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AIVL submission: ***Developing the Implementation Plans for the National Blood Borne Viruses and Sexually Transmissible Infections Strategies 2018 – 2022***

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Dear Colleagues

I am writing in response to the call for submissions on *Developing the Implementation Plans for the National Blood Borne Viruses and Sexually Transmissible Infections Strategies 2018-2022*. The Australian Injecting and Illicit Drug Users League (AIVL) welcomes the opportunity to provide comment to the Australian Government Department of Health in relation to this matter.

AIVL has been a pivotal partner in Australia's blood borne virus response. We welcome the five renewed national strategies released in December 2019 by the Australian Government. The strategies provide a comprehensive response to the complexities of the transmission, treatment and management of blood borne viruses (BBVs) and sexually transmissible infections (STIs). AIVL supports the content of the strategies and emphasises the below focus areas for consideration in the development of the national implementation plans:

- Increasing the capacity and coverage of needle and syringe programs nationally
- Strengthening focus on prevention, harm reduction and engagement with priority populations
- Ensuring equity of service delivery in rural, regional and remote Australia
- Acknowledging the importance of national peak organisations as key stakeholders in implementation
- The need for separate implementation plans with appropriate investment and resourcing

With the right investment, Australia is well-positioned to remain a world-leader in addressing the effects of BBVs and STIs in our communities.

Australian Injecting and Illicit Drug Users League (AIVL)

AIVL is the Australian national peak organisation representing the state and territory peer-based drug user organisations in relation to issues of national relevance for people with lived experience of drug use. AIVL's vision is a world where the health and human rights of people who use/have used

drugs are equal to the rest of community. This includes a primary focus on reducing the transmission and impact of BBVs including HIV and hepatitis C – including for those accessing drug treatment services – through the effective implementation of peer education, harm reduction, health promotion and policy and advocacy strategies at the national level.

Increase the capacity and coverage of needle and syringe programs (NSPs) nationally

AIVL welcomes the recognition in the national strategies that NSPs are an effective tool to reduce the transmission of BBVs. Injecting drug use that results in needle and syringe sharing is the major route of hepatitis C transmission.[1] In particular, access to NSPs in rural, regional and remote areas of Australia is limited. Further, it is known that there is a heightened risk of transmission in custodial settings[2]. Hepatitis C is 60% more prevalent in Aboriginal and Torres Strait Islander people compared with non-Indigenous Australians[3]. Therefore the overrepresentation of Aboriginal and Torres Strait Islander people in custodial settings results in a disproportionate increased risk of transmission to this priority population. We note that reducing the burden of BBVs on Aboriginal and Torres Strait Islander people in custodial settings is also a key area of focus for the Australian Indigenous Doctors' Association (AIDA), which emphasises the need for access to the full range of evidence-based services and medicines within custodial environments. At present, across states and territories, there is inconsistent access to bleach, refusal to implement regulated prison NSPs, and corrections and custodial staff are not released for BBV-related workforce training[4].

As acknowledged in the new national BBV and STI strategies, "*international research suggests that introductions of NSPs into Australian custodial settings would significantly impact on the transmission of hepatitis C*".[5] Prison needle and syringe programs (PNSP) have been operating internationally for years with evidence demonstrating their effectiveness.[6] PNSP have been shown to reduce risk behaviour, transmission and overdose without increasing rates of drug consumption or endangering staff or prisoner safety.

Through consultation with our member organisations, AIVL has also identified the need for enhanced support for people exiting custodial settings. Investments have been made by the Australian Government to provide people in custodial settings with access to curative hepatitis C medications. This is a significant public health investment. However, given the rates of recidivism around the country, it is known that there is a high chance that a person will re-enter the criminal justice system.[7] Therefore if someone is cured of hepatitis C during the period of their sentence,

[1] Australian Government. (2018) *Fifth National Hepatitis C Strategy 2018 – 2022*, p11
[2] Cunningham, E., Hajarizadeh, B., Bretana NA, et al. (2017) Ongoing incident hepatitis C virus infection among people with a history of injecting drug use in an Australian prison setting, 2005-2014: The HITS-p study, *Journal of Viral Hepatitis*, Vol. 24, p739
[3] Smirnov, A., Kemp, R., Ward, J., Henderson, S., Williams, S., Dev, A., & Najman, J. (2018) Hepatitis C viral infection and imprisonment among Aboriginal and Torres Strait Islander and non-Indigenous people who inject drugs, *Drug and Alcohol Review*, 37, p831
[4] Australian Injecting and Illicit Drug Users League. (2018) *Needle and Syringe Programs in Australia: Peer-led Best Practice*
[5] Australian Government. (2018) *Fifth National Hepatitis C Strategy 2018 – 2022*, p23
[6] Public Health Agency of Canada. (2006) *Prison Needle Exchange: Review of the evidence* available at: http://www.aidslaw.ca/site/wp-content/uploads/2017/11/Tab-4-06Jun-PNEP-Report-to-CSC.pdf
[7] Australian Institute of Criminology. (2016), *Recidivism among prisoners: Who comes back?,* available at: https://aic.gov.au/publications/tandi/tandi530

given the lack of PNSP, the likelihood of reinfection is high. The result being that investments made to eliminate hepatitis C in Australia are undermined while PNSP remains unimplemented.

