Tammy Kremer (00:03):

Providing services that fit within the context of people's lives is harm reduction, a movement born from supporting people who use substances. We'll discuss what harm reduction is and how it intersects with sexual health. Stay tuned for a bonus segment with our guest on the Supreme Court's draft decision on Roe v. Wade.

Welcome to Coming Together for Sexual Health, where we talk about enhancing sexual healthcare.

Dr. Ina Park (00:28):

For most of us, having sex is easier than talking about it.

Dr. Rosalyn Plotzker

This is not related necessarily to the people who have the infection. It's related to the healthcare system in which they exist.

Duran Ruteledge (00:43):

What can I do? What can I learn that impacts change for the people that are in my sphere of influence.

Dr. Rosalyn Plotzker (00:49):

This is so, so, so preventable.

Tammy Kremer (00:53):

These conversations are brought to you by the California Prevention Training Center at the University of California, San Francisco. It's time. Let's come together for sexual health.

I'm Tammy Kramer and this is a conversation with Jen Jackson. Just a note. All views expressed are those with the person speaking and not their employer or the CAPTC.

Welcome to Coming Together for Sexual Health, Jen Jackson. I'm so excited to have you here today.

Jen Jackson (01:25):

Thanks for having me here.

Tammy Kremer (01:26):

So, for our listeners, Jen Jackson has a background in capacity building and harm reduction. I know you've been in the field for over 20 years. You've worked in partner services, harm reduction, syringe services, and HIV testing, and you have experience in stakeholder engagement, capacity building training, and you're getting your PhD in translational health sciences. So, that's super exciting.

Jen Jackson (01:48):

Yeah. Yeah. Super exciting.

Tammy Kremer (01:50):

Great. So let's jump into what harm reduction is.

Jen Jackson (01:54):

So, harm reduction is... It's a model of service delivery and it's also a philosophy that incorporates... what we like to say... value-neutral, practical substance use strategies. And what that means is basically that we are setting aside the values, the attitudes, the judgments that we have in order to be able to provide that client-centered practical strategy. And then it's also a movement for social justice. It aims to assist individuals respectfully... again, non-judgmentally... with reducing negative consequences associated with substance use. And again, fitting within the context of their lives. It's providing these compassionate, practical services. Strategies to help to reduce harm. And usually primarily around drug use, though it can be applied to sexual behaviors. In the end, what we want to do is enhance the quality of life and reduce negative health outcomes. To make a short story long, that is harm reduction right there.

Tammy Kremer (03:10):

When would you say harm reduction really started to grow as a movement?

Jen Jackson (03:14):

Oh my goodness. It goes pretty far back, I would say. They say the birth of harm reduction was actually in the Netherlands. You look back through history and the eighties were a very popular time for harm reduction, particularly around the HIV epidemic that was going on. If you look through... I have all my little nerdy books here and I'm always reading about the history of harm reduction. There's mention of some of these concepts back in the seventies. So, yeah, it's been around for quite some time. The funny thing that we always joke about in the harm reduction field about the research is sometimes you don't see a lot of new harm reduction research because it's already been proven that it works. So it's like... A lot of times, you don't see a lot of new stuff coming around. It's been around for quite some time. I think that it's matured as time has gone on and people are getting a better understanding now what it is versus what it started as.

Tammy Kremer (04:18):

How did you get involved in harm reduction? What drew you to this field?

Jen Jackson (04:22):

Back in college, I was a volunteer for an AIDS service organization here in Baltimore. I got my bachelor's in Baltimore and I was a volunteer at HERO, which was the Health Education Resource Organization. They had this buddy program and what they would do is they would pair you up with somebody who was living with AIDS at the time. And this was, I believe, around 1993. Remembering that treatment options are not what they are now, so there were people with a lot more limited treatment options. Sarah had very limited treatment options, had a lot of resistance to a lot of the medication, and I was buddied up with her. She was a really interesting character. She was living with schizophrenia, had a history of IV drug use, was a former sex worker, had a lot of trauma in her life, was living in a pretty awful residential center here in the city because she was sick, had significant health issues, and was unable to live on her own. So I met Sarah and I would come every week and I'd hang out with her in that. Every once in a while, if she was doing well, they'd give her a little pass where I could take her out for a couple hours. We'd go to the thrift store. Go grab some food and hang out.

But I think that's really what got me into it. I grew up somewhat sheltered, so this was an eye-opening experience for me. I was a girl from the 'burbs. Here, I was with somebody who just had

completely different life experiences. I learned so much from her about trauma, about racism, about addiction, about substance use, about mental health issues, about poverty, about loneliness and isolation that people can be experiencing, particularly in those facilities. I just learned so much also about coping and how resilient people can be and how kind and compassionate individuals can be even when dealing with all those isms that she was dealing with and being faced with their own mortality like that. So I think she just not only pulled me into the field of harm reduction, but my interest in HIV, STI, all of that, was basically due to her and my experience with her.

