the use of written tools. Or through a combination of all methods may be implemented.

Creating a safe space – Ensuring safety is crucial when planning for an assessment or visioning exercise. Participants need to feel safe to speak openly as they begin looking at making positive changes.

Angry community members wanting change – Many community members may be fed up with chaotic substance use within their community and seek immediate prevention initiatives. This will need to be addressed and the energy may be redirected as members begin discussing plans and hearing the voices of others from the community. Diffusing anger through positive methods (allowing community to voice their concerns, discussions around possible changes) of moving the issues forward will assist in making progress and alleviating anger.

Dealing with change – Many people experience difficulties with change. They may feel that things are great the way they are and introducing change may create havoc within the organization/community.

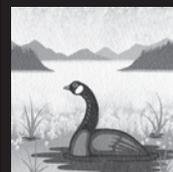
Negative Media attention – During crisis situations within an organization or community, the media may provide inaccurate or negative aspects of the crisis situation. Addressing the role of the media within the assessment, or during the visioning exercise, needs to be discussed with the community.

Innovative ways of creating change – Trying something new can be fun and exciting. Through research and training, a community may introduce evidence based methods into their programming which will produce effective change and reduce the incidence of HIV/AIDS and HCV.

5.2 Prevention and Education

Once the assessment is complete the organization, staff or leadership may wish to educate the public on the various high risk behaviors that are occurring which are negatively affecting the health of the community. The assessment and visioning is used to envision the educational and awareness needs of the organization and/or community. Prevention and education needs will vary according to age group, knowledge already received, incorporation of teachings, and location of where the activities will be taking place. For example, some schools will not allow condom distribution on school premises.

There are limitless ways in which culture may be applied to relevant programming and education within prevention activities. Use of Elders, facilitators with gifts for providing traditional teachings relevant to the people in the region, etc may all be incorporated to provide a culturally relevant prevention and educational program.



Prevention within the community and/or service organization can occur in various ways. Below are some concrete examples that service providers may wish to incorporate:

- Women need to be empowered as peer service providers. This includes programs by and for sex trade workers, women who use drugs, Aboriginal women, and women in prison⁴⁰.
- Harm Reduction measures as well as appropriate educational materials should be made available with up to date information in plain language. Discreetly packaged HIV/AIDS and HCV health information must be widely accessible.
- Transmission issues and access to needles and condoms: Few reserves have needle exchange programs but most reserves can provide condoms via their Community Health Representative (CHR), Community Health Nurse (CHN) or a health clinic to reduce the risk of HIV infection among people in the community⁴¹.
- Training and Harm Reduction: It is important to remember that the HIV/AIDS epidemic is primarily about the lack of education and not being tested. It is therefore essential to identify the target audience to determine their informational and training needs.
- Occupational safety needs: Warders and others who work in the system fear needle stick injury from contraband.
- Partner transmission: Male and female sexual partners have been known to become HIV positive through having unprotected sex and/or sharing needles.⁴²
- Prisoner transmission: The HIV infection rate among Aboriginal people who are or have been in prison is 10 times higher than it is in the general population. "HCV is 29 times more prevalent behind bars than in the general population."⁴³ In addition, regulations that prohibit the use or possession of drugs or needles make the likelihood of sharing much higher on the inside and therefore increase the risk for both HIV/AIDS and HCV infection. IDU is labeled as a 'major public health issue' and it is noted that Aboriginal people who are or have been in prison will continue to use after release. Dr. Peter Ford^M of the Ontario Medical Association reports that with the frequency of movement of individuals between prisons and the community means that 'any transmission of the disease within prisons will increase the risk for transmission in the community. Unfortunately, attitudes towards imprisoned injection drug users stem from stigma of criminality which discourages others from helping injection drug users. Secondly, it can be noted that prison officials do not want to appear soft on drugs and are unwilling to incorporate Harm Reduction programs.⁴⁴
- HIV/AIDS and HCV pre and post counseling must be provided as a mandatory part of all testing. Access to anonymous testing is essential and no one should be tested without counseling.



5.3 Implementation

Implementation of the Harm Reduction model has been discussed as a continuum of services designed to fill gaps for the four target groups, and where bridging is required, in order to address the issues faced on a daily basis.

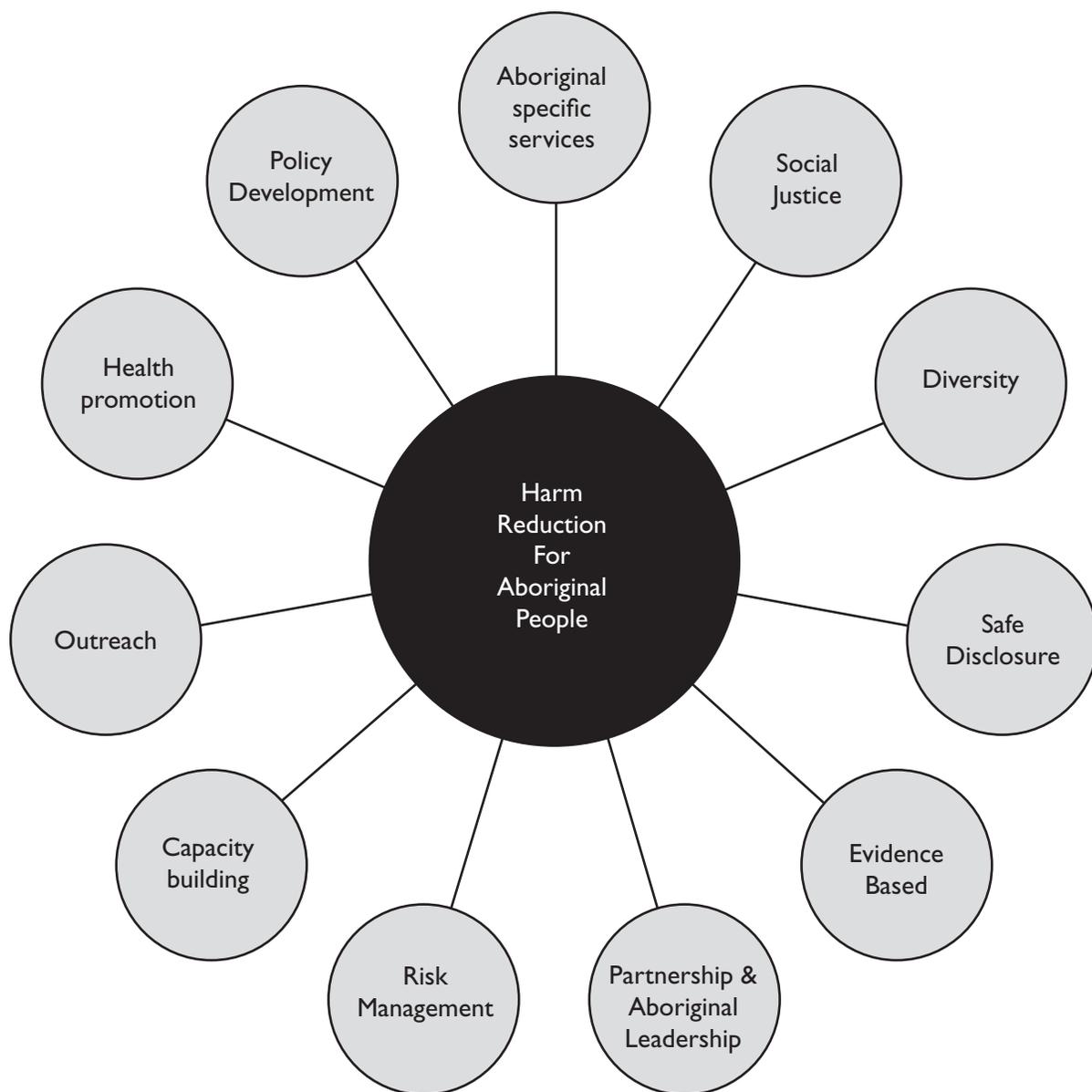
- Aboriginal-specific services will create a culturally relevant program which Aboriginal people may relate to when they receive a holistic treatment plan throughout the care, support and treatment services.
- Social Justice Issues must be addressed when considering the individual rights and needs of the entire community. That is, Aboriginal people who engage in high risk activities have the right to receive appropriate services according to their specific needs.
- The diversity within the three groups of Aboriginal people must be respected and incorporated into the services developed and implemented within the community and/or organization.
- Safe disclosure by clients, in a safe environment, will promote healing within the physical, emotional, mental and spiritual aspects of the person.
- Evidence based methods of services within the model will allow for a successful implementation of the Harm Reduction program. Evidence based activities include activities such as needle exchange programs, which will provide positive outcomes within the Harm Reduction strategy.
- Developing partnerships are encouraged in order to maintain consistent Harm Reduction messages throughout community programming, care, support and treatment.
- Risk management, or reducing harm to individuals, is a primary goal of the Harm Reduction Model.
- Capacity building will provide service providers with new tools to assist in normalizing Harm Reduction approaches and will work to reduce the incidence of HIV/AIDS and HCV.
- Outreach is an evidence based practice which reaches out to individuals who may not have had the opportunity to receive services.
- Health promotion, using a holistic perspective within a Harm Reduction approach will change the face of services within the nation, communities, and organizations.
- Policy development is a key method of applying new and innovative ways of reaching high risk clients and community members.

