

# **Guidelines for Syringe Exchange Programs Funded by the California Department of Public Health, Office of AIDS**



California Department of Public Health  
Center for Infectious Diseases  
Office of AIDS

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# Table of Contents

Ctrl + click on headings below to go directly to the pages indicated

<b>Introduction</b> .....	<b>3</b>
Public Funding of Syringe Exchange .....	3
Purpose of the Guidelines .....	4
What These Guidelines Are Not .....	4
Development and Review.....	4
<b>Guidelines for SEPs Funded by CDPH/OA</b> .....	<b>6</b>
Key Services.....	6
Policies and Procedures .....	7
Data Collection and Evaluation.....	7
<b>OA SEP Guidelines Self-Assessment Checklist</b> .....	<b>9</b>
<b>Appendix A: Authorization of SEPs in California</b> .....	<b>12</b>
Local Authorization of SEPs .....	12
State Authorization of SEPs .....	12
Local Health Department Role in Local SEP Authorization .....	12
<b>Appendix B: Glossary of Terms</b> .....	<b>14</b>
<b>Appendix C: California Legal Code Related to Access to Sterile Syringes</b> .....	<b>15</b>
<b>Appendix D: Framework for IDU Health and Wellness</b> .....	<b>16</b>
Purpose .....	16
Premise .....	16
Key Principles .....	17
Background .....	17
<b>Appendix E: Examples of Needle-Stick Injury Prevention and Response Protocols</b> .....	<b>19</b>
Sample Needlestick Prevention Protocol - <i>Washington Heights Corner Project (WHCP) Policy and Procedure Manual</i> .....	19
Sample Needlestick Prevention and Response Protocol Adapted from the <i>Guidelines and Operating Procedures manual of the Chicago Recovery Alliance (CRA)</i> .....	20
Additional Policy and Procedure Manuals for SEPs .....	21
<b>Appendix F: Examples of Client Confidentiality Protocols</b> .....	<b>22</b>
Santa Cruz AIDS Project .....	22
Safer Alternatives thru Networking and Education (SANE) Confidentiality Agreement .....	22
<b>Appendix G: Resources</b> .....	<b>25</b>
Best Practices.....	25
Websites with Additional Resources.....	25
<b>Appendix H: Issue Brief: Syringe Dispensing Policies</b> .....	<b>26</b>
Issue.....	26
Evidence Regarding Syringe Access Policies .....	26
Conclusion.....	27

# Introduction

## Public Funding of Syringe Exchange

Syringe exchange programs (SEPs) have been operating in California since 1988, when activists in San Francisco began providing sterile syringes and collecting used ones in response to the burgeoning AIDS epidemic. SEPs were soon established in other cities and counties in the state, and in 1999 Governor Gray Davis signed legislation that sanctioned local authorization of SEPs. The counties and cities in California that provided this authorization were among the first in the country to fund syringe exchange with public dollars.

Scientific research conducted over the more than two decades since those first street-based efforts has conclusively demonstrated that syringe exchange is highly effective in reducing the spread of HIV among people who inject drugs (PWID) and in linking them to other essential services. Research has consistently demonstrated that SEPs do not result in negative consequences such as increased drug use or increased syringe litter in the communities that are host to these programs.

In December 2015, President Barack Obama signed legislation that responded to calls from the scientific, medical and public health communities to allow federal funding of efforts to expand access to sterile syringes. Federal agencies, including the Department of Health and Human Services, the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Administration (SAMHSA), [issued guidance](#) to allow grantees to use their funds to support syringe services programs (SSPs).<sup>1</sup>

In a separate but equally impactful action, the California State Legislature passed and Governor Edmund G. Brown signed Senate Bill 75, Committee on Budget, Chapter 18, Statutes of 2015, which authorized funding that allowed the California Department of Public Health (CDPH), Office of AIDS (OA) to establish a Syringe Exchange Supply Clearinghouse. The Supply Clearinghouse provides a baseline level of supplies to authorized SEPs in order to enhance the health and wellness of people who inject drugs and increase the organizational stability of California SEPs.

OA considers access to sterile syringes to be a critical component of HIV prevention and care in California. OA supports an approach to working with PWID that fosters overall health and wellness through such services as wound care, overdose prevention, viral hepatitis testing and medication-assisted treatment, and involving drug users in the development of the programs that are meant to serve them. OA encourages its local partners to include syringe exchange funding among their locally-funded initiatives, where such local funds are available, and to include SEPs among the AIDS service organizations with which they consult on matters of policy and practice.

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<sup>1</sup> "SSP" is the term used by CDC and other federal agencies to denote programs that provide syringe exchange, distribution, and/or disposal for PWID. SSPs include SEPs, but may also include other programs or initiatives, such as nonprescription syringe sale in pharmacies, physician prescription for disease prevention purposes, and sharps disposal for PWID. This document refers specifically to syringe exchange program operation, and does not address other SSPs.

## Purpose of the Guidelines

These guidelines were developed in accordance with recommendations made by the United States Public Health Service, which state “for those who are unable to stop injection drugs, a new, sterile syringe should be used for each injection.”<sup>2</sup> The *Guidelines for SEPs Funded by CDPH/OA*:

1. Outline the minimum requirements for California programs to be funded with OA funds or receive materials through the California Syringe Exchange Supply Clearinghouse;
2. Provide information on legal requirements associated with SEP operations in California state statute;
3. Provide ancillary information such as *California Legal Code Related to Access to Sterile Syringes* (Appendix C) and the *Framework for Injection Drug User (IDU) Health and Wellness* (Appendix D) to assist local health jurisdictions (LHJs) and SEPs in understanding the environment in which they work, and the ways in which they can do their best work.

