

Reaching Populations at High Risk of Infection

- 5.1 This chapter includes evidence received by the Committee regarding current and potential hepatitis C prevention and treatment strategies for groups identified as being at a high-risk of acquiring an infection. According to the Australian Government's *Fourth National Hepatitis C Strategy* these groups include: injecting drug users, Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds and people in custodial settings.¹ Although each group will be addressed separately, it is important to note that individuals can belong to multiple high-risk groups.
- 5.2 Hepatitis C prevention strategies, testing and treatment options are also discussed in regard to specific high-risk populations.

Injecting Drug Users

- 5.3 It is estimated that 90 per cent of all new hepatitis C infections, and 80 per cent of existing infections, are caused by sharing or reuse of injecting equipment.² This section discusses hepatitis C among injecting drug users generally; issues that are particular to specific settings, such as injecting drug use in prisons, are discussed in the dedicated sections that follow.

1 This report uses the terms used for the priority populations listed in the *Fourth National Hepatitis C Strategy*. Australian Government, *Fourth National Hepatitis C Strategy 2014–2017*, July 2014, p. 13; sex workers were also identified in the *Fourth National Hepatitis C Strategy*, however the Inquiry did not focus on this particular priority population.

2 Australian Government, *Fourth National Hepatitis C Strategy 2014–2017*, July 2014, p. 3; see also, Australasian Society for Infectious Diseases, *Submission 11*, p. 8.

Prevention Strategies

- 5.4 Needle and syringe programs (NSPs) are an established means for helping to prevent the transmission of blood-borne viruses among injecting drug users, and a large number of individuals and organisations commended their public health value.³ Between 2000 and 2009, NSPs have directly averted 97,000 new hepatitis C infections,⁴ saving approximately \$1.28 billion.⁵
- 5.5 Hepatitis NSW described NSPs as ‘the most effective means to prevent hep C transmission’.⁶ In 2009, an Australian Government report concluded that NSPs are demonstrated to be a cost-saving strategy, providing a minimum of \$4 in return (through healthcare costs savings in the short term and considering direct costs only) for every \$1 invested.⁷ Further, the commissioned report found that when indirect costs were incorporated into the modelling, (including productivity gains and losses, patient costs and benefits), NSPs represent a \$27 saving for each dollar invested.⁸

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- 3 Kirstie Monson, *Submission 37*, p. 1; Anglicare Tasmania, the Tasmanian Council on AIDS, Hepatitis and Related Diseases, Tasmanian Aboriginal Centre, *Submission 41*, p. 25; Aboriginal Health and Medical Research Council of New South Wales; *Submission 45*, p. 5; Chris Lawrence, *Submission 47*, p. 3; Women’s Health Victoria, *Submission 52*, p. 6; Penington Institute, *Submission 54*, p. 3; National Drug and Alcohol Research Centre, *Submission 55*, p. 1; Australasian Society for HIV Medicine, *Submission 58*, p. 8; Hepatitis Victoria, *Submission 59*, p. 17; Fiona Patten MLC, *Submission 71*, p. 2; Name Withheld, *Submission 72*, p. 2; Burnet Institute, *Submission 66*, p. 8; National Association of People with HIV Australia, *Submission 69*, p. 3; Cancer Council Australia, *Submission 79*, p. 1; Scarlet Alliance, *Submission 81*, p. 3; Hepatitis Australia, *Submission 84*, p. 9; cohealth, *Submission 87*, p. 2; Hepatitis NSW, *Submission 91*, p. 35; NSW Health, *Submission 94*, p. 8; Tasmanian Government, *Submission 97*, p. 9; Australian College of Nursing, *Submission 100*, p. 11; Pharmacy Guild of Australia, *Submission 106*, p. 12; Mr Frank Farmer, Executive Director, HepatitisWA, *Committee Hansard*, Perth, 10 March 2015, p. 1; Professor Tarun Weeramanthri, Executive Director, Public Health and Clinical Services, Department of Health, Western Australia, *Committee Hansard*, Perth, 10 March 2015, p. 9.
- 4 Australasian Society for Infectious Diseases, *Submission 11*, p. 8; Victorian alcohol and Drug Association, *Submission 31*, p. 4; Northern Territory AIDS and Hepatitis Council, *Submission 42*, p. 2; Penington Institute, *Submission 54*, p. 3; Australasian Society for HIV Medicine, *Submission 58*, p. 8; Burnet Institute, *Submission 66*, p. 8; Hepatitis Australia, *Submission 84*, p. 9; Hepatitis NSW, *Submission 91*, p. 36. See also National Centre in HIV Epidemiology and Clinical Research, *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia*, 2009; cited in Australian Government, *Fourth National Hepatitis C Strategy 2014–2017*, July 2014, p. 15.
- 5 Northern Territory AIDS and Hepatitis Council, *Submission 42*, p. 2.
- 6 Mr Stuart Loveday, Chief Executive Officer, Hepatitis NSW, *Committee Hansard*, Sydney, 22 January 2015, p. 24.
- 7 Australian Government, ‘Return on Investment 2: Evaluating the Cost Effectiveness of NSPs in Australia’, 2009, viewed 15 April 2015. <<http://www.health.gov.au>>.
- 8 Australian Government, ‘Return on Investment 2: Evaluating the Cost Effectiveness of NSPs in Australia’, 2009, viewed 15 April 2015. <<http://www.health.gov.au>>.

- 5.6 However, the Australasian Society for Infectious Disease noted that the rate of people reusing needle and syringes has remained stable (25 to 28 per cent over the past five years), and advocated that ‘this indicates [that] a more concerted effort is essential to reduce the sharing of injecting equipment’.⁹
- 5.7 Australia has a national network of primary and secondary ‘bricks and mortar’ outlets, mobile and outreach services and vending or distribution machines together which assist to prevent the transmission of blood borne viruses and the reduction of other drug related harms.¹⁰ There are 3000 NSP outlets in Australia which are located in specifically designed primary outlets, existing health or community facilities and also in pharmacies. Thirty million clean syringes are distributed each year.¹¹
- 5.8 Table 5.1 shows how many NSPs operate in each jurisdiction, and the total units dispensed for the financial years 2012-13 and 2013-14.

Table 5.1 Needle and Syringe Programs operating in Australia for the Financial Years 2012-13 and 2013-14

	Primary outlets	Secondary outlets	Vending machines	Participating pharmacies	Total units dispensed
Australian Capital Territory	2	10	6	29	734 095 ^(a)
New South Wales	31	387	221	512	12 276 897 ^(b)
Northern Territory	3	10	0	14	380 000 ^(c)
Queensland	18	0	56	584	9 958 305 ^(d)
South Australia	4	78	4	202	3 000 000 ^(e)
Tasmania	6	20	0	90	1 000 000 ^(f)
Victoria	20	208	4	353	10 838 300 ^(f)
Western Australia	6	0	7	500	4 891 387 ^(h)

Source Penington Institute, Submission 54, pp 9-10.
 (a) FY 2012-13; (b) FY 2013-14; (c) approximate annual; (d) FY 2013-14; (e) approximate annual; (f) approximate annual; (g) FY 2013-14; (h) 2013.

