

Responding to Blood-borne Viruses in Australian Prisons

A community collaboration for an improved policy response to BBVs

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and AFAO

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Endorsing Organisations

This document was developed by Hepatitis Australia in partnership with the following organisations:



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Executive Summary

Australian prisons are a priority setting to reduce the incidence and burden of hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV). With high prevalence rates of HBV and HCV in prisons, Australia must ensure the deployment of proven prevention strategies, effective health monitoring and systems for ready access to treatment across Australia's prison network, including remand centres and other correctional facilities.

The current lack of an effective and evidence-based approach to the prevention of new infections within prison settings conflicts with the human rights' position that no person should leave prison in a worse state of health.

Due to the lack of a comprehensive approach to the management of BBVs, the risk of transmission is increased inside prisons and within the general community, where prisoners return once they have served their sentences. To date, despite evidence of successful approaches to the management of BBVs in prisons in other countries, there has been little sustained commitment from Australian governments to embrace a strategic and evidence-based framework for this public health concern.

The policy responses in the Australian Capital Territory (ACT) and more recently in South Australia offer some hope but are yet to be realised in practice. For example, implementation of the ACT government policy to provide prisoners with regulated access to sterile injecting equipment has stalled due to the vehement opposition of correctional officers.

The National Strategies for BBVs and sexually transmitted infections (STIs) are signed off by all Australian governments and provide a platform for Australia's response to BBVs. In contrast to community advocacy efforts, the National Strategies for 2014 – 2017 were altered from the previous iteration to reduce the emphasis on prisons and move away from a prior commitment to trial needle and syringe programs in prisons.

The recent global and national commitments to work towards the elimination of BBVs clearly demand much greater emphasis on correctional settings including a focus on:

- ensuring appropriate education about BBVs for people in prison and all prison staff
- increasing the proportion of people in prison who have received vaccinations for hepatitis B
- improving access to prevention technologies in prisons, including sterile injecting equipment and unimpeded access to condoms and water-based lubricant.
- increasing the number of people in prison who are diagnosed and engaged in treatment and care for their BBV infection.

This paper looks at the background of Australia's policy responses to BBVs and why a revitalised response to HBV, HCV and HIV in prison settings is essential. With advances in medical treatments, including a cure for hepatitis C, and increasing acceptance and use of proven prevention strategies, the elimination of BBVs as a public health concern is achievable if there is political will and a cohesive, nationally led response that includes addressing BBVs in Australia's prisons.

Recommendations

To support a more effective response to BBVs in Australian prisons (and other related correctional settings) the organisations, institutions and professional bodies endorsing this paper recommend:

1. The Australian Government raise the issue of BBVs in prisons as a public health priority and calls for the establishment of national standards for health delivery in prisons as part of the Council of Australian Governments (COAG) Health Council process.
2. All Australian governments develop and enforce policies and practices that ensure people in prison receive health care equivalent to that available in the broader community, without discrimination based on their legal situation.
3. The 2018-2022 suite of National Strategies for BBVs and STIs (or a separate strategy as recommended by the *Silent Disease Report*) recognises BBVs in prisons as a public health priority, acknowledges people in prison as a priority population and includes priority actions which cover:
 - a. education about BBV transmission for people in prison and all prison staff
 - b. access to confidential and culturally appropriate health services
 - c. access to best practice BBV testing that is offered and provided by suitably trained health staff
 - d. hepatitis B vaccination program for prison entrants
 - e. ready access to medicines used to treat, prevent and cure BBVs
 - f. ready access to sterile injecting equipment through prison-based exchange programs
 - g. provision of bleach and disinfectant and education about their use
 - h. access to opioid substitution therapy (OST) and other drug treatment and counselling services
 - i. ready and discreet access to condoms and water-based lubricant
 - j. ready access to personal hygiene products including razors, toothbrushes and safe barbering equipment
 - k. infection-control procedures that enable safe tattooing and body art
 - l. blood rules in sport or other physical engagement.
4. The 2018-2022 suite of National Strategies for BBVs make it a priority for federal, state and territory governments to develop a standard approach to data collection on the incidence, risk behaviours and treatment access associated with BBVs in prisons and that this data is reported in a timely manner to inform Australia's response to BBVs in prison settings.

