Oregon Syringe Services Program (SSP) Guidance

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Oregon Health Authority
PUBLIC HEALTH DIVISION

Note: This document was prepared by Civic Communications, LLC with direction and input from Oregon Health Authority staff.

Contents

Introduction

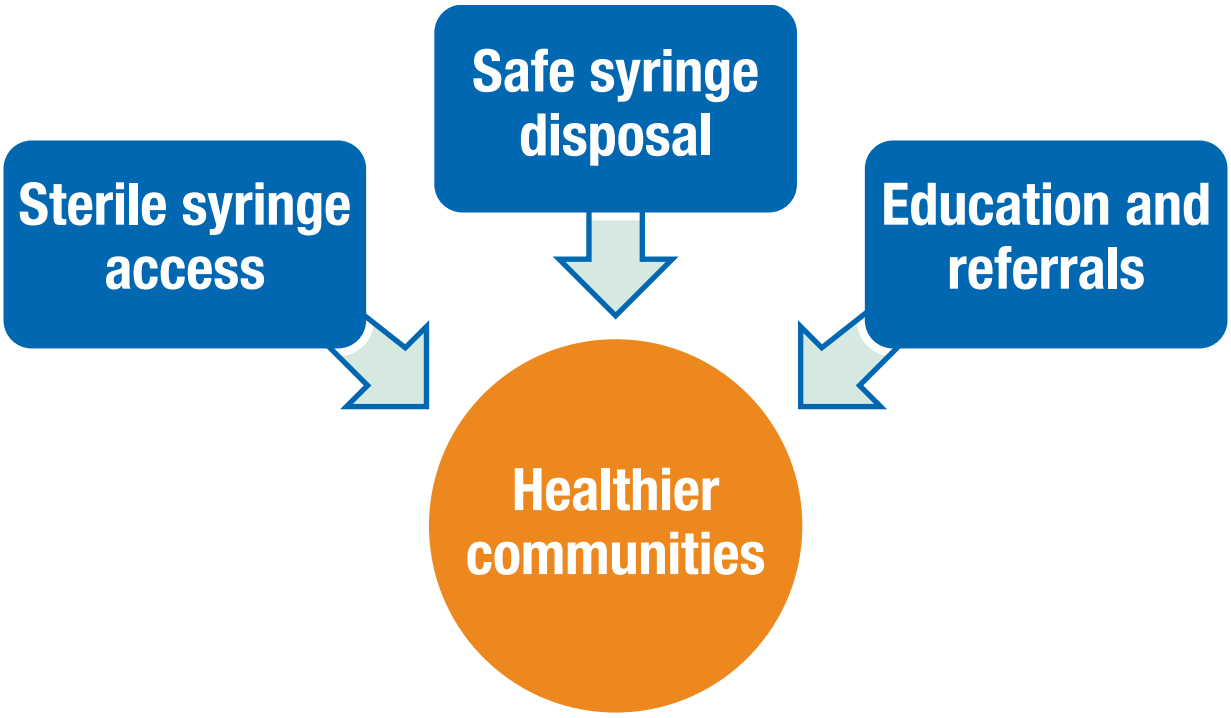
This document is for organizations interested in improving public health in Oregon through syringe services programs (SSPs). This document provides key information and recommendations for service planning and implementation.

What are syringe services programs (SSPs)?

SSPs are community-based programs that serve people who inject drugs (PWID). While SSPs can provide a wide range of services, they generally have three core components (Centers for Disease Control and Prevention (CDC), 2016):

1) Provide free, sterile syringes
2) Facilitate safe disposal of used syringes
3) Offer education and provide or refer to additional services, including rapid HIV and hepatitis C (HCV) screening

The primary goal of an SSP is to provide participants with a new, sterile syringe for every injection (New York State Department of Health, AIDS Institute, 2016). Other terms for SSPs include syringe exchange programs, needle exchange programs, needle-syringe programs and, in previous years, Oregon harm reduction outreach and care services (OHROCS) (Oregon Department of Human Services, 2006).



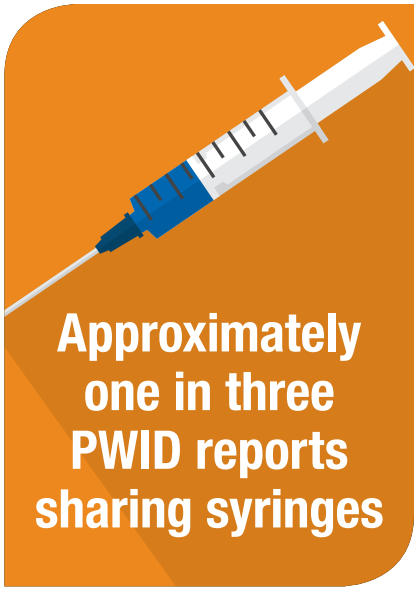
Background

Injection drug use is a serious problem throughout Oregon. In the western region of the United States, an estimated one in 30 adults has ever injected drugs, which is the highest prevalence in the country. Half of people who inject drugs (PWID) are estimated to live outside major urban areas (Oster et al., 2015), which describes much of Oregon.

People who inject drugs are a public health priority. Oregon's Integrated HIV Prevention and Care Plan (2017–2021) identifies PWID as one of three priority populations for HIV prevention services, and Oregon's State Health Improvement Plan (2015-2019) identifies interventions targeted to PWID as a key strategy for addressing hepatitis C. We will never substantively improve population health if some of our residents — such as PWID — are left to experience a disproportionate burden of disease (Oregon Health Authority, 2016). There are at least nine established SSPs in Oregon (North American Syringe Exchange Network, 2016).

Contaminated syringes and equipment place people at high risk for HIV, hepatitis B and C and other bloodborne viruses. It is well-documented that HIV and hepatitis B and C can be present in blood in syringes used by PWID and that reuse of syringes is common; approximately one in three PWID reports sharing syringes (World Health Organization, 2016; CDC, 2015). Sharing other injection equipment (e.g., water, spoons, filters, tourniquets, swabs) is also common; these items can be contaminated with blood and contribute to transmission risk, as well (CDC, 2012). Cleaning syringes and equipment prior to reuse is often inadequate, even when cleaning guidelines have been distributed widely. Efforts to promote disinfection of injection equipment have not been effective (World Health Organization, 2016; CDC, 1993).