9 Australasian Society for Infectious Diseases, *Submission 11*, p. 3.

10 Australian Injecting and Illicit Drug Users League, *Submission 85*, p. 10.

11 Professor Chris Baggoley, Chief Medical Officer, Department of Health, *Committee Hansard*, Sydney, 22 January 2015, p. 31.

- 5.9 The Department of Health advised that in the decade from 2000 to 2009, Australian jurisdictions invested \$243 million in NSPs with a historical average of around \$9.5 million per annum.¹²
- 5.10 A number of organisations and individuals recommended building upon these successes and expanding the capacity of Australia's NSP programs further.¹³ The Australian Injecting and Illicit Drug Users League (AIVL) commented that the current service models for NSPs were not sufficiently scaled 'to address the unique circumstances and challenges by the HCV epidemic among people who inject drugs'.¹⁴ AIVL further commented:
- If we want to focus on getting hep C prevention right, we quite literally need... to increase our distribution of and access to new injecting equipment... If we do hepatitis C prevention properly, pathways to hepatitis C assessment and treatment will follow because people will feel engaged, valued and respected.¹⁵
- 5.11 The National Drug and Alcohol Research Centre stated that 'increasing the provision of sterile injecting equipment to reach 90 per cent of all injection episodes' would lead to hepatitis C infections being 'substantially reduced with ...significant cost savings'.¹⁶ The Centre noted third-party research which found that distribution of sterile injecting equipment is limited by supply rather than demand, and that if NSP distribution doubled, the annual incidence of hepatitis C would reduce by 50 per cent.¹⁷ To achieve such an increase, the National Drug and Alcohol Research Centre proposed removing legislative barriers to peer

12 Mr Graeme Barden, Assistant Secretary, Health Protection Policy Branch, Department of Health, *Committee Hansard*, Sydney, 22 January 2015, p. 4; See also, Department of Health, *Submission 20.1*, p. 1.

13 Mr Frank Farmer, HepatitisWA, *Committee Hansard*, Perth, 10 March 2015, p. 1; Penington Institute, *Submission 54*, p. 3; Australasian Society for HIV Medicine, *Submission 58*, p. 8; Australian Injecting and Illicit Drug Users League, *Submission 85*, pp 10-11; Ms Annie Madden, Executive Officer, Australian Injecting and Illicit Drug Users League, *Committee Hansard*, Canberra, 20 March 2015, p. 25; National Drug and Alcohol Research Centre, *Submission 55*, p. 1; Burnet Institute, *Submission 66*, p. 8; Hepatitis Australia, *Submission 84*, p. 8; cohealth, *Submission 87*, p. 8; Victorian Department of Health and Human Services, *Submission 96*, p. 3; Hepatitis NSW, *Submission 91*, p. 36.

14 Australian Injecting and Illicit Drug Users League, *Submission 85*, pp 10-11.

15 Ms Annie Madden, Australian Injecting and Illicit Drug Users League, *Committee Hansard*, Canberra, 20 March 2015, p. 25.

16 National Drug and Alcohol Research Centre, *Submission 55*, p. 1.

17 JA Kwon, J Iversen, L Maher, MG Law and DP Wilson, (2009), 'The Impact of Needle and Syringe Programs on HIV and HCV Transmissions in Injecting Drug Users in Australia: A Model-Based Analysis', *Journal of Acquired Immune Deficiency Syndromes*, 51(4), 462-469; referred to in National Drug and Alcohol Research Centre, *Submission 55*, p. 2.

distribution of sterile injecting equipment,¹⁸ and placing NSPs in Australian prisons.¹⁹

- 5.12 The Burnet Institute also supportive of increasing the number of NSPs, opening hours and capacity in the NSP workforce. The Burnet Institute stated:

If NSPs are to be effective, high-level coverage is vital: a clean needle and syringe needs to be available for every injecting episode. This will require more NSP outlets, increased NSP hours, greater availability of vending machines and increased capacity in the NSP workforce.²⁰

- 5.13 Hepatitis Australia similarly supported increasing the number of NSPs, stating 'the evidence is that the investment in NSPs is not yet at an optimal level for [hepatitis C] prevention and that greater investment in NSPs will result in greater returns'.²¹

- 5.14 The Victorian Department of Health and Human Services recommended increasing the access to NSPs in community controlled settings in rural and regional Australia.²²

- 5.15 Hepatitis NSW expressed a similar view and commented:

NSPs are most effective in preventing hepatitis C transmission when they are easily accessible – geographically, in time, via different methods (including primary and secondary NSPs and vending machines) and, most importantly, by a wide range of priority population groups.

While many (although not all) metropolitan areas now have a variety of different NSP services (including 24 hour services and/or automatic dispensing machines), coverage is not as comprehensive in rural and regional Australia.²³

- 5.16 HepatitisWA stated that NSPs present opportunities other than a location to collect sterile equipment, stating 'an NSP is not just somewhere where someone comes and gets their equipment. There is a lot more that happens'. HepatitisWA emphasised that such services can build relationships with their clients, allowing more open conversations about

18 National Drug and Alcohol Research Centre, *Submission 55*, p. 2; See also Professor John de Wit, Director, Centre for Social Research in Health, University of New South Wales, *Committee Hansard*, Sydney, 22 January 2015, p. 26.

19 National Drug and Alcohol Research Centre, *Submission 55*, p. 3.

20 Burnet Institute, *Submission 66*, p. 8.

21 Hepatitis Australia, *Submission 84*, p. 8.

22 Victorian Department of Health and Human Services, *Submission 96*, p. 3.

23 Hepatitis NSW, *Submission 91*, p. 36.

high-risk behaviours, prevention strategies, as well as testing and treatment options: ‘So when you are talking about an NSP, we look at the whole person. Whilst our remit is to stop the transition of blood-borne viruses, it is actually about the health and wellbeing of these hard-to-reach and really vulnerable people’.²⁴

- 5.17 This was supported by the Penington Institute, which stated that NSPs are not only ‘essential to reducing risk of transmission’, but also provide a ‘health promotion intervention that can educate people who inject about the risks of transmission’.²⁵ The Australasian Society for HIV Medicine similarly noted the other important services NSPs can provide including primary healthcare, education, referrals to other services (including treatment) and increasing the safe disposal of injecting equipment. The Australasian Society for HIV Medicine promoted the importance of improving the ‘capacity of NSPs to inform and educate individuals about hepatitis C and provide referrals to testing and treatment where appropriate’.²⁶
- 5.18 The *Fourth National Hepatitis C Strategy* acknowledges that efforts to facilitate access to, and the safe use of, sterile injecting equipment can be impeded by the availability of NSP services after-hours. This is in addition to the location and geographical accessibility of NSP services, and stigma and discrimination experienced by people who have to identify as an injecting drug user when accessing health and some NSP services.²⁷

Peer Education and Syringe Distribution

- 5.19 A number of individuals and organisations discussed the importance of peer education and the capacity of peers to access priority populations which traditional services find difficult to reach.²⁸ According to AIVL, peer education is ‘one of the most efficacious tools we have for connecting and educating the community of people who use and inject drugs’.²⁹
- 5.20 The role of peers in education and prevention strategies was acknowledged in the *Fourth National Hepatitis C Strategy* where it was

24 Ms Sally Rowell, Community Services Manager, HepatitisWA, *Committee Hansard*, Perth, 10 March 2015, pp 7-8.

25 Penington Institute, *Submission 54*, p. 3.

26 Australasian Society for HIV Medicine, *Submission 58*, p. 8.

27 Australian Government, *Fourth National Hepatitis C Strategy 2014–2017*, July 2014, pp 15–16, 25.

28 Anglicare Tasmania & Tasmanian Council on AIDS and Related Diseases & Tasmanian Aboriginal Centre, *Submission 41*, p. 27; Ms Annie Madden, Executive Officer, Australian Injecting and Illicit Drug Users League, *Committee Hansard*, Canberra, 20 March 2015, p. 26; Burnet Institute, *Submission 66*, p. 8; Scarlet Alliance, *Submission 81*, p. 3; cohealth, *Submission 87*, p. 9.