And then on a personal note, I also had a very close friend, Dave, that I had grown up with and went to high school with, and he died of an overdose. There was a lot of stigma around it that, when his father gave me the news, he referred to it as a drug interaction, which was not really the case. And so I think that the stuff that happened with Sarah and things that happened with Dave really just solidified my belief in harm reduction, being nonjudgmental, being there for people, and also giving people voices when they need to be heard and having the right people come to the table. And so I just learned so much from that experience. It really sucked me in and I've worked in public health ever since.

Tammy Kremer (07:39):

Wow. And what a way to honor both of those people who touched you along the way.

Jen Jackson (07:44):

Absolutely. I think about them all the time.

Tammy Kremer (07:47):

Those are powerful sources of motivation.

So you've already kind of begun to touch on this, but what's the difference between harm reduction as a movement or a philosophy, harm reduction as a program, or harm reduction being integrated into other programs? I think there might be some confusion sometimes. What we're really talking about in a concrete way.

Jen Jackson (08:15):

Oh yeah. Absolutely. So the movement. When we're talking about the harm reduction movement. The movement of harm reduction centers around a belief in and respect for the rights of people who use drugs. When people who use drugs are not at the table, when they're not involved in leadership, when they're not valued in communities, you miss a really important perspective. These perspectives should be taken into consideration when we're providing services to communities, when we're creating policies, and ideally when we're creating laws as well. I remember I did a focus group once. I remember one community member said to me, "How do you create leadership when you silence the voices?" I really feel that that is integral to harm reduction. It's hearing those voices and then valuing what those voices are saying and then responding accordingly.

You think back... In the early seventies, for example. Like back when Nixon was in office and waged that "war on drugs." This war disproportionately affected communities of color and began an era of mass incarceration of minorities based on criminalizing drug possession, particularly with regard to marijuana and heroin. So you see a lot of the movement of harm reduction from that as well. A lot of times, you'll see it on all kinds of harm reduction merchandise, on harm reduction t-shirts. There's this quote by John Ehrlichman, who was Nixon's aide, and it's a very popular one talking about how these communities were targeted. He said, "The Nixon campaign in 1968 and the Nixon White House after

that had two enemies: the anti-war left and black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and the blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did."

So that kind of gives you into that window of the movement of harm reduction and people stepping up. It becomes political. And then the war on drugs has since continued. You see it in some drug policy, in laws, and sentencing that has affected people of color with regard to increased discrimination, aggressive encounters with law enforcement, repeated engagement with the judicial system, and also more sustained lifelong repercussions due to convictions and harsher sentencing and communities affected by mass incarceration. And mass incarceration, which stems from all this, affects overall health and wellness and contributes to health inequities, which is what a lot of times we see in a lot of the communities of color that we serve and people who have been incarcerated. So that's why there's a movement to support the health and dignity of people who use drugs. To address the inequities on the micro, the mezzo, and the macro levels. That's the interpersonal levels, the community level, the structural or institutional levels. And so we're not silencing the voices. We're creating space for people to be heard. So that's sort of that overview.

And when you're talking about providing services to individuals... Like harm reduction programs, for example. Their lens is harm reduction. These are organizations all throughout the US, mostly funded on shoestring budgets, that are focusing on meeting the needs of their clients. Like we say in harm reduction, meeting people where they're at. And then broader programs that you were talking about before... Those broad programs may not have a harm reduction lens. A lot of our broader programs that we have that are not necessarily harm reduction, but may provide other services, may need to kind of reframe their thinking, look at their policies, address biases, and train their staff accordingly.

Tammy Kremer (12:43):

On that note, at the CPTC, we do a lot of training for providers and for health workers, disease intervention specialists, all kinds of folks. How do you interweave or see the connection between harm reduction and other aspects of the California Prevention Training Center's populations that we serve?

Jen Jackson (13:02):

First of all, I am a huge fan girl of the California Prevention Training Center and have been since I went through my DIS training in about like... I think it was like 2006.

Tammy Kremer (13:13):

The disease intervention training, right?

Jen Jackson (13:15):

The disease intervention training, yeah, to be a disease intervention specialist. Absolutely have been a big fan girl. I'm also a fan girl of the mission and the vision. If you look at the mission of the California Prevention Training Center, it is to envision an environment where health equity exists for all. That was one of the things that... Whenever I'm training anybody, I'm having those conversations about sex. I always say, "Just assume everybody is doing everything with everyone." And then, if you make that assumption, you're not missing anything. And then you let your client or your patient clarify and narrow

it down to what's actually going on for them. Not making those assumptions about our clients and our patients. Really being open and really listening to them. You're going to hear me probably say a million times, "within the context of a person's life," over and over again, because that's what it's all about. It's all about being able to provide those services and really help individuals based on what is going on in their life. That way, you're really centered around the client or the patient.

Tammy Kremer (14:33):

Can you tell me why, from your perspective, it's important that we have an episode on harm reduction in a podcast that focuses on sexual health?