This living document offers a framework for best practices, and will be supplemented by yearly issue briefs. The first of these, the CDPH/OA [Issue Brief: Syringe Access Policies for California Syringe Exchange Programs](#) (Appendix H), summarizes scientific evidence on good practice for syringe distribution, and recommends that California SEPs adopt needs-based distribution policies with the goal of ensuring that program participants have a new, sterile syringe and other injection equipment for each injection. The Issue Brief recommends against restrictive syringe access policies such as variations on one-for-one exchange, which is not supported by public health evidence and may impose harm upon SEP participants.

## What These Guidelines Are Not

These guidelines are designed to outline the requirements for California SEPs to receive supplies through OA and/or be funded with OA funds and do not apply to the general operation of SEPs in California. These guidelines do not supersede legal requirements for SEP operation established in California state laws or by local California governments and their municipal laws. Federal funders may issue additional guidance to their grantees; if applicable, OA will integrate those requirements into future updates of this document.

These guidelines apply to SEPs themselves and do not include additional guidance for health departments that fund SEPs using OA, CDC or HRSA monies. Guidance for LHJs is available on the OA Prevention Branch [web page](#).

Suggestions for best practices can be found in Appendix G. Additionally, the *Framework for Injection Drug User Health and Wellness*, attached here in Appendix D, provides an overview of best practices for community-based organizations working with PWID from a California perspective.

## Development and Review

The *Guidelines for SEPs Funded by CDPH/OA* are based in part on a document developed by the San Francisco Department of Public Health, “San Francisco Syringe Access and Disposal Program Policy and Guidelines,” which was in turn modeled on guidance developed by the New South Wales Australia Department of Health.

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<sup>2</sup> CDC. (1997). Health Resources and Services Administration, National Institute on Drug Abuse and Substance Abuse and Mental Health Services Administration. [HIV prevention bulletin: Medical advice for persons who inject illicit drugs](#). Retrieved May 29, 2016, from

This document was written by Alessandra Ross, Injection Drug Use Specialist for OA, and was edited and reviewed by members of the California Syringe Exchange Network (CASEN), an association of syringe exchange providers. OA is grateful for the efforts of Rachel Anderson, Daniel Getzoff, Emalie Hurliaux, Joy Rucker, Hilary McQuie, and Shoshanna Scholar in the development of these guidelines. Rachel McLean (California Department of Public Health, STD Control Branch) also contributed to the development. Additional review was provided by Peter Simpson (Harm Reduction Services), Bob Lewis (Family Health Centers of San Diego), and Dallas Blanchard (Fresno Needle Exchange). The *Framework for Injection Drug Use Health and Wellness* (Appendix D) was developed in 2009 by the Substance Use/Injection Drug Use Task Force of the California Planning Group, the primary community advisory body to OA.

# Guidelines for SEPs Funded by CDPH/OA

These guidelines outline the minimal requirements for California SEPs to receive syringe exchange supplies through the California Syringe Exchange Supply Clearinghouse and/or to be funded with OA funds through contracts with local health departments to provide syringe exchange services.

The guidelines are followed by the *OA SEP Guidelines Self-Assessment Checklist*, which is designed to help California SEPs assess their readiness to apply for OA materials or receive OA syringe exchange funding through local health departments.

## Key Services

In order to be eligible for OA funding, each SEP must be authorized to operate pursuant to Health & Safety Code (HSC) Section 121349<sup>3</sup> or Business & Professional Code (BPC) Section 4145. Each program must provide the following materials and services:

1. Hypodermic needles and syringes;
2. Personal sharps disposal containers;
3. Harm reduction supplies including, but not limited to, safer injection and wound care supplies;
4. Condoms and other safer sex supplies;
5. Syringe collection and disposal;
6. Information and education including:
  - a. Overdose prevention and response training;
  - b. Safer injection education;
  - c. Education about proper sharps disposal and prevention of needle-stick injuries; and
  - d. Safer sex education.
7. Direct provision, direct linkage or referrals to:
  - a. Substance use disorder treatment services;
  - b. Screening for HIV, HCV and sexually transmitted infections;
  - c. HIV and HCV care and treatment;
  - d. Hepatitis A and hepatitis B vaccination;
  - e. Housing services; and
  - f. Naloxone.

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<sup>3</sup> HSC Section 121349 allows local governments to authorize SEPs in consultation with CDPH, and allows CDPH/OA to directly authorize applicant agencies to provide syringe exchange services.

## Policies and Procedures

In addition to the services listed above, SEPs that receive syringe exchange supplies through the California Syringe Exchange Supply Clearinghouse or are funded with OA funds through contracts with local health departments to provide syringe exchange services must have policies and procedures in place that are consistent with [harm reduction](#) principles. These policies and procedures must include the following:

1. Syringe dispensing policies designed to provide sufficient new syringes to meet the needs of program participants, in keeping with U.S. Public Health Service recommendations that people who inject drugs use a new, sterile syringe for each injection;<sup>4</sup>
2. Syringe collection and disposal policies and procedures that:
  - a. Encourage program participants to return used syringes to the program, and/or to dispose of them properly;
  - b. Collect sharps waste in such a way to minimize direct handling by program staff, volunteers and clients. Returned syringes should not be individually counted. The number of returned syringes may be calculated through recording volume or weight of returned sharps containers, or through other methods that avoid direct handling of sharps waste.
3. A [needle-stick injury protocol](#) and a plan for ensuring staff and participant familiarity with the protocol (see examples, Appendix E); and
4. Protocols to safeguard participant confidentiality (see examples, Appendix F).

