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Organizational Issues in the Implementation of a Hospital-Based Syringe Exchange Program

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Abstract

Little published information exists to guide health care institutions in establishing syringe exchange program (SEP) services. To address this gap, this article discusses organizational issues encountered in the implementation of a hospital-based SEP in San Francisco, California (USA). Investigators collaborated with a community organization in implementing a county hospital-based SEP. SEP services integrated into a public hospital presented unique challenges directly related to their status as a health care institution. In the course of introducing SEP services into a hospital setting as part of a clinical trial, various ethical, legal, and logistical issues were raised. Based on these experiences, this paper provides guidance on how to integrate an SEP into a traditional health care institution.

Keywords

syringe exchange; HIV; injection drug use; organizational; hospital

Introduction

Injection drug use is a major route for transmission of HIV and other blood-borne infections (Friedman et al., 2005; Friedman et al., 2004; Holmberg, 1996). Injection drug use accounted for 27% of all AIDS cases in the United States in 2003, and is the leading cause of hepatitis C virus infection (Centers for Disease Control, 2004; Garfein, Vlahov, Galai,

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Doherty, and Nelson, 1996; Murrill et al., 2002). Moreover, nonsterile injection practices also place individuals at risk for acquiring other infectious diseases and medical complications, such as skin and soft-tissue infections, bacteremia, endocarditis, and hepatitis C, among others. Medical complications arising from injection drug use lead to increased hospital admissions and visits, and account for substantial morbidity and mortality. In addition, the costs associated with treatment of drug use related medical complications place a significant financial burden on the public health care system (Mark, Woody, Juday, and Kleber, 2001; Masson et al., 2002).

Service delivery characteristics of Syringe Exchange Programs (SEPs) may be important determinants of HIV risk behavior among program participants (Des Jarlais and Friedman, 1998; Kral, Anderson, Flynn, and Bluthenthal, 2004). For example, operational characteristics of some SEPs such as their location [i.e., placement in neighborhoods where a large number of injection drug users (IDUs) reside], “user friendly” atmospheres, and specific program rules may have an impact on patterns of SEP use and risk behaviors among program participants (Henman, Paone, Des Jarlais, Kochems, and Friedman, 1998; Kral et al., 2004; Rockwell, Des Jarlais, Friedman, Perlis, and Paone, 1999). However, limited research has been conducted to examine the effectiveness of different SEP service models for increasing the availability of sterile injection equipment. Such studies are needed to gain a better understanding about how SEP characteristics affect the impact SEPs have on HIV transmission rates and on injection practices in a community.

SEPs have operated predominantly separate from health care facilities, yet the mission of preventing or reducing complications of injection drug use is common to both. Medical settings regularly see active IDUs and hence represent an important site at which to attempt to engage IDUs in measures to reduce HIV and blood-borne pathogen risk. Health care facilities are important points of entry into drug user treatment.¹ However, for IDUs not ready to cease drug use, or in settings or circumstances in which treatment slots are not available, efficient means of engaging IDUs in other risk reduction endeavors are needed (Burris, Lurie, Abrahamson, and Rich, 2000). Developing programs which link health care facilities to community-based SEPs through formal referral mechanisms or to SEPs on-site may help meet this need.

Although hospital-based SEPs have operated in other countries including Australia, Canada, and the United Kingdom, this approach has not gained general acceptance in the United States (Commonwealth Department of Health and Ageing, 2002; Hankins, 1998; Parsons et al., 2002). The U.S. public health response to HIV and other blood-borne infections among IDUs has been modest and geographically uneven (Tempalski, 2006). While there are over 25 SEPs in California, in most communities in the United States, IDUs are still not able to legally obtain sterile syringes through pharmacy sales or SEPs (Tempalski, 2006). Furthermore, communities that have been successful in their efforts to implement SEPs were those with wide support from activists, public officials, researchers, and proponents who effectively mobilized resources and worked to build community coalitions (Downing et al., 2005). Understanding issues that may arise in the course of developing hospital-based SEPs and developing ways to address issues that may arise, are important in expanding the access IDUs have to SEP services. We developed a hospital-based SEP in the course of initiating a clinical trial designed to compare outcomes among IDUs randomized to a community-based