29 Australian Injecting and Illicit Drug Users League, *Submission 85*, p. 12.

identified as a national priority.³⁰ The Strategy further stated that models of distributing sterile equipment should be reviewed and that the involvement of peers in distribution should be considered:

Models currently in use should be reviewed and updated to better address the known barriers and meet the changing needs of people who inject drugs in Australia. Models should consider how best to involve peers in the distribution of NSP equipment, which has shown to be cost effective. Legislative barriers restrict some of these practices at present, and should be reviewed in light of the goal of this Strategy.³¹

5.21 The AIVL commented on the unseen role of peer education and stated:

When I think about peer education and the value of peer education, is that, when I first started injecting, there were no health workers in the room. There were not needle and syringe program workers in the room, even if they existed at that time. It was other drug users who were in the room. They were the ones who educated me about health issues, and they did. I think that is one of the things that never gets discussed enough: drug users do really care for each other; people do look after each other. People call ambulances, if they feel safe enough to do so, for overdoses. People take people to doctors and hospitals. They help engage with information and share information with each other. So we need to equip people with the capacity to do that.³²

5.22 The AIVL stated that better equipping peer educators will encourage greater access to NSPs among new injecting drug users. Accessing these services prior to contracting hepatitis C is particularly important in light of AIVL's statement that '50 per cent of people will get hepatitis C within the first six months of starting injecting.'³³

5.23 The Burnet Institute also discussed the impact peer education can have on this population, but cautioned that there is insufficient evidence to demonstrate that peer education alone, is sufficient to reduce transmission rates:

Behavioural counselling and peer education interventions, when provided alone, have not been shown conclusively to significantly reduce hepatitis C transmission in [people who inject drugs]. That

30 Australian Government, *Fourth National Hepatitis C Strategy*, p. 15.

31 Australian Government, *Fourth National Hepatitis C Strategy*, p. 16.

32 Ms Annie Madden, Australian Injecting and Illicit Drug Users League, *Committee Hansard*, Canberra, 20 March 2015, p. 26.

33 Ms Annie Madden, Australian Injecting and Illicit Drug Users League, *Committee Hansard*, Canberra, 20 March 2015, p. 26.

said, the benefits of these programs are often difficult to measure due to their small size and the complex structural and legal settings in which they occur. Behavioural counselling and peer education may have broader benefits that cannot be measured in program evaluations.³⁴

5.24 However, cohealth recommended promoting peer networks for encouraging greater access to clean equipment, noting that 'the use of peer networks in communities or population cohorts where there are lower access rates, such as Aboriginal and Torres Strait Islander people, is of particular value and should be embraced'.³⁵

5.25 The AIVL commended the role of peer educators as an effective strategy to disseminate new information and assisting creating understanding. AIVL stated:

People who inject drugs are very effective when it comes to passing on information to their peers. The main problem is not encouraging people to share information but rather, making sure that the information that is in circulation is actually correct and useful. This is where the work of trained hepatitis C peer educators comes in. They are the people 'on the spot' who can not only pass on new information, but can also correct misinformation... Peer educators are the people who are best placed to engage with other drug users on hepatitis C, as they are often the only ones who are there when hepatitis C is actually transmitted - that is, when people are injecting.

5.26 A number of drug-user representative organisations have been involved in training peer educators in an effort to prevent hepatitis C transmission. However, in the view of AIVL, their capacity to provide this training 'has been severely under-resourced', advocating that if the transmission target of the *Fourth National Hepatitis C Strategy* is to be realised, resourcing for peer education programs should be increased.³⁶

5.27 At present, peer needle and syringe distribution for the purpose of injecting drugs is illegal in all Australian jurisdictions.³⁷

5.28 The AIVL stated that although several jurisdictions have attempted to increase the volume of distribution of needles and syringes at NSP

34 Burnet Institute, *Submission 66*, p. 8.

35 cohealth, *Submission 87*, p. 9.

36 Australian Injecting and Illicit Drug Users League, *Submission 85*, p. 13.

37 Australian Injecting and Illicit Drug Users League, *Submission 85*, pp 13-14.

services, there has not been a corresponding effect on the rates of people reporting reuse and sharing of injecting equipment.³⁸

- 5.29 The Scarlet Alliance also stated that peer distribution should form part of a multi-faceted prevention strategy.³⁹ As a result, the Scarlet Alliance ‘strongly recommended’ increasing the distribution of sterile injecting equipment by peers and advocated for legal reform to support peer distribution.⁴⁰

Testing

- 5.30 Introducing rapid testing (or point-of-care testing) into community settings where high-risk populations are more likely to access these services, was one option put forward to encourage higher testing rates. Point of care testing is a preliminary screening test that, if a positive result is generated, would be followed up by regular clinical tests.
- 5.31 AIVL stated that rapid testing is likely to be used by populations who ‘may not be reached through existing mainstream services’:
- For people who inject drugs, hepatitis C quick testing could play an important role in improving access to ... testing for people who do not use other health services other than NSP, have vein problems that make taking venous samples difficult, only access outreach based services or due to concerns about stigma, discrimination and confidentiality would prefer to access testing via peer-based quick testing service.⁴¹
- 5.32 HepatitisWA recommended that a pilot program of rapid testing be implemented for people who access NSPs. HepatitisWA explained that a key benefit of rapid testing in NSPs is that it responds to the reluctance to access conventional health services among injecting drug users. HepatitisWA referenced a 2013 pilot program in Wisconsin in the United States which resulted in 1 255 clients being tested, and of the infections found, 72% had not previously been reported.⁴²

Treatment

- 5.33 Historically, there have been lower rates of treatment referral and uptake of people who inject drugs, or have previously injected drugs. The

38 Australian Injecting and Illicit Drug Users League, *Submission 85*, p. 13; See Australasian Society for Infectious Diseases, *Submission 11*, p. 3 for information on sharing rates.