## Data Collection and Evaluation

In addition to the services, policies and procedures above, SEPs must evaluate their own programs, and contribute to knowledge about California syringe exchange programs. As part of those efforts, SEPs must:

1. Implement a community relations plan that:
  - a. Records adverse and/or positive incidents between law enforcement and SEP staff, volunteers or participants (in their role as SEP participants);
  - b. Documents concerns expressed by program participants, community members and law enforcement and makes a good faith effort to address any reasonable concerns;
2. Implement an evaluation plan that:
  - a. Incorporates evaluation data into program design;
  - b. Gathers both input and feedback from program participants and incorporates both into program design;

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<sup>4</sup> Op. cit.

3. Participates in a once-yearly survey that examines program capacity, successes and challenges, and reports, at minimum, the following data:
  1. Number of syringes dispensed;
  2. Number of syringes collected;
  3. Number of clients served;
  4. Number of naloxone kits dispensed (if applicable); and
  5. Hours of operation, locations, and additional services offered to accompany syringe exchange.

In additional to the data requirements listed above, CDPH/OA-Certified SEPs are also required to report on the total number and types of referrals made to drug treatment and other services annually, as required by HSC Section 121349.



# OA SEP Guidelines Self-Assessment Checklist

In order to determine ability to meet the above guidelines, complete the self-assessment checklist below.

## Materials and Services

*Our SEP provides the following, or will be able to provide within 30 days of receiving CDPH/OA supplies or funding:*

- Hypodermic needles and syringes;
- Personal sharps disposal containers;
- Safer injection supplies;
- Wound care supplies;
- Condoms and safer sex supplies; and
- Syringe collection and disposal for people who inject drugs.

## Policies and Procedures

*Our SEP has the following policies and procedures in place, or will be able to put them in place prior to receiving CDPH/OA supplies or funding:*

- Syringe collection protocols that:
  - Encourage participants to return used syringes and dispose of them properly;
  - Collect sharps waste and track returned sharps waste in such a way to minimize direct handling by staff, volunteers, and clients;
- Syringe dispensing policies that are in keeping with federal recommendations that PWID use a new, sterile syringe for each injection;
- Needle stick prevention protocols;
- Needle stick injury response protocols; and
- Participant confidentiality protocols.

## Data Collection and Evaluation Design

*Our SEP collects the following data, or will be able to within 30 days of receiving CDPH/OA supplies or funding:*

- Number of syringes dispensed;
- Number of syringes collected;
- Number of clients served;
- Number of naloxone kits dispensed (if applicable);
- Hours of operation, locations, and additional services offered to accompany syringe exchange; and
- Number and types of referrals made to drug treatment and other services (for CDPH/OA-Certified SEPs).

*Our SEP will establish a Community Relations Plan within 30 days of receiving CDPH/OA supplies or funding that:*

- Records adverse and/or positive incidents between law enforcement, SEP staff, volunteers, and participants; and
- Documents concerns expressed by participants, community members and law enforcement, which SEP will make a good faith effort to address.

*Our SEP will establish an evaluation plan within 90 days of receiving CDPH/OA supplies or funding that:*

- Incorporates evaluation data into the program design; and
- Gathers input and feedback from participants and incorporates it into the program design.

### **Data Reporting**

*Our SEP will be prepared to:*

- Submit a progress report to OA annually (for CDPH/OA-Certified SEPs);
- Participate in a yearly survey to examine program capacity, successes and challenges.

### **Harm Reduction Training and Information**

*Our SEP provides the following, or will be able to provide within 90 days of receiving CDPH/OA supplies or funding:*

- Overdose prevention and response training;
- Safer injection education;
- Education about proper sharps disposal and prevention of needle-stick injuries; and
- Safer sex education.

### **Testing, Screening, Linkage and Referrals**

*Our SEP will: 1) provide services on-site 2) provide direct linkage (warm handoff) or 3) provide referrals to the following:*

Substance use disorder treatment services

- 1) Provide
- 2) Direct Linkage
- 3) Referral

HIV screening

- 1) Provide
- 2) Direct linkage
- 3) Referral

HIV care & treatment

- 1) Provide
- 2) Direct linkage
- 3) Referral

HCV care & treatment

- 1) Provide
- 2) Direct linkage
- 3) Referral

Hepatitis A & hepatitis B vaccination

- 1) Provide
- 2) Direct linkage
- 3) Referral

Naloxone

- 1) Provide
- 2) Direct linkage
- 3) Referral

HCV screening

- 1) Provide
- 2) Direct linkage
- 3) Referral

Sexually transmitted infections screening

- 1) Provide
- 2) Direct linkage
- 3) Referral

Housing services

- 1) Provide
- 2) Direct linkage
- 3) Referral

# Appendix A: Authorization of SEPs in California

## Local Authorization of SEPs

California law allows local boards of supervisors, mayors and/or city councils to authorize syringe exchange within their jurisdictions in consultation with CDPH. (See Appendix C for complete text of applicable statute.)