¹Treatment can be briefly and usefully defined as a planned, goal directed change process, which is *bounded* culture, place, time, etc.) and can be categorized into professional-based, tradition-based, mutual-help based (AA, NA, etc.) and self-help (“natural recovery”) models. There are no unique models or techniques used with substance users- of whatever types- which aren’t also used with non-substance users. In the West, with the relatively new ideology of “harm reduction” as well as a consideration of *quality of life* there are now a new set of goals in addition to those derived from/associated with the older tradition of abstinence driven models. Editor’s note.

SEP or to a hospital-based SEP. Those eligible to participate in the study were out-of-treatment IDUs who were not interested in receiving drug user treatment, and receiving medical care at the public hospital. In this article we describe organizational issues encountered in the design and implementation of this SEP and discuss ways in which consensus to establish such a program was reached.

History of Community-Based Syringe Exchange in San Francisco

Needle exchange in San Francisco began in 1988 when a group of volunteers who called themselves Prevention Point responded to the HIV/AIDS epidemic by supplying IDUs with sterile syringes and other safer injection supplies. The primary objective was to provide a street-based, anonymous, nonjudgmental, syringe exchange. In the first few years of operation, activities carried on by Prevention Point were illegal given that at the time California State law prohibited the furnishing and distribution of syringes without a prescription. Although local officials could have subjected SEP volunteers to citation, arrest, and prosecution, the program was allowed to operate without police interference. Because of the recognition by the public health system of the importance of efforts to reduce HIV, an agreement was reached with the police to allow the safe provision of SEP services.

In 1993, the City and County of San Francisco utilized the California Emergency Services Act to declare a “local emergency” that would temporarily exempt the City and County from compliance with state law governing syringe distribution. In the same year, the San Francisco AIDS Foundation founded the HIV Prevention Project, which exchanged 780,000 syringes in its first year. Although the declaration of local emergency allowed SEPs to operate legally in the City and County of San Francisco, this declaration had to be made every two weeks to justify continuing SEPs. Despite these declarations, there was uncertainty regarding the legal status of locally authorized SEPs, thus many SEP advocates continued to pursue statewide legislation to legalize SEPs (Collins and Summers, 2002). In October 1999, California Governor Gray Davis signed Assembly Bill 136 (AB 136) into law. This law protects local governments and their employees and authorized contractors that provide syringe exchange services from criminal prosecution for distributing hypodermic needles or syringes if there is a declaration of a local emergency. Two new laws recently passed in California make it easier for cities and counties to maintain SEPs and to expand access to sterile syringes through pharmacy sales. The first law (AB 547) removes from state law requirements that cities and counties declare a health emergency every two weeks to justify continuing SEPs. Instead local governments may now reauthorize SEPs annually. The second recently passed law (SB 1159) allows adults to buy up to ten sterile syringes at pharmacies without a prescription and decriminalizes syringe possession if acquired from an authorized source.

Currently, SEPs in San Francisco operate legally and the San Francisco AIDS Foundation HIV Prevention Project (SFAF HPP) is one of several programs in the city. The SFAF HPP is funded by the San Francisco City/County Department of Public Health and by private donations. As of 2006, SFAF HPP operates 8 SEP sessions per week at 7 different neighborhood locations, and exchanges over 2.3 million syringes per year. In addition, the SFAF HPP provides safer injection equipment and sex supplies and offers community-based services such as HIV testing, drug treatment referrals, and medical care.