Background

Australia has much to be proud of in its response to blood-borne viruses (BBVs). The strong bipartisan responses to human immunodeficiency virus (HIV), including the use of confronting public prevention messages and the early introduction of needle and syringe programs (NSPs), enabled Australia to maintain a comparatively low number of HIV infections. This strategy was effective in controlling the transmission of HIV among people who inject drugs because it was implemented early in the epidemic.

Needle and syringe programs have also been effective in preventing many cases of hepatitis C (HCV) and hepatitis B (HBV). However, at the time when the focus was on sterile needles, HCV (then known as non-A, non-B hepatitis) was already established as a significant epidemic among people who inject drugs and continued to spread due to the sharing of other injecting paraphernalia such as syringes, swabs and spoons. In addition, the screening for HCV in donated blood did not commence until 1990, meaning there are people today who may have medically acquired HCV, without a history of injecting drug use.

Since 1985, Australian state and federal governments have adopted a harm minimisation policy in responding to alcohol and other drugs (AOD)¹. Harm minimisation aims to address AOD issues by reducing their harmful effects on individuals and society. The introduction of NSPs in the community supports this approach from a harm reduction perspective in reducing the transmission of infections such as BBVs and providing information to reduce other health risks associated with injecting. However, this is not effectively applied in Australian prisons. In the context of this document prisons include remand centres.

Harm minimisation also includes a focus on supply reduction and demand reduction. It is evident that the supply of injectable products continues within prisons and the demand reduction through access to opioid substitution therapy is inconsistent across settings.

Since 1 March 2016, most people living with HCV now have a real chance to cure their infection. The availability of new treatments for HCV through the Pharmaceutical Benefits Scheme (PBS) making them affordable, and the fact that access to the new medicines through the PBS is independent of stage of liver disease or whether a person is currently injecting drugs, placed Australia as a world leader in treatment access. This, along with changes to the prescribing and dispensing of medicines for HBV, HCV and HIV, and current studies, highlight the important role treatment has in preventing further transmission and significantly reducing the burden of disease.

While Australia may be a world leader in access to medicines, there is much more to be done before Australia can truly claim to have the most effective response to BBVs. A continuing blight on Australia's record in responding to BBVs is the lack of evidence-based prevention strategies in Australia's prisons. It is well documented that the prevalence of BBVs in prisons is higher than that in the general population. Adopting treatment based prevention strategies will be much more effective when complemented by a comprehensive suite of evidence-based prevention strategies, including access to sterile injecting equipment and opiate substitution therapy (OST), to reduce risks of primary and post-treatment reinfections.

In Australia, the responsibility for prison services falls to state and territory governments, including the provision of health services within prisons. Some governments directly manage prison facilities while others contract private companies for the day-to-day

operations. Some health services are led by the respective Departments of Health while others are led by Corrections. Inconsistent jurisdictional policies and oversight has led to varying approaches to the prevention, management and treatment of BBVs in prisons.

Blood-borne Viruses in Australia

Blood-borne viruses (BBVs) include hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV). There is a preventative vaccine for HBV but not for HCV or HIV. Only HCV is curable in most people when treated with new direct-acting antiviral medicines. Other antiviral medicines used for the treatment of HBV and HIV can significantly reduce the risk of disease progression and, in the case of HIV, transmission through treatment-induced reductions in HIV viral load.

Hepatitis B (HBV)

Hepatitis B is a potentially life threatening liver infection. While many people spontaneously clear the virus, in others it is a lifelong infection, causing chronic liver disease and places some at risk of death from cirrhosis and liver cancer. HBV is both a blood-borne and sexually transmitted infection.

In 2015, there were an estimated 419 deaths in Australia attributable to HBV infection. HBV is a slow progressing infection and treatment is used at appropriate times to further slow and reduce the impact of the infection but cannot cure HBV infection.