Injection drug use accounts for a substantial portion of communicable diseases in Oregon, including new diagnoses of HIV (15%), hepatitis B (12%) and hepatitis C (64%) (Oregon Health Authority, 2015; Oregon Health Authority, Multnomah County Health Department, 2016). As many as one in 10 (11%) PWID in large United States cities have HIV, and the prevalence of hepatitis C among PWID is estimated to range from 40% to 90% (CDC, 2015; Hagan et al., 2010; Page et al., 2009). Public health officials are concerned the heroin and prescription opioid epidemics could lead to new outbreaks of HIV and hepatitis C (CDC, 2016). As observed in Indiana and Kentucky, areas without SSPs may be at increased risk for an outbreak (amfAR, The Foundation for AIDS Research, 2015).



SSPs improve community health by providing access to sterile syringes, safe syringe disposal, health education and referrals to other important services (CDC, 2016).

- There is strong evidence that **SSPs reduce HIV transmission** and are cost effective. SSPs can also reduce risk for other bloodborne viruses, such as hepatitis B and C (World Health Organization, 2016; Wodak and Cooney, 2005).
- **SSPs do not increase drug use.** There is no evidence of major unintended negative consequences of SSPs, such as increased injection drug use among clients or initiation of injection drug use among people who have not injected previously (World Health Organization, 2016).
- **SSPs connect people to services** that improve health, such as HIV pre-exposure prophylaxis (PrEP), testing and care services; drug treatment; and primary health care (Hagan and McGough, 2000; Barocas et al., 2015).
- **SSPs facilitate safe syringe disposal** to protect the public from accidental needlestick injuries (World Health Organization, 2016).

SSPs are an important part of a comprehensive strategy to ensure access to sterile syringes. An ideal strategy should include over-the-counter pharmacy sales and syringe prescriptions from health care providers. Syringe sales from pharmacies have been found to reduce injection risk behavior and HIV infections among PWID; they can help ensure around-the-clock availability and access to sterile syringes in locations where conventional SSPs are lacking or limited (World Health Organization, 2004; Dolan et al., 2005).

Guiding principles

The following guiding principles are the foundation of SSPs.

- **Harm reduction strategies are necessary.** Many PWID are unable to access drug treatment or are not yet ready to abstain from drug use (Appel et al., 2004). We can minimize the harmful effects of injection drug use by providing and connecting PWID to evidence-based services that protect the health of clients and the broader community.
- **People should be able to access health services without judgment.** PWID who experience stigma related to their drug use may be less likely to access SSPs (Rivera et al., 2014; CDC, 2012). Staff should provide factual information and avoid statements that indicate their own values or judgments (Oregon Department of Human Services, 2006).
- **Successful programs are community informed and data driven.** Staff are encouraged to implement the evidence-based practices described in this document and to seek and respond to input from PWID and other stakeholders.

Planning

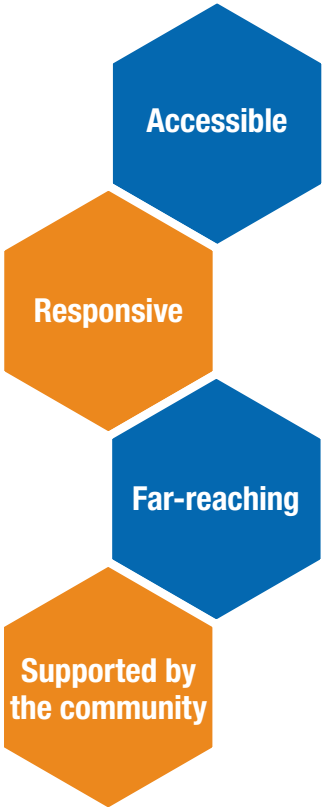
Know the characteristics of effective SSPs

The following characteristics are indicators of effectiveness and considered best practices for SSPs (New York City Department of Health and Mental Hygiene, 2016):

Services are easy to access.

- Clients are not required to participate in other services.
- Participation is anonymous. Clients are not required to say or write their name, and an identification card is only requested if a person appears younger than 18 years of age. PWID may avoid using an SSP if they believe it may increase their likelihood of being identified as engaging in illegal drug use by authorities (Tucker et al., 2009).

Services are responsive to community needs.



- There are no limits on the number of syringes clients can receive or the number of times they can visit the SSP (New York City Department of Health and Mental Hygiene, 2016; Drach et al., 2011). Limiting the number of syringes distributed (e.g., providing new syringes only to clients who return syringes) may result in insufficient numbers of sterile syringes to meet their injecting needs. It is estimated that an individual PWID injects approximately 1,000 times per year (Lurie et al., 1998), and the frequency of SSP visits vary widely among PWID. If a limit must be set due to budget constraints, a high number is preferred (e.g., up to 600 syringes per transaction) (New York State Department of Health, AIDS Institute, 2016).
- Services are not limited to clients who report residing within a specified geographic area.
- Service models, hours and location(s) are determined with client input.
- Staff offer or connect participants to other health and social services. Programs may choose to integrate additional services with their SSP or to integrate syringe services with existing programs (e.g., testing, case management). At a minimum, SSPs should have strong referral systems in place, as described in the education and referrals section of this document.

- The program engages and adapts to the needs of subgroups of PWID. For example, some SSPs have established locations and times to provide services to groups with unique needs, such as transgender clients who use syringes to inject hormones or soft tissue fillers (e.g., silicone) for gender affirmation.

Secondary syringe distribution is encouraged.

- Secondary distribution occurs when a client visits an SSP, obtains sterile syringes and distributes a portion of the syringes to other PWID who may be unable to visit the SSP. Secondary distributers are often trained to provide risk reduction education, as well.

Diverse stakeholders are engaged to help create a community environment that is supportive of the SSP.

Assess community needs

Community needs assessments can help determine and demonstrate the local need for an SSP and inform program operations (e.g., education and referrals offered). Because injection drug use is illegal and PWID are a highly marginalized population, local data may be limited. Assessments can include both primary data (new data collected by staff) and secondary data (from existing data sources). Consider the following assessment questions and data sources:

To what extent is HIV a problem among PWID in my county?

- Data sources:
  - Oregon Health Authority HIV Data webpage
  - Chime In survey (limited to counties in the Portland Metropolitan Statistical Area)

To what extent is viral hepatitis a problem in my county?

- Data source: Viral Hepatitis in Oregon Report (Oregon Health Authority, 2015)

To what extent is injection drug use a problem in my community?