Program Description—As the legal entity authorized by the City of San Francisco to operate syringe exchange programs, SFAF HPP agreed to provide program staff, sterile syringes, other HIV prevention supplies (i.e., bleach, distilled water, cotton, latex tourniquets, alcohol wipes, antibacterial cream, “cookers”, and condoms), educational materials, and logistical expertise to the hospital-based SEP. Referrals to drug user treatment

programs, medical care, and social service programs were also provided. A wide range of drug user treatment services available in San Francisco were offered to SEP participants, including traditional abstinence-based treatment programs (e.g., therapeutic communities), methadone detoxification and maintenance services, harm reduction psychotherapy, spiritual recovery programs based on the Twelve Step philosophy (e.g., Narcotics Anonymous), and alternative self-help groups (e.g., Rational Recovery, Moderation Management). In addition to syringe exchange services, program participants were offered HIV pre- and post-test counseling services, and a one-hour HIV prevention education session. The educational program included the following components: 1) information on HIV disease and its transmission; 2) behavioral strategies to avoid exposure to HIV; and 3) instructions on safer self-injection practices. The program was also designed to foster a user-friendly environment for IDUs in which minimal requirements for program participation were applied, refreshments were provided, and where volunteers, staff, and participants treated each other with mutual respect. The hospital-based SEP was located on the grounds of SFGH at the Volunteer Center, a building adjacent to the main entrance of the hospital. The hospital-based SEP operated on Saturdays between the hours of 12:00–2:00 p.m. Because of space and funding constraints, the hospital-based SEP began operating one session per week.

Issues Encountered in the Implementation of a Public Hospital-Based SEP

The hospital-based SEP began as a collaborative research program between the SFAF HPP and researchers at the University of California, San Francisco (UCSF), initiated by the researchers as part of the clinical trial. A critical first step in gaining the support needed to successfully implement a hospital-based SEP was to develop a working relationship between SFAF HPP leadership and program staff on the one hand, and researchers, administrators, and clinicians at SFGH on the other. SFAF HPP and UCSF staff concurred on a common goal: a commitment to explore ways to reduce adverse health consequences of injection drug use. Another unifying factor was their acceptance, to varying degrees, of a “harm reduction model”, in which measures that reduce but do not eliminate risk behaviors are considered a commendable goal when elimination of such behaviors is not feasible. Based on this model of service delivery, the SFAF HPP and researchers sought to integrate SEP services into the public hospital setting. Despite a recognition by hospital staff and researchers of the need for enhanced services within a public hospital setting, several potential issues were identified that required resolution prior to implementation of SEP services at the public hospital: (1) ethical; (2) legal/administrative; and (3) logistical considerations. All these issues were raised by the hospital administration shortly after the SEP opened, and SEP services were halted and could not be resumed until they had been resolved.

Ethical Considerations

SEPs Do Not Encourage Drug Use—There was initial concern by some hospital staff that conducting SEP services could be construed as encouraging IDUs to continue using drugs. Some individuals felt that implementing an SEP in a hospital setting was inconsistent with a medical center’s mission to improve or maintain the health and quality of life of its patients. To address this issue, the researchers met with hospital staff including physicians, nurses, hospital administration, environmental health and safety personnel, and the institutional police to discuss the program goals and potential benefits of engaging out-of-treatment IDUs, pointing out that the SEP was ultimately an infectious disease prevention program. The discussion focused on the potential of an SEP to reduce morbidity, mortality, and economic costs associated with injection drug use. Data from the medical literature were presented addressing the effectiveness of SEPs as an HIV prevention strategy, including studies showing that SEPs do not encourage drug use among SEP participants or the recruitment of first-time users, do not result in an increase in needle littering or crime, and

may in fact be ideal sites for recruiting IDUs into drug user treatment (Guydish et al., 1993; Hartgers, Buning, van Santen, Verster, and Coutinho, 1989; Hudoba, Grenyer, and O'Toole, 2004; Khoshnood, Blankenship, Pollack, Roan, and Altice, 2000; Wodak and Cooney, 2006). In addition, the Centers for Disease Control and Prevention guidelines (Centers for Disease Control and Prevention, 2000; Centers for Disease Control and Prevention, 1999), which recommend syringe exchange for IDUs who are not ready to enter drug user treatment were reviewed and provided authoritative support for the value and acceptance of syringe exchange as an HIV prevention strategy to many who were not previously familiar with the published data. These meetings were effective in addressing hospital members' initial concerns regarding SEPs and garnering internal support for and acceptance of the proposed project.