At the end of 2015, an estimated 232,600 Australians were living with HBV, of which 38% remain undiagnosed. It is estimated 88,621 (38%) people living with HBV in Australia were born in Asia-Pacific and 21,632 (9.3%) are Aboriginal and Torres Strait Islander people². Unsafe drug injecting practices are estimated to account for at least 50% of newly diagnosed hepatitis B infections.³

Most adults (95%) will spontaneously clear an acute infection but infants and young children are more susceptible to develop a chronic infection, highlighting the importance of vaccination and monitoring of at risk populations.

Hepatitis C (HCV)

Chronic HCV infection can lead to cirrhosis, end-stage liver disease and liver cancer. By the end of 2015 an estimated 227,306 people in Australia were living with chronic hepatitis C. The estimated number of people with severe fibrosis has increased by 73% since 2006 to 29,070 and hepatitis C-related cirrhosis increased 96% over the same period to 17,149. An estimated 818 people died from hepatitis C liver-related illness in 2015; an increase of 112% since 2006².

While the rate of diagnosis of hepatitis C has been slowly decreasing, many people remain at high-risk, including people who inject drugs, people in prison or with a history of incarceration and Aboriginal and Torres Strait Islander people.

New treatments made available on the Pharmaceutical Benefits Scheme from March 2016 present the opportunity of a cure for the vast majority of people living with HCV. The subsidised treatments are available to all Medicare eligible people in Australia, including people in prison, and are not based on stage of disease or whether a person is currently injecting drugs.

Human Immunodeficiency Virus (HIV)

As with HBV, there is no cure for HIV. However, the use of antiretroviral medicines to maintain low or undetectable levels of the virus in the body, has greatly improved the

health and life expectancy of people living with HIV and can reduce the risk of sexual transmission to zero.⁴ At the end of 2015, an estimated 25,513 people in Australia were living with HIV. The number of newly diagnosed cases has remained stable in recent years with 1,025 people diagnosed in 2015.² Based on these newly diagnosed cases, the main route of HIV transmission in Australia continues to be sexual contact between men, which accounted for 68% of the HIV cases nationally in 2015, although the relative contribution of different routes of transmission vary across jurisdictions. It has previously been estimated that 13% of people living with HIV in Australia also have chronic hepatitis C.⁵

Blood-borne Viruses in Australian Prisons

The transmission of BBVs in prisons occurs predominantly through the use of non-sterile equipment for injecting drugs, tattooing and body piercing and unprotected sexual contact. The sharing of non-sterile barbering and shaving equipment also poses a risk of transmission.

Overcrowding in Australian prisons is at record levels. The Community and Public Sector Union (CPSU), a union that represents prison officers, has acknowledged that overcrowding results in more people in cells and longer waiting lists for alcohol and other drug (AOD) programs and this exacerbates the risk of transmission of blood-borne viruses.⁶

Epidemiology

The *National Prison Entrants' Blood-borne Virus and Risk Behaviour (NPEBBVRB) Survey*, conducted in 2004, 2007, 2010 and 2013 has consistently demonstrated the high prevalence of BBVs in prisons compared to the non-incarcerated community. The fifth iteration of this research is anticipated to be released later in 2017.

In 2013, 8% of those entering prison believed they did not have HCV but tested positive⁷. While this figure has decreased over time, it continues to reinforce the benefits of testing this population.

The prevalence of HCV in prisons has been estimated to be 35-47% of males and 50-70% of females, or about half the full-time prison population. Among those in prison with a history of injecting drug use, the prevalence of HCV in 2013 was 58% and 54% among those who were also Aboriginal or Torres Strait Islander⁸. The heightened rate of infection is attributed to several factors, including the high rate of people imprisoned for drug related offences and unsafe injecting practices.⁹

In 2013, the NPEBBVRB Survey found 18% of those tested were positive for HBV, of which 44% showed no evidence of immunity, and among those who reported being vaccinated, only 58% showed clinical evidence of immunity.