- Consider local sources for the following data:
  - Drug-related arrests
  - Drug-related overdose mortality
  - Substance use disorder treatment (e.g., medication-assisted treatment for opioid use disorder)

- Emergency department or other medical care data related to diagnoses of substance use disorder and infective endocarditis in PWID, as well as frequency of naloxone administration
- Photographs and counts of used syringes discarded in public locations (e.g., parks, sidewalks) from visual inspection walkthroughs (Tookes et al., 2012)

What are the **demographic characteristics and risk behaviors** among local PWID?

- Data sources:
  - Surveys, key informant interviews or focus groups with PWID and professionals who provide services to PWID
  - Chime In survey (limited to counties in the Portland Metropolitan Statistical Area)

What are the perceived **barriers and motivators** for SSP use?

- Data source: Surveys, key informant interviews or focus groups with PWID and professionals who provide services to PWID

What are the **service needs** among local PWID?

- Data source: Surveys, key informant interviews or focus groups with PWID and professionals who provide services to PWID

Engage stakeholders

Stakeholder engagement is vital to fostering community support, promoting the program, and ensuring the program is responsive to local needs. Consider which stakeholders should be engaged together or separately to ensure comfort and openness.

Consider engaging the following stakeholders, as applicable (World Health Organization, 2016):

- Local government officials
- Lawmakers
- Law enforcement
- Health care providers
- Prison staff

- PWID, including subpopulations such as:
  - People of different racial/ethnic backgrounds
  - Non-English speaking people
  - People experiencing homelessness
  - Sex workers
  - Women with children
  - PWID who use different drugs (e.g., heroin, amphetamine, cocaine)
  - Transgender PWID
  - Gay, bisexual, and other men who have sex with men and inject drugs, a population with a particularly high HIV prevalence (CDC, 2015)
  - Younger PWID, who may be more likely to share syringes (CDC, 2016)
  - People currently or previously incarcerated, who may be at risk from reusing equipment for drug injection or tattooing (Nelles and Harding, 1995)

Communications with law enforcement should highlight how SSPs help protect both law enforcement personnel and the public from needle stick injuries, as described in the Foundation for AIDS Research's fact sheet on public safety, law enforcement and syringe exchange (2013).

Develop procedures and training plans

Written procedures and trainings can help SSP staff and volunteers prepare for SSP implementation and serve as references during implementation. SSP staff and volunteers are encouraged to practice (role play) client scenarios with experienced staff during training.

In addition to the content in this guidance document, consider adding the following topics and resources to your training plans, as applicable:

- Key information about HIV, viral hepatitis, cultural sensitivity and risk reduction counseling
  - Resource: HIV Prevention Essentials online training
- Safer injection
  - Resource: Safer Injection Materials from the Harm Reduction Coalition

- Occupational safety
  - Resource: Oregon Occupational Safety and Health Division (Oregon OSHA)
  - Resource: The National Institute for Occupational Safety and Health
- Medical first aid training
  - Resource: Rules and publications from the Oregon OSHA
- Incident reporting procedures
  - Recommendation: Incidents involving the SSP, including community opposition, law enforcement encounters, needlestick injuries, theft or violence at the program site, potential legal action or media surveillance should be documented and reported to management within 24 hours.
- Overdose prevention, recognition and response
  - Resource: Naloxone protocols and training videos from the Oregon Health Authority and Multnomah County Health Department
  - Recommendation: Provide overdose prevention, recognition and response training and make naloxone available to staff, volunteers, and participants, if resources permit (NASTAD, 2012).
- Trauma informed care
  - Resource: Trauma Informed Oregon
- Data collection
  - See monitoring and evaluation section

Model SSP policies, guidelines and practices are available from other government agencies and community-based organizations, including:

- New York State Department of Health, Aids Institute (2016)
- San Francisco Department of Public Health (2014)
- Government of the District of Columbia (2009)
- Harm Reduction Coalition (2010)

Both new and existing SSPs in Oregon can learn from each other's experiences, and regular communication is encouraged.

General safety procedures

Safety is a priority. Programs should consider the following recommendations (Harm Reduction Coalition, 2010; Multnomah County Health Department, 2012):

- Ensure multiple staff are present during hours of operation.
- Handle syringe transactions one person at a time.
- If necessary, staff should remind participants not to crowd the exchange area.
- Ensure all staff and volunteers wear closed-toe and closed-heel shoes. Clothing that covers legs and arms may be recommended, as well.
- Never give clients rides, money or any other goods.
- Use caution when disclosing personal information.
- If a client becomes upset or angry, use active listening to de-escalate the situation.
- If a client becomes violent or hostile, shut down the exchange site and contact the program manager and the police.
- Avoid bringing valuable possessions to the site or lock them in a safe place.
- Keep a cell phone on you.
- Conduct operations in spaces that are free of clutter and have adequate lighting.
- Ensure the following items are accessible at all times:
    - First aid kit
    - Fire extinguisher
    - Naloxone kits, if possible
    - Materials to be used in the event of a sharps spill:
        - Puncture-resistant utility gloves
        - Tongs
        - Bleach

Preventing occupational exposures

To prevent needlestick injuries and other occupational exposures to blood, organizations should have an exposure control plan and review and update the plan annually (OAR 437, Division 2). The Oregon Occupational Safety and Health Division (Oregon OSHA) offers free resources to help organizations meet infection control requirements, including consultation, onsite assistance, and a sample bloodborne pathogens exposure control plan and sharps injury log (visit the link above and select "Publications").

A person who is accidentally pricked by a used needle or syringe is at risk of exposure to bloodborne viruses. A worker's estimated risk for infection following a needlestick with infected blood is approximately:

- One in 300 (0.3%) for HIV
- One in 55 (1.8%) for hepatitis C
- Up to one in three (6%–30%) for hepatitis B if unvaccinated, depending on the hepatitis B e-antigen status of the source person. Workers who have received the hepatitis B vaccine and developed immunity are at virtually no risk (CDC, 2013).

SSP staff should assume that blood and other bodily fluids are potentially infectious and use infection control precautions at all times. The following precautions are recommended (NASTAD, 2012; New York City Department of Health and Mental Hygiene, 2016):

Avoid handling participant syringes and equipment.

- SSP staff and volunteers should never handle used syringes or unofficial biohazard containers brought in by a client. Clients should be asked to place these containers in a large biohazard container at the site.
- Do not require returned syringes to be counted by hand. Estimates can be made by observation or by weighing returned syringes.
- If loose syringes or injection equipment fall outside of a sharps container, the participant depositing items should pick them up and place them in the sharps container. If this is not possible, staff should wear puncture-resistant utility gloves while using tongs to pick up the supplies and clean surfaces exposed to blood with bleach.