39 Scarlet Alliance, *Submission 81*, p. 3.

40 Scarlet Alliance, *Submission 81*, p. 3.

41 Australian Injecting and Illicit Drug Users League, *Submission 85*, p. 21.

42 Hepatitis WA, *Submission 9*, p. 1.

Australasian Society for HIV Medicine stated that this is in part due to the location of treatment and management services in tertiary healthcare centres.⁴³

- 5.34 Approximately 50 000 people are on opioid substitution treatment (OST) programs in Australia, and surveys of pharmacotherapy clients reveal a 'willingness to consider hepatitis C treatment, many people are declining treatment'.⁴⁴ The Burnet Institute reported on the findings of a Canadian study into the provision of hepatitis C treatment at OST clinics with similar findings.⁴⁵ The AVIL stated that although integrating hepatitis C treatments with OSTs 'will have appeal for some people... it is equally important to recognise that not all people... will want to undergo hepatitis C treatment'. The AVIL stated:

The current rush to incorporate hepatitis C treatment into OST settings as a 'magic-bullet solution' to low hepatitis C treatment numbers among people with a history of injecting drug use belies the reality of the pharmacotherapy treatment experience for many people on these programs. Some people prefer to keep their drug dependency treatment separate to the management of other health conditions.⁴⁶

- 5.35 Mr Sione Crawford noted that although 'new resources may help... what is really needed is redeployment of resources and thinking outside the box'. Mr Crawford advocated for the 'meaningful inclusion of the community most affected: people who inject drugs', and commented:

A true long-term partnership approach was undertaken with the affected community in blood-borne virus prevention, HIV and hep C when the HIV epidemic first broke. That has borne fruit for us, with very low HIV rates amongst people who inject drugs, and it is because people who inject drugs got on board. This has never happened in hepatitis C treatment, and the time has come to include us meaningfully. This means involvement in planning and implementing services, and including us, with an essential and determining role, when planning services for us.⁴⁷

43 Australasian Society for HIV Medicine, *Submission 58*, p. 8.

44 Australian Injecting and Illicit Drug Users League, *Submission 85*, p. 27.

45 The study found that less than six percent of the hepatitis C infected population attending the service underwent treatment, with a 'cure rate' of 51 per cent for people with genotype one hepatitis C and 68 per cent for people with genotype three hepatitis C. See Burnet Institute, *Submission 66*, pp 7-8

46 Australian Injecting and Illicit Drug Users League, *Submission 85*, p. 27,

47 Mr Sione Crawford, Manager, Canberra Alliance for Harm Minimisation and Advocacy, *Committee Hansard*, Canberra, 20 March 2015, p. 26.

Aboriginal and Torres Strait Islanders

- 5.36 Hepatitis C rates are three times higher among Aboriginal and Torres Strait Islanders compared to non-Aboriginal and Torres Strait Islanders.⁴⁸ Infection rates are higher within certain age groups of Indigenous Australians: six times higher for the 15 to 19 year old age group; and five times higher for the 20 to 29 year old age group.⁴⁹
- 5.37 As stated in Chapter 2, new diagnoses of hepatitis C have been gradually increasing in the Aboriginal and Torres Strait Islander population (from 130 per 100 000 in 2008 to 166 per 100 000 in 2012).⁵⁰ Among Aboriginal and Torres Strait Islanders who inject drugs, the rate of hepatitis C infection is estimated to be between three and 13 times higher than that of the non-Aboriginal and Torres Strait Islander injecting drug user population.⁵¹ Aboriginal and Torres Strait Islanders also have lower rates of treatment than non-Aboriginal and Torres Strait Islanders.⁵²
- 5.38 A range of factors contribute to the reported high rates of hepatitis C infections in Aboriginal and Torres Strait Islanders. The Aboriginal Health and Medical Research Council of NSW (AH&MRC) cited a range of health and other conditions which make Aboriginal and Torres Strait Islanders more susceptible to acquiring a hepatitis C infection, affect the disease's progression and complicate treatment. These are higher rates of hepatitis B; obesity; unsafe levels of alcohol consumption; poly drug use; exposure to blood borne viruses; higher rates of diabetes; a higher level of social and emotional wellbeing issues; and, high incarceration rates.⁵³

48 Aboriginal Health and Medical Research Council of New South Wales, *Submission 45*, p. 2.

49 Aboriginal Health and Medical Research Council of New South Wales, *Submission 45*, p. 4.

50 It is also expected that the figures for the Aboriginal and Torres Strait Islander population are likely to be under-reported, partly because Aboriginal and Torres Strait Islander status is not always included when an infection is notified. See Australian Government, *Fourth National Aboriginal and Torres Strait Islander Blood-borne Viruses and Sexually Transmissible Infections Strategy 2014–2017*, July 2014, pp 4, 6.

51 Australian Government, *Fourth National Hepatitis C Strategy 2014–2017*, July 2014, p. 17; see also Australasian Society for Infectious Diseases, *Submission 11*, p. 8.

52 Australian Government, *Fourth National Hepatitis C Strategy 2014–2017*, July 2014, pp 3, 7, 22–23.

53 Ms Sandra Bailey, Chief Executive Officer, Aboriginal Health and Medical Research Council of NSW, *Committee Hansard*, Sydney, 22 January 2015, p. 37.

Figure 5.1 Aboriginal and Torres Strait Islander Notification rates of newly diagnosed hepatitis C infection in the Northern Territory, South Australia, Tasmania and Western Australia for the years 2009 to 2013

Source *The Kirby Institute, Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander People: Surveillance and Evaluation Report 2014*

Prevention Strategies

- 5.39 The AH&MRC has developed and delivered a number of campaigns specifically designed to prevent further infections among Aboriginal and Torres Strait Islanders. These include a hip-hop song writing program (which won an award at the 2011 National Hepatitis Health Promotion Conference),⁵⁴ a street art based hepatitis C project (delivered in five juvenile detention centres and four community settings), and plays performed by Aboriginal theatre companies.⁵⁵
- 5.40 Seven Aboriginal controlled community health services (ACCHS) operate NSPs. None of these services are directly funded for providing NSPs and the need for new injecting equipment outstrips the supply in some locations. To address this latter concern, the AH&MRC stated that 'all methods of distribution of injecting equipment should be explored, in partnership with local Aboriginal communities'. In the view of the AH&MRC, these could include distribution through ACCHSs and other Aboriginal community organisations, vending machines, self-service models and peer distribution.⁵⁶

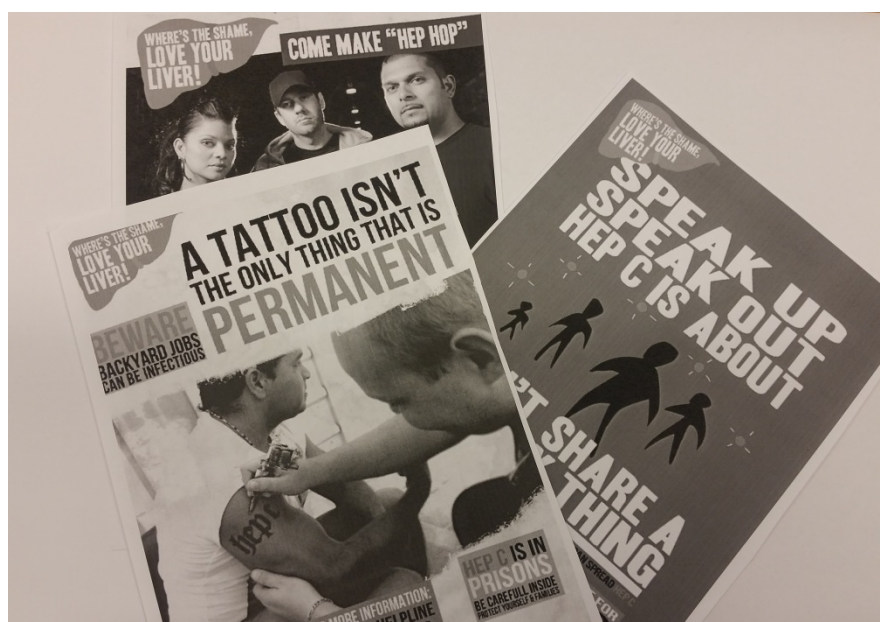
54 See www.loveyourliver.net.au.