HIV prevalence in the general population of Australia is 0.1%². The prevalence of HIV in prisons has remained similarly low in all jurisdictional surveys. Of the 501 prison entrants tested in 2013, none tested positive for HIV, suggesting prevalence in Australian prisons is likely similar to the general population.¹⁰

Continuing to offer testing to prison entrants provides monitoring of this trend and creates opportunities for education when entering a high risk environment. This also supports the prevention of HIV transmission in prison environments.

Risk Factors

As the NPEBBVRB Survey highlights some people are either unaware of their HCV infection and conversely some may believe they have HCV when in fact they have cleared the virus but continue to put themselves at risk of reinfection. This underscores the need for appropriate testing algorithms in the community and prison settings that include follow-up Polymerase Chain Reaction (PCR) testing.

Similarly, it is important that individuals understand whether they have already contracted HBV, whether they have achieved immunity through vaccination or whether they continue to be at risk.

A study of New South Wales (NSW) prisoners showed 71% of men who injected during their current period of incarceration reported at least one person had used the needle prior to them using it on their last injecting occasion. Twenty per cent said that the needle had been used by six or more people.

Of the survey respondents, 39% of men and 20% of women reported getting tattoos in prison and 14% of men and women reported receiving a piercing in prison.¹¹ Not surprisingly, documented cases of in-prison transmission of hepatitis C (between prisoners) have been recorded in every Australian state and territory.

A pragmatic approach to drug use is needed to reduce the risk to prisoners being released with potentially life-threatening infections and to reduce the risk of legal action being taken against prisons and justice authorities for breaches of their duty of care.¹² This may also reduce the likelihood of legal action based on the equivalence of prison health care compared to that available in the broader community.

Preventing BBVs in Prisons

As described above, the high prevalence of BBVs and unsafe injecting practices make prisons high risk environments for the transmission of BBVs.¹³ Therefore, it must be acknowledged by all Australian governments that injecting drug use and sex between people in prison occurs and that this should be responded to as a public health matter ahead of drug interdiction and disciplinary considerations. Imprisonment should relate solely to the loss of certain liberties that do not include the diminishment of health and access to health services by people in custody.

The health of people in prison is also a broader community health issue, as prisoners living with a BVV who exit prison, without appropriate support or knowledge, may go on to transmit BBVs and STIs within the broader community through their sexual and injecting networks.¹⁴

As is the case in the community, the prevention of BBVs in prisons requires a comprehensive strategy that includes ready access to:

- Appropriate, peer informed education
- sterile injecting equipment
- sterile equipment for barbering and tattooing
- condoms and water-based lubricant
- HBV vaccinations
- treatments used for the management and curing of BBVs
- support for people wishing to cease or abstain from illicit drug use while in prison, including access to opioid substitution therapy.

Community-based hepatitis or HIV organisations and some health services have provided education for people in prison about the transmission and prevention of blood-borne viruses. To create a better understanding of HBV, HCV and HIV in the prison environment it is important that those incarcerated and prison staff have the same information about BBVs. The barbaric practice of using spitting hoods in some prisons or remand centres clearly demonstrates a lack of knowledge among prison staff about how blood borne viruses are transmitted.

Educational curriculum for people in prison and prison staff should be standardised nationally and should include the aims of minimising risks, reducing stigma and discrimination and dispelling myths.

While HIV prevalence might appear low in prisons compared to HBV and HCV, it is similar to the HIV prevalence in the general population. It is important to note that HBV is also a sexually transmitted infection with higher rates among men who have sex with men. Despite this, access to condoms in Australian prisons remains inconsistent.

When a person enters a prison it provides an opportunity to screen for BBVs and also provides opportunity to ensure any person, especially those at higher risk of HBV, receives the full course of vaccine for HBV.

Providing access to opiate substitution therapy (OST) is an important element of a comprehensive prevention and harm minimisation strategy. Some people will be on OST prior to incarceration or may seek access to OST after entering prison. Some prisons do not provide access to OST services or the service is severely restricted. For example, OST may only be provided to people already receiving therapy in the community but is not initiated in prison. In situations where incarceration means a loss of such a service or a person wishes to reduce or cease drug use while in prison, not providing access to OST services is a breach of duty of care.