Handle sharps/biohazard containers carefully.

- Ensure all used injection equipment collected is placed in approved biohazard containers that are leak-proof, rigid, puncture-resistant and labeled appropriately, with lids that close securely.
- Wear puncture-resistant utility gloves at all times when opening, sealing or handling sharps containers.
- Never hold sharps containers during a transaction. Place sharps containers on a level surface and at a safe distance from agency staff, between the participants and staff/volunteers.
- Close sharps containers when being transported by vehicle or foot.
- Never insert hands into biohazard bins or forcibly push used injection equipment into containers (supplies should be dropped into the containers).
- Empty biohazard containers when they are 3/4 full; do not let them get to full and risk a spill.
- SSP staff and volunteers should never handle unofficial biohazard containers brought in by a client. Clients should be asked to place these containers in a large biohazard container at the site.

Wash hands and other skin surfaces immediately after contact with blood or body fluids.

Programs are encouraged to educate staff, volunteers and clients on safety precautions for handling, transporting and disposing of hazardous waste routinely.

Responding to occupational exposures

If a worker experiences a needlestick or sharps injury or is exposed to another person's blood or other body fluids, the following steps should be taken immediately:

- First, **clean the exposed area:**
  - For needlesticks or cuts: Wash wounded skin with soap and warm water, if possible
  - For splashes to the nose, mouth or skin: Flush with water
  - For splashes to the eyes: Irrigate eyes with clean water, saline or sterile irrigants

- Second, **report the incident to a supervisor and seek medical treatment** (National Institute for Occupational Safety and Health, 2016).

A health care provider should help determine whether the following actions are warranted:

- Testing
- Initiation of treatment to help prevent infection (post-exposure prophylaxis or PEP) for HIV and/or hepatitis B
- Initiation of the hepatitis B vaccine series
- Follow up monitoring and testing (CDC, 2001; Kuhar et al., 2013)

If a health care provider or safety worker* has a substantial exposure† to another person's (the "source person") bodily fluids, knowing whether the source person has HIV can assist the worker in determining whether to obtain PEP. Eligible workers who have experienced a substantial exposure can request HIV testing of the source person if the exposure is determined to be work-related (occupational) and substantial. The process for requesting that a source person be tested for HIV is set out in OAR 333-022-0300. If, after going through the appropriate process the source person refuses to consent to an HIV test, the health care provider or safety worker can petition the circuit court and ask the court to order testing. The petition process is described in OAR 333-022-0305.

* Workers" include persons licensed or certified to provide health care (under ORS chapters 677, 678, 679, 680, 684 or 685, or ORS 682.216); employees of licensed health care providers, health care facilities or clinical laboratories (defined in ORS 438.010); firefighters; law enforcement officers (defined in ORS 414.805); and corrections, parole or probation officers (OAR 333-022-0300(1)).

† "Substantial exposure" means an exposure to blood or certain body fluids that have a potential for transmitting HIV based upon current scientific information and may include but is not limited to contact with blood or blood components, semen, or vaginal/cervical secretions through percutaneous inoculation or contact with an open wound, non-intact skin, or mucous membrane of the exposed person (OAR 333-022-

Core component 1: Syringe distribution

Syringe distribution is central to meeting the primary goal of a SSP: provide participants with a new, sterile syringe for every injection (New York State Department of Health, AIDS Institute, 2016).

Relevant policies

Federal policies

The Consolidated Appropriations Act, 2016 (Pub. L. 114-113) prohibits the use of federal funds to purchase sterile needles or syringes for the purposes of hypodermic injection of any illegal drug (Department of Health and Human Services, 2016). However, federal funds may be used for other SSP-related purposes (e.g., personnel, naloxone) if a state or local health department can, in consultation with CDC, determine that such a program is needed and is allowable under state and local law (Department of Health and Human Services, 2016).

Therefore, Oregon SSPs should either avoid using federal funding or ensure the use of federal funding is approved and those funds are spent on allowable activities. For further information and guidance around federal policies, please contact the HIV/STD/TB Section at 971-673-0149.

State policies (Oregon Legislature, 2015)

In Oregon, SSPs are legal due to the explicit exclusion of needles and syringes from the state's drug paraphernalia laws. It is unlawful for any person to deliver or possess drug paraphernalia, knowing that it will be used to unlawfully prepare or inject a controlled substance (as defined by ORS 475.005). Oregon Revised Statutes (ORS) 475.525, Drug paraphernalia includes equipment or materials of any kind which are marketed or designed for storing, preparing, injecting, ingesting, inhaling or otherwise introducing a controlled substance into the human body, but the law explicitly states that "drug paraphernalia" ***does not include*** hypodermic syringes or needles. ORS 475.525(3)

It is unlawful to "sell or give a hypodermic device (needle, syringe or any instrument adapted for the injection of a controlled substance) to a minor unless the minor demonstrates a lawful need therefor by authorization of a physician, physician assistant licensed under ORS 677.505 to 677.525, nurse practitioner licensed under ORS 678.375 to 678.390, parent or legal guardian or by other means acceptable to the seller or donor." ORS 475.744,

Therefore:

- Oregon SSPs should distribute needles or syringes only to people who are at least 18 years of age (unless authorized by a health care provider as described in ORS 475.744).
- Oregon SSPs should not distribute other equipment or materials marketed or designed for preparing or injecting drugs (as described in ORS 475.525).
- It is legal to sell or purchase needles or syringes without a prescription in pharmacies and in other retail outlets.
- Though over-the-counter syringe sales are legal, pharmacies may refuse to sell syringes at their discretion.

Notably, some other states have chosen to explicitly authorize and establish requirements for SSPs (Colorado Revised Statutes 25-1-520; Vermont Statute 18-4478; Nevada Revised Statutes 439.985; Temple University, 2016).

Supplies

"Syringe dead space" refers to the leftover fluid that remains inside a syringe after the plunger is fully depressed. Syringes can be classified as high dead space or low dead space. Conventional or high dead space syringes consist of a detachable needle connected to a syringe, with dead space ranging from approximately 51 to 158 µL (Figure 1). In contrast, most low dead space syringes on the market have needles that are thin and permanently attached, with dead space ranging from 1 to 9 µL.