At present, the lack of NSP in custodial settings is an identified policy gap.[8] The *National Drug Strategy 2017 – 2026* outlines Australia's commitment to a harm minimisation approach with 'evidence-informed responses' and 'national direction, jurisdictional implementation' being among its underpinning principles.[9] Given that custodial settings are under the jurisdiction of states and territories, commitment is needed by the Australian Government to raise the issue of implementation of PNSP as a public health priority at the national level. Without leadership and guidance from the Commonwealth, actions within the implementation plans relating to custodial settings are unlikely to achieve all of the desired outcomes. Alignment of policy with strategy is needed if Australia is going to optimise its world-leading investment in hepatitis C elimination[10].

Strengthening focus on prevention, harm reduction and engagement with priority populations

In order to eliminate BBVs as a public health threat the national implementation plans require a focus on peer-based prevention and harm reduction measures. Whilst treatment is necessary, there needs to be a strengthened focus on cost-effective preventative measures. Reducing the rates of transmissions makes economic sense as a way of reducing the high costs involved in post-diagnosis treatment. Furthermore, consideration needs to be given to the complexity of reasons why people use drugs and how this impacts harm reduction messaging and engagement strategies.

Within the identified priority populations outlined in the national strategies, there are subpopulations that require targeted engagement. Through consultations held by AIVL in 2018, the increasing complexities surrounding methamphetamine use were highlighted. Rates and routes of BBVs and STIs transmissions among this subpopulation require attention. Methamphetamine can be either smoked or injected, both methods present risks. Legislative barriers mean that the purchasing of smoking equipment is illegal in most jurisdictions, which is subsequently influencing people to inject. Whilst injecting equipment is easier to access than smoking equipment, greater risk remains regarding transmission. Harm reduction and health promotion measures need to be developed for this growing subgroup of people who use drugs.

Another identified issue which deserves attention in the development of the national implementation plans, is the high-risk sexual behaviour associated with methamphetamine use[11]. Given the effect that the drug has on the libido, sexual activity is typically longer lasting, rougher, often unprotected and occurs across more casual partners. Feedback through consultations indicates that this behaviour can lead to blood-to-blood contact thus increasing the risk of STI and BBV transmission.

A range of evidence-based harm reduction initiatives are needed in response to these identified issues with often hard to engage priority populations. New and innovative solutions such as the use of technology should be explored as a means to promote harm reduction messages and aid with peer-to-peer engagement. Furthermore, given AIVL's strong connection to people who use drugs

[8] Australian Government. (2018) *Fifth National Hepatitis C Strategy 2018 – 2022*, p28
[9] Australian Government. (2017) *National Drug Strategy 2017-2026*
[10] Lafferty, L., Wild, C., Rance, J., & Treloar, C. (2018) A policy analysis exploring hepatitis C risk, prevention, testing, treatment and reinfection within Australia's prisons, *Harm Reduction Journal*, Vol 15, p7
[11] McKetin, R., Voce, A., & Burns, R. (2017) *Research into Methamphetamine Use in the Australian Capital Territory*, p33

through its member organisations, feedback on issues can be provided to the Government in a timely manner. This allows the Australian Government's policies to be responsive to trends as they arise.

Ensuring equity of service delivery in rural, regional and remote Australia

Rates of BBVs in rural, regional and remote areas of Australia are high[12][13]. The national strategies acknowledge that health and community care should be accessible to all. However, barriers to access exist due to multiple layers of inequality and complexity that provide challenges in achieving this. One of those factors is geography.

Access to testing, treatment and harm reduction tools, especially for priority populations is essential, regardless of their locality. It is essential that the national implementation plans place an emphasis on responses in rural, regional and remote areas of Australia. It is known that certain priority populations such as Aboriginal and Torres Strait Islander people have a higher incidence of BBVs and STIs. Yet this priority population is disproportionality disadvantaged in terms of accessing health care and harm reduction measures due to structural and institutional barriers[14].