Jen Jackson (14:43):

Well, one comprehensive sexual education is a harm reduction activity. So bam! Right there. It's really, really relevant. Harm reduction and sexual education has walked hand in hand forever. That's one of the reasons why I'm so excited about you having harm reduction as an episode and that we're talking substances during a sexuality podcast. It is just so relevant. Most of the people that I talk to as a DIS have experience with substance use. You have, like, SAMHSA that looks at comprehensive sex education as a harm reduction activity. And so one of the things that I wanted to present to you is the Venn diagram between sex and substance use. It has a lot of overlap in the middle for many, many people. Not everybody who is having sex is using substances and not everybody who's using substances is having sex, but yet there's a nice hearty overlap in the middle. And for some people, it is literally a perfect circle. When they are having sex, they are always using substances. And, a lot of times, we use substances that impact our sexual decision making. So it would almost feel negligent to not include conversations about both when you're talking about harm reduction.

Another thing. I was thinking back to HIV in the eighties, before it was HIV, and the focus of harm reduction in certain communities that had an increased risk of infection for HIV transmission. So with condom distribution, then dental dam distribution, as well as clean needles. There is like a lot of overlap with that. Harm reduction has its place among prevention, treatment, recovery, and sexual health. Another thing I was thinking of is that pregnant people use substances. And so there's another tie in with it as well. I know that a lot of sex workers use harm reduction strategies for their own personal safety, for their health, for their substance use, with their clients. So you look at things like PrEP, you look at things as viral hepatitis testing and treatment, condom access, comprehensive sex education. All of these things are also harm reduction activities. As well as syringe service programs, fentanyl test strips, Naloxone distribution. Hey, we're in times of COVID. Using a mask and social distancing as well. All of it is harm reduction and it's all how we are engaging with other people, whether it's sexually or not.

Tammy Kremer (17:42):

How can providers connect with clients meaningfully in order to share ideas that are actionable for them and help someone reduce harm in a way that's relevant to their lives?

Jen Jackson (17:53):

I would say one way that we can help someone reduce harm is by engaging them in a conversation, non-judgmentally, around their substance use and then really listening to them. Active listening with our clients and our patients. Literally, one of the skills of active listening is withholding judgment. I mean, what's more harm reductionist than that, right? We want the individual to know that they are heard and

we want to provide guidance, options, recommendations, and support that are actionable, that are practical for them, and fit where? Within the context of their lives, right?

And so providers utilize harm reduction with individuals every day. We all utilize harm reduction in our daily lives. Seat belts are harm reduction. I don't know about you, but I look both ways before I cross the street. I would consider that harm reduction as well. When providers recommend dietary changes. Reducing sodium to watch blood pressure or encouraging exercise. All of that is harm reduction. But yet when we get to sensitive topics that have more stigma or shame... and it can have stigma or shame not only for our clients and our patients, but providers as well. When that's attached such as with sex and substance use, all of a sudden those comfort levels tend to waiver. People are less comfortable talking about people's substance use and their sexual activity than they are about reducing the amount of sodium intake that they have. Rather rightfully so.

And then when you think about also, a lot of times, with some of the medical establishment having that traditional abstinence-based guidance. Sometimes that falls short with clients and patients. That harm reduction approach can really help where the abstinence-based guidance falls by the wayside. Because for some people... For example, let's talk about smoking cigarettes. Some people aren't ready to quit right away, but they might be ready to cut down smoking right away. When somebody goes from smoking a pack a day to maybe smoking a half a pack and starts to wean down on it, it's harm reduction. I think that also providers need to be creative with it. Creativity is a huge part of harm reduction. Particularly with providing guidance, recommendations. Thinking outside that proverbial box. I have an example of it if you-

Tammy Kremer (20:28):

Yeah, I'd love an example. Some stories would be great.

Jen Jackson (20:30):

Story time with Aunt Jen.

Tammy Kremer (20:32):

Bring it on.

Jen Jackson (20:36):

When I worked in San Francisco, one of the organizations I worked for was Continuum HIV Services, which now I believe is Tenderloin Health. They had [inaudible 00:20:46] program for people living with HIV coming out of jail or prison. We would temporarily house people. Housing. Another great form of harm reduction. So we would temporarily house people while we linked them to services like medical care, behavioral health, food, and then a little more permanent housing. I mean, it's the Bay Area. There's never totally permanent housing, but something that was a little more solid than where we were because we just had some rooms that were very temporary. So on that floor where we had our offices... We were based out of an SRO in the Tenderloin on McAllister. So we had a floor, we had some of our rooms, and then we had rooms that were... And we had our offices and then there were people who actually lived there.

There was a guy named Pete who lived on the floor, who had an affection for speed. Not driving fast. The drug. And so he would come and hang out on the couch in my office and we would chat. Super nice guy. One day, we were having a conversation and he said to me, "Jen, it kills me that, by the end of the month, I'm completely out of money. I've been having to..." Basically, break into cars. He was

breaking into cars and stealing people's stuff. And he said, "I feel really bad robbing people, but by the end of the month, I'm hurting." And so we sat there talking and I said, "Well, if you and I could work on a budget together, Pete..." And remember. He's not even a client of the program. This is just a conversation I'm having with somebody who's living there. I said, "Would you be willing to work on a budget with me so we can start figuring out where you can cut expenses?" Because he was getting GA.