55 Aboriginal Health and Medical Research Council of New South Wales, *Submission 45*, p. 7.

56 Aboriginal Health and Medical Research Council of New South Wales, *Submission 45*, p. 7

- 5.41 Other prevention strategies proposed by the AH&MRC included: 'providing more accessible and culturally sensitive detox and drug treatment services; needle and syringe programs in prison settings more research into understanding the hepatitis C epidemic among Aboriginal people; increased funding and training for ACCHS clinicians; and a Aboriginal community led program to reduce stigma and discrimination around injecting drug use.'⁵⁷
- 5.42 The AH&MRC stated that the success rates in the evaluation of its prevention programs have been due to 'the high level of Aboriginal community involvement in the design and delivery and even in the initiation of those projects and how they look'.⁵⁸

Figure 5.2 Hepatitis C Promotional Material



Source Aboriginal Health and Medical Research Council of New South Wales

Role of Aboriginal Medical Services

- 5.43 A significant issue for Aboriginal and Torres Strait Islanders seeking hepatitis C treatment is inaccessibility of services. Accessing treatment and management services can also be impacted by a lack of experience among hepatitis C clinicians who work with Indigenous Australians.⁵⁹ To address these barriers, participants advocated that community-based

57 Aboriginal Health and Medical Research Council of New South Wales, *Submission 45*, p. 7.

58 Ms Sandra Bailey, Aboriginal Health and Medical Research Council of NSW, *Committee Hansard*, Sydney, 22 January 2015, p. 32.

59 Ms Sandra Bailey, Aboriginal Health and Medical Research Council of NSW, *Committee Hansard*, Sydney, 22 January 2015, p. 10.

- treatments would have a significant and positive impact on the number of Indigenous Australians being tested and completing treatment.
- 5.44 Aboriginal Community Controlled Health Services (ACCHS, also known as Aboriginal Medical Services (AMS)), operate in over 150 communities nationally. Together, the services form a network, but each is autonomous and independent. The ACCHS range in size from small services reliant on Aboriginal health workers and nurses who provide primary care; to large multidisciplinary services.⁶⁰
- 5.45 Larger ACCHS may have extensive services (provided by staff and by visiting health practitioners) which have been established at a local level to serve their community. These may include 'general practice clinics, liver health, sexual health, chronic care, social and emotional wellbeing health care, drug and alcohol services and other health programs which are highly relevant to the support and management of people with [chronic hepatitis C] and to shared care with tertiary [hepatitis C] treatment services'.⁶¹
- 5.46 The Australasian Society for HIV Medicine commented that ACCHSs 'have the ability to provide integrated multidisciplinary primary health care for people living with hepatitis C that is culturally appropriate'. As many hepatitis C patients are likely to have multiple health issues, larger ACCHSs are often well placed to provide comprehensive primary health care for these complex needs, as well as having strategies to overcome socioeconomic, geographical, system-related and other barriers to health management.⁶²
- 5.47 In New South Wales, a number of ACCHS currently conduct hepatitis C clinics which allow patients to access a broad range of primary health care services, including visiting hepatitis C specialists.⁶³ Further, an ACCHS in Western Sydney also employs a GP who is an accredited s100 prescriber who operates in a shared care arrangement with a specialist in administering treatment therapies.⁶⁴
- 5.48 In South Australia, one blood-borne virus specialist is funded by the state government to coordinate HIV and viral hepatitis services across ACCHS

60 Australasian Society for HIV Medicine, *Chronic HCV Models of Care: Aboriginal Community Controlled Health Services*, p. 2, viewed 15 April 2015, <<http://www.ashm.org.au>>.

61 Australasian Society for HIV Medicine, *Chronic HCV Models of Care: Aboriginal Community Controlled Health Services*, p. 2, viewed 15 April 2015, <<http://www.ashm.org.au>>.

62 Australasian Society for HIV Medicine, *Submission 58*, p. 8.

63 Aboriginal Health and Medical Research Council of New South Wales, *Submission 45*, p. 5.

64 Aboriginal Health and Medical Research Council of New South Wales, *Submission 45*, p. 5; Ms Sandra Bailey, Aboriginal Health and Medical Research Council of NSW, *Committee Hansard*, Sydney, 22 January 2015, pp 9-10.

within that jurisdiction. Hepatitis SA noted that while this position delivers viral hepatitis education to the Aboriginal health workforce, there is a lack of specialist knowledge. Hepatitis SA stated:

...there can be a lack of specialist knowledge about hepatitis C amongst Aboriginal primary healthcare workers within [ACCHS], and thus a lack of information about hepatitis C prevention, testing and treatment flowing to communities. Aboriginal primary healthcare workers at [ACCHS] reported that other co-morbidities such as mental health... are often a barrier to treatment for Aboriginal people, and that what they felt was needed was a "one stop shop" in [ACCHS] so that a person can be treated for hepatitis C without being sent to an array of others services.⁶⁵

- 5.49 The Victorian Department of Health and Human Services recommended the development of a national Aboriginal Health Worker competency to specifically address hepatitis C screening, treatment, care and support.⁶⁶ The Australian College of Nurses also emphasised the need for health care workers in Aboriginal health service settings to receive the appropriate knowledge and skills in sexual health, blood-borne virus prevention, treatment and care.

Culturally and Linguistically Diverse Backgrounds

- 5.50 The *Fourth National Hepatitis C Strategy* identified people from culturally and linguistically diverse backgrounds from countries with a high prevalence of hepatitis C as a high-risk population.⁶⁷ Hepatitis C disproportionately affects people from some of the countries that are the source of migrants to Australia, and a recent study found hepatitis C antibodies in four per cent of immigrants from Africa, 80 per cent of which had confirmed chronic hepatitis C.⁶⁸
- 5.51 In addition to language and cultural barriers, Hepatitis Australia highlighted that new migrants' health, social and economic needs may present further obstacles to managing their hepatitis C infection.⁶⁹ The

65 Hepatitis SA, *Submission 33*, p. 5.

66 Victorian Department of Health and Human Services, *Submission 96*, p. 3.

67 Australian Government, *Fourth National Hepatitis C Strategy 2014–2017*, July 2014, p. 18.

68 Australasian Society for Infectious Diseases, *Submission 11*, p. 4.

69 Ms Helen Tyrrell, Chief Executive Officer, Hepatitis Australia, *Committee Hansard*, Melbourne, 21 January 2015, p. 31.