Hospital-Based Syringe Exchange as Research Versus Service—Some other hospital staff, already involved with SEP services in different settings, questioned whether hospital-based SEP services in fact needed to be evaluated in a comparative study design (hospital-based SEP vs. referral to community-based SEPs) as opposed to being implemented solely as a clinical preventive service. To address these concerns, the research team held a meeting with the concerned clinicians. Some clinicians inferred that, because SEPs have been found to be effective in community settings, hospital-based programs would also be effective. On the other hand, there were plausible reasons that a hospital-based SEP might not work as well. Arguments in favor of effectiveness included the consideration that because IDUs use public hospital emergency departments as a regular source of care, this setting would afford the opportunity to identify out-of-treatment IDUs, refer patients to local drug treatment programs, counsel patients about ways to reduce their risk of exposure to HIV and other infectious diseases, and provide them with the means to inject more safely. In many settings, referral to services off-site constitutes a potential impediment to engaging individuals in services and hence syringe exchange services on-site in health care facilities might circumvent this issue. Further, among the factors previously found to contribute to the success of SEPs in reaching high-risk persons is the “user” friendly atmosphere of many syringe exchanges (Kral et al., 2004). Such an atmosphere might be difficult to replicate within the context of a health care facility. Therefore, consensus was reached in support of a comparative program design.

Diverting Motivated IDUs From Treatment—Of concern to both hospital and SEP staff, was the issue of offering SEP services to individuals who were interested in stopping drug use and enrolling in drug user treatment. This concern was addressed by offering drug user treatment to all IDUs and limiting hospital-based SEP participation to IDUs who declined referral to drug user treatment.

Using Monetary Rather Than Nonmonetary Incentives—Another issue raised by some hospital staff was whether monetary compensation for taking part in research interviews provided within a hospital setting might be inappropriate. Participants were asked to participate in three research interviews and compensated for their time and effort. Participants were paid \$20 following the initial interview, \$25 for the six-month interview, and \$30 for the twelvemonth interview. While the issue of compensation was related more to the development of a hospital SEP as part of a clinical trial rather than to its development for clinical and public health services per se, it reflected general concerns about the development of services for drug users. It has been proposed that incentives, including monetary ones, be considered ethical if they constitute a welcomed and persuasive influence, but not a “controlling influence” (Faden and Beauchamp, 1986; Tishler and Bartholomae, 2002). As a study, issues of participant compensation were reviewed and approved by the Institutional Review Board (IRB) of UCSF. However, some hospital staff

retained concerns despite the project's formal IRB approval. An issue was the concern that participants would use stipends to purchase drugs. Prior to the implementation of the research program, the appropriateness of the stipend was discussed with the hospital staff. It was generally agreed that research participants were entitled to be compensated for the inconvenience of participating in structured interviews and other aspects of the research program. Although vouchers that could be exchanged for goods or services was considered as an alternative to monetary compensation, it was deemed not to be a particularly effective solution given that such surrogates could potentially be converted to cash. Further, staff were informed that monetary incentives have been shown to increase attendance at HIV prevention sessions significantly more than nonmonetary incentives, to be more effective at promoting adherence to TB skin testing and hepatitis B vaccination than nonmonetary incentives or educational interventions, and in some settings to be cost saving from a societal perspective (Deren, Stephens, Davis, Feucht, and Tortu, 1994; Des Jarlais et al., 2001; Perlman et al., 2003). Moreover, because monetary incentives are regularly used as compensation in a variety of approved research studies in this health care facility, potential ethical issues arise in the presumption that such stipends are acceptable for some but not for other research participants. Ultimately consensus was reached regarding the use of monetary incentives.