Once locally authorized, SEPs do not need to be re-authorized unless local ordinance requires it. An SEP that is authorized through local government action is considered an authorized program and does not need to apply to the state for authorization.

## State Authorization of SEPs

California law also allows CDPH to authorize SEPs in locations where the conditions exist for rapid spread of viral hepatitis, HIV or other potentially deadly diseases. The [CDPH/OA Syringe Exchange Certification Program](#) allows agencies that serve PWID to apply directly to OA to add syringe exchange to their current services. Key provisions of the program include:

- OA SEP certification lasts two years and is made after consultation with the local health officer (LHO) and local law enforcement official, and after a 45-day public comment period;
- Before the end of the two-year authorization period, OA may reauthorize the SEP in consultation with the LHO and local law enforcement officials.

Counties and cities maintain the authority to authorize SEPs and set their own standards for program operation.

## Sale or Provision of Syringes by Licensed Pharmacists and Physicians

California law allows pharmacists and physicians to furnish or sell an unlimited number of hypodermic needles and syringes to adults age 18 and older. The law also permits adults age 18 and older to possess syringes for personal use if acquired from a physician, pharmacist, authorized SEP or any other source that is authorized by law to provide sterile syringes or hypodermic needles without a prescription.

Syringe services provided by physicians and pharmacists are authorized by BPC Section 4145 and do not require separate authorization by state or local government.

Physician-operated syringe services administered in accordance with BPC Section 4145 are eligible to participate in the California Syringe Exchange Supply Clearinghouse.

## Local Health Department Role in Local SEP Authorization

HSC Section 121349.3 requires the LHO in counties and/or cities that have authorized SEPs to present information about SEPs at an open meeting of the local authorizing body (city council or

board of supervisors).<sup>5</sup> These presentations must be made biennially (every other year). The LHO is not required to report on syringe access services led by physicians and pharmacists.

The information the LHO must report to the city council or board of supervisors is required to include, but is not limited to, relevant statistics on blood-borne infections associated with syringe sharing and the use of public funds to support SEPs.

Although not codified in law, in practice many boards of supervisors, mayors and city councils have relied on recommendations made by their LHO in order to take action to authorize syringe exchange within the jurisdiction. Technical assistance is available from OA in order to support these recommendations, and the [OA Syringe Access web page](#) provides background information that may be useful in developing presentations and reports.

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<sup>5</sup> The LHO has no responsibility to report on SEPs that are authorized by CDPH/OA, however, when CDPH/OA authorizes SEPs in a county it is required by law to both consult with the LHO prior to authorization, and to provide the LHO with data gathered by the SEP on an annual basis. See Appendix C for further information.

# Appendix B: Glossary of Terms

Terms	Definition
Harm reduction	<p>A set of strategies to reduce drug-related harm experienced by individuals, families and communities. These strategies do not require the drug user to cease or modify his or her drug use prior to taking action to reduce harm. The term may also be applied more broadly to non-drug-related harms: the British Columbia Centre for Disease Control defines harm reduction as “taking action through policy and programming to reduce the harmful effects of behavior” (BC Centre for Disease Control, 2004).</p> <p>Harm reduction principles are outlined in the <a href="#">Key Principles</a> section of the <i>Framework for IDU Health and Wellness</i>, Appendix D.</p>
Needle-stick injury protocol	Policies and procedures that outline both immediate and subsequent remedial and prophylactic actions to take in the event of a needlestick injury.
Sharps waste	Used needles, syringes and lancets. Sharps waste from individuals is termed “home-generated sharps waste” by California law, and is not regulated as “medical waste”, which is sharps and other waste generated on site by medical providers, and is subject to different laws and regulations.
Syringe exchange program	Program that provides access to sterile syringes and other sterile injection supplies and collects used syringes from program participants. Programs also provide relevant information and education, including overdose prevention and response, as well referrals to medical care, drug treatment, and other social services.
Syringe services programs	Term used by the federal Department of Health and Human Services and its agencies to refer to 1) syringe exchange programs and 2) syringe disposal programs for PWID.

# Appendix C: California Legal Code Related to Access to Sterile Syringes

See OA's Website. [California Legal Code Related to Access to Sterile Syringes](#)

# Appendix D: Framework for IDU Health and Wellness

Excerpt from the California HIV/AIDS Planning Group *Framework for Injection Drug User Health and Wellness*, 2009.

## Purpose

*The Framework for IDU Health and Wellness* was written by the California HIV Planning Group's Substance Use/IDU Task Force in collaboration with OA staff and in consultation with community experts. It was inspired by the *Framework for Gay Men's Health and Wellness*, which was developed in 2004 by the Gay Men's Task Force of the CHPG. In that document, the authors state that the Task Force concluded that "sustained HIV prevention efforts have faltered, in part, because they focused singularly on a disease—AIDS—rather than focusing on the diverse health and wellness of gay men...[H]ealth promotion must be the platform and disease prevention one of the planks among all health-related initiatives targeting gay men. HIV prevention, therefore, must begin with promoting overall health and wellness including physical, mental, spiritual, and sexual." A similar comprehensive approach is emerging as best practice for HIV prevention and care for injection drug users. The World Health Organization and the Centers for Disease Control and Prevention are among the organizations that have recommended comprehensive services as the most effective way of preventing HIV for IDUs and other drug users.

