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Discussion Paper to Secretary, Department of Health for the Blood Borne Viruses (BBV) and Sexually Transmissible Infections (STI) Prevention Programme

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Background

The AMA notes that in the Department of Health's *Discussion Paper for the Blood Borne Viruses (BBV) and Sexually Transmissible Infections (STI) Prevention Programme*, prisoners and those in custodial facilities is not specifically mentioned in the priority populations or the Prevention Programme Activities.

The issue of prisoner health and BBV was raised in December 2015, when Minister Sussan Ley announced that the Government would make available new treatments for Hepatitis C to all patients with chronic Hepatitis C infection, across all disease genotypes and disease severities. The Minister for Health stated that general practitioners will be able to prescribe these antiviral medications in, or following, consultation with a specialist physician. Specialists will also be able to prescribe these medicines.

Importantly, in the Minister's media release, it stated that the Commonwealth recognised that people in custodial facilities are a priority population for treatment of Hepatitis C, and agreed to fund the cost of these medicines for prisoners through the PBS. State and Territory health and justice departments will now be able to put in place processes so that prisoners are prescribed and provided with these medicines.

In light of the Minister's recognition that people in custodial facilities are a priority population for treating a BBV (Hepatitis C), the AMA believes that the Department of Health should include this cohort in all activities and planning related to prevention and treatment of BBV in Australia.

Blood-borne viruses (BBVs) in Australia

Blood-borne viruses (BBVs) are viruses that are carried in the blood and are spread from one person to another. Blood-borne viruses can be transmitted through: infected blood, exposure to contaminated blood products, sharing injecting equipment (needles and syringes), failures in infection control in healthcare, mother to child transmission, and unsafe tattooing or body piercing practices.

The most prevalent BBVs are human immunodeficiency virus (HIV) – a virus which causes acquired immunodeficiency virus (AIDS), a disease affecting the body's immune system; Hepatitis B (HBV) and Hepatitis C (HCV).

HTLV-I (Human T-cell lymphotropic virus type 1 or human T-lymphotropic virus type 1), which is also called the adult T-cell lymphoma virus type 1, is transmitted through sexual contact, and from mother to child via breastfeeding. It can also be transmitted through exposure to contaminated blood.

Priority populations for preventing, managing and treating BBVs and STIs in Australia include:

- gay men and men who have sex with men
- Aboriginal and Torres Strait Islander people
- people from refugee and Culturally And Linguistically Diverse backgrounds (CALD)
- People Who Inject Drugs (PWID)
- people living with chronic BBVs
- sex workers
- communities prone to HTLV-1
- prisoners and those in custodial settings

BBVs in Australian prisons and custodial facilities

The AMA recognises that prisons and custodial facilities are high-risk environments for the transmission of blood borne viruses. According to the Fourth National Hepatitis C Strategy 2014-2017 and the *Consensus Statement: Addressing Hepatitis C in Australian Custodial Settings* (Hepatitis Australia, June 2011) the prevalence of BBVs is significantly higher in prisons due to a range of factors, including: the high rate of imprisonment for drug-related offences, the prevalence of injecting drug users, the rate of pre-existing infection among prisoners and unsafe injecting drug practices in prisons.

The AMA's position is that the well-being and health of people in custodial facilities has wider community health implications as any prisoner infected with a BBV or STI may transmit that infection within the prison population or to the wider community.

The AMA also sees a broader human rights issue in prisoner health. Those people who are held in custody should have the same human rights to access equivalent health services as those available to the general Australian community. It is the judicial sentence that is the penalty applied to those convicted of a criminal offence or awaiting sentencing, not the conditions under which they are incarcerated.

In preventing and managing the spread of BBVs in Australia, there is evidence that prevention strategies reduce the risk of transmission of BBVs and STIs in custodial facilities. Prevention and treatment also establishes a safer environment for both prisoners and prison officers, who are both in a high risk categories.

The *Discussion Paper for the Blood Borne Viruses (BBV) and Sexually Transmissible Infections (STI) Prevention Programme* does not appear to address the issue of prisoners transitioning from prison into the general community, which the AMA sees as a health issue that should be addressed by both State and Territory governments and the Commonwealth. A critical component of prevention of BBVs in Australia should be the adoption of programmes and policies that ensure that prisoners do not return to the community with worse health outcomes, particularly BBVs.