The Role of Needle and Syringe Programs

Since the impact of HIV became apparent in the 1980s there have been calls to introduce strategies to support jurisdictional consistency for BBV prevention, treatment and care. This has included calls to provide people in prison with access to condoms, NSPs and OST to reduce the transmission of BBVs. Advocacy occurred at both national and state and territory levels and, while condoms and bleach have been provided in some prisons, implementation remains inconsistent across Australia. As the prominence of HCV and HBV as a public health concern increased, so did the push for effective prevention, treatment and care for people with HCV or HBV within prison settings.

The effectiveness of NSPs has been known for some time and should be a key element of a robust harm minimisation based policy approach. There is substantial evidence that prevention strategies, such as NSPs, reduce the risk of transmission of BBVs in prisons and create a safer environment for those in prison, prison staff and the broader community. In 2010, the Harm Minimisation in Prisons Committee¹⁵, established to provide advice and assistance to the Pennington Institute on its policy directions and activities in regard to improving access to NSP services in prisons in Australia, concluded that:

There is irrefutable evidence that injecting drug use occurs within prisons and that the unnecessary transmission of blood borne viruses is occurring as a result of the institutionalised sharing of unsterile needles. Prison-based NSPs would contribute to a stronger continuity of care by more closely aligning prison health services with those provided in the community.¹⁶

A report from the Human Rights and Discrimination Commissioner in 2007, looking into remand centres in the Australian Capital Territory (ACT), recommended that a pilot NSP be developed for the new Alexander Maconochie Centre. The Centre has since been built and a decade later, despite government support, debate continues about the introduction of a pilot needle exchange program (referred to as NSPs in this document).

The Australian Government commissioned evaluations of NSPs within the community have twice shown that NSPs are highly effective at reducing the transmission of BBVs and a good return on investment for governments. The most recent return on investments report estimated that, between 2000 and 2009 alone, NSPs in the community had directly averted 32,050 new HIV, 96,667 new HCV infections and saved \$1.28 billion in healthcare in Australia¹⁷.

There have been several reports which have examined the implementation and maintenance of prison-based NSPs in other countries. Prison-based NSPs in other countries have proven safe for prisoners and staff as well as being effective at reducing BBV infections¹⁸.

The latest analysis in 2015 by the Australian Injecting and Illicit Drug Users League (AIVL) and Canberra Alliance for Harm Minimisation & Advocacy (CAHMA) resulted in the publishing of the *Needle & Syringe Programs in Prisons – An international Review*, which reinforces the value of introducing NSPs into Australian prisons.

As identified in the most recent analysis¹⁹ of international models, there are various approaches being used to disseminate and collect injecting equipment. These include peer-led and health worker or community worker implemented models that separate involvement in the activity from other prison staff. Ultimately, as in the community, prison NSPs need to be sufficiently low threshold to be effective in preventing BBVs. In some international trials, prison-based NSPs have been ineffective because of a lack of trust in the service by prisoners and a perceived risk that accessing the NSP will result in an increased risk of sanctions and drug searches¹⁹. While low threshold NSPs enhance service access, more accessible prison NSP models are often perceived by prison officers and governing departments as resulting in less institutional control of injecting equipment in prison and greater occupational health and safety risk. This has not shown to be the case based on more than 25 years of international experience¹⁹.

The *Handbook for starting and managing needle and syringe programmes in prisons and other closed settings*, published in 2014 by United Nations Office on Drugs and the joint publication with the World Health Organisations, *Prisons and Health* (2014) provides good reference points to inform the potential introduction of NSPs.