## Premise

The Substance Use/IDU Task Force asserts that one of the best ways to discourage self-destructive behaviors is to foster value for health and wellness among drug users, as well as a sense of worth and self-acceptance that is not contingent upon abstinence from drugs. The Framework emerges from the philosophy of harm reduction, which holds as one of its key principles that drug users are treated with dignity and as full members of society. The harm reduction model holds much in common with strength-based models of social work and social change, which emphasize the assets of individuals and communities over their deficits.

It is crucial to recognize that the social stigma that exists in this country against injection drug use is institutionalized in ways that affect the health and wellness of IDUs and their communities. This stigma probably deters many people from beginning injection. However, once a person begins injection, that same stigma can pervade every aspect of an individual's life, determining where and how they live, whether or not they receive health care, whether they are treated well or poorly in many different situations and whether they are free or imprisoned. Incarceration increases risk of disease transmission and overdose, and further jeopardizes IDU health. Homophobia, sexism, racism, ageism, classism, and other oppressions that IDUs face, and sometimes perpetrate, also affect IDU health. Additionally, it is well documented that IDUs of color disproportionately bear the burden of HIV disease. Drug using youth also experience multiple oppressions resulting in health disparities. Understanding the debilitating effects of discrimination must be a priority for research, service design and delivery.



## Key Principles

The *Framework for IDU Health and Wellness* is based on the following key principles:

1. Drug users have a right to protect their own health and the health of those around them;
2. Drug users should have the means by which to protect their health, including access to sterile injection equipment sufficient to meet their needs;
3. All drug users should receive accurate, non-biased and non-judgmental information on illicit drugs and other substances;
4. All drug users should receive the same level of care as any other individual accessing health care or social services;
5. Drug users should have access to drug and alcohol treatment on demand;
6. Providers should recognize the valid and valuable expertise that people who use drugs can give to designing, delivering and evaluating effective services;
7. Health care and social service professionals should ensure that the provision of services to drug users is not contingent upon the individual's agreement to enter drug treatment, or abstain from drug use. Service providers must not withhold appropriate treatments or services from drug users; and
8. Services should be provided in a manner that encourages engagement and retention in care.

## Background

Injection drug use has been a familiar aspect of California community life for many decades. With some notable exceptions, state and local governments have not successfully addressed the complex social and medical needs of IDUs who are not in drug treatment programs. The emphasis on identifying and serving the needs of IDUs outside of the drug treatment system is important: research indicates that fewer than half of all injectors report having ever used any substance abuse treatment services in their lifetimes.

In California, drug users, their allies and advocates started rallying around issues of IDU health in the 1980s, when SEPs were first established in order to reduce the risk of HIV infection for drug users, their partners and families. Despite considerable legal and social barriers, IDUs and their allies were successful in establishing [more than 35] SEPs in California, and in integrating services for drug users into countless other health and social service programs in the state. Numerous success stories point to the little-recognized fact that IDUs have been successfully taking responsibility for their own health and the health of their communities for many years.

Community-based organizations (CBOs) are crucial points of intervention and care. People who use drugs interact with virtually every social service system in California. Syringe exchange programs have taken the lead to engage and serve current injection drug users; however, there

remain many untapped opportunities for community-based service programs to help reduce negative health outcomes for drug users, and enhance drug user health and wellness.

Some of the actions CBOs may take include:

1. Provide safer injection education to all active drug users;
2. Offer overdose prevention education and response, and distribute naloxone<sup>6</sup>, especially to people who have been recently incarcerated;
3. Examine policies that exclude active drug users or limit their program participation by referring potential program participants to other agencies rather than serving them directly;
4. Recognize the expertise drug users have by training and employing them as volunteers and staff;
5. Expand syringe access by providing sterile syringes and safe disposal to people injecting drugs;
6. In regions where syringe access is limited by law, provide IDUs with ancillary materials, such as cookers and sterile water, in order to protect IDU health;
7. Ensure that staff members are trained to provide education and treatment referral for significant IDU health issues, including hepatitis, abscess prevention and wound care;
8. Ensure referrals to drug treatment are up-to-date, and include referrals to buprenorphine and methadone maintenance therapy where available;
9. Ensure that staff members are educated in the effects of incarceration on IDU health and are able to provide services that reduce its negative impacts.

This [Framework for Injection Drug User Health and Wellness](#) document is available on the OA website.

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<sup>6</sup> Naloxone, sometimes known by the brand name Narcan, is an opiate antagonist used to reverse the effects of an overdose.

# Appendix E: Examples of Needle-Stick Injury Prevention and Response Protocols

## Sample Needlestick Prevention Protocol - [Washington Heights Corner Project \(WHCP\) Policy and Procedure Manual](#)

To prevent needlestick injuries to WHCP personnel and participants, the following procedures must always be followed:

- a. WHCP SEP staff, peers, volunteers and participants must be educated regarding safety precautions for carrying and handling of syringes and other “sharps”, with emphasis on the agency’s safety policies and procedures during visits to the exchange.
- b. If necessary, WHCP SEP staff, peers and volunteers should remind participants not to crowd the exchange area(s).
- c. Areas where WHCP SEP operations are conducted should have adequate lighting.
- d. WHCP staff, peers and volunteers conducting exchange operations must never handle or touch used injection equipment.
- e. All used injection equipment collected by the program must be placed in approved leak-proof, rigid, puncture-resistant containers (sharps containers).
- f. During syringe exchange program transactions sharps containers should be placed between the participants and staff/volunteers.
- g. WHCP SEP personnel should never hold the sharps container during an exchange; the container should be placed on a secure table or on the ground and should be kept level at all times.
- h. Any injection equipment that falls outside of the sharps container should be retrieved by the participant and placed in the sharps container. If this is not possible, program staff/peers/volunteers should use tongs to retrieve used injection equipment that falls outside the container.
- i. Sharps containers should NEVER be filled beyond the manufacturer's fill line; the container should never be more than 3/4 full.
- j. WHCP SEP staff/peers/volunteers/participants should be instructed never to insert their hands into the sharps container or to forcibly push used injection equipment down into the container beyond the opening at the top.