Legal and Administrative Considerations

Issue of Potential Risk of Arrest and Criminal Prosecution—A consideration raised was the notion that by providing sterile syringes to IDUs, researchers and the institution might be construed as encouraging individuals to engage in an illegal activity that could subject them to criminal prosecution. During the time of the implementation of the hospital-based SEP, State of California paraphernalia and prescription laws prohibited the distribution and sale of syringes for the purpose of illicit substance use (Burris, Vernick, Ditzler, and Strathdee, 2002). However, it was the formal policy of the San Francisco Police Department to allow these exchanges to operate without interference. For several years, police officers had been instructed not to confiscate needles and other HIV prevention supplies at or near SEP sites. Prior to program implementation, hospital staffs were informed about the legal status of SEPs in San Francisco and the existing relationship between the SFAF HPP and San Francisco Department of Public Health. In addition, hospital staffs were assured that the hospital-based SEP would operate in accordance with all rules and policies instituted by the San Francisco Department of Public Health. Also, prior to implementing the hospital-based SEP, the researchers met with the Chief of SFGH's Institutional Police and supervising staff in an effort to obtain their cooperation and support. This was done in recognition that police posture toward syringe exchange appears to have a direct impact on program utilization (Bluthenthal, Kral, Lorvick, and Watters, 1997). As a result, the SEP was allowed to operate with the support of both the police and hospital security.

Concerns Regarding Potentially Unwelcome Visitors to the Hospital—A related concern raised by hospital staff was that awareness of the SEP might encourage persons who were not enrolled in the research program to visit the hospital-based SEP. Administrative staff was especially concerned about the potential unintended adverse consequences that may arise from syringe distribution to unmanageable numbers of persons given the study's limited resources. Although use of the hospital-based SEP was limited to study participants and verified by presentation of an identification card to staff during each exchange episode, anonymous exchange of syringes could also be performed. We anticipated that this would occur infrequently as the hospital-based SEP was not placed on publicly available lists of active SEPs. The use of identification cards would also facilitate collection of data on program utilization. Additionally, identification cards could potentially provide some measure of protection during encounters with law enforcement officials for SEP research

participants by identifying the individual as participant in a research study, as has been done by community-based SEPs in a number of settings (Burris et al., 2002).

Concerns Regarding Potential for Dangerous Litter and Needle Sticks—

Hospital staff raised the concern that the SEP might increase the number of discarded syringes on the hospital grounds, and consequently increase the risk for needle sticks. A related concern was the issue of the hospital's liability for accidental needle sticks. These concerns were addressed in part by informing hospital staff that studies have found no evidence of increases in discarded syringes around active SEPs or following the closure of SEPs (Doherty, Garfein, and Vlahov, 1997; Khoshnood et al., 2000). Further, because the SEP would provide the opportunity for program participants to safely dispose of used syringes and to receive a sterile syringe in exchange for every used one, there would in fact be a disincentive to discard used syringes anywhere other than the disposal containers at the SEP site. However, in the event of a needle stick accident, the hospital-based SEP would comply with the hospital's existing protocol for blood and body fluid post exposure management which requires reporting of any needle stick injury, immediate evaluation and offer of post exposure prophylaxis, and follow up treatment through the institutional occupational health services.

Concerns Regarding Potential for Increased Drug Use Problems at the

Hospital—Finally, hospital staff was concerned that the SEP might contribute to security concerns if SEP participants were to engage in drug use, drug sales, and petty crimes on the hospital grounds. However, since the institution already cared for large numbers of active drug injectors, it was determined that such risks already existed. The institution already had in place procedures and policies to address any potential issues of drug use and drug possession on its property. Further, study SEP subjects were to be recruited from among IDUs who, independent of the hospital-based SEP, had already sought care at SFGH. Recent evidence suggests that implementation of an SEP in a community setting is not associated with increases in overall crime rates or specific illegal acts (Marx et al., 2000) and these data were reviewed with relevant hospital staff.