Unions representing prison workers have played a significant role in delaying the commencement of Australia's first prison-based NSP. In Australia, there has been one case of a worker acquiring a blood-borne virus in an Australian prison. The case, often cited by Unions as a reason NSPs have no place in prison settings, is that of Geoffrey Pearce. Mr Pearce acquired HIV as direct result of being attacked by a prisoner with HIV who used a syringe filled with his own blood. The prisoner was also suffering from a mental illness at the time. Mr Pearce died in 1997²⁰. This tragic situation occurred in the early days of the HIV epidemic in an environment without an effective needle and syringe exchange program. In overseas prisons where such programs are implemented there have been no recorded cases of prison staff becoming infected or reports of increased drug use.

The Pearce case also occurred at a time before highly effective treatment for HIV became available and there are no other known cases of a worker acquiring HIV via a used needle and syringe in a prison environment. Should such a situation occur today, the individual would have access to post exposure prophylaxis and it is highly likely that the prisoner would be taking treatment and be virally suppressed; in which case the prisoner would represent virtually no HIV transmission risk. This is also becoming the case for HCV. As HCV treatment programs expand in prisons and the community HCV prevalence among people who inject drugs declines, there will be a lower risk of transmission. Secondly, if prison staff were to contract HCV, they would have access to highly effective antiviral treatment and would, in almost all cases, be cured of the virus within 8-12 weeks of taking an oral, highly tolerable treatment.

While there is no current cure for HBV, all workers considered to be at risk should be offered vaccination against HBV by their employer.

Treatment and Care of BBVs in Prisons

It is a basic human right that no prisoner should exit an Australian prison unhealthier than when they entered. People in custody have human rights, such as the right to access equivalent health services as those available in the general community. It is the segregation from society that is the penalty applied to the prisoner, not the conditions under which they are detained. Access to health care, including the prevention and treatment for blood-borne viruses should be applied in the following context:

International frameworks from the United Nations (UN) and the World Health Organisation (WHO), supported by national principals in Australia, stipulate that prisoners should receive health care equivalent to that available in their community, without discrimination based on their legal situation.²¹

The United Nations Office on Drugs and Crime (UNODC) and WHO Regional Office for Europe *Good governance for prison health in the 21st century* recommended that in light of poor practices for prisoners across Europe – including being subjected to avoidable health risks; health personnel not acting independently of prison authorities; and public health challenges not being adequately met – that the management and coordination of all relevant resources and agencies should be a whole of government responsibility; and that health departments should provide and be accountable for health services in prisons.²²

There are a number of factors to consider for the treatment and care of a person living with a blood-borne virus when in prison. These include:

- the impact of diagnosis
- the availability of appropriate care and clinical monitoring
- the availability and timeliness of treatment
- the ability to comply with treatment regimens in prison
- the length of a person's custodial sentence and the availability of ongoing care
- management of potential treatment side-effects
- a person's right to privacy about their health status
- treating to reduce the risk of onward transmission.

The way in which these elements need to be managed will vary depending on whether a person was previously diagnosed and on treatment prior to being taken into custody or whether the person is diagnosed while in prison.

In situations where a person is taken into custody, and the person identifies as having a blood-borne virus, it is essential that the person has timely access to any current medications, particularly where the treatment regimen requires regular dosing and good patient adherence. Continuity of care and timely access to medicines is also important when a person is transferred from one facility to another or when a person is released from prison.

The Pharmaceutical Benefits Scheme (PBS) listing of HCV, HBV and HIV therapies and the ability for primary care practitioners to prescribe them has enhanced accessibility of these medicines. In the case of the new medicines for HCV, the Australian Government explicitly included access for people in prison in the PBS listing, resulting in minimal cost to state and territory governments.

In Australia prisons, the medicines used to treat HBV, HCV and HIV are usually accessed via the PBS Highly Specialised Drugs Program, requiring an authority to prescribe. The medicines also require regular dosage and good patient compliance with the prescribed regimen for the greatest effectiveness. The systems within prisons and similar settings need to ensure ready access to the medicines used to treat BBVs.

It is known that there were some initial difficulties experienced by staff in accessing the Medicare information for people in prison needing treatment for their HCV. This highlighted the need for consistency in government systems and policies to ensure a person in prison does not experience any delays in accessing vital medicines, whether continuing or commencing treatment for a BBV.