Tammy Kremer (22:31):

General assistance?

Jen Jackson (22:33):

Yeah, general assistance. I think he had some disability that was coming in or something. So he had some money coming in. It was paying for the SRO, the room that he was renting there, and then the money that he had would go quickly. We started looking at what he was spending his money on. He did spend a lot of money on food. A lot of fast food and stuff like that, but he was spending money on food. So we figured out a way that we could utilize the food resources in San Francisco at the time. We were looking at the different soup kitchens. There's a pantry. There was lots of different ways that you could go about getting food, trying to get free food, trying to get food on the cheap.

And so we figured out that, if there was a way for him to reduce the amount of money that he was spending on food and some other things too, that his money would last longer. And he might have to cut back a little bit on his speed usage in order to be able to maximize it and have enough speed for the month and money for the month. But we figured out a way that he could do it where he would not have to break into people's cars anymore. If you've ever had a car lived in San Francisco, chances are it's been broken into, so you're welcome. So he and I sat there together, figured it out, and he was totally good with it. He gave it a try and started doing it.

Now, soon after that, I ended up leaving that position and I always think about him. I always think about him with that harm reduction for him and wondering, did he stick with it? We talked about maybe him trying to generate some sort of income somehow. In a positive way versus breaking into people's cars. That right there is harm reduction because not only are we reducing the harm to him because there's a chance he could get busted and end up in jail. We're reducing the harm to the community as well. When I talk about creativity with harm reduction, that's one of those examples of thinking outside the box and figuring out ways that you can work with people that benefits them within the context of their life and benefits the community as well.

Tammy Kremer (24:45):

Yeah. Such a great example of bringing that creativity to play and drawing out someone's true desire. Recognizing that he didn't want to be breaking into people's cars and so starting with that. Like, okay, great. Let's work on that issue as opposed to talking about his decision to use speed or not to and really focusing on where the life force is for him.

Jen Jackson (25:09):

Absolutely. And it's funny because I did it at the time and didn't think anything of it. And then as I've been going through my career, when I started doing trainings about harm reduction, I looked back at that. Because I remember somebody asked for some practical examples and I remember that with him because I think about him a lot. I think about all my clients a lot that I've had in the past. I carry everybody with me. But I do think about him a lot. In retrospect, I was really proud of myself. It was

creative. It was forward thinking. I totally pat myself on the back for it. And I think that's what we need to do as providers. We really need to really listen to what people are saying and then figure out ways that we can help give them that guidance. I always say I'm really nosy and it is. It's about being curious and it's about being creative. To really help them figure that out.

Tammy Kremer (26:07):

On that note of what individual providers can do, I think there's sometimes a tension between what providers can offer in terms of harm reduction services and what the context is that they work within. Like the policies and structures around them. Can you speak to some of that? What's in the power of providers versus the systems that they're in?

Jen Jackson (26:26):

Yeah, absolutely. And that can be challenging, right? I mean, that's a huge challenge. I think the best way for providers to create that change within their practice... I feel like they need to identify what policies and structures need to change. Because you don't really know what's not happening because you're a provider. You don't have that perspective. So my advice... this is Aunt Jen's advice now for providers... is to ask people. Ask clients. Ask patients. Get feedback. Do an anonymous satisfaction survey. Or, even better, do a small study and pay people for their perspective. Find out what is not working within your practice or your organization. What are the barriers for clients or patients? What would they like to see?

I remember there was a program that I worked for... This was in California. I worked for San Mateo County. I coordinated a mobile HIV testing van and syringe exchange with a great team of people. We had a blast. It was a lot of fun being out there in the community. We did a survey and found that... We were doing syringe exchange and we had the small drug needles, that's what we were exchanging, but found that people wanted hormone syringes and we didn't have those at our exchange. And so we ordered hormone syringes and started providing them to people. Again, it's giving voices to the people who are living their lives and experiencing our services. Ask questions of clients and of patients. And then when you get the answers to those questions, do something. Don't collect data for the sake of collecting data and say, "Oh, well we did this survey." Yeah, what are you going to do with it? So, it's listening and finding out because we only have our perspective of what we see and that is not going to really give us what the client or the patient experiences.

Tammy Kremer (28:36):

When people are advocating for that kind of change... providers in a system, for example, that hasn't had a harm reduction framework in the past... what kinds of research or resources can people turn to when advocating for organizational change towards a harm reduction approach?

Jen Jackson (28:53):

You have to market the message. Whether you are talking to a client or a patient and you're marketing a message for them or you are talking to the powers that be that are in charge of the policies and the structures that are going on, you need to market the message. There's lots of different ways that you can do that. One way is talking about which organizations support harm reduction and see value in it. This means the World Health Organization, the CDC, the United Nations, the Open Society Foundation, Drug Policy Alliance, the Harm Reduction International Organization. And there's various universities, state and local health departments, community-based organizations, aid service organizations, and medical associations such as the American Medical Association that support harm reduction strategies. And so that carries a little bit of weight when you're going to be talking to people who have sort of like

that power and position. To be able to present that. I know Open Society Foundation did a report on the UN stance of harm reduction. I love this quote. It was something along the lines of "the effectiveness of harm reduction services for HIV prevention and prevention of drug-related mortality is beyond dispute." I mean, that's some solid cred right there.