- k. Each WHCP SEP site must have the following safety equipment on-site during exchange operations: puncture-resistant utility gloves, bleach, and forceps or tongs; all of which could be used in the event of a container spill.
- l. WHCP program staff/peers/volunteers are encouraged to wear puncture-resistant utility gloves at all times when opening, sealing, or handling sharps containers.
- m. All WHCP staff and volunteers at the exchange site should be encouraged to wear protective clothing, including long pants and closed footwear to have limbs protected against possible needlesticks.
- n. All WHCP SEP staff/peers/volunteers involved in the transport of hazardous waste must receive appropriate training in handling and disposal procedures and only staff/volunteers receiving such training are authorized to transport waste.
- o. Sharps containers must be properly sealed and placed in leakproof, disposable cartons with lids that close securely. These cartons must be clearly labeled "infectious waste."

**Sample Needlestick Prevention and Response Protocol Adapted from the [Guidelines and Operating Procedures manual of the Chicago Recovery Alliance \(CRA\)](#)**

### **Syringe Collection**

Throughout all CRA operations at no time are syringes to be touched.

The people bringing syringes into exchange are responsible for placing them directly into our puncture-proof sharps container.

If a syringe falls on the ground or otherwise does not make it into the sharps container CRA personnel will ask the person who brought it in to place it in the sharps container. Photo tongs will be available to assist anyone in reducing their contacts with the syringes.

When a sharps container is full to the line indicated on its side, it should be closed with the attached lid and put in a safe, out-of-the-way place. It is not reopened or reused after this point and it proceeds directly to disposal (as outlined below).

*These procedures are more stringent than the Blood Borne Pathogens Standards as promulgated by the Occupational Safety and Health Administration (OSHA) for health care settings.*

### **Accidental Needlesticks**

While it is policy for volunteers or staff to not touch used or potentially used syringes at any time during the operation of the outreach, an accidental needle stick may occur.

If anyone is stuck by a needle and the skin is broken the following actions should be immediately taken:

1. Encourage bleeding through the wound caused by the needle. Bleeding through the fresh wound may help cleanse the wound and avoid infections.
2. Wash the wound with soap and water as soon as possible.
3. Immediately page the site supervisor \_\_\_\_\_(name) at \_\_\_\_\_(number) and inform them of what happened. They will advise you of the current CDC protocol for post-exposure treatments for needle sticks and guide you to these treatments, if indicated. If the site supervisor is not available, page \_\_\_\_\_(name) at \_\_\_\_\_(number)
4. Collect the syringe that stuck you, if possible without additional risk, for testing.
5. The site supervisor will accompany you to \_\_\_\_\_(name of medical facility.)

### **Additional Policy and Procedure Manuals for SEPs**

The Harm Reduction Coalition's technical assistance web pages include several examples of [policy and procedure manuals](#).

# Appendix F: Examples of Client Confidentiality Protocols

## Santa Cruz AIDS Project

In order to preserve the dignity and privacy of all people, it has been recognized that any intimate information by or given to people in the helping profession is so privileged, and that such information is protected under law with prescribed method, circumstances and penalties for its release.

The sole duty of this agency, its individuals, employees, and volunteers is to treat the people who come to us with trust, respect and to protect the confidentiality of any information provided by or about them.

Information obtained about the Santa Cruz AIDS Project, while working in the office or one of its programs is also considered to be of a delicate and sensitive nature. It is not to be repeated within the community at large.

In becoming a volunteer you have accepted a responsibility which carries with it a privilege of service to our community. As a volunteer, you are an integral part of this agency and accept the same ethical responsibility as the program's staff. All information which you may hear, directly or indirectly, concerning a person with HIV disease, their family, friends and or anyone else connected with the program, must also be considered as strictly confidential. Such information should never be discussed with anyone either inside or outside the program, except with authorized and specifically designated case manager as arranged.

I \_\_\_\_\_, agree not to divulge any information obtained during my volunteer work to any unauthorized persons. I recognize that unauthorized release of confidential information may make me subject to civil action under provisions of the welfare and institutions code of the State of California, and application federal laws concerned with the individual's right to privacy.

## Safer Alternatives thru Networking and Education (SANE) Confidentiality Agreement

This agreement applies to all SANE "workforce members" including: employees; medical staff and other health care professionals; volunteers; agency, temporary and registry personnel; and students and interns (regardless of whether they are SANE trainees or rotating through SANE facilities from another institution).

