

APPENDIX A

Social and Environmental Context of Hepatitis C in Multnomah County

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Strengths

Needle Exchange Services

There are more than one million people in the U.S. who inject drugs. This costs society (in health care, lost productivity, accidents, and crime) more than \$50 billion a year. People who inject drugs are at high risk of contracting HIV, HCV, and HBV. If they contract any of these diseases, their needle-sharing partners, sexual partners, and unborn children may also be at risk for infection.

We know that abstaining from drug use, especially drug use involving needles, is the single best way to reduce the risk of HIV and HCV transmission. We also know that many people who inject drugs will continue to do so, putting themselves and others in the community at risk. Providing a source of sterile syringes and other injection drug use equipment has been shown to reduce the spread of infectious diseases, such as HIV, and provides essential links between injectors, drug treatment programs, and other social services that provide life stability. There is no evidence that needle exchange programs increase the amount of drug use by clients or the wider community. Additionally, mathematical models show the cost effectiveness of exchange programs over five years for clients, their sex partners, and their children at an average cost of \$9,400 per HIV infection prevented. This is far below the \$119,000 lifetime average cost of treating one HIV infected person.

Multnomah County has been providing exchange services since 1989, beginning at Outside In, a community based organization that received county general funds to provide exchange, making it one of the first in the U.S. In the spring of 1996, the Multnomah County Health Department began its own exchange services. MCHD currently hosts 12 sites throughout the week for exchange services. In 2002, MCHD exchanged almost a quarter of a million syringes. In addition to exchange services at these sites, MCHD also provides:

- Safer sex supplies
- Wound care supplies
- Health information (i.e. HIV, HCV, HBV, STDs, abscess care, overdose prevention, etc.)
- Referrals to drug treatment, medical, homeless, and other social services
- Behavioral counseling to decrease risk of infectious diseases and to increase likelihood of clients seeking drug treatment services
- Positive contact with a health care professional that can then build bridges to other health and social services
- Social work support for HCV positive clients

The Oregon Health Plan

The Oregon Legislature created the Oregon Health Plan (OHP) in 1989 to address the growing problem of Oregonians who lack access to health care. The Legislature identified three reasons for the high rate of uninsured: medical history causing some individuals to be considered too

high of a risk to insure, a lack of funds within the households of the working poor to purchase insurance that may or may not be offered by their employer, and a growing segment of the population living below the federal poverty level that were eligible for publicly funded health care.

OHP operates under a waiver from the federal government that allows the state to serve more low-income people using federal Medicaid money. This is done through an innovative system that prioritizes health care, using a list of hundreds of conditions and their treatments. Higher priority is given to conditions that can be successfully treated, and to avoiding illness through preventive care.

Currently, the full range of HCV western medical care is covered by the OHP including laboratory testing, vaccinations, Interferon and Ribavirin therapy, ongoing primary and specialty care provider visits. OHP has gone through numerous reforms and iterations since its inception, but nonetheless follows the strategy of prioritizing health care.

Challenges

Paraphernalia Laws

Drug paraphernalia laws in Oregon exclude hypodermic syringes, with the exception of hypodermic devices being provided to minors unless there is a demonstrated, lawful need for the minor to possess the syringe, as well as authorization of a physician, parent or legal guardian or by other means acceptable to the seller or donor.

Although it is legal to possess syringes in Oregon, a problem arises when an individual carrying used syringes (for example, someone who is accessing needle exchange services) is stopped by the police. In this case, if the syringes have residual, illicit drugs, they can be used as evidence of possession of a controlled substance. Qualitative data collected at needle exchange sites indicate that this is a deterrent for needle exchange participants to properly dispose of used syringes, increasing multiple uses of syringes as well as dangerous disposal practices (i.e. public garbage disposal, on the ground, in the street or park). Additionally, because needle exchange operates on a one-for-one basis, if an exchange participant does not bring in syringes to exchange, the participant can only receive an emergency health kit (consisting of three syringes) which may be insufficient to fulfill safer injection needs.

Drug Free-Zones

Drug-Free Zones (DFZ) are areas in the city of Portland that are designated by the City Council. In a DFZ, a person is subject to an “exclusion” (meaning they may not enter the designated area without express permission from the police, referred to as a “variance”) from the designated area for a period of 90 days if that person has been arrested based upon probable cause to believe that that person has committed a specified offense within a DFZ. Additionally, a one-year exclusion can be issued under certain circumstances. A variance can be granted to a person with an exclusion to enter the DFZ for certain services, such as meeting with an attorney or a scheduled appointment with a social service provider. More specific information about the DFZs can be found in the city of Portland charter, title 14, addressing public order and police.