And also checking with other harm reduction organizations like the National Harm Reduction Coalition. They have valuable resources on harm reduction as well as the various movements that intersect harm reduction like racial equity or decarceration or sex work, housing, reproductive justice, healthcare. I mean, they have so many other resources that intersect with it. And then I think also, for providers, one great thing to read about and to know about is, if they have an interest in reading about intersectional stigma, which people face and particularly... When you have people who use drugs, people with HIV, we don't exist just as one aspect of ourselves. There are various aspects to who we are. There was this great peer reviewed article by [inaudible 00:31:20]. They conducted a study of stigma among HIV-positive women. It's called HIV, Gender, Race, Sexual Orientation, and Sex Work: A qualitative study of Intersectional Stigma Experienced by HIV-positive Women in Ontario, Canada. Seeing what people experience when they meet with providers, the types of stigma that they experience, and then also substance use stigma as well. That's another thing that people encounter.

Tammy Kremer (31:50):

It's interesting, hearing you respond to this question, how clear and resounding the consensus is amongst so many of these organizations and yet how much resistance actually does exist in the field and the ways in which harm reduction is not always used as a lens in governmental spaces, in different hospital systems. It's just a really interesting duality of we have all this information and yet there is this resistance. Stigma, as you were mentioning, is a huge barrier. What other barriers would you say exist when we have all this great information, but it's not always being acted on?

Jen Jackson (32:30):

I feel like stigma is huge with providing services, but also accessing services. And particularly... We're talking about harm reduction and we're looking maybe through more of a lens with people who use drugs, but keeping in mind that people who use drugs often experience structural, institutional, and systemic barriers with regard to accessing services. And then also can face stigma with regard to their substance use, whether the stigma is... It could be internalized. They just think, well, I use drugs and so I'm not going to go to the doctor for this, that, or the other, because I'm afraid of what they're going to say. But also keeping in mind that there's many other ways that people experience that type of stigma.

In order to transform stigma, we're going to have to address these biases towards people who use drugs, whether they are implicit or explicit. It starts at looking within ourselves and our own values and our own judgements because we all have that that we carry around with us. Identifying our own biases and looking at our policies and what structural barriers there are that are contributing to it. For example, a lot of times people don't really know how to engage with people who use drugs. I know for a fact that, like we do, the PTC offers a learning collaborative on cultural humility with people who use drugs. The Harm Reduction Coalition offers trainings as well as addressing ways providers can utilize cultural humility and also providers need to learn about active listening, motivational interviewing.

These are all the tools that providers can be using within their practices and within their organizations as well as incorporating into those policies. I know that when I worked at Health HIV, for example, we had an Opioid Learning Institute and we created a harm reduction online module for providers. Samhsa.gov has resources and information available as well. And Harm Reduction International has the Harm Reduction Journal. That's an open access, peer reviewed online journal. So

there's a lot out there that people can do to access information. And then we don't want to just access the information, right? Because we're all about implementation. So looking at ways to be able to implement that into practice.

Tammy Kremer (35:08):

Can you give us an example of an environment where there was resistance or stigma that was preventing people from utilizing a harm reduction approach and any changes that were implemented?

Jen Jackson (35:21):

I've seen it in partner services, for example. A lot of people don't know what partner services is, but that's when... There are certain infections that are reportable to health departments and then they trigger contact tracing, which we see with COVID. If you had COVID or you know somebody who has, chances are somebody from a health department was calling them to let them know if somebody was positive for COVID, how they needed to isolate. There's also specialists that go out there for different sexually transmitted infections and stuff like that.

And so one of the things that I had noticed when I was working for the State of Texas, we noticed that some of the DIS that we were observing out there were not really giving guidance to their clients that they were meeting with that harm reduction lens. There was a lot of like, you need to do this every single time. You need to wear a condom every single time you have sex. You need to do this, you need to do that. And so we worked with the DIS, did some harm reduction training for them, and worked with them on how to have these conversations with people who used drugs. And we did see there were better engagements for it. One of the things that we did out there for new disease investigators is, when we would go and visit their sites, sometimes we as the consultant would actually talk to the client and model it for DIS. I think it's helpful if somebody doesn't really know how to have those conversations. I remember that exact time too.

So here's another story from Aunt Jen. I was observing a new DIS who was having issues with talking about substance use with this client. The client didn't want to talk with them. So I stepped in and started having a conversation with the client and the DIS stepped back for a minute, but we were talking about... He had some abscesses on his hands and I could tell that he'd been injecting into his hands. He had sores on them. And so I started having a conversation with him about like, has he had that looked at yet? We had a nurse there. "I'd love to be able to do that because that can be really dangerous." I sort of explained that. He was like, "Oh my goodness. Yes, absolutely. I would love for a nurse to be able to look at that." Then we talked about rotating his sites when he injects because it looked like he just kept injecting into the same areas.