Disclosure relating to HBV, HCV and HIV is also an important concern. People living with a blood-borne virus and people who inject drugs often experience stigma and discrimination. Unless disclosure is required by law, a person's health status is a private matter. The delivery of health services in prisons and other internal protocols should acknowledge this and be carried out in a manner that enables a prisoner to maintain confidentiality about his or her health.

National Strategies and BBVs in Australian Prisons

Australia has been a world leader in developing National Strategies to guide its response to BBVs and sexually transmitted infections (STIs). At the time of writing the National Strategies included:

- *The Second National Hepatitis B Strategy 2014 - 2017*
- *The Third National Sexually Transmissible Infections Strategy 2014 - 2017*
- *The Fourth National Hepatitis C Strategy 2014 - 2017*
- *The Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2014 – 2017*
- *The Seventh National HIV Strategy 2014-2017*

The Strategies, which are signed off by all Australian Health Ministers, are reviewed and developed every three years in consultation with a broad range of stakeholders. The National Strategies are intended to guide government and non-government policy and service delivery.

Within the National Strategies, people in prison are regularly identified as a priority population. The two primary populations over represented within correction settings are people who inject drugs and Aboriginal and Torres Strait Islander people.

People in prison were clearly identified in the Priority Action Areas of the National HIV and National Hepatitis C Strategies for 2010-2013. Both documents clearly identified the implementation and maintenance of comprehensive BBV and STI prevention strategies in Australian prisons as an essential element of effective responses to HIV and HCV control. Both documents also discussed the need to identify suitable locations in Australia to trial a prison NSP, citing evidence from overseas.

The content of the current National Strategies (2014-2017) is vastly different as they barely mention prisons despite there being little change in prison policy and practice in the prevention of BBVs and in the urgency for an effective response in these settings.

The only mention of prisons in the *Seventh National HIV Strategy 2014 – 2017* is a single note that Indigenous Australians are over represented in prisons and correctional settings. The *Fourth National Hepatitis C Strategy 2014 -2017* acknowledges prisons at various points in the document but only suggests strengthening of inter-service relationships, with the conspicuous omission of the reference made in the 2010-2013 Strategy of trial prison-based NSP sites. The current Strategy also does not discuss any other specific ways to respond directly to hepatitis C within prisons.

In its response to the *Silent Disease: Inquiry into hepatitis C in Australia* report, the Australian Government stated that all priority actions for the *Fourth National Hepatitis C Strategy 2014-2017* applied equally to prisoners as to any other priority population.²³ The Australian Government reinforced that state and territory governments have responsibility for the health and welfare of people in prison and have agreed to meet the goals and objectives in the Strategy.

The exclusion of priority actions relating specifically to prisons in the National Strategies for 2014 – 2017 is considered by those involved in the BBV health, community and research sectors as a retrograde step and a clear policy failure in developing an effective and evidence-based national response to BBVs.

Other Policy and Strategic Recommendations in Australia

Over the past decade a series of government and expert committee reports have highlighted the need to address the prevention and management of BBVs in Australia's prisons.

In 2008, the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis - Hepatitis C Subcommittee released the *Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings*, which provided basic guidelines that aimed to improve consistency in approaches across prisons in Australia. In light of developments in the treatment of HCV these guidelines need to be updated.

In 2011, Hepatitis Australia led the development of the *Consensus Statement: Addressing Hepatitis C in Australian Custodial Settings*, which was signed by 22 national, state and territory organisations.

On 7 November 2014, the then Minister for Health, Peter Dutton, referred the Inquiry into Hepatitis C in Australia (the Inquiry) to the Standing Committee on Health. Representations to the Inquiry highlighted the importance of prison environments in the

response to hepatitis C, resulting in a special hearing in May 2015 which focused specifically on hepatitis C in prison settings.