Within this holistic model, implementation can occur within all program areas within an organization or community.



Diagram on Implementation within program areas on Harm Reduction

The diagram below provides a visual on various elements to consider when implementing Harm Reduction Practices.



5.4 Evaluation

The evaluation of programs may consist of a process that is on-going, or it may include a full scale evaluation which tracks client progress and provides data reflecting programming outcomes. Evaluating workshops, awareness sessions and the educational elements of programming will help to keep an ongoing record of how workshops can be modified and tailored to meet the specific needs of the clientele.

Follow up with clients may present a number of challenges, as when dealing with clients who are engaged in high risk behaviours, due to inconsistent and sporadic sessions. Client lifestyles are often chaotic and may be difficult to coordinate effective and regular follow up visits. Trust needs to be built and this will occur within a Harm Reduction approach. Innovative ways of tracking client's behaviour is required and workers need to be flexible and ensure that a non-structured environment is maintained.

Upon completion of the evaluation, this model may be utilized to develop methods that may be used for programming. Clients and service providers may create innovative methods of service and policy that will be relevant to the client, organization and/or community.

5.5 Scenarios

Harm Reduction Scenarios

To assist in the process of incorporating a Harm Reduction approach, the scenarios depicted below include questions to think about, which assist in understanding how to best implement appropriate services. Think of the questions and determine the ways in which care, support and treatment may be applied within a Harm Reduction approach.

Scenario Number One:

A young First Nations woman is brought into the National Native Alcohol and Drug Abuse Program (NNADAP) office by her mother. She is 19 years old and is a mother to a newborn baby. The young woman has been injecting drugs on a regular basis. Her child has been placed with the grandmother due to her high risk behaviors and involvement with the law. The grandmother attempts to "straighten" out her daughter by bringing her in to the office to receive services.

Questions to consider:

- How can the community address this situation using a holistic healing framework?
- How can a professional involve other professionals, leadership and community? What would this involve?
- What would be involved at all phases of the services for this young person and her family? What do you need to consider in the assessment, prevention, implementation and evaluation of the services?



Scenario Two:

A Two-Spirit Métis man has just been diagnosed as HIV positive after being released from prison. He is at a half-way house and will return to his home community within four months. He has been injecting drugs and also engages in other high risk activities such as engaging in unprotected sex, especially when he is intoxicated.

Questions to consider:

- What should the professional consider in arranging with the community worker for the man's return to his home community? (re-integration plan)
- What referrals should be made, from a Harm Reduction standpoint for the client and for the half-way house?
- How can the half-way house work with the community in establishing Harm Reduction strategies?

Scenario Three:

A high school located in a city centre has an increase in teen pregnancies and has some concerns about youth selling and using drugs on the school premises. The school has a high population of Aboriginal students, (the school is located in an area of the city where many Aboriginal families reside). The high school wants to educate the youth on HIV/AIDS, HCV, IDU, drinking and driving, use of condoms and other Harm Reduction activities, as well as introduce Harm Reduction approaches. At the present time, the school is not permitted to distribute condoms.

Questions to consider:

- The school has been providing harm initiatives, such as a drinking and driving campaign and sex education. What are the school's options for implementing other Harm Reduction approaches?
- Which would be best applied to this school, an assessment, or a visioning exercise? And why?
- How can the school incorporate the three cultures into its Harm Reduction strategy? List possible options for cultural programming related to Harm Reductions.
- What policies need to be reviewed, and who needs to be involved in making these changes?



Scenario Four

A guest speaker is invited to a remote Inuit community by the leadership and speaks to community members about the links between drug use and HIV/AIDS and HCV. The speaker introduces the idea of people traveling to urban centres, who engage in high risk activities while there and then return to the community. Community leaders are aware of two spirit men within the community who travel to urban centres and engage in sexual activities with other men.

Questions to consider:

- What exercises can the guest speaker use to determine the cultural practices of the community?
- What can the leadership do to promote Harm Reduction initiatives within their community? How might they envision policy development impacting community members' travel? How can they become aware of legalities surrounding this issue?
- How can Harm Reduction approaches work in a community when the harm is happening outside of the community? How can the community put a strategy in place for this kind of situation?



Section Six – Moving Forward

Through the training and implementation of the Harm Reduction Model, it is hoped that the communities will reduce the incidence of HIV/AIDS and HCV. With every new Harm Reduction Strategy that will be created, there will be a new hope for new Pathways to Health. People will walk together on their journey to healing.

Providing new needles can open the door to counseling. Counseling may help the individual understand how their chaotic substance use may be high risk and help them to make healthier lifestyle choices. They may never give up their drug use, nor abstain from sex, but they may learn to use safe practices, get tested on a regular basis and practice safe sex.

There needs to be a concerted effort within Canada to bring an end to stigma and discrimination; the WHO states that action towards achieving this objective must be supported by top leadership and at every level of society. Further, that 'it must address women's empowerment, homophobia, attitudes towards sex workers and injecting drug users, and social norms that affect sexual behavior – including those that contribute to the low status and powerlessness of women and girls'.⁴⁵

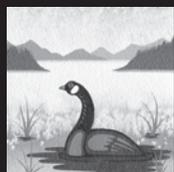
A key recommendation from the World Health Organization (WHO) Global HIV/AIDS Report – 2006 is that products for HIV prevention and treatment must be made available and affordable, and that national governments should remove legal or regulatory barriers that block access to effective HIV prevention interventions and commodities such as condoms, Harm Reduction services and other prevention measures.⁴⁶

In Canada, the focus needs to be on advocating for work that needs to be done for Aboriginal people. CAAN and other Aboriginal Service Organizations (ASO) have clearly stated these needs; the work being done by groups such as the Aboriginal HIV/AIDS Harm Reduction Task Force and others will move strategies into action. The political will to do so, is an integral component and positive advancements such as the Federal Government's recent announcement regarding AIDS vaccines is an example.⁴⁷ HIV/AIDS organizations need to be adequately resourced to continue the advocacy and service work in communities.

The World Health Organization (WHO) reports that the global HIV/AIDS epidemic is growing and in fact that some countries are seeing 'resurgence' in new HIV/AIDS infection rates which were previously stable or declining.⁴⁸ WHO also reports that HIV prevention programs need to be sustained and be adapted to the changes of the epidemic in order to lower the infection rate. In November 2006, 'UNAIDS/WHO 2006 AIDS Epidemic Update', stated that in North America, HIV/AIDS prevention programs have not been sustained and the number of new infections has remained the same.^N

The current Canadian picture of HIV/AIDS prevalence in Canada's Aboriginal population is also acknowledged internationally. The WHO, in 2006 AIDS Epidemic Update: North America, Western and Central Europe, reports that Canada's current data, highlights the need to ensure effective strategies are in place to prevent new HIV/AIDS.

There is a documented need for more research for Aboriginal people with respect to Harm Reduction and HIV/AIDS. Wise practices need to be grounded with a solid evidence base. An important aspect of



research related to Aboriginal populations is the need for Aboriginal people themselves to take control and lead their own research practices⁹.

The WHO calls for aggressively addressing HIV/AIDS-related stigma and discrimination, and to put an end to the pandemic. This will depend largely on 'changing the social norms, attitudes and behaviors that contribute to its expansion.'⁴⁹ When an individual's rights and needs are met and they are able to begin their healing journey, it will in turn affect their family, which will have an effect on the community, and on to the nation and the globe. It is a positive effect and as each community embraces community-driven Harm Reduction approaches, there will be global change. Harm Reduction needs to become normalized and awareness of such approaches may be extended to all walks of life. Embracing Harm Reduction will help in preventing the spread of HIV/AIDS and HCV.

6.1 Actions for Change

Accepting Harm Reduction initiatives may be introduced into every department throughout all levels of services being provided to clients. Providing training on the model to service providers, leadership, community members, etc, while addressing policy is a crucial step to reducing HIV/AIDS and HCV. Actions for change are listed below for incorporating a Harm Reduction Strategy within various elements of programming and services. The listed activities are not limited to the following lists and are meant to serve as an example of possible activities/tasks which are meant to be a starting point. It is expected that through brainstorming sessions and focus groups, communities and organizations may develop their own activities and policies that would best meet their needs.

Actions for change for Elected Leaders would include:

- Presenting awareness of change to community members.
- Administering change and delegating duties to staff in order to incorporate a full Harm Reduction strategy throughout all departments.
- Assessment of current policies and making appropriate changes in order to incorporate Harm Reduction practices.
- Conducting assessment, visioning and evaluations within the community.
- Creating forums involving clients, service providers and community members to discuss Harm Reduction Approaches.