Operational and Logistical Considerations

A number of logistical and health and safety concerns were raised by hospital staff regarding the impact that an SEP might have on other hospital-based programs, staff, and patients. Would the SEP interrupt the routine flow of other clinical activities? Would SEP participants steal hazardous waste disposal containers from medical clinics? How would the potentially agitated patient be managed? In response to these and other concerns, the researchers coordinated several meetings with hospital staff to provide information and to seek their cooperation and support. As a result of these meetings, researchers and hospital staff reached a mutually agreed upon solution to locate the SEP in a separate building on the hospital grounds.

Another health and safety issue raised by the hospital occupational health personnel was how hazardous waste was to be collected and disposed of at the hospital-based SEP. Specifically, researchers were asked to describe procedures for handling biological spills or other potentially infectious materials (i.e., nonsterile injection equipment). An SEP hazardous waste collection and disposal plan was developed to comply with state and federal occupational safety and health standards for exposure to transmissible blood-borne pathogens. Consistent with the hospital's blood-borne pathogen exposure control plan, all research staff were required to attend an initial and annual standard health and safety training at the public hospital. The cooperating SEP volunteer staff also received hospital-mandated infection control training. In addition, those who attended the hospital-based SEP

were provided instructions by the SEP volunteer staff about how to safely store, transport, and exchange used injection equipment.

Discussion

There are a wide variety of potential concerns, regulatory issues, and operational considerations that may arise in the course of developing SEP services in any setting. Within health care institutions, there may be additional administrative and regulatory issues involved in the process of integrating community-based services into a hospital setting. The delivery of SEP services in a public hospital presents a number of unique challenges that is directly related to its status as a health care institution. The restrictions placed on public hospitals by governing bodies and regulatory agencies as well as the cultural perspectives of hospital and SEP staff must be considered in the process of developing and implementing a hospital-based SEP. Divergent philosophical views of key institutional players could potentially lead to conflicts about how an SEP should be implemented in a hospital setting (Miller, 2001). Therefore, in the process of developing and implementing hospital-based SEPs it was critical to address concerns and develop consensus in order to garner the support and commitment needed for successful implementation. It was also important to consider the potential impact of SEP services on other hospital-based programs, employees, patients, visitors, and program participants. Despite encountering a number of ethical, legal, and operational issues in the course of program development, the cooperative relationship that was developed between hospital staff, community SEP leadership, and the researchers contributed to the successful implementation of the project. A critical process was the use of ongoing dialogue as a means of assisting participating and potentially impacted hospital staff in becoming comfortable with the implementation of on-site SEP services. In the process of developing SEP services in health care settings, developing collaborative relationships with hospital clinicians and administrators in the design of such services is a critical first step. This participatory process may assist program developers in anticipating many of the potential legal, ethical, and logistical concerns, which may arise in the course of hospital-based SEP development. A collaborative relationship may also create opportunities in which concerns can be verbalized and addressed, and may facilitate greater dissemination of syringe exchange as a potential health promotion strategy within health care settings.

The strategies employed and the conclusions drawn from these observations and experiences may not all be applicable in other settings. For example, the issues related to expanding SEP services to health care settings in communities that have established community-based SEPs, may differ from the issues that may arise in settings, such as in many developing countries, in which SEPs are not in use at all (Wodak and Cooney, 2006). Further, potential issues may differ in settings with varying existing access to or regulations regarding legal access to community-based SEP services or sterile syringes (e.g., pharmacy sales, vending machines). However, many of the issues encountered may reflect areas of common concern and hence anticipating and having strategies to address such potential areas of concern may have general value. In fact, many of the issues encountered resemble those faced in the course of establishing drug treatment programs in various settings (Joseph, Stancliff, and Langrod, 2000).