The Global State of Harm Reduction 2018 report states that 28% of Aboriginal and Torres Strait Islander people attending NSPs reported sharing of injecting equipment. Reasons given by people who inject drugs as to why they share injecting equipment include a lack of transport and lack of convenient access to NSPs[15]. The most widely used type of NSPs are pharmacies. However only 9% of pharmacies that are authorised NSPs are located in 'very remote areas' of Australia[16]. Given that a significant proportion of Aboriginal and Torres Strait Islander people live in regional, remote and very remote parts of Australia, this is an issue that requires a committed course of action and investment by the Australian Government. Building the current workforce in Indigenous health, and increasing expertise and capacity in the BBV/STI space will be particularly important in underpinning implementation efforts. Engaging Indigenous health practitioners and Aboriginal Community Controlled Health Services (ACCHOs) in implementation planning and activities will be an important area of focus.

Access and equity to the public health system also extends to subpopulations such as older people who inject drugs. Australia's population is ageing, with 1 in 7 Australians now aged 65 years or more. In real numbers there are currently 3.7 million older Australians and projections suggest that by 2056, more than 8.7 million Australians will be aged 65 or older[17]. As such, an emerging subpopulation for the national strategies is older people who inject drugs. Latest trend data has

[12] Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. (2016) *Hepatitis B Mapping Project: Estimates of geographic diversity in chronic hepatitis B prevalence, diagnosis, monitoring and treatment – National Report 2016*, available at: https://www.ashm.org.au/products/product/HepB-Mapping-Report-2016
[13] Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. (2016) *Hepatitis C Mapping Project: Estimates of geographic diversity in chronic hepatitis C prevalence, diagnosis, monitoring and treatment – National Report 2016:* https://www.ashm.org.au/products/product/HepC-Mapping-Report-2016
[14] Australian Government. (2018) *Third National Hepatitis B Strategy 2018 – 2022*, p20
[15] Harm Reduction International. (2018) *The Global State of Harm Reduction 2018*, p136 https://www.hri.global/global-state-harm-reduction-2018
[16] Heard, S., Iversen, J., Kwon, J., & Maher, L. (2018) *Needle Syringe Program National Minimum Data Collection – National Data Report* 2018, p8
[17] Australian Institute of Health and Welfare. (2017) *Older Australians at a glance*. Accessed 18 February 2019, available at: https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/demographics-of-older-australians/australia-s-changing-age-gender-profile

found that 17% of people accessing injecting equipment through NSPs are aged 50 years or more[18]. With these figures in mind, ensuring access and equity to the public health and aged care systems is essential for this subpopulation whose barriers to accessing testing, treatment and management are heightened if they are further marginalised by living in rural, regional and remote areas of Australia.

The implementation plans can facilitate improved access to best-practice preventative measures such as improving access to sterile injecting equipment. There are significant barriers in accessing formal NSPs in rural, regional and remote areas, as outlined above. In addition, legislation in each state and territory varies in relation to the legality of peer distribution of sterile injecting equipment. In five states, the practice remains illegal with the implication being potential prosecution[19]. Peer distribution in geographically isolated places should be enabled and encouraged as a harm reduction measure. The existence of legislation that places limits on the peer distribution of sterile injecting equipment jeopardises the Australian Government's ability to achieve the goals outlined in the national strategies.

AIVL believes that stronger investments need to be made to ensure greater reach and accessibility of peer-based programs, evidence-based harm reduction programs, and workforce development in rural, regional and remote Australia.

Acknowledging the importance of national peak organisations as key stakeholders in implementation

In order for the implementation plans and consequent actions to be successfully carried out there must be strong connection with the target demographic. The strategies recognise this by calling for "*meaningful involvement of priority populations and those affected*"[20].

Peak bodies, such as AIVL, play a pivotal role in facilitating links between 'key areas for action', peer-based drug user groups and community-led service providers to ensure outcomes are enhanced. Ensuring the role that peaks play is recognised and valued means that community-level and peer-based responses will be strengthened. Peer-based work and responses are acknowledged within the strategies as a key means to deliver prevention education and harm reduction outcomes. Studies show that the peer-based programs are the proven method for effecting health-related behaviour changes[21].

AIVL is uniquely placed to undertake engagement with the injecting and illicit drug using community to inform policy and program development. Throughout 2018 AIVL undertook a number of consultations in collaboration with our network of member organisations in each state and territory. As a result of this direct engagement, a number of issues within the community have been identified. For example, there is a need to build the capacity of aged care providers to respond to

[18] Heard, S., Iversen, J., Kwon, J., Maher, L. (2017). *Needle Syringe Program Minimum Data Collection: National Data Report 2017*. Kirby Institute, UNSW: Sydney.
[19] Australian Injecting and Illicit Drug Users League. (2018) *Needle and Syringe Programs in Australia: Peer-led Best Practice*, p7
[20] Australian Government. (2018), *Fifth National Hepatitis C Strategy 2018 – 2022*, p6
[21] Webel, A., Okonsky, J., Trompeta, J., & Holzmer, W. (2010) A Systematic Review of the Effectiveness of Peer-Based Interventions on Health-Related Behaviors in Adults, *American Journal of Public Health*, 100(2), pp. 247 – 253.

the unique needs of older people who inject drugs, are on pharmacotherapies or are living with hepatitis C.