Actions for change for para-professionals/professionals:

- Assessment of clients, incorporating culturally appropriate assessment tools, reviewing the client's personal, drug, and social history etc.
- Providing culturally relevant prevention and education to all clients in group settings or on an individual basis. These include education sessions on the impacts of IDU, transmission issues, and the importance of HIV and HCV testing
- Providing a model of healing to the client which is holistic and provides access to cultural elements important to a client's healing journey. These include, access to medicine people, ceremonies, teachings as a foundation for learning healthy living, etc
- Partner with Aboriginal organizations to address the needs of Aboriginal clientele (if a non-Aboriginal organization).



Actions for change within a community:

- Discussions at community meetings addressing the introduction of Harm Reduction approaches to chaotic substance use.
- Partnerships with other communities to apply a strategy that is consistent and reaches neighbouring communities and services.
- Providing safe access to Harm Reduction initiatives within the community, including the provision of free condoms, new needles, needle works, or needle exchange services.
- Incorporate information and prevention activities to various community events to incorporate the normalizing of Harm Reduction.

Actions for change within volunteer groups or individuals in promoting and providing Harm Reduction within a community or organization:

- Share personal stories on how Harm Reduction approaches have or have not been utilized, and how it has affected the family, community and self.
- Advocate for services, education and activities which incorporate a Harm Reduction approach.
- Provide assistance to staff during workshops, education sessions and various programming. Organizations are often short staffed and volunteers are encouraged.
- Volunteers can get involved in committees where their expertise would be valued and put to good use for the introduction and implementation of Harm Reduction strategies.

Actions for change which are applicable to service organizations:

- Partner with various organizations and services that can assist with legalities, policies, ideas and sharing of services, such as Addictions organizations, CAAN, and neighbouring communities.
- Applying relevant policies to address and support Harm Reduction strategies in all programs within the service organization.
- Incorporating appropriate tools for collecting data on Harm Reduction services being provided, and recording changes resulting from Harm Reduction initiatives.
- Within non-Aboriginal organizations, full scale implementation of Aboriginal specific services may be incorporated, such as the hiring of Aboriginal staff, training of Aboriginal volunteers and implementing Aboriginal programming. Applying quick fixes will not provide efficient services, but working with Aboriginal communities will assist in implementing Aboriginal specific programming and services.

Actions for change for assessment and visioning can include:

- Utilizing the Harm Reduction Model to incorporate the ideas of all parties involved including community members, staff, youth, Elders, families, etc.
- Providing awareness on what Harm Reduction entails before conducting the assessment/ visioning.
- Conducting assessment/visioning within various levels of programming, in various departments, or within the organization as a whole.
- Hire a facilitator to conduct assessments, or visioning, so that they are unbiased and have no hidden agendas which may influence the outcome.



Actions for change for prevention/education:

- Using the assessment to determine the prevention and education needs of the community, target groups, and service organizations.
- Pamphlets, workshops, special guests, school programs addressing Harm Reduction initiatives, IDU services – needle exchange and new needle services, handing out condoms, HIV/AIDS and HCV testing locations, all need to reflect a culturally relevant perspective.
- Educating staff on safe practices in dealing with clients.
- Incorporating Harm Reduction into all program areas in order to normalize such practices and the strategy as a whole.

Actions for change within implementation can include:

- Having a well rounded strategy that addresses all aspects of Harm Reduction programming within a community or organization, and putting it into action.
- Reviewing legalities of incorporating Harm Reduction practices and making appropriate changes within policy, and within services.
- Providing awareness to the community, and normalizing Harm Reduction and incorporating needle exchange, etc discreetly within the community.
- Educating staff, providing all necessary tools for workers in order to provide culturally appropriate services and provide Harm Reduction approaches on a regular basis within various components of programs offered.

Actions for change within evaluation processes in Harm Reduction can include:

- Evaluation sheets provided to participants of workshops, education and awareness sessions.
- Providing follow-up with clients, and assessing the needs of the clients on an on-going basis.
- Incorporating the Harm Reduction Strategy into full program and community evaluations.
- Collecting and analyzing data related to Harm Reduction.

Actions for change for organizations serving Aboriginal people who are or have been in prison:

- Provide pamphlets on transmission and harmful activities which may affect their health and the health of others upon entering the prison, half-way house or treatment facility (development of an orientation package for Aboriginal people who are or have been in prison/clients, with Harm Reduction information included).
- Provide testing, with appropriate pre and post-test counseling for Aboriginal people, entering the facility.
- Work with the Justice departments to incorporate new and innovative ways of providing Harm Reduction strategies within the facility; be open to trying new things, while putting health first.
- Educate staff (at treatment centres, half-way houses, and various institutions), on possible harm, and provide safe working environments (if not currently provided).

Actions for change for increased services/programming for Two-Spirit Men:

- Create support, care and treatment services for Two-Spirit men and provide Harm Reduction prevention and awareness sessions within a community which is inclusive. Awareness sessions



need to be relevant and designed to educate the Two-Spirit population and/or to educate the community as a whole on information specific to Two-Spirit Men.

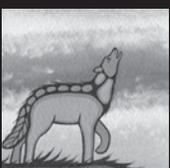
- Provide care, support and treatment for any Two-Spirit men who may be diagnosed with HIV/AIDS or HCV. Do not ignore the situation but address it and include these men in the overall goals of the community programming. Treat any ailments with equal attention as would be paid to any other health situation within the community, honouring the individual rights and needs of the client.
- Include Two-Spirit Men when incorporating the Harm Reduction Model within the community and/or organization. Involvement may be within committees, policy development exercises, and through volunteerism within the community. This will allow for acceptance and applicable services that will meet the needs of Two Spirit Men.
- Partner with organizations which will provide communities with current trends of Two-Spirit Men, Harm Reduction, modes of transmission, etc., in order to apply to current programming, and to provide consistent messages with neighbouring communities and organizations.

Actions for change for Aboriginal Youth:

- Partner with Youth organizations, schools, youth justice, and various organizations that provide services to high risk youth in the community and introduce Harm Reduction strategies which are consistent within all services.
- Advocate for changing policies within schools and communities in order to provide appropriate Harm Reduction practices applicable to the Youth. (Currently, some schools will not allow condoms, or other Harm Reduction practices that are required to reduce harm to the youth)
- Include parents in workshops designed for the youth to educate and make them aware of the issues that their children/youth may be facing. Inclusion of parents creates a bond between parents and youth which makes the youth feel that parents care. Inclusion of parents also creates a stronger team in the battle of combating harm.
- The inclusion of youth on planning committees, assessments, and policy development will allow youth to share their success stories and thus becoming role models that are Harm Reduction oriented.

Actions for change for Aboriginal Women:

- Organizations which serve high risk Aboriginal women may consider adopting a Harm Reduction approach. The creation of partnerships, education, awareness, needle exchange programming, condom distribution, (to name a few), are all necessary to help reduce the high rates of women becoming HIV/HCV positive.
- Suggested organizations where this Harm Reduction Model may be implemented may include but is not limited to Welfare Departments, Women's Shelters, Crisis Centres, Food Banks, Child Protection Agencies, Walk-in Clinics, Schools, Outreach Services, Probation, Treatment Centres, Police Departments, Volunteer Organizations, and any other agencies which address the needs of Aboriginal women.
- Teaching Aboriginal women about their individual rights, especially at a young age, helps to improve their self-esteem, and self-respect. This is especially true for women who, as a result of trauma, may feel that she has no voice. It may be instructive to practice role playing with Aboriginal women, teaching them how to say no, how to get a man to wear a condom, and to improve their voice in harmful situations.



- Create new and innovative ways of reaching Aboriginal women through Harm Reduction approaches and to begin to address unhealthy lifestyles which they may be living. Such lifestyles may include living on the street, prostitution, and finding themselves isolated in their own homes.
- Including women in the development and planning of policies and strategies which relate to women's issues and Harm Reduction will ensure that services are applicable to this target group.

6.2 Closing

In closing, the Walk with Me Pathways to Health is a Harm Reduction Service Delivery Model which reaches out to meet the needs and protect the rights of individuals who fall within the four target groups as outlined. Injecting drugs, living on the streets, engaging in the sex trade, having unprotected sex, and not being educated on what is harmful or feel worthy or empowered to want to protect oneself are no basis for why any of the individuals identified in this manual should be ignored or forgotten.

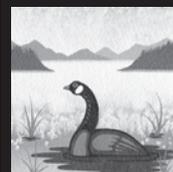
Through providing the Harm Reduction Service Delivery Model, these target groups can receive the education and awareness they need, and find supportive service providers so that healing may occur and protecting the individual and family will take place.

A holistic healing perspective is the basis of this service delivery model so that the diverse and many needs of Aboriginal people who inject drugs may be met. Ultimately ownership of the program rests with Aboriginal individuals and communities.

