



# Best Practices for British Columbia's Harm Reduction Supply Distribution Program

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*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.*

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*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.*

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# 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](http://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

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](http://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](http://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

## 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](http://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



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](http://www.aidslaw.ca).

Several groups are currently active in BC, including Vancouver Area Network of Drug Users (VANU) and DTES HIV/AIDS Consumer's Board in Vancouver; Society of Living Intravenous Drug Users (SOLID) in Victoria; KANDU 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

<b>Appendix A</b>	Examples of Mobile Services in British Columbia
<b>Appendix B:</b>	Example of Outreach Services
<b>Appendix C:</b>	Examples of Injecting Equipment Provision in Pharmacies
<b>Appendix D:</b>	New South Wales Health Data Collection List
<b>Appendix E:</b>	WHO Service Evaluation Categories
<b>Appendix F:</b>	Vancouver Coastal Health Data Collection Form
<b>Appendix G:</b>	Staff Core Skills and Knowledge, Queensland Health, Australia
<b>Appendix H:</b>	Safer Crack Use Initiatives
<b>Appendix I:</b>	Coordinated Service Delivery in Prince George
<b>Appendix J:</b>	Peer Education
<b>Appendix K:</b>	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	Additions	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](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](http://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](http://www2.worksafebc.com/PDFs/healthcare/faq_safety_engineered_needles.pdf)



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