Figure1: Mean Volume of Fluid Retained with Plunger Depressed

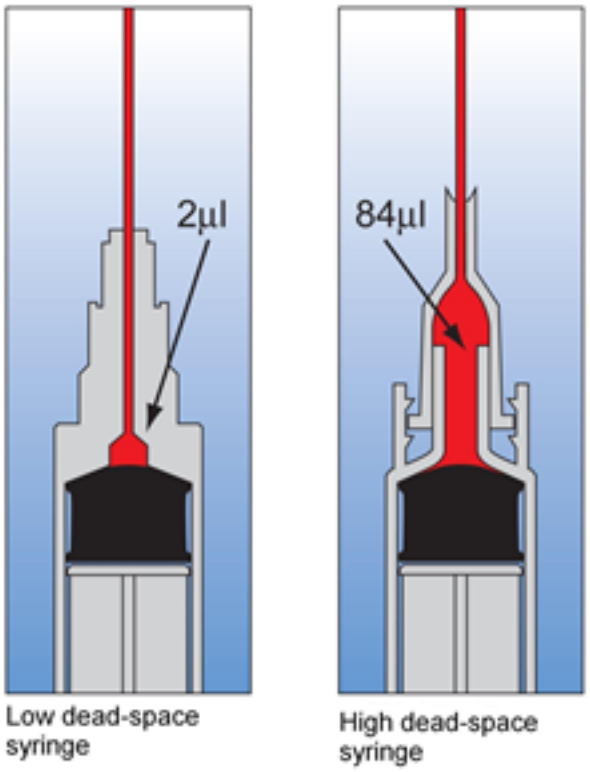


Image source: Wikimedia Commons

Programs should offer and recommend low dead space syringes, which retain less blood after use and may reduce the risk of HIV and hepatitis C infections by 50% or more (World Health Organization, 2012; New York City Department of Health and Mental Hygiene, 2016; Bobasgev and Zule, 2010). Binka et al. (2015) found that 1 mL insulin syringes with fixed 27G½" needles were most effective at reducing the amount of hepatitis C virus retained in syringes, outperforming all detachable syringe and needle combinations tested. Most low dead space syringes with permanently attached needles can hold one milliliter (mL) of fluid, which is sufficient for most PWID in the United States (Oramasionwu et al., 2015). Some PWID prefer low dead space syringes due to their safety and thin needle, which can help reduce the number of "missed hits" and the size of injection marks.

Larger, high dead space syringes should also be offered if substantial numbers of local PWID do not find low dead space syringes acceptable (World Health Organization, 2012; New York City Department of Health and Mental Hygiene, 2016; Oramasionwu et al., 2015). High dead space syringes may be preferred by people who inject prescription opioids and larger volumes (five to 10 mL), who have concerns about smaller syringes becoming blocked during drug preparation or who want detachable needles (Oramasionwu et al., 2015).

The success of an SSP is dependent upon whether syringes distributed are acceptable to the local population of PWID. Consider the following:

- Populations of PWID have been known to prefer shorter needles (one half to five eighths inch), higher gauge needles (27–29 gauge), and smaller syringes (one mL), as found in standard insulin sets (Oramasionwu et al., 2015; Harm Reduction Coalition, 2010)
- Some organizations advise against purchasing single-use, auto-disable syringes, which contain a locking mechanism that retracts the needle after its initial insertion. These syringes are frequently rejected and reused, despite their intended design (Harm Reduction Coalition, 2010; New York City Department of Health and Mental Hygiene, 2016). The syringes also prevent PWID from adjusting the volume of substance in the syringe during an injection, a common practice that can be protective against overdose (Des Jarlais, 1998).
- Asking members of the local population what types of syringes they use and want can help inform program purchases.

Consider distributing supplies for sanitation and for safer sex, which also serve the goal of preventing infections (World Health Organization, 2016).

- Cleaning supplies may include:
  - Alcohol wipes
  - Gauze pads
  - Bandages
  - Bleach
  - Sterile water
- Safer sex supplies may include:
  - Condoms made of latex, polyisoprene or polyurethane
  - Silicone-based lubricant

Supplies should be stored in a locked, secured space.

SSP clients can also benefit from safer sex supplies.

Implementation

SSPs may use one or more models to provide services (Table 1). The use of multiple models may help expand the reach of services and achieve greater public health benefits (Harm Reduction Coalition 2010 and 2011; World Health Organization 2007 and 2016).

Table 1. Service delivery models

Model	Description	Strengths	Limitations
Fixed site	The SSP is housed in a building (e.g., local health department, community-based organization, prison).	• Participant privacy • Staff security • Protection from the weather • Onsite storage space • Easily supports online record-keeping systems • Potential room for service expansion	• Participants must come to you • Potential limitations on hours of operation • Higher overhead and upkeep (e.g., maintenance, security system) • SSP building visibility and potential for opposition from neighborhood residents and businesses • Potential difficulty adjusting to changes in the neighborhood or locations where PWID congregate
Mobile or outreach based	Services are delivered from a vehicle or bicycle or by foot. Stops are made at designated locations at specified times.	• Accessible and may reach PWID less likely to come to a fixed site • Flexibility to adjust locations if warranted by changes in the neighborhood or drug scene • Often more acceptable to community residents and businesses • Potential room for service expansion in a mobile van	• Potential difficulty providing additional services (e.g., testing, vaccination) • Potential for strenuous conditions for staff (e.g., weather, safety concerns, carrying supplies) • Challenges related to supervising outreach staff • Van may involve high overhead (e.g., insurance, fuel, upkeep, parking) • Need for offsite storage • Privacy concerns if clients can be seen in open spaces

...Table 1 continued

Model	Description	Strengths	Limitations
Home delivery	Syringes are delivered to a home or another agreed upon site, such as a shooting gallery (buildings in which drugs are sold, produced or used). Service delivery can occur on a regular schedule or by appointment.	• Participant safety, privacy and comfort • Participants do not need to transport used injection equipment • Potential for large transactions • May reach PWID less likely to come to a fixed site • Potential to interact with and educate family and support networks • Often easier to start up	• Participant must be at home • May require substantial trust to overcome privacy concerns • Potentially time consuming and difficult to sustain • Requires a vehicle
Secondary or peer-delivery	Participants distribute syringes within their drug-using networks after being supplied with equipment by SSP staff.	• Uses peer knowledge of the local drug scene • Increases access to sterile syringes for PWID less likely to seek services • Encourages clients to discuss and promote the SSP • Empowers peers to provide services to their own community • Increases volume of sterile syringes distributed	• Cost of training and supervision of peers • Managing boundaries can be challenging • Risks involved with peers collection and transportation of other participants' used injection equipment
Hospital or clinic setting	Syringes are provided out of a hospital or clinic-based setting.	• Opportunities to access immediate medical care, including wound care and screening for HIV or hepatitis C • May provide increased privacy • Access to onsite biohazard disposal	• Clients may feel uncomfortable in or have negative associations with the clinical environment • Education and referral systems may be limited