Leadership is an important element who can be more responsive to the populations they serve. While liability issues are important to any community, so are the cultural needs that can help design and deliver Harm Reduction services which are backed up by the right policies and community support.

Through the distribution and implementation of this Harm Reduction Service Delivery Model, the Canadian Aboriginal AIDS Network is taking one step closer to reducing harm and breaking down barriers for a healthier tomorrow by Walking with Individuals on a Pathway to Health.

These are our relatives.



Section Seven – Bibliography

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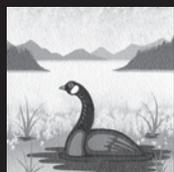
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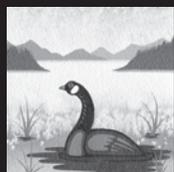
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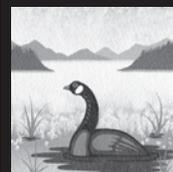
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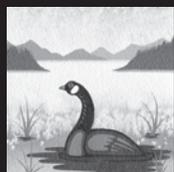
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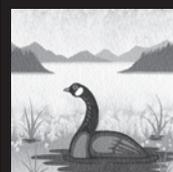
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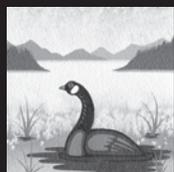


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Section Eight – Appendices

8.1 Appendix One: Harm Reduction National Steering Committee

Ken Clement
BC Healing Our Spirit HIV/AIDS Society

Monique Fong
Healing Our Nations HIV/AIDS Network

Fred Anderson
CAAN Representative

Denise Lambert
Kimamow Ataskanow Foundation

Gordon Sinclair
All Nations Hope HIV/AIDS Network

Kim Thomas
Canadian AIDS Society

Anne Marie Dicenso
Prisoners HIV/AIDS Support Action Network

Alana Klein
Canadian HIV/AIDS Legal Network

Kevin Barlow
Canadian Aboriginal AIDS Network

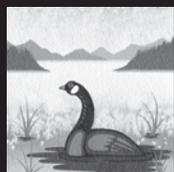
Trevor Stratton,
Canadian Aboriginal AIDS Network

8.2 Footnotes

- ¹ See CAAN – Lit Review. P. 8
- ² See CAAN – HCV and HCV/HIV Co-Infection Fact Sheets
- ³ See PHAC – HIV/AIDS Epi Updates
- ⁴ See the Public Health Agency of Canada report – HIV/AIDS Epi Update: HIV/AIDS Among Aboriginal Peoples In Canada: A Continuing Concern
- ⁵ See PHAC – About Hepatitis C: Virus Information
- ⁶ See CAAN – Harm Reduction project proposal
- ⁷ See CAAN – HCV and HCV/HIV Co-Infection Fact Sheet
- ⁸ Ibid.



- 9 See PHAC – The Federal Initiative to Address HIV/AIDS in Canada. (2005)
- 10 See PHAC – Epi Update - HIV/AIDS Among Aboriginal Peoples
- 11 See CAAN – Life Experience of Aboriginal Women Living With HIV/AIDS in Canadian Journal of Aboriginal Community-Based HIV/AIDS Research
- 12 See PHAC, Centre for Disease Prevention and Control – HIV/AIDS Epi Update HIV/AIDS Among Women in Canada – 2006
- 13 Ibid.
- 14 See PHAC, Centre for Disease Prevention and Control – HIV/AIDS Epi Update: HIV/AIDS Among Aboriginal People: A Continuing Concern. 2006
- 15 See NWAC – Companion Document First Minister’s Meeting Kelowna, British Columbia, November 24-25, 2005.
- 16 See NWAC – Companion Document First Minister’s Meeting Kelowna, British Columbia, November 24-25, 2005.
- 17 See CAAN – HIV/AIDS and Aboriginal Women, Children and Families. 2004
- 18 Ibid.
- 19 See CAAN – Strengthening Ties
- 20 Ibid.
- 21 See PHAC – Epi Update 2006 HIV and AIDS Among Youth in Canada
- 22 See PHAC, Centre for Disease Prevention and Control – HIV/AIDS Epi Update: HIV/AIDS Among Aboriginal People: A Continuing Concern.
- 23 See Farris-Manning & Zandstra, 2003; First Nations Child and Family Caring Society of Canada, 2003
- 24 See http://www.oci-bec.gc.ca/newsroom/bk-AR0506_e.asp
- 25 See PHAC – Epi Update 2006 HIV and AIDS Among Youth in Canada
- 26 See www.cps.ca and Dr Roger Tonkin, McCreary Centre, BC, Adolescent Health Training Model, NTIAH - 2003
- 27 See http://www.oci-bec.gc.ca/newsroom/bk-AR0506_e.asp
- 28 Ibid.
- 29 See The Way of The Pipes: Aboriginal Spirituality and Symbolic Healings in Canadian Prisons p 22. 1997
- 30 See <http://racisms.conference.com/2001/report.html>, Recommendation 57, p 13
- 31 Ibid.
- 32 See CAAN Strengthening Ties – Strengthening Communities
- 33 See UNAIDS – Fact Sheet – Men Who Have Sex With Men
- 34 See PHAC – Epi Update 2006 – HIV Infections Among MSM in Canada
- 35 Ibid.
- 36 Ibid.
- 37 See UNAIDS – Fact Sheet – Men Who Have Sex With Men -
- 38 Ibid.
- 39 Ibid.
- 40 See “Vectors, Victims and Vessels”: HIV/AIDS and Women’s Human Rights in Canada. Canadian HIV/AIDS Legal Network. 2005
- 41 Ibid.
- 42 Ibid.
- 43 See CBC news article – Prisons Need Needle Exchange Plans, OMA Says.
- 44 See AAN – Joining the Circle – Harm Reduction Phase I
- 45 Ibid.



- ⁴⁶ Ibid.
- ⁴⁷ See Federal Government announcement – Canada’s New Government and the Gates Foundation announce support for an HIV/AIDS vaccine.
- ⁴⁸ See WHO report – Global AIDS epidemic continues to grow
- ⁴⁹ See WHO Global Report on HIV/AIDS 2006

6.3 Endnotes

- ^A There are various terms for people who use drugs. The term chaotic substance use recognizes that there are many reasons why an individual is using drugs in his/her life and is seen as a less judgmental term.
- ^B The Literature Review entitled; ‘Literature Review and Model Building in Harm Reduction for Selected Populations’ will be available via the CAAN website.
- ^C Focus Groups were held in Vancouver in February, 2007 at the CAAN –hosted research conference ‘Walking a Path to Wise Practices’. These were with Aboriginal women, two-spirit and ex-prisoners. The Youth focus group was held in Victoria at the Healing Our Spirit Annual Conference.
- ^D It should be acknowledged that challenges related to ethnicity reporting continue to be a factor in accurately reporting about Aboriginal AIDS cases and positive HIV test reports.
- ^E Ethnicity reporting also varies among provinces and territories.
- ^F This is a 1999-2001 statistic from ‘Epidemiology of Hepatitis B and Hepatitis C in Canada, 1999-2001’. However, the Canadian Centre on Substance Abuse reports that a review of international studies suggests that 50%-90% of IDU populations are HCV infected. With the high rate of Aboriginal IDU it can be expected that the numbers are much higher.
- ^G CAAN reports that the success rate is only 25% for those with genotype 2 or 3 leaving many susceptible to accelerated liver damage and failure.
- ^H PHAC reports that this data was for the period of 1998 to 2005.
- ^J Alternatives exist to federal correctional services. Alternative justice is a non-adversarial, non-retributive approach to justice that emphasizes healing in victims, meaningful accountability of offenders, and the involvement of citizens in creating healthier, safer communities. Problem solving for the future is seen as more important than establishing blame for past behaviour. Restorative models such as, Victim-Offender Mediation, Group Conferencing, and Community Circles (Sentencing Circles, Peacemaking Circles, Healing Circles) work to repair the damage and promote healing and growth. (For more information please see <http://www.sfu.ca/crj/populars.html>.) In Canada, particularly in First Nations communities, Circle Sentencing operates on the basis that both victims and offenders require healing, and that offenders can be reintegrated into the community. A model such as this is hopeful and speaks to the complementary principles of harm reduction.
- ^K The UNAIDS Fact-sheet reports that MSM are found in all societies, yet remain invisible in many places.
- ^L The CAS document HIV Transmission: Guidelines for Assessing Risk provides a list of suggestions for further reading.
- ^M Dr. Ford is an AIDS expert who has worked in federal prisons for over 20 years.
- ^N See WHO press article – Global AIDS epidemic continues to grow (<http://www.who.int/hiv/mediacentre/news62/en/index.html>) It is noted that Europe has also not sustained programming and that this is also reflected in their HIV infection rates which have stayed the same.