Australian Liver Association, provided the following insight into how hepatitis C may be diagnosed and managed within migrant communities:

...about 30 per cent of the Egyptian population is infected with hepatitis C. A large proportion of them are represented in liver transplants in Australia, and they actually do not present until the late state, because of lack of awareness and by that time they have liver cancer because of comorbidities such as obesity and diabetes and so forth. That should be factored in – that it is not all about IV drug use. We should factor in the migrant population, which is a marginalised population, and awareness is quite lacking in that setting as well.⁷⁰

- 5.52 Similarly, hepatology nurse, Mrs Saroj Nazareth, provided the following account of how language barriers impact an individual's understanding about hepatitis C. Mrs Nazareth stated:

I had a patient from the Vietnamese community who we looked after for nearly a year, and it was only towards the last three months of his treatment that, because he was responding so well, he came out through his interpreter and said, 'I will be so happy when I get rid of this virus, because I can finally sit with my family and have dinner together.' That really shocked us, because for all these months he has been thinking that even by sharing cutlery he can pass the disease on to his family. So education to raise awareness is really important.⁷¹

- 5.53 A study of GPs who work in an area of Sydney with a large migrant population revealed that, of the GPs surveyed, 89 per cent identified language difficulties as the main barrier to treatment of hepatitis C among migrants. Limited culturally and linguistically diverse appropriate resources for patients was also identified as a barrier by the majority of GPs surveyed. The GPs considered that increased access to health care workers from a non-English speaking background and translated literature on hepatitis C would be the most useful improvements in treating viral hepatitis in migrants.⁷²
- 5.54 The Australian Research Centre in Sex, Health and Society highlighted the unique challenges experienced by culturally and linguistically diverse people who are infected with hepatitis C could be overcome through the development of community-based liver clinics, where GPs have a greater

70 Professor Amany Zekry, Chair, Australian Liver Association, *Committee Hansard*, Sydney, 22 January 2015, p. 25.

71 Mrs Saroj Nazareth, Private Capacity, *Committee Hansard*, Perth, 10 March 2015, p. 30.

72 M Guirgis et al, 'General practitioners' knowledge and management of viral hepatitis in the migrant population', *Internal Medicine Journal*, vol. 42, no. 5, May 2012, pp 497, 499–500.

role in managing hepatitis C patients. Further the Centre advocated that such clinics could address the 'cultural needs of their patients', which, in its view, would include:

- interpreters;
- cross-cultural training of staff;
- recruitment of staff of similar cultural background to the likely client group; and,
- flexible delivery of care to accommodate patients difficulties in attending appointments for cultural reasons.⁷³

5.55 Relationships Australia – South Australia, which runs a multicultural health program which includes support for migrants with viral hepatitis, also recommended that 'attention needs to be given to the use of interpreters as cultural taboos and language incongruities can have devastating impacts on people receiving accurate health information'.⁷⁴

People in Custodial Settings

5.56 Professor Michael Levy AM, Clinical Director of Justice Health Services ACT described the prison environment as a 'perfect storm for hepatitis C'.⁷⁵ Other witnesses outlined why prisons were a high risk environment for hepatitis C transmission:

- the concentration of hepatitis C-infected individuals in an over-crowded setting⁷⁶;
- fights;
- unsafe barbering, tattooing and body piercing;
- the 'stultifying boredom'⁷⁷ of prison life; and
- the availability of illicit drugs and injecting equipment.⁷⁸

73 Australian Research Centre in Sex, Health and Society, *Submission 19*, p. 4.

74 Relationships Australia – South Australia, *Submission 95*, p. 5.

75 Professor Michael Levy AM, *Submission 2*, p. 3.

76 According to the CPSU, in mid-April 2015, NSW had an inmate population of 11 500, whilst its capacity is 11 600. Other jurisdictions are significantly over capacity in the same period: Victoria's prison population was 500 over capacity; South Australia was 200 over capacity and Western Australia is more than 1000 over capacity. See Mr Troy Stephen Wright, Senior Industrial Officer, Community and Public Sector Union, *Committee Hansard*, Canberra, 4 May 2015, p. 15.

77 Professor Michael Levy, Australian National University, *Committee Hansard*, Melbourne, 21 January 2015, p. 12.

78 Professor Michael Levy, *Submission 2*, p. 4; *Committee Hansard*, Melbourne, 21 January 2015, p. 12.

5.57 Mr Rodney Hatch, who was detained in a prison in Western Australia for a period of his life, provided the following account:

I observed prisoners injecting together, sharing a single syringe between four men. These men were willing to fatalistically accept that they were almost certainly infecting themselves and each other with bloodborne viruses. Their desire for the drug effect at that time, driven by negative emotions aroused in a prison environment, over-rode their fear of infection. They were resigned to the fate of infection in order to receive the change of mood and feeling they craved at that time. These are men who ordinarily, and given the opportunity, would take the effort to protect themselves and minimize the risk of infection by using sterile injecting equipment.⁷⁹

5.58 The Penington Institute explained that needle access in prisons 'is run as a black-market-economy item', with needles expensive and altered to allow transport. These needles can be 'shared by up to 100 people' and present 'extraordinary' hygiene and blood-borne virus risks.⁸⁰

Prevalence and Testing

5.59 There is no national surveillance system for hepatitis C infection in custodial facilities in Australia. In custodial settings, the general prevalence of hepatitis C infection has been estimated to be between 23 and 47 per cent.⁸¹ Further, among women in prison, the prevalence is estimated to be over 70 per cent.⁸²

5.60 The National Drug and Alcohol Research Centre stated that although the frequency of injecting drug use may reduce in prison, 33 per cent of prisoners continue to inject drugs while incarcerated, 90 per cent of whom also share injecting equipment.⁸³ Hepatitis NSW stated that prior to entering prison, 75 per cent of people who inject drugs reported using sterile injecting equipment each time they injected, but, while in custody,

79 Rodney Ian Hatch, *Submission 99*, p. 1.

80 Mr John Ryan, Penington Institute, *Committee Hansard*, Melbourne, 21 January 2015, p. 31. See also Dr Susan Carruthers, Research Fellow, National Drug and Research Institute, *Committee Hansard*, Canberra, 4 May 2015, p. 2.

81 Hepatitis Australia, *Submission 84 - Attachment D*, p. 3; Australian College of Nursing, *Submission 100*, p. 5; See also Australian Institute of Health and Welfare (2012), *The Health of Australia's Prisoners*, Cat no PHE 170, AIHW, Canberra.