People who use drugs are a priority population across all five national strategies. Accordingly, AIVL is specifically mentioned in all five national strategies in recognition of the critical role that its national network of peer-based organisations will have in ensuring the successful implementation of the national strategies, particularly through the engagement of priority populations and subpopulations. There are many examples of collaborative efforts to achieve better health and social outcomes for people with complex needs. Facilitating and supporting national peak organisations and their members to work together has the potential to lead to significantly improved outcomes for priority populations.

The need for separate implementation plans with appropriate investment and resourcing

Having separate specialised national strategies acknowledges the uniqueness of the communities and priority populations affected by BBVs and STIs. To compliment this, AIVL supports the development of separate implementation plans that are aligned to the national strategies. As noted by the Department of Health, responses need to be built upon an evidence-base of high quality research and surveillance data. Routes of transmission, prevention, testing, treatment and management vary between disease types and communities.

Furthermore the implementation plans need to be adapted for priority and subpopulations. For example, addressing stigma and discrimination within healthcare settings will require a considered and tailored approach. How this matter is approached regarding hepatitis C will be different to that of HIV. Separate implementation plans will also allow for a greater emphasis on developing culturally appropriate responses. Another example is the high prevalence of hepatitis B in subpopulations such as those from South-East Asia. Suitable organisations needed to be resourced to deliver targeted peer-based programs specific to these subpopulations and contexts.

Across the suite of strategies it is consistently recognised that enhanced efforts are needed to reduce the further transmission of BBVs and STIs in Australia. The 'key areas of action' outlined in the strategies speak of scaling-up and increasing education and prevention programs. Development of new programs is also suggested. For example, "*develop systems for active case management for people released from prison*"[22] which has the potential to improve the continuity of hepatitis C treatment. AIDA has also identified the need for a greater focus on activities that ensure treatment continuity for Aboriginal and Torres Strait Islander people transitioning from custodial to community settings. The development of culturally appropriate community-based viral hepatitis education and health promotion messages/resources/activities with Aboriginal and Torres Strait Islander communities to address infection rates will also be important.

Programs of this nature would be highly valuable to achieve the overarching goals of the national strategies. Furthermore, a renewed focus on transmission and elimination will help Australia achieve international targets as outlined in the World Health Organization's *Global Health Sector Strategy on Viral Hepatitis 2016-2021*[23]. In order for such action to be effectively undertaken additional

[22] Australian Government. (2018), *Fifth National Hepatitis C Strategy 2018 – 2022*, p26
[23] World Health Organization. (2016), *Global Health Sector Strategy on Viral Hepatitis 2016-2021: Towards Ending Viral Hepatitis*, available at: https://apps.who.int/iris/bitstream/handle/10665/246177/WHO-HIV-2016.06-eng.pdf;jsessionid=F0F2433C8F77AFF3B75670322965B1C6?sequence=1

investment in resourcing is required to enable effective engagement in implementation by the non-government sector.

AIVL has recently conducted a number of consultations with its member organisations on issues of relevance to implementation of the national strategies. It has been identified that resources are needed to develop a broader network of peer workers to engage priority populations and subpopulations. It is known that hard-to-reach populations typically do not access primary health services. Peer-based services have proven to be an effective means of reaching these marginalised groups. AIVL's broad network of member organisations in each state and territory would be well-placed to provide peer-based service delivery options given their existing strong connections to priority communities.

It must be recognised that some previous national strategies have been released without significant additional funding. A continued lack of additional investment will hinder the potential of progress moving forward. If the Australian Government is committed to reducing the negative health, social and economic impacts of BBVs and STIs, appropriate additional financial resourcing is essential to enable this.

Concluding statement

In summary, for Australia to progress in the reduction of BBVs and STIs national implementation plans need to enable an enhanced peer-based response. Key priorities such as strengthening access to evidence-based harm reduction measures like NSP need to be emphasised, especially within custodial settings where transmission rates are known to be high. This should include specific actions to progress discussions at state and territory level. Legislative barriers to peer distribution of sterile injecting equipment also need to removed.

Additionally, equitable access to harm reduction measures ought to be ensured consistently across the country. Rural, regional and remote parts of Australia are seeing a growing rate of BBV and STI transmissions that must be addressed. The new national strategies are only as strong as their weakest link. Investments need to be made to engage hard to reach, marginalised priority and subpopulations. The development of the national implementation plans must be cognisant of the important role that peer-based services play in connecting with these communities.

As outlined, AIVL and its peer-based member organisations are well placed to work with the Australian Government to ensure the delivery of outcomes in line with the new National BBV and STI Strategies. Further, AIVL notes that complementary submissions have also been provided by the other national peaks represented on BBVSS, in relation to the additional specific needs of their particular stakeholder groups.