- It is noted that Indigenous Peoples around the world are taking up the challenge to reclaim ownership of their traditional knowledge and are developing standards of research for and with their peoples. Aboriginal people have been researched to death as expressed bluntly by the Assembly of First Nations. (AFN) Aboriginal and non-Aboriginal groups are now looking at new ways of defining Aboriginal research protocols. This process is in keeping with current movements towards self-determination by Canada's three constitutionally recognized Aboriginal groups.



Additional Readings:

This list is broken into the following sections:

- Coming out
- Community Diversity
- Counselling
 - Counselling – Crystal Meth
 - Counselling – Sex Addiction
 - Counselling – Trauma
- Domestic & Sexualized Violence
- Relationships and Sexuality
- Residential Issues
- Spirituality

Coming Out

Always My Child: A Parent's Guide to Understanding their Gay, Lesbian, Bisexual or Transgender or Questioning Son or Daughter. Kevin Jennings.

And Then I Met This Woman: Previously Married Women's Journeys into Lesbian Relationships. Barbee Cassingham and Sally O'Neil, Ph.D.

Being Homosexual and Becoming Gay. Richard Isay.

Beyond Coming Out: Experiences of Positive Gay Identity. Kevin Alderson.

Coming Out Every Day. Bret Johnson.

Is it a Choice?: Answers to 300 of the Most Frequently Asked Questions About Gays and Lesbians. Eric Marcus.

Lesbian Epiphanies: Women Coming Out Later in Life. Karol Jensen, MPh, Ph.D.

Loving Someone Gay (4th ed). Don Clark, Ph.D.

Nobody Passes: Rejecting the Rules of Gender and Conformity. Ed. Matt Burnstein Sycamore.

Now That You Know: A Parent's Guide to Understanding their Lesbian and Gay Children. Betty Fairchild & Nancy Hayward

The New Gay Teenager. Ritch C. Savin-Williams

The Testosterone Files: My Hormonal and Social Transformation from Female to Male. Max Wolf Valerio

Transparent: Love, Family and Living the T with Transgender Teenagers. Cris Beam.

Community Diversity

Asian American Sexualities: Dimensions of the Gay and Lesbian Experience. Ed. Russell Leong.

Changing Ones: Third and Fourth Genders in Native North America. Will Roscoe.

Chicana Lesbians: The Girls Our Mothers Warned Us About, Ed. Carla Trujillo.

Companera – Latina Lesbians: An Anthology. Ed. Juanita Ramos

The Imaginary Indian: The Image of the Indian in Canadian Culture. Daniel Francis.

A National Crime - The Canadian Government and the Residential School System 1879 to 1986. John S. Milloy

Prison of Grass: Canada from a Native Point of View. Howard Adams.

Q & A: Queer in Asian America. Eds. David L Eng & Alice Y. Hom.

Queerly Classed: Gay Men & Lesbians Write About Class. Ed. Susan Raffo.

Restricted Access: Lesbians on Disability. Ed. Victoria Brownworth.

The Sacred Hoop: Recovering the Feminine in American Indian Traditions. Paula Gunn Allen.

The Spirit and the Flesh: Sexual Diversity in the American Indian Culture. Walter L. Williams.

Stolen from Our Embrace: The Abduction of First Nations Children and the Restoration of Aboriginal Communities. Suzanne Fournier and Ernie Crey.

Trans Forming Families: Real Stories About Transgendered Loved Ones. (2nd ed) Mary Boenke.

Trans People in the Criminal Justice System: A Guide for Criminal Justice Personnel. Joshua Mira Goldberg. Download from <http://www.transalliancesociety.org/education/publications.html>.

The Trans Biography Project: Stories From the Lives of Eleven Trans People in BC. Kathleen Cross. Download from <http://www.transalliancesociety.org/education/publications.html>.

True Selves: Understanding Transsexualism--For Families, Friends, Coworkers, and Helping Professionals. Mildred E. Brown & Chloe Ann Rounsley.

Two - Spirit People: American Indian Lesbian Women and Gay Men. Lester B. Brown.

Transition and Beyond: Observations on Gender Identity. Reid Vanderburgh

Counseling

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals. Download from <http://kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf>.

Asking the Right Questions 2. Centre for Addiction and Mental Health. Download from [http://www.camh.net/Care Treatment/Resources for Professionals/ARQ2/index.html](http://www.camh.net/Care_Treatment/Resources_for_Professionals/ARQ2/index.html).

Caring for Transgender Adolescents in BC: Suggested Guidelines: Clinical Management of Gender Dysphoria in Adolescents. Annelou L.C. de Vries, M.D., Ph.D., Peggy T. Cohen-Kettenis, Ph.D., and Henriette Delemarre-Van de Waal, M.D., Ph.D. Download from <http://www.vch.ca/transhealth/resources/library/index.html>.

Caring for Transgender Adolescents in BC: Suggested Guidelines: Ethical, Legal, and Psychosocial Issues in Care of Transgender Adolescents. Catherine White Holman and Joshua Goldberg. Download from <http://www.vch.ca/transhealth/resources/library/index.html>.

Counselling and Mental Health Care of Transgender Adults and Loved Ones. Walter Bockting, Ph.D., Gail Knudson, MD, MPE, FRCPC, Joshua Mira Goldberg. Download from <http://www.vch.ca/transhealth/resources/library/index.html>.

Dual Identities: Counselling Chemically Dependent Gay Men and Lesbians. Eds. Dana G. Finnegan, Ph.D. & Emily B. McNally Ph.D.

Nurturing Queer Youth: Family Therapy Transformed. Linda Stone Fish, Rebecca G. Harvey.

Social and Medical Advocacy with Transgender People and Loved Ones: Recommendations for BC Clinicians. Catherine White Holman and Joshua Mira Goldberg. Download from <http://www.vch.ca/transhealth/resources/library/index.html>.

Therapeutic Perspectives on Working with Lesbian, Gay and Bisexual Clients (Pink Therapy, 2). Domenic Davies.

Transgender Emergence: Therapeutic Guidelines for Working With Gender-Variant People and Their Families. Arlene Istar Lev.

Counseling - Crystal Meth

Overcoming Crystal Meth Addiction. Steven Lee, MD.

Breaking the Grip: Treating Crystal Meth Addiction Among Gay and Bisexual Men. Gay & Lesbian Medical Association (www.glma.org).

Staying Off Crystal – You CAN Do It! download from <http://www.homohealth.org/images/Crystal%20book%20Web.pdf>

Counseling - Sex Addiction

Clinical Management of Sexual Addiction and *Out of the Shadows: Understanding Sex Addiction* and *Don't call it love: Recovery from sexual addiction* and others. Patrick Carnes.

Cruise Control: Understanding Sex Addiction in Gay Men. Robert Weiss MSW, CAS.

Cybersex Exposed. Jennifer Schneider and Robert Weiss.

Counselling - Trauma

Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. Lisa Najavits.

The Tricky Part: A Boy's Story of Sexual Trespass, A Man's Journey to Forgiveness. Martin Moran.

Waking the Tiger: Healing Trauma. Peter A. Levine with Ann Frederick.

Domestic & Sexualized Violence

No More Secrets: Domestic Violence in Lesbian Relationships. Janice Ristock.

Removing Barriers & Building Access: A Resource Manual on Providing Culturally Relevant Services to Lesbian, Gay, Transgender and Bisexual Victims of Violence. Contact educationoutreach@lgbtcentrevancouver.com to get copies.

Relationships & Sexuality

Growth & Intimacy for Gay Men. Christopher Alexander.

Joy of Gay Sex. Charles Silverstein.

Whole Lesbian Sex Book 2. Felice Newman.

Sex for One: The Joy of Selfloving. Betty Dodson.

Residential Issues, Housing, and Homelessness

Lesbian, Gay, Bisexual and Transgender Youth: An Epidemic of Homelessness. National Gay and Lesbian Task Force: Nicholas Ray. Download from http://www.thetaskforce.org/reports_and_research/homeless_youth

Sexual Exclusion: Issues and Best Practice in Lesbian, Gay and Bisexual Housing and Homelessness. Stonewall Housing: Deborah Gold. Download from http://www.stonewallhousing.org/agenda_setting.html

Transitioning Our Shelters: A Guide to Making Homeless Shelters Safe for Transgender People. National Gay and Lesbian Task Force: Lisa Mottet & John Ohle. Download from <http://www.thetaskforce.org/downloads/reports/reports/TransitioningOurShelters.pdf>

Spirituality *What the Bible Really Says About Homosexuality.* Daniel Helminiak.

Glossary of Terms

Acronyms & Umbrella Terms

LGBTQQI - is acronym for lesbian, gay, bisexual, transgendered, transsexual, two-spirit, queer, questioning and intersex. Common variations used include LGBT, GLBT, LGBT2S

Queer- originally used as a homophobic insult, it has to an extent been reclaimed and used as a term of pride denoting a gay man, lesbian, bisexual or pansexual person.

LGBT communities or queer communities- identify the fact that there are a diverse range of communities of LGBT people – that there is not a singular homogenous LGBT community.