He wasn't ready to stop using drugs. That was not part of the conversation with him because he was very clear about it. So I had to think of different ways that we could give him some guidance on how he could be safer. I have this little diagram that has the body. It has the green areas of where it's safer to inject and the red areas. Like you don't want to inject into the neck. You don't want to inject into the groin. Things like that. And then we got talking a little bit further about his syringes. Where does he get them? How often does he use new ones? How often does he share them? What about his works? Like his cottons or his cookers and things like that.

It became this beautiful moment between the two of us where we're having this conversation and he's getting so much from it because I'm not judging him at all. What I'm doing is giving him... In public health, we like to call it that buffet of options. We're talking about that buffet of options of what are these other options for him. And so we talked about that. So then I asked him about disposal. "How do you dispose of your syringes?" So he told me he had a pickle jar, glass pickle jar, and that's what he

put them in, which is great on one hand because it shows he is very conscious. That he's putting it in like a rigid container. However, glass breaks.

So then that opens the conversation, which is around harm reduction, saying that maybe he should go with more of a heavy plastic container. We could give him a sharps container if he'd like to take that with him, but if he doesn't want it to be obvious having that in his home, that he could just use.... From the laundry detergent. When you pour the laundry detergent, you have the hard side container. You could just use something like that. When I told him that... Because I explained to him, "Well, I love what you're doing and I totally see that you're caring about other people." He was worried about people getting stuck when he throws it away. So I explained to him that glass can break in the trash, so the best bet is to use this. And he was like, "That's a fantastic idea and I never ever thought of that." I validated what he was doing and then we had the discussion on what could some better options be.

So it ended up being a great moment and it was a great moment for that new DIS that got to see the conversation and experience it. So if you are new in public health, if you are new in the field or new in your position, it really is helpful to shadow somebody who is seasoned and who knows what they're doing around having those conversations. And if you are working in a place that doesn't have that, then it's seeking out those resources. Take some trainings online. Learn about strategies. Because all the strategies I know are just things that I've picked up over the many years that I've worked in public health. And I love passing them down. It's like the lore and the legacy around the campfire, where we love to share our stories and pass it down so that other people can take it and apply it to what they're doing.

Tammy Kremer (40:58):

That's such a great story. Whatever resources you've just mentioned too as you were sharing, we'll make sure we put those in the show notes so people can find them easily. What a way to join with somebody and really partner in envisioning what can improve their quality of life and support what their goals and motivations are. I know you've done a bunch of research on clients and what clients feel their providers need in order to provide them with better services. So I was hoping we could pivot into that and talk about the research that you did at Health HIV, why you conducted this research with clients, and what the impact of the research was.

Jen Jackson (41:35):

Yeah, absolutely. When I was working for Health HIV... They're in Washington DC. I was a capacity building manager there. I worked on the Opioid Learning Institute. I did a lot of capacity building assistance on various programs. Harm reduction was kind of like my thing there. I loved it so much, so they pulled me into a lot of this stuff for that. One of the things that we wanted to do is we were providing, for the Opioid Learning Institute, their online modules for providers around prescribing opioids. We did a harm reduction module on there. There's all these different modules on there for providers, but we wanted to do more. We were wondering like, so what should we do? It's like, well, I know just from my experience being in the field what I think, but it really doesn't matter what I think.

And so we decided to do focus groups with community health workers who are actually out there doing the work. Some providers that were prescribing medications for opioid use disorder, those data wave providers, and some providers that were not yet data wave. So we had two different types of providers and then also community members. People accessing those services. The purpose of the focus groups... We were going to gather this qualitative data to guide the development of our eLearning modules for these providers and other healthcare professionals. And so we figured going to the people

who are in the field firsthand is going to give us this robust information and then we can sort of go from there. We did these focus groups. We paid people for their time.

We found that... Particularly the community member group, people who were using drugs. We found that individuals who are using drugs are experiencing trauma, shame, fear, anxiety, oppression, and degradation when they are trying to access care and treatment. That is what they told us. They said that providers who are polite, courteous, open minded, nonjudgmental, understanding, and compassionate are more effective at engaging them to access care and getting them into treatment as well. And so they were saying that the providers, a lot of the providers that they saw, they just lacked experience around substance use, around opioid use disorder. They were not knowledgeable, they were stigmatizing their patients, or they created rules and policies that are... does this all sound familiar... that are barriers and create challenges for patients wanting to access care.

We got just this amazing information. We got from providers what they felt they would like to know. We got from community health workers, who are the middle man because they work with the providers and they're working with the clients. And then we got the clients there telling us what they were experiencing. So based on those four focus groups, there were 19 proposed training topics that came out of that. This was an embarrassment of riches for us. We just found all of these wonderful things that we could do to build the capacity of providers and other health professionals.