...Table 1 continued

Model	Description	Strengths	Limitations
Integrated syringe access	An organization serving PWID adds syringe access to their existing array of services (e.g., testing, case management), rather than creating a separate SSP. In some cases, syringe services may be restricted to programs clients, rather than available and advertised to all PWID in the community.	• Pre-existing infrastructure (e.g., staff, referral systems) and client base	• Staff may be resistant to new duties • Multiple funding streams may limit program autonomy to implement best practices
Pharmacy voucher	Organizations provide clients with vouchers redeemable for free syringes at participating pharmacies.	• Useful in areas that have been unsuccessful in implementing SSPs • Likely that services are highly accessible due to pharmacy hours of operation and locations	• Potential need to offer in-depth ongoing cultural competency training for pharmacy staff so participants feel comfortable and are not served selectively • PWID may receive less education and referrals • Pharmacies may be unwilling to dispose of used equipment • Pharmacies may limit the number of syringes distributed per transaction

Core component 2: Syringe disposal

Safe syringe disposal seeks to prevent accidental needlestick injuries among SSP staff, volunteers, clients and the public (World Health Organization, 2016).

Relevant laws

ORS 459.386 to 459.405 address the storage, collection and disposal of infectious medical wastes, including sharps. This law applies to health care facilities and private individuals and helps protect both workers who handle infectious wastes and the general public.

ORS 459.390 provides procedures for segregation and containment of infectious waste:

- Infectious waste shall be segregated from other wastes by separate containment at the point of generation. Enclosures used for storage of infectious waste shall be secured to prevent access by unauthorized persons and shall be marked with prominent warning signs.
- Infectious waste, except for sharps, shall be contained in disposable red plastic bags or containers made of other materials impervious to moisture and strong enough to prevent ripping, tearing or bursting under normal conditions of use. The bags or containers shall be closed to prevent leakage or expulsion of solid or liquid wastes during storage, collection or transportation.
- Sharps shall be contained for storage, collection, transportation and disposal in leakproof, rigid, puncture-resistant red containers that are taped closed or tightly lidded to prevent loss of the contents. Sharps may be stored in such containers for more than seven days.
- All bags, boxes or other containers for infectious waste and rigid containers of discarded sharps shall be clearly identified as containing infectious waste.
- Infectious waste shall be stored at temperatures and only for times established by rules of the Oregon Health Authority.
- Infectious waste shall not be compacted before treatment and shall not be placed for collection, storage or transportation in a portable or mobile trash compactor.
- Infectious waste contained in disposable bags as specified in this section shall be placed for collection, storage, handling or transportation in a disposable or reusable pail, carton, box, drum, dumpster, portable bin or similar container. The container shall have a tight-fitting cover and be kept clean and in good repair. The container may be of any color and shall be conspicuously labeled

with the international biohazard symbol and the words Biomedical Waste on the sides so as to be readily visible from any lateral direction when the container is upright.

- Each time a reusable container for infectious waste is emptied, the container shall be thoroughly washed and decontaminated unless the surfaces of the container have been protected from contamination by a disposable red liner, bag or other device removed with the waste.
- Trash chutes shall not be used to transfer infectious waste between locations where it is contained or stored.
- Generators that produce 50 pounds or less of infectious waste in any calendar month shall be exempt from the specific requirements of subsections (5), (7) and (8) of this section. [1989 c.763 §5; 2009 c.595 §942]

ORS 459.405 states that each person who **transports infectious waste** for consideration, other than waste that is an incidental part of other solid waste, shall:

- Provide written certification to a person who discards more than 50 pounds per month of infectious waste that such waste will be disposed of in compliance with the provisions of ORS 459.386 to 459.405.
- Maintain records showing the point of origin and date and place of final disposal of infectious waste collected from generators. A copy of these records shall be given to the generator or the Department of Environmental Quality upon request.

Therefore, sharps must be:

- Disposed of in approved sharps containers (available at many local pharmacies, medical supply stores and hazardous waste facilities)
- Transported and documented appropriately

The Oregon Health Authority supports all forms of safe disposal that are in compliance with Oregon Revised Statutes and Occupational Safety and Health Administrative (OSHA) guidelines. Potential options include:

- Drop boxes: Collection sites in locations such as SSP sites, doctors' offices, hospitals, pharmacies and police or fire stations.
- Hazardous waste sites: Public collection sites for hazardous materials (e.g., paints, cleaners and motor oil) may accept sharps containers.
- Residential pickup programs: Some communities have pickup services for waste that includes sharps containers.
- Mail-back programs: These programs allow FDA-cleared sharps disposal containers to be mailed to a collection site for proper disposal.

Supplies

SSPs may wish to purchase multiple types of FDA-cleared sharps containers, which are available in a range of shapes and sizes.

- **Sharps containers** at SSP sites may be used for disposal of used syringes returned by clients and also distributed to clients for future syringe disposal. Sites may wish to maintain large (e.g., eight gallon) sharps containers and provide clients with smaller containers. Fit packs are small, portable containers with separate compartments for storing both new and used syringes.
- **Drop boxes** may be available in doctors' offices, hospitals, pharmacies, public bathrooms and other community locations.

Implementation

The NeedyMeds Safe Needle Disposal website includes a number of resources to help guide implementation, including:

- Sharps disposal locations in Oregon
- Sharps mail-back programs
- Print materials

The FDA website also offers print materials promoting safe sharps disposal.

Syringe disposal practices should adhere to the recommendations for preventing occupational exposure, as described in the planning section of this document.

A printable poster. Source: FDA

Core component 3: Education and referrals

SSPs should be a part of a comprehensive service program that connects clients to other important health and social services (Department of Health and Human Services, 2016). SSPs aim to engage clients on a regular basis, offering multiple opportunities to provide education and referrals (World Health Organization, 2016).