82 Hepatitis Australia, *Submission 84 - Attachment D*, p. 3; Australian College of Nursing, *Submission 100*, p. 5.

83 National Drug and Alcohol Research Centre, *Submission 55*, p. 3.

- 70 per cent of people who inject drugs reported sharing injecting equipment.⁸⁴
- 5.61 Within these estimates of hepatitis C prevalence and drug use whilst in custody, it is not known whether the transmission of hepatitis C occurred prior to entry to prison or while in prison. Estimates on the prevalence of prison-acquired hepatitis C vary considerably and there is no detailed and consistent data on the prevalence of prison-acquired hepatitis C.
- 5.62 Associate Professor Mark Stoové stated that ‘research in the prison space in Australia – particularly amongst people with a history of injecting drug use – is incredibly scant’.⁸⁵
- 5.63 The lack of detailed, consistent data about the rate of prison-acquired hepatitis C is primarily as a result of inconsistent or absent testing of prison entrants for the virus. Jurisdictions have individual policies for testing for hepatitis C,⁸⁶ and this can complicate the statistical integrity of those limited studies. Reflecting upon the limited data collected, the CPSU stated that the ‘prevalence of hepatitis C transmission in custody is not known’.⁸⁷
- 5.64 In 2008, the Department of Health acknowledged that the lack of national surveillance data makes it difficult to determine the incidence of hepatitis infection within a custodial environment.⁸⁸
- 5.65 Of the few studies which were referred to the Committee about the rate of prison-acquired infections, the National Drug and Alcohol Research Centre cited a study that found ‘among 114 prisoners with a history of injecting drug use who tested negative for HCV antibodies [upon entry to prison], 13 subsequently tested positive, despite being continuously incarcerated.’⁸⁹
- 5.66 Hepatitis ACT acknowledged that the data (on hepatitis C in a custodial setting) ‘lacks a little clarity’, commenting that testing in the ACT is

84 Mr Alistair Lawrie, Policy and Media Officer, Hepatitis NSW, *Committee Hansard*, Sydney, 22 January 2015, p. 30; See also Hepatitis NSW, *Submission 91*, p. 39.

85 Associate Professor Mark Stoové, Private Capacity, *Committee Hansard*, Canberra, 4 May 2015, p. 9.

86 Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 6; for information on testing in Western Australia, see Mr Andrew Smith, Assistant Secretary, Western Australian Prison Officers’ Union, *Committee Hansard*, Canberra, 4 May 2015, p. 10.

87 Mr Troy Wright, Senior Industrial Officer, Community and Public Sector Union, *Committee Hansard*, Canberra, 4 May 2015, p. 4.

88 Department of Health, *Background to Hepatitis C in Custodial Settings in Australia*, 2008, viewed April 2015, <<http://www.health.gov.au>>.

89 F Luciani, NA Bretana, S Teutsh, J Amin, L Topp, GJ Dore, L Maher, K Dolan, AR Lloyd, (2014), ‘A prospective study of hepatitis C incidence in Australian prisoners’, *Addiction*, 109, 1695-1706, referred to in National Alcohol and Drug Research Centre, *Submission 55*, p. 3.

'suboptimal and that the notification criteria [leads to] ... underreporting'.⁹⁰ Referring to data from the Australian Institute of Health and Welfare, Hepatitis ACT reported that Australian prisoners who are injecting drug users are 'at least eight times more likely to contract the virus while in prison than non-injecting drug users'.⁹¹

5.67 The Kirby Institute's *National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report* was described as 'the most reliable repeated evidence that is collected over time'.⁹² In the last iteration of that study (2013),⁹³ the Kirby Institute reported that 31 per cent of prison entrants were hepatitis C antibody positive, representing an increase from 22 per cent in 2010. The Survey Report also found that hepatitis C antibody prevalence was higher among those with a history of injecting drug use than those who had not injected (58 per cent) and also higher among women who injected than men who injected (67 per cent versus 56 per cent).⁹⁴ The Kirby report did not reach a conclusion on the rate of prison-acquired hepatitis C.

5.68 The Western Australia Prison Officers' Union (WAPOU) stated that while testing remains voluntary, establishing prevalence data is statistically compromised. WAPOU stated:

Speaking from Western Australian experience, it is not mandatory for any testing; it is an opt-in when prisoners come into a prison. To make a general statement that Australia-wide it is a certain percentage – where does that data come from? When prisoners enter the Western Australian system, they are not tested. We have 5,500 prisoners, and possibly a movement of between 2,000 and 3,000 are coming in and out generally during the year. How do

90 Mr John Didlick, Executive Officer, Hepatitis ACT, *Committee Hansard*, Canberra, 4 May 2015, p. 6.

91 Mr John Didlick, Hepatitis ACT, *Committee Hansard*, Canberra, 4 May 2015, p. 10.

92 Associate Professor Mark Stoové, Private Capacity, *Committee Hansard*, Canberra, 4 May 2015, p. 9.

93 The Study is a consecutive, cross-sectional sample of prison entrants over a two week period. Participants were 794 of the 1 235 (64 per cent) prisoners entering Australian correctional centres who were offered the survey, (*The Public Health Association of Australia, Exhibit 13: National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report 2004, 2007, 2010 and 2013: Prevalence of HIV, Hepatitis C, Hepatitis B, Sexually Transmissible Infections, and Risk Behaviours Among Australian Prison Entrants, UNSW Australia and Kirby Institute, March 2015, p. 13*).

94 *The Public Health Association of Australia, Exhibit 13: National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey Report 2004, 2007, 2010 and 2013: Prevalence of HIV, Hepatitis C, Hepatitis B, Sexually Transmissible Infections, and Risk Behaviours Among Australian Prison Entrants, UNSW Australia and Kirby Institute, March 2015, p. 7*.

you arrive at that figure if they are not actually tested? It cannot be relative.⁹⁵

- 5.69 To correct these issues with data collection and retention, the Public Health Association of Australia recommended improvements to the 'consistency and a comprehensive collection of data and reporting'.⁹⁶ The CPSU and Hepatitis Australia made similar recommendations.⁹⁷

Prevention Strategies

- 5.70 Strategies to prevent the transmission of hepatitis C in prison environments must be threefold: harm minimisation, supply reduction and demand reduction strategies.⁹⁸ Much of the evidence presented during the Inquiry focused on the introduction of an NSP into the prison environment as a specific harm-minimisation strategy.
- 5.71 There are currently no NSPs operating within Australian prisons. In 2013, the ACT Government announced that it intended to introduce a prison NSP. At the time of writing, stakeholder consultation was continuing.⁹⁹
- 5.72 A large number of participants in the Inquiry supported the introduction of NSPs in Australian prisons.¹⁰⁰ The Penington Institute 'strongly

95 Mr Andrew Smith, Western Australian Prison Officers' Union, *Committee Hansard*, Canberra, 4 May 2015, p. 10.

96 Adjunct Professor Michael John Moore, Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 25.

97 Mr Vince McDevitt, Australian Capital Territory Secretary, Community and Public Sector Union, *Committee Hansard*, Canberra, 4 May 2015, p. 25; Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 25.

98 Mr Troy Wright, Community and Public Sector Union, *Committee Hansard*, Canberra, 4 May 2015, p. 4; Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 4; Ms Melanie Walker, Deputy Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 11.