There is evidence to support the policy that the spread of BBVs is more effectively managed if BBVs are prevented in prisons and custodial settings by the provision and maintenance of safe injecting equipment along with other harm minimisation and prevention measures.

The AMA acknowledges the unique health care needs of prison inmates and has a long standing policy in this area. The AMA Position Statement *Health Care of Prisoners and Detainees* (1998) highlights the need for access to equitable healthcare, including preventative health programs such as needle and syringe exchange programs (NSPs).

The AMA Federal Council has endorsed a policy specifically supporting clinical trials of needle and syringe exchange programs in prison settings.

The AMA believes that the health and safety of corrections staff will best be preserved in the long term by the operation of suitably controlled NSPs.

The AMA recognises that the introduction of NSPs and other harm minimisation procedures have been adopted overseas to prevent the transmission of BBVs in custodial settings. The provision of NSPs and harm minimisation strategies further reduces the risks of transmission to the general public from prisoners who leave prison with a BBV (or STI).

The AMA notes the findings of the Harm Minimisation in Prison Committee,[1] which 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.*

It should also be noted that in prisons that have introduced NSPs, there has not been evidence of an increase in illicit drug use, nor has there been security or safety concerns. In these prisons, the risk of needle-stick injuries to prison staff has been reduced. Evaluations of these prisons have shown that NSPs actually make prisons safer. NSPs also result in more people accessing drug treatment.

[1] Committee members: Professor Nick Crofts Nossal Institute for Global Health; Associate Professor Kate Dolan National Drug and Alcohol Research Centre; Professor Michael Good National Health and Medical Research Council; Professor Margaret Hamilton AO University of Melbourne; Ms Annie Madden AIVL (Australian Injecting and Illicit Drug Users League); Ms Helen McNeil Hepatitis Australia; Professor Chris Puplick AM Former Chair of Australian National Council on AIDS, Hepatitis C and Related Diseases; Adjunct Professor George Rubin Royal Australian College of Physicians, Australasian Faculty of Public Health; Mr John Ryan Anex; Mr Gino Vumbaca ANCD (Australian National Council on Drugs); Dr Alex Wodak AM St Vincent's Hospital Alcohol and Drugs Service.

The AMA concurs with the *Consensus Statement: Addressing Hepatitis C in Australian Custodial Settings* that custodial facilities provide a unique opportunity to protect the health of those in custody and the general community by providing evidence-based prevention, treatment and management, including harm reduction practices such as NSPs, that underpin effective measures to prevent the transmission of viral hepatitis and HIV in prisons.[2]

AMA Guiding principles

To support improvements in the prevention, treatment, and management of BBVs and STIs, the AMA believes that polices, programs and service delivery should be informed by the following principles:

- The responses to preventing and treating BBVs and STIs must align with the five key Commonwealth strategies:
    - The Second National Hepatitis B Strategy 2014-2017
    - The Third National Sexually Transmissible Infections Strategy 2014-2017
    - The Fourth National Hepatitis C Virus (HCV) 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 prevention, management and treatment of BBVs and STIs requires Commonwealth, State and Territory governments, medical practitioners, researchers, community and professional organisations, NGOs and individuals to commit to setting the direction for a coordinated response to addressing the rising rates of BBVs and STIs.
- The prevention, treatment and management of BBVs and STIs is a public health priority and managing BBVs and STIs requires a coordinated and strategic policy response with national leadership driving actions to sustain improvements in their prevention, detection and treatment.
- Allocation of resources, health services and strategic responses to BBVs and STIs must be co-ordinated with all jurisdictions to ensure the most at-risk cohorts have access to appropriate preventions and treatments. Resources should be allocated according to need, not geographic location.
- An exclusive focus on risky behaviours, without consideration of the context in which these behaviours occur, is less likely to be successful in preventing and managing the spread of BBVs and STIs in Australia. Cultural and social attitudes and expectations can contribute to unsafe sex or other risky behaviours, as can a range of social determinants such as homelessness or insecure housing, unsupportive social relationships, and limited literacy and low levels of education.

[2] *Consensus Statement: Addressing Hepatitis C in Australian Custodial Settings*, Hepatitis Australia, June 2011, p. 6.

- The availability of new treatments must be developed alongside an increased focus on testing and prevention.