Materials

Offer clients **educational materials** related to safer injection, including:

- SSP locations and hours of operation
- Safer injection practices
- Safe syringe disposal
- Other topics such as those included in your resource (see below)

Develop a **resource list** to share with clients. Services that may be important for PWID include:

- Primary health care
- Mental health care
- Substance abuse treatment, including medication-assisted treatment for opioid use disorder
- Overdose prevention, recognition and response
- Food and clothing distribution
- Housing
- Screening, care and treatment for HIV and other sexually transmitted infections
- Partner notification services for people who may have been exposed to a sexually transmitted infection through sex or injection practices

- HIV Pre-exposure prophylaxis (PrEP)
- HIV post-exposure prophylaxis (PEP)
- Hepatitis A and B vaccination
- Hepatitis B and C screening and treatment
- Intimate partner violence services

Implementation

In addition to offering educational materials and referrals to community resources, staff should be prepared to answer common questions and discuss risk behaviors. The following information (Table 2) is intended to help staff understand and communicate how injection supplies can either contribute to or reduce risk (Harm Reduction Coalition, 2010; Multnomah County Health Department, 2012; Scott, 2008; Huong et al., 2015).

Table 2. Understanding injection equipment and risk

Item	Purpose	Risk	Message
Syringes	Inject drugs	The syringe may contain blood from someone who previously used the syringe or any other item that came in contact with the syringe (e.g., cooker, cotton, water).	• "One needle, one use": A new, clean syringe for each injection is recommended to prevent disease. • Sharing syringes can spread disease and bacteria. • If reusing a syringe is necessary, reusing your own syringe is better than using someone else's. Clean the syringe properly with a bleach and water solution to reduce the spread of disease. Cleaning does not eliminate risk for hepatitis C. • Bring used syringes back to our program for disposal. • We recommend low dead space syringes. These syringes retain less blood after they have been used and can reduce the risk of getting HIV and hepatitis C by 50%. Some people prefer low dead space syringes and say they reduce pain and scarring. We offer other syringes, as well, but they are not as safe.

...Table 2 continued

Item	Purpose	Risk	Message
Cookers/ Caps	Mix (cook) a drug solution before injection	Blood inside used cookers can transmit hepatitis C and other bloodborne infections. Blood can get in a cooker from contact with a contaminated syringe, cotton or drug mix placed back into a cooker after a failed injection attempt.	• A new cooker for each shot helps prevent disease. • Do not touch the inside of the cooker as our hands carry germs. • Sharing cookers can spread hepatitis C and other infections. • If reusing a cooker is necessary, reusing your own cooker is better than using someone else's. Clean the cooker properly with a bleach and water solution to reduce the spread of disease. If bleach is not available, use soap and water.
Cottons/ filters	Filter impurities in the drug mix when pulling it into the syringe	Blood in used cottons can transmit HCV and other bloodborne infections	• New, clean cotton is recommended for every injection. • Reusing cottons can cause abscesses and can spread hepatitis C and other infections. • Wash your hands before handling cotton. • If reusing cotton is necessary, reusing your own cotton is better than using someone else's. • Small cottons are dense and filter better than big cotton balls.
Sterile water vials	Dissolve drugs and flush syringes after use	Water used for injection can easily be contaminated with blood from a syringe and transmit infections.	• Sterile water from a new bottle that you do not share is recommended for every injection. You can buy sterile water from a store, but if you can't get it, you can use water that has been boiled for 10 minutes or clean tap or bottled water. • Sharing water from bottles or cookers can spread disease.

...Table 2 continued

Item	Purpose	Risk	Message
Alcohol wipes	Clean the injection site before injecting (or clean hands if soap and water are unavailable)	Wipes help make veins visible and prevent infections and abscesses.	• Use alcohol wipes before you inject, not after. • Wipes help prevent abscesses and bring the veins up so you are less likely to miss • Wipe one time in one direction to keep germs off the injection site • If alcohol is not available, wash your hands and the injection site with soap and water. • Cleaning the injection site will not prevent HIV or hepatitis infections
Tourniquets/ ties	Helps identify veins and reduce missed hits, which can lead to abscesses	Ties can get blood on them during the injection process.	• A new, sterile tie is recommended for every injection. • If you reuse your tie, mark it to identify which one is yours. Clean with bleach and water solution to reduce the spread of disease. If bleach is not available, use warm soapy water. • Even if you clean the tie, germs that you cannot see may be on the tie and get into what you are injecting. • Try not to tie off over a recent injection site. • Untie before you inject in order to reduce bleeding after the needle is removed.
Bleach kits (containing bleach and water)	Clean surfaces or injection equipment	Although bleach has been proven effective in killing HIV, it is not 100% effective in killing hepatitis C.	• New, sterile equipment is recommended for every injection to help prevent HIV and other infections. • If not possible to use new, sterile equipment, disinfecting with bleach may help prevent infections.

...Table 2 continued

Item	Purpose	Risk	Message
Powdered citric or ascorbic acid	Break down and dissolve crack or other solid drugs before injection	People commonly use vinegar or lemon juice, which can cause bacterial infections and abscesses	• Powdered citric or ascorbic acid is recommended and may reduce the risk of abscesses compared to other acidifiers, such as vinegar or lemon juice.
Sharps containers/ Fit packs	Sharps containers are for used syringes and other bio-hazardous materials. Fit packs are small containers with separate areas for storing both new and used syringes.	Proper disposal may reduce accidental needlestick injuries, and syringe reuse and sharing.	• Keeping sterile syringes with you and disposing of used syringes can help you use a new one every time.
Gauze pads	Stop blood flow after injection	If not used, blood may spread to other surfaces.	• Gauze pads are sterile and stop bleeding.
Bandages	Cover injection sites.	An exposed wound increases the risk of infection and the spread of blood to other surfaces.	• Covering your injection site helps you avoid infection.

The Oregon Health Authority's HIV Prevention Essentials online training offers additional information and resources.

Marketing and communication

Due to the social and legal implications of injection drug use, PWID are considered a "hidden population." While this presents a unique challenge for programs, some effective practices for marketing to PWID have been identified.

Use peers: Reaching and promoting safer injection practices through peer-based efforts have generally been found to be highly effective (World Health Organization, 2004). Programs should give serious consideration to implementing a peer-based service delivery model (previously described in Table 1). To identify PWID interested in becoming trained peer educators, conduct outreach to PWID in locations such as parks, single-room occupancy hotels, shelters and other public places where drug users congregate. Results from a needs assessment may be useful for identifying specific outreach locations. Keep in mind that building trust with PWID takes time (Harm Reduction Coalition, 2010).