Some of those topics, just offhand, I remember was... One, for example, was addressing the needs of returning citizens, post incarceration, particularly those with opioid use disorder. I mean, is there anything more harm reduction than that? Understanding and overcoming stigma and discrimination related to opioid use disorder and people who use drugs. That was one thing. One of the other things was best communication practices to reach and engage and reengage persons with opioid use disorder. Someone else asked about harm reduction advocacy from public policy to the pharmacy and everything in between. I mean, it was just very, very, very rich data that we got from this. Very meaty. And so we could take that and then use those to be able to determine what the next modules would be.

So that's why I always say go to the people. Go to the people who are experiencing it. You hear that phrase a lot, where they'll say, "Nothing about us without us." Yes. Go to those communities that you're planning on serving and talk to them. I remember, when I was working on the syringe exchange mobile testing van, we were in a neighborhood. And I remember somebody came up to me and said, "I'm just curious as to why you're here." And I said, "Oh, well, we're here to provide services, and ah, ha, ha." We're doing this and we're doing that. They're like, "But you're here on this street and yet, two streets over, is a trap house where everybody's using drugs. There's like a shooting gallery over there. You're in the wrong place." And so that was really valuable feedback. It's checking in with the community. Are you even in the right place providing services? We were not. So we ended up moving it. That's why it's so important to check in with the communities that you're serving about what their needs are and where those needs are and how they would like to receive those services.

I remember another time we were doing a public health campaign, it was a black women's health campaign. This was in San Mateo County. And we wanted people to get tested and treated. Before that, there was a lot of really negative, like "he's on the down low" and stuff like that, and we wanted something uplifting. So we did... It was I take risks, because I'm all that. I take the risk to talk with my partner about sex and I take the risk to go and actually get tested for HIV. We turned it around on that. I remember we came up with all of these fantastic images of different women, different ages.

And then I remember. We were talking to people in the community and the people in the community were like, "I want to be in that campaign." And so we ended up getting those model release forms and took pictures of real people from the community who wanted to be a part of that campaign.

We listened to the people and incorporated them into it and it was fantastic. People felt a lot more... There was more buy-in on it. When we're talking about marketing that message, when you're seeing people that you know from your community right there, on all the marketing materials, it definitely makes a difference. So, again, it's that listening to the community.

Tammy Kremer (48:30):

And the examples are so helpful because, it's really easy to say these things, but to put these into practice in ways that have a meaningful outcome, I think, can be a lot more challenging. And recognizing all of the different moments of needing to check in. It's not just a one and done. It's this ongoing evolution. Like, we've got the mobile clinic going, we've got the mobile syringe services, but we're on the wrong street. Fortunately, you put the band together, but now you've got to drive two blocks over. It's that ongoing need to continually be in conversation and make adjustments.

Jen Jackson (49:06):

I always say once you know something, you can't unknow it, so what are you going to do about it? I'll get off my soapbox for a second.

Tammy Kremer (49:20):

After recording this episode, a draft decision from the Supreme Court to strike down Roe v. Wade was leaked. I invited Jen Jackson back to share her take on the connection between access to abortion and harm reduction. This is what she had to say.

What does that bring up for you as a harm reductionist in terms of the kinds of services and support that we can be providing to our communities that may have severely restricted access to abortion?

Jen Jackson (49:47):

I mean, abortion is harm reduction and it's literally going the opposite way. It's good public health to be able to have people make their own decisions about their health in that way. I really feel that we need to be supportive as a community in figuring out what the buffet of options can be for individuals who are going to be living in states that may be more restrictive or eliminate abortion together. We're all going to have to get more creative to help reduce the harm for those individuals who are going to be faced with some major challenges and some very difficult situations based on this potential ruling.

Tammy Kremer (50:39):

How about with birth control or barriers that they use?

Jen Jackson (50:43):

Well, I mean, birth control is harm reduction. I remember as a teen just thinking like, oh, I think I may be ready to have sex and I'm going to Planned Parenthood and I'm going to talk to a health educator about the pill and what that means. Luckily, I had that access. There's going to be some major implications that, once abortion is attacked, then the next step looks like it would be birth control and that's going to be a really big challenge for all of us as well.

Tammy Kremer (51:16):

It's just so big and so heavy. Just even talking about it right now. It's just...

Jen Jackson (51:21):

I'm somewhat living in denial that this is actually happening. Because I never really thought that I would see this happening in my lifetime. It's really shocking. It's counter to good public health and it's counter to the American Medical Association and it's counter to science. And so that's why it's kind of mind blowing for me as somebody who prides herself as being a little bit of a science nerd. I like looking to evidence-based interventions and evidence-based services and I like looking at what the data says. It just doesn't make sense to move this way that is counter to logic, reason, and science.

Tammy Kremer (52:10):

Yeah. Mind blowing and heartbreaking.