Several needle exchange sites are located within DFZs. Because a person can be excluded from an area based on probable cause, many exchange clients say they are afraid to carry used syringes within the zones. Thus, many IDU do not bring used syringes back to the syringe exchange site, increasing the likelihood for syringe-sharing, multiple use, improper disposal, and exposing IDU and other community members to infectious diseases.

A ruling by a Multnomah County judge indicated that the appeal for DFZ exclusions may be unconstitutional. This case resulted in the dismissal of a dozen defendants who decided to challenge the constitutionality of their exclusion appeal. However, most people do not appeal their exclusion and city officials are currently attempting to change the appeals process to respond to this case.

Oregon Health Plan

As of this writing, OHP faces continuing challenges due to rising health care costs, lower-than-projected state revenues, failed tax increases, and a limited Medicaid budget. These circumstances mean that access to health care will be reduced. Specifics about who will lose health care coverage and the associated long term costs remain to be seen.

General Information about Multnomah County

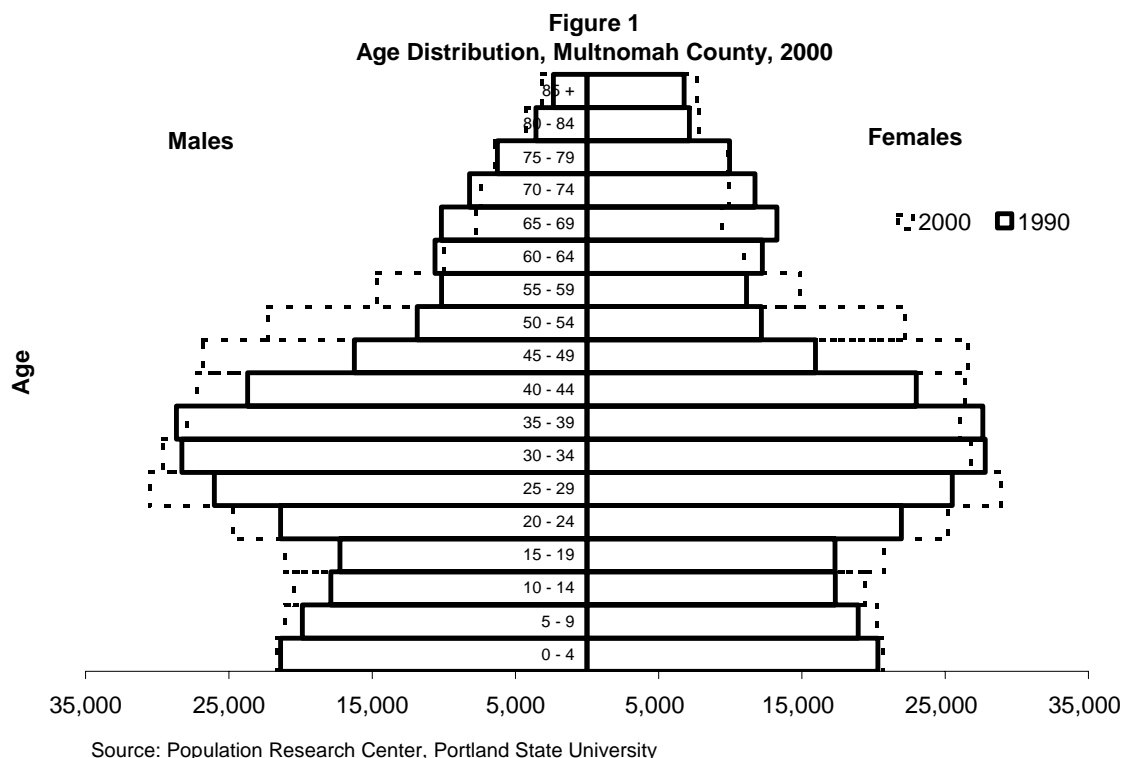
General Population

Multnomah County is largely urban, and home to 19.3% of Oregon's population. The city of Portland is the county seat and comprises 80% of the county population. The next largest city is Gresham with 14% of the population. The cities of Troutdale, Fairview, and Wood Village comprise the remainder of the population.