LGBT-sensitive- is used to describe programs, services, and individuals that have made a commitment to serving the needs of LGBT people and communities. That commitment is rooted in knowledge and awareness of the needs of this population.

LGBT-specific- is used to describe supports, programs or activities geared primarily or exclusively to LGBT people.

Terms related to sexual orientation-based identities

Bisexual or Bi- describes anyone romantically and sexually attracted to both males and females.

Butch/Femme- are terms used by some queer people to describe their unique expression of gender.

Gay, gay man, fag, faggot- are terms that men who are sexually and/or emotionally involved primarily with other men use to describe their sexual orientation. Fag / faggot can be used as an insult or can be reclaimed as a positive term.

Homosexual- refers to a person who has emotional, romantic and sexual attractions predominantly to the same gender. Many people reject all usage of "homosexual" as too clinical and dehumanizing, as the word only refers to one's sexual behavior, and does not refer to non-sexual romantic feelings. The terms lesbian, gay or queer tend to be preferred. Heterosexual/Straight- is a sexual orientation where an individual forms sexual and romantic relationships with the "opposite" gender. This is a term people apply to themselves because it represents their basic sexual orientation, even though they may occasionally experience attraction to people of their own gender.

Lesbian, dyke, gay woman- are terms that women who are sexually and/or emotionally involved primarily with other women to use to describe their sexual orientation. Dyke can be used as an insult or can be reclaimed as a positive term.

MSM- refers to any man who has sex with a man, whether he identifies as gay, bisexual, or heterosexual. This term highlights the distinction between sexual behaviour and sexual orientation. For example, a man may call himself heterosexual, but may engage in sex with men in certain situations.

Pansexual or Pan- is used to describe anyone romantically and sexually attracted to people of all genders.

Questioning- refers to people who are exploring their sexual orientation and/or gender identity.

Transsensual- is a term for a person who is primarily attracted to transgendered or transsexual people.

Two-Spirit- is a term used by some Aboriginal people to describe themselves in a way that is closer to their cultural construct of sex/gender/sexuality than the dominant Western view. The term Two-Spirit can have specific meaning in some First Nations cultures that is not about sexuality or gender, but rather describes the spiritual makeup of a person. In acronyms, sometimes abbreviated as 2-S or 2S.

WSW- refers to any woman who has sex with a woman, whether she identifies as lesbian, bisexual, or heterosexual. This term highlights the distinction between sexual behavior and sexual orientation. For example, women who identify as lesbian can also have sex with men and not all WSW identify as lesbian or bisexual.

Terms related to concepts & experiences (sexual orientation)

Biphobia- is the fear and dislike of bisexuality. Biphobia exerts a powerful, negative force on the lives of bisexual people.

Homophobia- is generally seen as the fear of or discrimination against homosexuals or homosexuality. It refers more to the specific actions or prejudices of a smaller group or singular person, rather than the broader societal bias of heterosexism. It can be directed externally towards others, as well as internally towards oneself.

Heterosexism- is the belief or perception that heterosexuality is the normal, natural or moral way of life, and that anything other than that is abnormal, unnatural or immoral. It is a cultural or societal bias that is often unconscious, and bears similarities to racism or sexism, and limits or oppresses the acceptance of anything other than heterosexuality.

Transphobia- is the aversion to or prejudice against transsexuality or transgender people, such as the refusal to accept the individual's expression of their gender identity. It can be direct or indirect.

Sexual orientation- refers to our romantic, erotic, emotional, and social attractions to other people. Sexual preference- incorporates both desire and attractions to others, as well as preferences for specific sexual activities. A person's sex or gender does not determine a person's sexual orientation or sexual preferences.

Terms related to Trans peoples' identities

Trans -people have gender identities that are not as simple as 'man' or 'woman', or express their genders in ways that contravene societal expectations of the range of possibilities for men and women. We use the term trans rather than transgender, because some transsexuals feel that the word transgender minimizes or misrepresents their experiences.

Two-Spirit- is a term used by some First Nations people to describe themselves in a way that is closer to their cultural construct of sex/gender/sexuality than the dominant Western view.

Bi-gendered- people identify and/or express two genders, much as bilingual people can express themselves in two languages. It should be noted that the two genders expressed by bi-gendered people are not necessarily man/woman.

Crossdressers- enjoy wearing clothing and possibly other accoutrements (such as makeup/hairstyle) that is considered appropriate for the 'opposite' gender. Some prefer to do this privately, while others enjoy publicly presenting as crossdressers.

Drag king/queen- refers to those who crossdress in a showy or campy way, often for theatrical purposes and often to caricature famous men or women.

FtM (or F2M): Female-to-male. Generally used to refer to anyone assigned female at birth who identifies or expresses their gender as male/masculine/man part or all of the time. An FtM who identifies as male may describe himself as a *trans man*.

Gender Queer-used to describe a very fluid sense of both gender identity and sexual orientation, as it does not constrain people to absolute or static concepts, but leaves people to relocate themselves on continuums of gender identity and sexual orientation.

Intersex- is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male. Intersex is a term that has replaced "hermaphrodite" or "hermaphroditism."

MtF (or M2F): Male-to-female. Generally used to refer to anyone assigned male at birth who identifies or expresses their gender as female/feminine/woman part or all of the time. An MtF who identifies as female may describe herself as a *Trans woman*.

Pan-gendered or multi-gendered - people identify and/or express the many shades of gender.

Transsexuals- have a gender identity that they feel is not congruent with their birth sex. Most transsexuals want to be perceived as the gender that is congruent with their identity, regardless of what physical changes they have pursued.

Definitions have been adapted from:

Goldberg, J.M. (2003). *Making the Transition: Providing services to trans survivors of violence and abuse: A guide for workshop instructors*. Women/Trans Dialogue Planning Committee, the Justice Institute of BC, and the Trans Alliance Society.

LGTB Health Matters: An education & training resource for health and social service sectors (2006, January), The Centre: A Community Centre Serving and Supporting Lesbian, Gay, Transgender, Bisexual People and Their Allies.

Barbara, A.M., Chaim, G. and Doctor, F. (2004). *Asking the Right Questions 2: Talking with clients about sexual orientation and gender identity in mental health, counselling and addiction settings*. Centre for Addiction and Mental Health.

ACTIVITY : 7A**Engagement Exercise: Role Play**

Participants form groups of three or four (2 role play- one worker, one client; one or two observers)

Tell the “client” what their role is; the worker/interviewer does not receive this information

Scenarios:

- 1) You are male, gay and have been using crack cocaine. Your new boy friend injects drugs and you have recently injected for the first time. You are asking for some information on how to safely inject.

Tips to Facilitators for discussion:

- What supplies does he need? Injection supplies and condoms
- Safer using: Rotating sites, tourniquet, alcohol swabs, bevel up
- Signs and symptoms of infection (redness, heat, streaking, swelling)
- Would you ask about the new relationship? Are there different things to consider if you know someone is GBLT?

- 2) You are a female who has been using injection drugs for a long time and are asking for HR supplies. You are Aboriginal and injected heroin about 15 minutes ago. You are falling asleep on and off (on the nod). You are irritable; you wake up every so often and get angry.

Tips to Facilitators for discussion:

- What are her health concerns (vein maintenance, diet, sleep, use)?
- Where is she going next: safety/shelter?
- How sedated is she?
- Are there different things to consider if you know someone is Aboriginal?

- 3) You are a 16 yr old female who is new in town and are homeless. You are hanging out with other youth who are smoking crack cocaine.

Tips to Facilitators for discussion:

- What supplies does she need?
- What might she need to know about that drug?
- What are the safety issues?
- What about community resources because she is new in town?
- Would there be different things to consider given that she is 16 yrs old?

February 2010

ACTIVITY : 7B**5-Minute Elevator Pitch**

You are distributing needles and someone from your community/town says, “You are promoting drug use”. What do you say?

Some sample scripts:

“Clean needles help stop the spread of infections like HIV or hepatitis.”

“The reality is people are using needles right now. I want to provide a way for them to be safer.”

“If people feel judged they won’t utilize services. I want to remain accessible to every one and by providing a service that meets the reality of people’s lives we provide good health care.”

“If people are told “don’t do drugs” they will likely hide their drug use. This isolates people who use drugs further and puts people at greater risk for HIV and hepatitis.”

“Until someone is ready to stop using drugs I want to provide a way for them to not get or give infections. If I don’t judge them they will be more likely to come to me for support around treatment, detox and referrals when the time is right for them.”