It is the responsibility of all SANE workforce members, as defined above, including employees, medical staff, students and volunteers, to preserve and protect confidential patient, employee and business information. The Federal Health Insurance Portability Accountability Act (HIPAA) Privacy Law, the Confidentiality of Medical Information Act (California Civil Code § 56 et seq.) and the Lanterman-Petris-Short Act (California Welfare & Institutions Code § 5000 et seq.) govern the release of patient identifiable information by hospitals and other health care providers. The State Information Practices Act (California Civil Code sections 1798 et seq.) governs the acquisition and use of data that pertains to individuals. All of these laws establish

protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or individual.

Confidential Patient/Client Care Information includes any individually identifiable information in possession or derived from a provider of health care, substance use treatment, and/or HIV/AIDS education services regarding a patient's/client's medical history, drug use history, mental, or physical condition or treatment, as well as the patients/clients and/or their family member's records, test results, conversations, treatment records, research records and financial information. Examples include, but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Mainframe and department based computerized patient data and alphanumeric radio pager messages;
- Visual observation of patients receiving medical care or accessing services; and
- Verbal information provided by or about a patient/client.

Confidential Employee and Business Information includes, but is not limited to, the following:

- Employee home telephone number and address;
- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from SANE's records which if disclosed, would constitute an unwarranted invasion of privacy; or
- Disclosure of confidential business information that would cause harm to SANE.

Peer review and risk management activities and information are protected under California Evidence Code section 1157 and the attorney-client privilege.

I understand and acknowledge that:

I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.

It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to SANE, including business, employment and medical information relating to our patients, clients, employees and health care providers.

I shall only access or disseminate patient/client care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of SANE, or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient/client care records or any other patient/client care, peer review or risk management information, except to persons authorized to receive it in the conduct of SANE affairs.

SANE performs audits and reviews patient/client records in order to identify inappropriate access.

My user ID is recorded when I access electronic records and I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether by me or anyone else. I will only access the minimum necessary information to satisfy my job role or the need of the request.

I agree to discuss confidential information only in the work place and only for job related purposes and not to discuss such information outside of the work place or within hearing of other people who do not have a need to know about the information.

I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.

I understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal and/or disciplinary action.

My obligation to safeguard patient/client confidentiality continues after my termination of employment/volunteer service with SANE.

I understand all volunteers and staff members that are not Mandated Reporters at SANE have a moral obligation to report any elder or child abuse or neglect, crimes on program premises or against program personal, and report all medical emergencies to supervising staff.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge SANE may, as applicable and as it deems appropriate, pursue disciplinary action up to and including my termination from SANE.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Appendix G: Resources

## Best Practices

Scott G, Irwin K, eds. [Recommended Best Practices for Effective Syringe Exchange Programs in the United States: Results of a Consensus Meeting](#). New York City Department of Health and Mental Hygiene. 2009.

*In addition to best practices, this brief consensus report includes a list of practices to avoid, both on the part of policymakers and on the part of service providers. The recommendations include the rationale and research behind the recommendations.*

Winkelstein E. [Guide to Developing and Managing Syringe Access Programs](#). New York: Harm Reduction Coalition. 2010.

*This manual is a practical guide to starting an SEP that is rooted in field-tested best practices. It includes sample job descriptions, forms and program protocols to address challenges ranging from engaging community support to staff supervision. Includes an excellent list of resources.*

Strike C, Leonard L, Millson M, Anstice S, Berkeley N, Medd E. [Ontario Needle Exchange Programs: Best Practice Recommendations Toronto](#). Ontario Needle Exchange Coordinating Committee. 2006.

*This comprehensive manual is practically laid out with topics covered both “in brief” in one section, and “in detail” in another. Covers almost all aspects of SEP operations, including such topics as which materials to distribute and services to offer, and the benefits and drawbacks of different service delivery models.*

Benjamin A, Davila C, Frost, T et. al. [Peer-Delivered Syringe Exchange Toolkit: Models, Considerations and Best Practices](#). New York: Harm Reduction Coalition, 2012.

*This toolkit provides examples of policies and practices of peer-delivered syringe service programs. Each section contains insight and ideas drawn from the experience of various programs and ends with questions to consider based on each program’s needs.*

Wheeler E, Burke K, McQuie H, Stancliffe, S. [Overdose Prevention and Naloxone Manual](#). New York: Harm Reduction Coalition, 2012.

*This manual provides information necessary to develop and manage an overdose prevention and education program, with or without a naloxone component. Includes downloadable worksheets and additional resources.*

## Websites with Additional Resources

[CDPH/OA’s Access to Sterile Syringes](#)

[Harm Reduction Coalition](#)

[CDC Syringe Services Programs](#)

[Chicago Recovery Alliance](#)

# Appendix H: Issue Brief: Syringe Dispensing Policies

*The California Department of Public Health, Office of AIDS advises SEPs to adopt needs-based distribution policies with the goal of ensuring that program participants have a new, sterile syringe and other injection equipment for each injection.*

*Restrictive syringe access policies such as variations on on-for-one exchange or the imposition of limits on the number of syringes participants may acquire per transaction are not supported by public health evidence and may impose harm upon SEP participants.*

*This recommendation follows the U.S. Public Health Service guidance that advises people who inject drugs to use a new, sterile needle and syringe for each injection.*

*This issue Brief does not supersede legal requirements for SEP operation established in California state laws or by county or municipal laws.*

## **Issue**

Syringe exchange programs have operated in California since the 1980s, and California law allows local governments and CDPH to authorize SEPs. Because most California SEPs have been approved by county or municipal bodies, there is significant jurisdictional variation in operating regulations, including policies that govern how program participants may obtain new syringes.