From 1990 to 2000, the population of Multnomah County grew 13%, from 583,887 to 660,486. During the same period, the population of Oregon grew 20%.

Age Distribution

In 2000, the median age of Multnomah County residents was 35 years. Population growth was not evenly distributed among age groups. Figure 1 shows absolute population growth in the county between 1990 and 2000. The population of adults 74 years and older has remained relatively constant as has the population of very young children (0-4). The population of children (5-9), adolescents (10-19), and young adults (20-29) has increased. The largest increase in the adult population was among 45-54 year olds. The county has seen a decrease in the population of 60-74 year olds and 35-39 year olds.



Race and Ethnicity

The 2000 U.S. Census asked individuals to respond to the question of race differently than it had in the past. In 2000, individuals had the opportunity to choose more than one racial category to describe themselves. In addition, the category Asian/Pacific Islander was divided into two categories: Asian and Native Hawaiian/other Pacific Islander. This resulted in racial categories

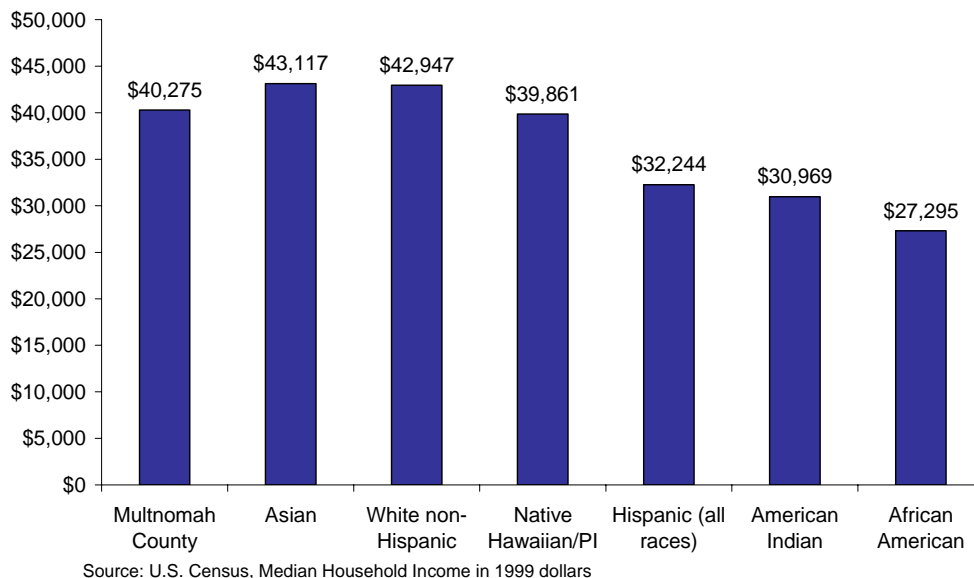
of White, African American, Asian, Native Hawaiian/other Pacific Islander, American Indian, two or more races, and some other race. The question of Hispanic or non-Hispanic ethnicity remained unchanged in 2000. These changes make comparisons to earlier census data on race difficult. According to the 2000 U.S. Census, White non-Hispanics make up the largest percentage of the population of Multnomah County (Table X). Among populations of color, Hispanics make up the largest percentage of the population, followed by African Americans and Asians.

Table X	
Race/Ethnicity	Percent
White non-Hispanic	76.5%
Hispanic (of any race)	7.5%
African American	5.7%
Asian	5.7%
American Indian	1.0%
Native Hawaiian or Pacific Islander	0.4%
Two or more races	4.1%
Some other race	4.0%

Income and Poverty

The 2000 U.S. Census reports that, at \$40,275, the median income in Multnomah County was 1.8% higher than median income for Oregon (\$39,575), and 2.8% lower than median income for the United States (\$41,433). In Multnomah County, Hispanic, American Indian, and African American populations have a lower median household income than other racial/ethnic groups. The median household income for African Americans is the lowest of any racial/ethnic group and is 33% lower than the county median household income.

**Median Household Income by Race/Ethnicity
Multnomah County 2000**



African Americans and Hispanics have higher percentages of individuals at or below 100% of federal poverty level, followed closely by American Indians (Figure 4). The percentage of African Americans in poverty is more than twice as high as for the county as a whole.

**Population below 100% Federal Poverty Level
Multnomah County 2000**