“I see we have different opinions about this. I acknowledge your thoughts on this and thank you for talking about keeping people safer in their drug use with me. ”

Write your script here and practice with the person beside you at your table (or share with them the points you would cover):

February 2010

ACTIVITY : 7C**Peer Engagement**

“Historically, people who use drugs have rarely been included in discussions of issues that affect their lives. Marginalized because of their drug use and other factors, such as homelessness, mental health needs, or social exclusion, they have often been distanced from mainstream services and structures”

This activity poses questions to the participants and their responses are recorded. This activity may be used in a community development session using flip charts or pre printed handouts with headings but blank content. The results are summarized below

Question 1 : WHAT IS A PEER?**Possible answers:**

- people who we share experiences, values, language, etc. with people who use drugs
- people, who use drugs, -experiential peers including special groups:
 - men, women, transgender and 2 spirited people who have engaged in sex work
 - Aboriginal peers, Lesbian Gay Transgender Bisexual Queer (LGTBQ) peers, community peers

Background

History of peer-run and peer-to-peer harm reduction programs; exist in some countries since 1970s, 1980s peer-led initiatives began in Downtown East Side (DTES); mid-90s increase in HIV & Hepatitis C.

Current peer initiatives in BC include -Vancouver e.g. Vancouver Area Network of Drug Users (VANDU); DTES HIV/AIDS Consumer's Board, BC Association of People on Methadone; Victoria- Society of Living Intravenous Drug Users (SOLID); Kelowna Area Network of Drug Users (KANDU), Western Aboriginal Harm Reduction Society (WAHRS)

References

Canadian HIV/AIDS Legal Network: Nothing About Us Without Us — Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative: <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=85>

A framework for peer education by drug-user organisations: <http://www.aivl.org.au/files/FrameworkforPeerEducation.pdf>

Question 2: WHAT ARE THE BENEFITS AND CHALLENGES OF PEER ENGAGEMENT to various groups peer workers, service/resource organizations, those accessing the service and the broader community.

February 2010

Peer Involvement Benefits and Challenges Worksheet

Using the table provided, write down benefits and challenges of peer involvement in your community as peer workers; within services, resources and organizations; within the community of peers; and within your broader community. This is best performed as a group activity.

BENEFITS of peer involvement;

Peer Workers	Service, Resource, Org	Community of peers	Broader Community

CHALLENGES (for peers, for organization, for clients):

Peer Workers	Service, Resource, Org	Community of peers	Other Community Members

BENEFITS of peer involvement;

- build on existing capacities; desire to effect change; recognize and values

Peer Workers	Service, Resource, Org	Community of peers	Broader Community
<ul style="list-style-type: none"> -empowerment -self-determination -skills-building -financial & social supports -stability -use of knowledge -fight stigma & discrimination -ownership and self-worth -stepping stone 	<ul style="list-style-type: none"> -skills-building -effectiveness & accessibility -policy change & development -use of knowledge -fight stigma & discrimination -awareness of important issues and changing trends, etc. -targeted communication 	<ul style="list-style-type: none"> -skills-building -effectiveness & accessibility -support -use of knowledge -fight stigma & discrimination -ownership and self-worth 	<ul style="list-style-type: none"> -skills-building -policy change & development -use of knowledge -fight stigma & discrimination -awareness of important issues and changing trends, etc. -targeted communication

CHALLENGES (for peers, for organization, for clients):

Peer Workers	Service, Resource, Org	Community of peers	Other Community Members
<ul style="list-style-type: none"> -need for training & education -triggering -prohibition and legal issues -interpersonal histories -stigma and discrimination -meaningful involvement -confidentiality -addiction and other medical 	<ul style="list-style-type: none"> -need for training & education -prohibition and legal issues -stigma and discrimination -funding -meaningful involvement -confidentiality -need for policies and procedures 	<ul style="list-style-type: none"> -interpersonal histories -stigma and discrimination -confidentiality 	<ul style="list-style-type: none"> -need for education -stigma and discrimination

ACTIONS/CONCRETE MEASURES FOR ENSURING BENEFITS AND ADDRESSING CHALLENGES

Ensure:

- adequate training for peers, staff and community;
- the space is non-judgmental
- peers understand roles and power structure
- transportation available/reimbursed
- participants are comfortable
- peers can create guidelines;
- written contracts and evaluation
- flexibility of hours, expectations

-addiction as an ongoing medical condition
Adequate/appropriate compensation (respects their contributions, provides security, compensates for inadequate welfare rates, may decrease need to get money in more dangerous or criminalized ways

-increasing interest in opportunities for advocacy and representation, training and workshops, and other skills-building

How can peers be involved?

- peer education
- peer support
- peer outreach
- general administration
- Coordinating, managing, Executive Directors
- community involvement and engagement
- conference attendance

8. RESOURCES

1. HARM REDUCTION

Vancouver Four Pillars Drug Strategies <http://vancouver.ca/fourpillars/>

Harm Reduction Health File <http://www.healthlinkbc.ca/healthfiles/hfile102.stm>

Harm Reduction: A British Columbia Community Guide
<http://www.healthlinkbc.ca/redirect.stm>

Strategies Newsletter
BC Centre for Disease Control (BCCDC) Harm Reduction Strategies and Services Newsletter
<http://www.bccdc.ca/prevention/HarmReduction/default.htm>

Canadian and International websites with harm reduction practices or organizations within:

Toronto Harm Reduction Task Force - Peer Manual
<http://www.harmreductionnetwork.mb.ca/docs/thrtf.pdf>

Canadian Harm Reduction Network www.canadianharmreduction.com

UK Harm Reduction Alliance www.ukhra.org

The International Harm Reduction Association www.ihra.net

Drug Policy Alliance www.drugpolicy.org

2. HIV/AIDS

AIDS Vancouver www.aidsvancouver.org

Public Health Agency of Canada
www.phac-aspc.gc.ca/publicat/ccdr-rmtc/97vol23/23s2/23s2ce.html

Options for Sexual Health – Sexual Health Services & Support for BC
www.optionsforsexualhealth.org/

3. INFECTIONS

Hepatitis

British Columbia Center of Disease Control- Hepatitis Services: <http://www.bccdc.ca/dis-cond/a-z/ h/Hepatitis-/default.htm>

Healthlink BC www.healthlinkbc.ca/kbase/list/ht/h.htm

Hepatitis C Teaching Toolkit <http://www.bccdc.ca/dis-cond/a-z/ h/Hepatitis-/educmat/default.htm>

Hepatitis 101 <http://www.bccdc.ca/dis-cond/a-z/ h/Hepatitis-/educmat/default.htm>

Hepatitis 202 <http://www.bccdc.ca/dis-cond/a-z/ h/Hepatitis-/educmat/default.htm>

The BC 2007 Annual Summary of Reportable Diseases
<http://www.bccdc.ca/util/about/annreport/default.htm>

Health Canada www.phac-aspc.gc.ca/hcai-iamss/bbp-pts/hep-eng.php

Hepatitis Australia website www.hepedu.org.au/

4. DRUG EFFECTS

Canadian Centre on Substance Abuse www.ccsa.ca

5. MENTAL HEALTH

Centre for Addictions and Mental Health <http://sano.camh.net>

6. WORKING WITH INDIVIDUALS

Youth

Information on age of consent www.ageofconsent.com/canada.htm

Youth resource www.youthco.org/cms/

Aboriginal Youth Network www.ayn.ca

The National Youth In Care Network (NYIC) www.youthincare.ca/

Drug Education and Awareness for Life (DEAL) www.deal.org

Make a Noise www.makeanoise.ysp.org.au

Office of the Child, Youth and Family Advocate of British Columbia
www.advokids.org

Youth Resource www.youthresource.com/

Lesbian, Gay, Transgender, Bisexual, Queer

Specific to LGBT Communities:

Asian Society for the Intervention of AIDS <http://asia.bc.ca/>

BC Association of Specialized Victim Assistance and Counseling Programs (BCASVACP) host Safe Choices, a program that provides resources and training about same sex partner abuse.
www.endingviolence.org/publications.php?order=chrono

Listing of social, recreational & other community resources
www.gayvancouver.net/search/

Vancouver gay men's resource exchange <http://gayway.ca/>

A listing of grassroots & more formal community organizations that serve & support LGBT populations
http://glba.org/directory/community_services

The LGTB Centre has many different programs & services for LGBT people
www.lgtbcentrevancouver.com/

Through this website, people can find an online, facilitated group for LGBT2S people who are supporting a loved one (relative, partner, friend, roommate, family of choice etc...) with a mental illness to share experiences and find LGBT-friendly resources. www.support.bcscs.org

VariAsian is a peer support group for men of Asian descent who identify as either Gay, Bisexual, or MSM and for their friends www.variasia.com/

VCH's Transgender Health Program serves BC. The website includes a Health Care Provider Referral Guide; Clinical Protocol Guidelines; On-line library; and a list of BC Trans groups www.vch.ca/transhealth

YouthCO AIDS services society <http://youthco.org/cms/>

General Information about LGBT2S Communities:

Two Spirit people in Canada www.2spirits.com/

Bisexual resources www.biresource.org/

Deaf Queer Resource Centre www.deafqueer.org/

National organization that advances equality and justice for LGBT people and their families across Canada <http://egale.ca/>