The U.S. Public Health Service recommends that PWID use a new, sterile syringe for every injection,<sup>1</sup> which is reiterated in the CDPH *Guidelines for Syringe Exchange Programs*.<sup>2</sup> This issue brief reviews public health evidence surrounding various models of syringe distribution for disease prevention among PWID and recommends that SEPs eliminate restrictions on access in order to meet the objectives described in U.S. Public Health Service and CDPH guidance.

## **Evidence Regarding Syringe Access Policies**

California SEPs currently employ several different models of syringe distribution, including (a) strict one-for-one exchange in which used syringes are required to be returned for an equal number of new syringes, (b) “one-for-one-plus” models which provide a fixed number of additional syringes (e.g. 10) beyond the number returned, (c) limits on the total number of syringes that may be acquired during a single transaction, and (d) needs-based distribution that provides an unlimited number of syringes based on how many PWID request. Policymakers have sometimes instituted restrictive syringe access policies in the belief that such policies would reduce syringe litter or serve as a means of changing behavior among PWID.<sup>3</sup> These concerns have not been born out in research on syringe distribution policies.

Research has found that needs-based policies are not associated with unsafe syringe disposal.<sup>4</sup> Syringes obtained from SEPs are more likely to be safely disposed than syringes obtained from other sources.<sup>5,6,7,8,9</sup> Syringes are more likely to be safely disposed in cities with SEPs compared to those

without; a study comparing cities with and without SEP found that PWID were 34 times more likely to safely dispose of used syringes if they had access to an SEP,<sup>10</sup> and the establishment of SEPs in Baltimore was associated with a 50% decline in syringe litter.<sup>11</sup> In locations where syringe litter remains a concern, strategies for improving access to safe disposal – such as increasing SEP hours and locations<sup>12</sup> or installing publicly accessible sharps disposal– are appropriate public health responses. In addition, while all SEPs encourage participants to dispose of syringes safely, other factors may impede PWID’s ability to return used syringes. Notwithstanding the public health provisions of California drug paraphernalia law,<sup>13</sup> police often target people based on syringe possession,<sup>14</sup> which may deter PWID from carrying syringes for safe disposal and increase disease risk.<sup>15,16,17,18</sup> Moreover, confiscation of syringes by police or other agencies, for example during homeless encampment sweeps, result in PWID being unable to return used syringes in order to obtain new equipment from restricted exchange programs.<sup>19,20,21</sup>

Public health research has consistently found that restrictive models increase syringe re-use and sharing among program participants. Studies have found that difficulty accessing syringes is associated with receptive syringe sharing,<sup>22,23,24</sup> which puts PWID at greater risk of viral and bacterial infections including HIV, viral hepatitis, and skin and soft tissue infections.<sup>25,26,27,28,29</sup> Restrictive syringe access policies contribute to syringe scarcity, which has been found to increase the amount of time that infectious syringes circulate in the community<sup>30</sup> and the likelihood that PWID will acquire syringes from potentially non-sterile sources.<sup>31</sup> Women, young people, African American and Hispanic PWID have been found to be at greater risk of experiencing syringe scarcity.<sup>32,33</sup>

In California, participants of needs-based SEPs have been found to have 57% lower odds of reusing syringes compared to participants of SEPs with restrictive syringe access policies.<sup>34</sup> In another California study examining syringe coverage, PWID with the greatest access to syringes were half as likely to report receptive syringe sharing, and were nearly 40% less likely to share other injection equipment.<sup>35</sup>

Several studies have examined the public health impact of policy changes to move from one-for-one to needs-based syringe access. In Vancouver, a change in local syringe exchange policy to adopt a needs-based model was associated with a greater than 40% reduction in syringe sharing as well as a decline in HIV incidence.<sup>36</sup> These results were replicated in Hawaii, where syringe sharing and HIV prevalence declined after a cap on the number of syringes dispensed per transaction was discontinued.<sup>37</sup> Similarly, comparisons of U.S. cities with needs-based versus restricted syringe access policies have found that needs-based SEP results in greater syringe coverage and greater relative decline in HIV incidence.<sup>38</sup> In contrast, a move toward more restrictive syringe access policy in Baltimore resulted in large decreases in the number of syringes both distributed and returned and the number of SEP participants.<sup>39</sup> Partial easing of restrictions (e.g. increasing limits on syringes per transaction from 10 to 30) has not been found to significantly increase syringe access among PWID.<sup>40</sup>

## **Conclusion**

In summary, the U.S. Public Health Service and CDPH/OA recommend that PWID use a new, sterile syringe for each injection in order to prevent disease transmission and other harms associated with injection drug use. Scientific studies of different syringe exchange models have consistently found that needs-based syringe distribution is most likely to achieve that objective. Research has not found needs-base syringe distribution to be associated with increases in unsafe syringe disposal. Restricted syringe access models, in contrast, result in lower coverage and increase syringe re-use and sharing and do not increase safe syringe disposal.

A commitment to high quality harm reduction services is central to *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*,<sup>41</sup> and needs-based syringe access policies are essential to ensuring that PWID have the tools they need to protect themselves. **CDPH/OA recommends that California SEPs employ a needs-based syringe access model in their work.** Doing so reaffirms that California values the lives and contributions of people who inject drugs in our communities and that publically supported SEPs exist to foster safety, health, and wellbeing among the people they serve.

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