Jen Jackson (52:13):

I fear for a lot of people out there who are going to see their access... I mean, we already saw it in certain states, where they were limiting access to... We had health centers closing down. We saw that in Texas. People didn't have access just to get their basic well woman exam. I used to work for Planned Parenthood and it's bad enough to have to go and access care through people who are screaming at you, but we do it because we need to access those services for our health. What happens when those services aren't there anymore? Or people have to travel out of state to be able to access those services? People who may have limited resources that wouldn't be able to afford to travel out of state. Again, it's thinking how creative we're going to have to be to help people really be able to take care of their personal health.

Tammy Kremer (53:23):

I'd love to hear what you see as on the horizon in the world of harm reduction. What are people talking about now that's new or different? What is the vision that people are forming now and advocating for?

Jen Jackson (53:37):

There are wonderful, sexy things happening in harm reduction. And there's things not just along the lines of training staff. I mean, you're seeing a lot more of that. But we're also seeing different strategies. For example, in Vegas, they were doing harm reduction vending machines and now I know they're going to be doing that in DC as well. And so, all of a sudden, there's other strategies that people are using in order to engage people because maybe people don't want to access services in a traditional route and they'd rather go to a vending machine. I just think that is fantastic. There's so many wonderful things out there on the horizon and that's one that I think just fabulous because they can really be anywhere and it can also be a way to link people to services.

Another harm reduction thing that I know that we've all seen if we've traveled at all, for example, is the sharps containers in the bathrooms in airports. It's giving people a great place to dispose of their used needles, their works, and all of that. It's protecting the public. It's also getting that out of the general circulation so that nobody else uses that needle too. I mean, it's just wonderful. So, it's really everywhere and it's just sort of keeping your eyes open and maybe using that lens now to be able to see the world that way.

Tammy Kremer (55:10):

Yeah. It makes me think too about, for example, clubs or bars sometimes having condoms in the bathrooms or even test strips for drugs to be able to check their drugs. Putting things in places where

people are going to find them and utilize them according to their own understanding of what their needs are.

Jen Jackson (55:27):

Absolutely. Putting public health messages too in places where people are going to see them and access them. You sometimes see that in bathrooms. I know that when I worked for San Mateo County, we branded messages for HIV testing. We did it on hot sauce bottles and gave them out to the... People loved it. It was great hot sauce.

Tammy Kremer (55:47):

I love that.

Jen Jackson (55:47):

Yeah. I mean, it was-

Tammy Kremer (55:47):

I want one.

Jen Jackson (55:48):

Oh, it was so cool. I think I still have the label somewhere. It was so cool. We gave them to some of the little soul food places in East Palo Alto at the time. People would come up to us and be like, "Do you have any of that hot sauce?" Meanwhile, it's a hot sauce with messages on how to get HIV tested on it. Like, right there. They could call us. We did testing on demand. Yeah. It's just being, again, creative and marketing your message and reaching people the way that they want to be reached. I mean, that was received really well.

Also, on our syringe services van, for example, there was a time where people were asking about did we have socks and underwear and stuff, which we didn't at the time, but we had some one-time funds and we went and we bought some. We gave out socks to people who needed socks. It's a great giveaway. So, again, listening to people, when they say that there's a need. And then they feel fantastic because they've been heard and they're actually receiving resources and services that they need and you're not two streets over not HIV testing anybody and not doing syringe exchange for anyone because you're in the wrong place.

Tammy Kremer (57:04):

Coming to a close here, the podcast is called Coming Together for Sexual Health. And so I'm curious. What do you hope that we can create by coming together for sexual health?

Jen Jackson (57:14):

I'm hoping that we can create environments... whether you're at a CBO, whether you work in a clinic, whether you work in a health department... that is just more engaging for people, that is more accepting, that is inclusive for all kinds of people regardless of what substances they're using, how they identify. Just seeing that people are not feeling that stigma in accessing services. Any services. And with sexual health, being sex-positive with our clients.

Tammy Kremer (57:57):

Yeah. Thanks for sharing that vision and the work that you have been doing steadily towards it. And thanks so much for all you shared today.

Jen Jackson (58:05):

Oh, thank you. Thanks for having me.

Tammy Kremer (58:07):

You're welcome.

Jen Jackson (58:08):

You don't have to twist my arm to talk about harm reduction.

Tammy Kremer (58:14):

Thanks for listening and check out the show notes for the resources mentioned in this episode. You'll also find the link to the transcript of the show. Please follow and rate us wherever you get your podcasts. This will help more people find us. Connect with us on Instagram @comingtogetherpod and learn more about us and get in touch at comingtogetherpod.com. This podcast is brought to you by the California Prevention Training Center, where we build the capacity of healthcare professionals working in sexual health and emerging infectious diseases. Check us out at californiaptc.com and follow us on Twitter @CaliforniaPTC. This podcast is produced by me, Tammy Kramer, with Laura Marilozar and Catalina McDonalds. It is edited by Layla Mohimani and Isaiah Ashburn with original music by Layla Mohimani. We're based at the University of California, San Francisco. I would like to acknowledge the Ramaytush Ohlone people, the traditional custodians of the land that UCSF sits upon. Thank you for coming together for sexual health.