Includes a discussion with definitions of terms: Sex and Gender; Transgender Definitions, Terminology; Sexual Orientation vs. Gender Identity vs. Sexual Identity. www.gendertalk.com/tgism/tgism.shtml

LGBT web resources for Latin America & the Caribbean www.indiana.edu/~overseas/lesbigay/GLatinAmerica_res.htm

Intersex Society of North America www.isna.org

Information on Canadian immigration for same-sex partners, and refugee information www.legit.ca/

The International Journal of Transgenderism (IJT) is an electronic scientific journal publishing peer-reviewed, original articles on a quarterly basis. In addition, they republish important and seminal articles in their Archives section www.symposion.com/ijt/ijintro.htm

Queer South Asian people. www.trikone.org/

Transsexual FAQ: "The Transsexual Person in Your Life: Responses to some frequently asked questions/frequently held concerns". Geared towards families and friends; this is actually better than the title might suggest. www.tsfaq.info/

Standards of Care from the World Professional Association for Transgender Health – formerly Harry Benjamin International Gender Dysphoria Association. These internationally recognized Standards suggest protocols transsexuals must conform to, to receive treatment from participating medical professionals. www.wpath.org/soc.htm

Addiction / Mental Health Information:

Online LGBT mental health syllabus developed by the LGBT Issues Committee of the Group for the Advancement of Psychiatry www.aglp.org/gap/

Updated February 2010

CAMH - Asking the Right Questions 2

www.camh.net/Care_Treatment/Resources_for_Professionals/ARQ2/arg2.pdf

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals

<http://kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf>

The association of Lesbian, Gay, Bisexual and Transgender Addiction Professionals and Their Allies.

www.nalgap.org

Prism Alcohol & Drug Services: Vancouver-based addiction services for substance-affected Lesbian, Gay, Bisexual, Two-Spirit and Queer people, *and* for Trans people of all sexual orientations.

www.vch.ca/prism

Health resources:

Canadian Rainbow Health Coalition <http://rainbowhealth.ca/>

Gay and lesbian medical association www.glma.org

Domestic & Sexualized Violence Resources:

(BC Association of Specialized Victim Assistance and Counseling Programs (BCASVACP) hosts Safe Choices, a program that provides resources and training about same sex partner abuse).

www.endingviolence.org/publications.php?order=chron

(FORGE - For Ourselves, Reworking Gender Expression has information on a sexual violence project focusing on trans people).

www.forge-forward.org/index.php

(The NW Network of Bi, Trans, Lesbian and Gay Survivors of Abuse)

www.nwnetwork.org/about.html

Focused on the needs of trans & intersex survivors of domestic & sexualized violence

www.survivorproject.org/

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^{xix} Thorpe LE, Ouellet LJ, Hershov R, Bailey SL, Williams IT, Williamson J, Monterroso ER. Risk of hepatitis C virus infection among young adult injection drug users who share injection equipment. *American Journal of Epidemiology*. 2002;155(7):645-653.

Changes and Additions to the 2011 Harm Reduction Training Manual

A. To update your 2009 hardcopy to 2011

January 2011: Changes and Additions	2011 ed. Pages (Print pages from link to the left)
<p>Remove 2009 Table of Contents and replace with 2011 Table of Contents</p> <p>Remove pages 5-9, 12, 16, 20, 23-25 and replace with 2011 pages 5-9, 12, 16, 20, 23-25 from the Harm Reduction Training Manual for Frontline Staff which can be found at: http://www.bccdc.ca/prevention/HarmReduction/default.htm</p>	<p>3 – 4</p> <p>5-9, 12, 16, 20, 23-25</p>
APPENDICES	
<p>Add ‘History of Harm Reduction in British Columbia’ as first page in Appendices: www.bccdc.ca/NR/rdonlyres/7B9F63E8-7D50-4985-9BC2-38D78C4E77AD/0/BCHRhistoryOct21.pdf</p>	
<p>Please note that Section 1C now includes both ‘Harm Reduction health files’ #102a and #102b</p>	
<p>Section 1E is now the ‘BC Harm Reduction Strategy and Services (HRSS) Committee Primary, Secondary and One-off Distribution Site Policy’</p> <p>Add this section from the link below: http://www.bccdc.ca/NR/rdonlyres/2038F63C-1F5E-4AAA-95A8-3AFBB68C38E5/0/HarmReductionPolicyonprimary_secondary_oneoffdistributionsitesJan2011.pdf</p>	
<p>Please note that Section 1F is now the newsletter section (no longer Section 1E)</p> <p>Add ‘May, 2010 Harm Reduction Strategies and Services Newsletter Issue 3’ from link: www.bccdc.ca/NR/rdonlyres/22473E16-6664-475D-84A5-5A2CACF8E0A2/0/StrategiesNewsletter_2010.pdf</p>	
<p>Remove 2A and replace with the updated version ‘HIV/AIDS #08m’: http://www.healthlinkbc.ca/healthfiles/pdf/hfile08m.pdf</p> <p>Remove 2B ‘Hepatitis B infant vaccine #25c’ and replace with the updated version ‘Hepatitis B Vaccine #25a’: http://www.healthlinkbc.ca/healthfiles/pdf/hfile25a.pdf</p> <p>Remove 2G and replace with the updated version ‘Syphilis #08e’: http://www.healthlinkbc.ca/healthfiles/pdf/hfile08e.pdf</p>	
<p>Remove 4A: ‘Harm Reduction Program: Supply Requisition Form’ and 4B ‘Harm Reduction Supply Ordering at the BCCDC’ and replace with updated 4A and 4B (PDF pages 113 and 114) from the Harm Reduction Training Manual for Frontline Staff which can be found at: http://www.bccdc.ca/prevention/HarmReduction/default.htm</p>	<p>PDF #s: 113-114</p>

<p>Remove 4C: ‘Questions and Answers for Plastic mouthpieces for glass stems and Crack pipe push sticks’</p> <p>Replace with the items at: www.bccdc.ca/prevention/HarmReduction/FAQ/default.htm</p> <p>Female condoms Sterile water Cookers and Injected Drug Use Stericup® cooker: Cooker instructions Acidifier (Ascorbic acid) and Injection Drug Use Crack pipe push sticks Crack pipe mouthpieces</p> <p>Note: Please leave first page on ‘Rationale for Crack Pipe Mouthpiece Distribution’</p>	
<p>Remove 8: Resources and replace with 2011 pages from the Harm Reduction Training Manual for Frontline Staff 2011 which can be found at: http://www.bccdc.ca/prevention/HarmReduction/default.htm</p>	<p>PDF #s: 232-235</p>

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<p>APPENDICES</p>	
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<p>Please note that:</p> <p>Section 1C now includes ‘Harm Reduction health files’ #102a and #102b (which was Section 1D)</p> <p>1E is now 1D: ‘BC Harm Reduction Strategies and Services Policy and Guidelines’</p> <p>1F is now 1E: ‘BC Harm Reduction Strategies and Services (HRSS) Committee Primary, Secondary and One-off Distribution Site Policy’</p> <p>1G is now 1F: ‘BC Harm Reduction Strategies and Services newsletters’</p>	
<p>Remove Section 1E and replace with the updated 2011 ‘BC Harm Reduction Strategy and Services (HRSS) Committee Primary, Secondary and One-off Distribution Site Policy’ from: http://www.bccdc.ca/NR/rdonlyres/2038F63C-1F5E-4AAA-95A8-3AFBB68C38E5/0/HarmReductionPolicyonprimary_secondary_oneoffdistributionsitesJan2011.pdf</p>	
<p>Remove 2A and replace with the updated version ‘HIV/AIDS #08m’: http://www.healthlinkbc.ca/healthfiles/pdf/hfile08m.pdf</p> <p>Remove 2B ‘Hepatitis B infant vaccine #25c’ and replace with the updated version ‘Hepatitis B Vaccine #25a’: http://www.healthlinkbc.ca/healthfiles/pdf/hfile25a.pdf</p> <p>Remove 2G and replace with the updated version ‘Syphilis #08e’: http://www.healthlinkbc.ca/healthfiles/pdf/hfile08e.pdf</p>	
<p>Remove 4A ‘Harm Reduction Program: Supply Requisition Form’ and 4B ‘Harm Reduction Supply Ordering at the BCCDC’ and replace with updated 4A and 4B (PDF pages 113 and 114) from the 2011 Harm Reduction Training Manual for Frontline Staff which can be found at: http://www.bccdc.ca/prevention/HarmReduction/default.htm</p>	<p>PDF #s: 113-114</p>
<p>Remove 4C ‘Acidifier (Vitamin C – Ascorbic Acid) Q and A’ and replace with updated ‘Acidifier (Vitamin C – Ascorbic Acid) Q and A’ from: http://www.bccdc.ca/prevention/HarmReduction/QuestionsandAnswers/default.htm</p>	

<p>Please note that any pages that were cut off when printed from the 2010 online manual have been corrected in the 2011 manual.</p>	
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