Expansion of SEP services to include their more routine use within health care institutions has the potential both to complement existing HIV prevention programs found in health care institutions (i.e., HIV counseling and testing), and to complement SEP services available in community-based settings. Because IDUs have frequent episodic encounters with the health care system, these encounters may serve as valuable opportunities to engage IDUs in longitudinal care and interventions designed to reduce the adverse health consequences of nonsterile injection drug use (Kerr et al., 2005). Preliminary findings from this randomized

trial of hospital- versus community-based syringe exchange suggested that it was feasible to integrate syringe exchange program services within a hospital setting and that both strategies were capable of engaging high-risk active drug users in a longitudinal risk reduction intervention (Brown et al., 2003). Increasing access to sterile syringes through a hospital-based SEP may have the potential to engage IDUs in longitudinal health care, increase drug user treatment entry, and reduce HIV risk behaviors.

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James L. Sorensen, Ph.D., is a California drug abuse researcher, teacher, and clinical administrator. He serves as Professor of Psychiatry at the University of California, San Francisco and Medical Staff Member at San Francisco General Hospital. Dr. Sorensen's work in drug dependence research began 25 years ago, directing an investigation of heroin detoxification. With support from the National Institute on Drug Abuse, NIMH, and American Foundation for AIDS Research Dr. Sorensen has developed and evaluated numerous innovative treatment approaches, including a Community Network approach to drug treatment, family therapy, small-group HIV education with drug users, case management approaches, and interventions to improve medication compliance of drug abusers with HIV/AIDS. Dr. Sorensen has authored 200 professional publications, including several recent studies of AIDS and drug abuse. Currently he is investigating how well patients on methadone maintenance fare in a therapeutic community setting and leading a collaboration of California and Arizona programs participating in multi-site studies in the NIDA Clinical Trials Network. He is first author of **A Family Like Yours: Breaking the Patterns of Drug Abuse** (Harper and Row, 1987) and **Preventing AIDS in Drug Users and Their Sexual Partners** (Guilford Press, 1991). Dr. Sorensen also is senior editor of

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Nina Grossman, B.A., is currently the Community Liaison for Tibotec Therapeutics. Ms. Grossman began her work in HIV and substance use 15 years ago as an intern for the Marin AIDS Project. She was then hired on to coordinate the Peer Education Program at San Quentin State Prison. She then moved to Center force to continue her work with HIV-positive inmates at the prison. While working at Center force, Ms. Grossman was involved in many research projects with the Center for AIDS Prevention Studies and was an author of “Reducing Post-Release Behavior Among Seropositive Prisoners”. Ms. Grossman joined the staff of the San Francisco AIDS Foundation in 1999 as the Director of the HIV Prevention Project. Her main responsibility was to coordinate operations for the needle exchange program and to build better relationships with the community and the San Francisco Police Department.

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Glossary

Blood-borne Infections	An infection that is spread through blood or blood products.
Harm Reduction Model	A strategy aimed at decreasing the harms associated with drug use including HIV transmission, hepatitis, overdose, etc. This approach includes a range of actions such as abstaining from drug use to minimizing the number of individuals one injects drug with and using sterile syringes.
Health Care Institution	Traditional medical care settings including private and public hospitals, community-based urgent care, and outpatient primary care medical clinics.
HIV/AIDS Epidemic	HIV is a retrovirus responsible for the frequently fatal AIDS. AIDS was first officially recognized on June 5, 1981 and somewhat later was found to be caused by the HIV infection. HIV/AIDS is a pandemic that has claimed the lives of over 20 million people worldwide.
Syringe Exchange Program	Programs where injection drug users can trade a used syringe for a new sterile one.
Vouchers	A coupon that can be exchanged for goods and services.

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