Use posters and written materials: Public health officials in Sacramento, California observed a significant decrease in injection risk behaviors following a campaign implemented for nearly two years. The decrease in risk behavior was associated with exposure to a quarterly newsletter and to small posters placed in venues frequented by PWID, such as public restrooms, donut shops, cash-checking services, motels and convenience stores. The posters contained an image of cookers, cotton, water and a needle with the messages, "Don't share any of these" and "Spread the word, not the virus" (Gibson et al., 2010).

Use qualitative data: Following a campaign promoting the use of low dead space syringes in Vietnam, there was a four- to six-fold increase in both sales and reported use of low dead space syringes. Before the campaign, qualitative research findings indicated that some PWID preferred low dead space syringes for three reasons: 1) less risk of losing and wasting drugs as a result of less dead space, 2) decreased incidence of pain or scaring, and 3) reduced risk for HIV and hepatitis C infection. The campaign emphasized these perceived benefits in print materials, community events and face-to-face communication (Huong et al., 2015).

The Centers for Disease Control and Prevention offers additional guidance for health communication and social marketing efforts.

Monitoring and evaluation

The public health benefits of SSPs are well-documented (see Background section). Thus, the data collection burden on both SSP staff and clients should be minimized to optimize efficiency and reduce barriers to services. All SSP data collection should be voluntary and anonymous (New York City Department of Health and Mental Hygiene, 2016).

The following data should be recorded during or after each transaction and routinely aggregated to assess and demonstrate the reach of services provided:

- Number of transactions
- Number of new, sterile syringes distributed
- Number of used syringes received

We recommend keeping an inventory with the number of items distributed, collected for disposal, purchased for future distribution, and in storage. Including dates and updating records routinely helps with tracking, purchasing and reporting.

Additional data that may be of interest include:

- Gender
- Age
- Race/ethnicity
- Current ZIP code or geographic area
- Date of last visit to SSP
- Number of people for whom client is obtaining syringes
- Site/service location
- Date and time
- Description and/or number of other services delivered (specify)
    - Supplies (e.g., sanitary items, condoms)
    - Health services (e.g., HIV testing, wound care, naloxone provision)
    - Education (e.g., safer injection, PrEP, hepatitis C, wound care)
        - Includes educational materials distributed or topics discussed
    - Referrals (e.g., PrEP, drug treatment, health care, HIV care, housing)
- Description and number of peer education trainings and number of attendees (if applicable)

Some SSPs do not collect or record any additional data. Programs that request additional data from clients are encouraged to be mindful of clients' comfort level, recognizing the client may not return if they fear authorities could identify them (Tucker et al., 2009). Some programs collect additional data from each SSP client to create a unique identifier used each time the client returns to the SSP. Other programs use surveys, key informant interviews and focus groups to collect additional data from subsets of clients or stakeholders periodically (e.g., annually or quarterly).

Conclusion

SSPs are an important strategy for preventing disease outbreaks and improving community health. There is strong evidence that SSPs:

- Reduce HIV transmission
- Do not increase drug use
- Are cost effective
- Help clients access other health services

We hope this document will inform and advance SSP implementation throughout the state. Thank you for your interest in improving public health in Oregon by providing services to people who inject drugs.

For technical assistance, please contact the Oregon Health Authority, HIV/STD/TB Program at 971-673-0153 or prevention.info@state.or.us.

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Appendix A: Fact sheet

The fact sheet is shown on the following page to provide a print-ready document.

Syringes Services Programs

Safer options. Healthier communities.

The problem

Injection drug use is a serious problem throughout Oregon. In the western region of the United States, it is estimated that one in 30 adults has injected drugs and half live outside major urban areas.1 Many people who inject drugs are not ready or able to access drug treatment.[2]

Reuse of contaminated syringes and equipment contributes to disease transmission.[3,4] Injection drug use accounts for approximately 15% of new HIV diagnoses, 12% of new hepatitis B diagnoses and 64% of new hepatitis C diagnoses in Oregon.[5,6] As observed in Indiana and Kentucky, areas without syringe services programs may be at increased risk for disease outbreaks.[7]

The solution

Syringe services programs improve community health by providing:

- Access to sterile syringes;
- Safe syringe disposal; and
- Health education and referrals to other important services.

Syringe services programs are available in communities throughout Oregon.[8] These programs recognize the critical importance of services for people who inject drugs. We will never substantively improve population health if some of our residents are left to experience a disproportionate burden of disease.

Over-the-counter pharmacy sales play an important role as well. In Oregon, it is legal to distribute, sell or purchase needles and syringes without a prescription. Needles and syringes are explicitly excluded from Oregon's drug paraphernalia law.[9]

The evidence

The science is clear. Syringe access and services:

- Reduce HIV transmission;
- Do not increase drug use;
- Are cost effective; and
- Help clients access other health services.[10,11]

Oregon Health Authority

References: 1. Oster et al., 2015; 2. Appel et al., 2004; 3. World Health Organization, 2016; 4. CDC, 2015; 5. Oregon Health Authority, 2015; 6. Oregon Health Authority, Multnomah County Health Department, 2016; 7. The Foundation for AIDS Research, 2015; 8. North American Syringe Exchange Network, 2016; 9. ORS 475.525; 10. World Health Organization, 2016; 11. Barocas et al., 2015.

Appendix B: Readiness assessment

This form helps assess an organization's readiness to implement an SSP.

Task	Completed			Next steps (if needed)
	No	Almost	Yes	
Assess community needs				
Engage and garner support from stakeholders				
Select one or more service delivery models				
Develop procedures and training plans addressing topics such as: • Syringe distribution • Disposal of sharps and other infectious waste • Safety procedures, including occupational exposure prevention and response • Education and referrals • Data collection • Incident reporting • Overdose prevention, recognition and response • Medical first aid training • Rapid HIV and hepatitis screening • Cultural sensitivity				
Identify and train SSP staff				
Determine days and times of operation				
Order supplies for distribution and for hazardous waste disposal				
Develop a resource list				
Identify or develop educational and promotional materials				
Notify the Oregon Health Authority, HIV/STD/TB Section of SSP plans and any technical assistance needed				

Oregon Health Authority
PUBLIC HEALTH DIVISION
HIV/STD/TB Section
971-673-0153

You can get this document in other languages, large print, braille or a format you prefer. Contact the HIV Prevention Program at 971-673-0153 or email prevention.info@state.or.us. We accept all relay calls or you can dial 711.

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