Resulting from the Inquiry, the final report of the Standing Committee on Health, titled *Silent Disease: Inquiry into hepatitis in Australia*, calls on federal, state and territory governments to work together in responding to blood-borne viruses and sexually transmitted infections in Australian prisons. The recommendations in the Report acknowledged the need to address BBVs and STIs in prisons and proposed a way forward to establish a robust policy approach to guide the prevention, monitoring and treatment of BBVs in Australian prisons. However the recommendations fall short of acknowledging the need to respond to illegal practices of prisoners within Australian prisons which places them at risk of contracting a BBV.

The following recommendations from the report, *Silent Disease: Inquiry into hepatitis C in Australia*, relate specifically to Australian prisons:

Recommendations from the Silent Disease Report	
Recommendation 8	<p>The Committee recommends that the Department of Health work with State and Territory health and corrections agencies to:</p> <ul style="list-style-type: none"> • develop a standard approach to data collection and reporting of prisoner health in custodial settings; and • give consideration to the provision of support for safe tattooing, barbering and any other legal practices which may present a risk of hepatitis C transmission in custodial settings.
Recommendation 9	<p>The Committee recommends that a national strategy for blood-borne viruses and sexually transmissible infections in prisons be developed. The strategy should accompany and support the five existing jurisdictional strategies and be developed, implemented, reviewed and assessed in the same way.</p>
Recommendation 10	<p>The Committee recommends that the Australian Government raise the issue of hepatitis C in prisons, and the establishment of national standards in prison health delivery as part of the Council of Australian Governments (COAG) Health Council process.</p>

Jurisdictional Action

The complexity and sensitive nature of federal versus state and territory jurisdictional control of policy, funding and the management of prisons, should not be a deterrent to effective and consistent policies for BBV prevention and care in Australia's prisons.

While some state and territory governments have made small investments in responding to BBVs in prisons, such as community organisations providing support and education to people in prison, there needs to be a greater focus on systemic change. To support change in Australia's state and territory systems advocacy efforts from state-based community organisations needs to complement action from a national level.

A recent example of government action that encompasses systemic change comes from South Australia. The Government of South Australia Departments for Correctional Services and Health and Ageing has produced the *South Australian Prisoner Blood Borne Virus Prevention Action Plan 2017 – 2020*.

The South Australian *Action Plan* takes a comprehensive approach that encompasses both people who are incarcerated and the community who may have contact with them and is monitored by joint departmental committees. The *Action Plan* identifies important partnerships and aligns with the strategic and policy frameworks at national and state levels. It also aligns with *HIV Prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*; which was published in 2013 by the World Health Organization's Joint United Nations Program on HIV/AIDS.

The *Action Plan* focuses on four priority action areas:

- prisoner blood-borne virus education and workforce development for staff working in prisons
- testing, vaccination, treatment, care and support of prisoners living with blood borne viruses
- implementation of evidence-based harm reductions strategies
- governance and partnerships to enable and monitor actions.

Each of these areas is explored in detail and clear actions with performance indicators or output measures are included.

Importantly it states "...this *Action Plan* aims to align the health services offered to prisoners with the 'usual care' available in the community." The term 'usual care' in this context means the full spectrum of medical and public health interventions that are routinely available to people in the general community or practised by clinicians when providing care and treatment. This is an admirable aim in terms of human rights and equitable access to health care.

Conclusions

With advances in treatment and prevention technologies, the elimination of BBVs as public health issues can be a reality in Australia. Australian prisons will play a significant part in making this possible. National leadership and consistent policy approaches across all state and territories in Australia that support a proactive response to BBVs in Australian prisons is needed to progress this important issue.

For some time there has been sufficient international evidence and existing blueprints for effectively responding to BBVs in prisons¹⁸. With appropriate education, consultation, policy and careful implementation, a comprehensive suite of prevention strategies and health services for responding to BBVs in prisons is possible.

The first steps to making this happen in Australia are captured in the recommendations made at the beginning of this document. Taking these steps would truly put Australia on a path to be at the forefront of blood-borne virus prevention policy in prisons around the world and help make the elimination of BBVs in Australia a possibility.

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