- Managing the spread of BBVs and STIs is best achieved through the continuation of successful 'partnership models', such as the models of collaboration initiated to combat the HIV/AIDS epidemic. Strategies that address the spread of viral hepatitis, HIV and sexually transmissible infections must be supported by the close collaboration of governments, medical practitioners, health workers and relevant NGOs.

- Managing and treating BBVs and STIs necessitates addressing the inequities and cultural and social determinants that shape exposure to BBVs and STIs and their impact on access to and uptake of prevention, detection and treatment services.

- Prioritisation of resources is needed to target those most at risk, including those from countries with a high prevalence of BBVs and STIs, people who inject drugs, gay men and other men who have sex with men, people from Aboriginal and Torres Strait Islander backgrounds, people in custodial settings and sex workers.

- Disease prevention, health promotion, and early intervention are essential approaches that incorporate evidence-based and mutually reinforcing biomedical, behavioural and structural interventions.

- Support and advocacy for harm reduction approaches is integral to minimising the transmission of BBVs.

- The provision of non-judgmental, confidential and quality care by both specialist and generalist medical practitioners, and team-based interdisciplinary approaches, is integral to the prevention, detection and treatment of BBVs and STIs.

- Removal of discrimination and stigma associated with BBVs and STIs, including recognition that people with HIV or other BBVs have a right to participate in the community without experiencing stigma and discrimination, and have the same rights to comprehensive and appropriate healthcare, as do other members of the community (including the right to confidential and sensitive handling of their personal and medical information).

- Ensuring working environments are safe and equipment and procedures are in place to prevent the transmission of BBVs in healthcare settings and other occupations.

- Development of evidence based and accountable policies and programs that are underpinned by research, systematic data collection, and ongoing evaluation and monitoring.

- Supporting the harm reduction approach, which recognises that some people will choose to inject drugs or engage in behaviours that elevate their risk of exposure to BBVs and STIs. Harm reduction principles underpin effective measures to prevent the transmission of HIV and viral hepatitis, including through needle and syringe programs (NSPs) and drug treatment programs.

- NSPs prevent the spread of BBVs and are a frontline approach to prevention among people who inject drugs. The evidence demonstrating the effectiveness and cost-effectiveness of NSPs is extremely strong.

- People in custodial settings must be a priority for BBV prevention, treatment and management.

The AMA supports:

- Access to Medicare and PBS for all Australians, including those in custodial settings.

- Improving screening and testing, particular for at risk population groups.

- Ensuring affordable and accessible treatment for people infected with BBVs and STIs.

- On-going research and data collection to improve understanding of the behavioural and environmental risk factors associated with BBVs and STIs, and the development of interventions to minimise these risk factors.

- Strengthening the linkages between interdependent policies and strategies at local, state and national levels, including improved coordination between BBVs strategies, drug and alcohol policy, sexual and reproductive health strategies, and policies targeting mental health and homelessness, to reduce the behavioural and environmental risks associated with BBVs.

- Infection control precautions in healthcare, aged care, and community settings to prevent the transmission of BBVs and STIs.

- Improved access to reliable and affordable testing, particularly for populations and groups at elevated risk to identify the large numbers of people with undiagnosed BBVs and STIs.

- The development and implementation of health promotion interventions, with particular attention given to developing resources and approaches that are appropriate to people with limited literacy and relevant to Aboriginal and Torres Strait Islander people and people from culturally diverse backgrounds.

- Focus on Aboriginal and Torres Strait Islander people at risk of BBVs and STIs, including specific attention to HTLV-I.

- Health promotion about BBVs specific to people in custodial settings.

- Strengthening linkages to care and referral pathways.

- Ensuring standardised clinical guidelines are regularly revised and accessible.

- All healthcare workers, including medical trainees and students, involved in exposure-prone procedures, acknowledging a professional and ethical responsibility to be voluntarily tested annually for BBVs, and immediately after potentially acute exposure associated with a risk of disease acquisition.

- The introduction of nationally consistent policy and/or legislation aimed at preventing needlestick injuries in healthcare.

- Prevention measures that include the implementation and use of safely engineered medical devices, combined with relevant training and education.

- Policies that aim to achieve the safest possible working environment for employees in the hospital and healthcare sector, and to establish an integrated approach to assessing and preventing risks as well as training and informing workers.

- Regular training, education and continuing professional development to support medical practitioners and other healthcare providers deliver quality prevention, detection and treatment services. Ongoing education, training and professional development is essential given growing service demand and constantly evolving treatment modalities.

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