99 See ACT Government, *Strategic Framework for the Management of Blood-Borne Viruses in the Alexander Maconochie Centre 2013–2017*, August 2013, viewed 10 February 2015, <<http://www.health.act.gov.au>>

In April 2015, the ACT Government reached an agreement with the CPSU to develop a working group to progress the proposed introduction of an NSP at the ACT prison, the Alexander Maconochie Centre. According to news reports, the agreement envisages a model will be developed in 12 months, and then proceed to a ballot among correctional staff. Its introduction will only proceed if the majority of staff support the model in the ballot. (See: Canberra Times, 'Corrective services staff to vote on Alexander Maconochie Centre needle exchange program', 1 April 2015, viewed, 12 April 2015, <<http://www.canberratimes.com.au/act-news/corrective-services-staff-to-vote-on-alexander-maconochie-centre-needle-exchange-program-20150401-1mcp4v.html>>)

100 Hepatitis SA, *Submission 33*, p. 12; Kirstie Monson, *Submission 37*, p. 1; William Lenane, *Submission 39*, p. 1; Anglicare Tasmania, the Tasmanian Council on AIDS, Hepatitis and Related Diseases, Tasmanian Aboriginal Centre, *Submission 41*, p. 26; Northern Territory AIDS and Hepatitis Council, *Submission 42*, p. 3; Aboriginal Health and Medical Research Council of New South Wales, *Submission 45*, p. 7; Penington Institute, *Submission 54*, p. 5; Hepatitis ACT,

- believes' that the State's legal duty of care to prisoners 'must include providing prisoners with access to sterile injecting equipment to prevent the spread of blood borne viruses – as is done in all Australian communities'.¹⁰¹
- 5.73 A number of individuals and organisations discussed the variety of different models which have been introduced internationally, and whether they could be used as models for Australia to implement.¹⁰² The Kirby Institute noted that around 60 prisons around the world operate NSPs through various mechanisms, such as peer distribution, distribution by medical staff and vending machines.¹⁰³
- 5.74 Hepatitis ACT referenced the results of an NSP located in a Spanish prison where, after ten years of the program, the prevalence of hepatitis C had decreased from 40 per cent to 26 per cent.¹⁰⁴ The National Drug and Research Institute commented however that these international models would need to be adapted to an Australian context, further noting that within Australia, one model will not be successful in all states and territories, or even within those jurisdictions.¹⁰⁵
- 5.75 The National Drug Research Institute commented that prior to entering prisons, 90 per cent of all prison entrants were 'active users' of community-based NSPs, arguing that there is a high level of awareness among the cohort and a high level of desire not to contract blood-borne viruses, including hepatitis C.¹⁰⁶

Submission 56, p. 3; Name Withheld, *Submission 72*, p. 2; Public Health Association of Australia, *Submission 68*, p. 6; National Association of People with HIV Australia, *Submission 69*, p. 3; Cancer Council Australia, *Submission 79*, p. 1; Scarlet Alliance, *Submission 81*, p. 4; Hepatitis Australia, *Submission 84*, p. 9; Hepatitis NSW, *Submission 91*, p. 38; Relationships Australia – South Australia, *Submission 95*, p. 7; Australian College of Nursing, *Submission 100*, p. 10; Mr Frank Farmer, Executive Director, Hepatitis WA, *Committee Hansard*, Perth, 10 March 2015, p. 2; Dr Susan Carruthers, National Drug Research Institute, *Committee Hansard*, Perth, 10 March 2015, p. 17; Associate Professor Mark Stoové, Private Capacity, *Committee Hansard*, Canberra, 4 May 2015, p. 2.

- 101 Penington Institute, *Submission 54*, p. 5; National Drug and Alcohol Research Centre, *Submission 55*, p. 3. See also, Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Melbourne, 21 January 2015, p. 13.
- 102 Professor Michael Levy, *Submission 2*, p. 4; Professor Lisa Maher, Kirby Institute, University of New South Wales, *Committee Hansard*, Sydney, 22 January 2015, p. 3; Professor Margaret Hellard, Director, Centre for Population Health, Burnet Institute, *Committee Hansard*, Melbourne, 21 January 2015, p. 12; Hepatitis ACT, *Submission 56*, p. 3.
- 103 Professor Lisa Maher, Kirby Institute, *Committee Hansard*, Sydney, 22 January 2015, p. 30.
- 104 Hepatitis ACT, *Submission 56*, p. 3.
- 105 Dr Susan Carruthers, National Drug and Research Institute, *Committee Hansard*, Canberra, 4 May 2015, pp 1-2.
- 106 Dr Susan Carruthers, National Drug and Research Institute, *Committee Hansard*, Canberra, 4 May 2015, p. 7.

- 5.76 It was the view of both Professor Hellard and Hepatitis Australia that NSPs in prisons could reduce the risk of transmission for prisoners, but also prison staff.¹⁰⁷
- 5.77 However, the CPSU stated that introducing NSPs in prisons represents a ‘serious and tangible risk to occupational health and safety’. The CPSU stated that this risk is twofold: either a deliberate attack through the use of a needle as a weapon or an accidental needle-stick injury, and that both risks could result in a transmission of a blood borne virus.¹⁰⁸
- 5.78 Despite these concerns, a number of individuals and organisations stated that there is no evidence internationally of injecting equipment being used as a weapon in a prison where an NSP was operating.¹⁰⁹
- 5.79 Rodney Hatch, a former prisoner in WA stated:
- Working towards the elimination of any risk associated with prison NSPs will be greatly enhanced by the cooperative efforts and goodwill of all stakeholders.¹¹⁰
- 5.80 The community health organisation cohealth similarly noted that a ‘harm minimisation approach’ should be developed ‘in a manner which is not detrimental to the safety of correctional officers’.¹¹¹ The organisation recommended the adoption of a transparent ‘co-design process’ where all stakeholders across the health and corrections systems with an interest in the issue including correctional services management, correctional health services management, custodial officers, health specialists, prisoners and prisoner advocates can ‘establish a shared objective of translating the harm minimisation approach to drug use into the correctional setting’.¹¹²
- 5.81 Hepatitis ACT similarly noted that it would not support measures that increase the risks or harms to any one stakeholder, commenting: ‘we do not believe that creating safer and healthier prisons needs to have winners

107 Professor Margaret Hellard, Burnet Institute, *Committee Hansard*, Melbourne, 21 January 2015, p. 12; Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 4.

108 Mr Troy Wright, Community and Public Sector Union, *Committee Hansard*, Canberra, 4 May 2015, pp 3-4.

109 Mr John Ryan, Penington Institute, *Committee Hansard*, Melbourne, 21 January 2015, p. 32; Penington Institute, *Submission 54*, p. 6; Dr Susan Carruthers, National Drug Research Institute, *Committee Hansard*, Canberra, 4 May 2015, p. 1; Associate Professor Mark Stoové, Private Capacity, *Committee Hansard*, Canberra, 4 May 2015, p. 3;

See also, United Nations Office on Drugs and Crime, *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings*, 2014. Exhibit 8b.

110 Rodney Ian Hatch, *Submission 99*, p. 1.

111 cohealth, *Submission 87*, p. 2.

112 cohealth, *Submission 87*, p. 7.

and losers. Safer and healthier prisons are in the best interests of everyone'.¹¹³

- 5.82 Prevention strategies proposed by the CPSU included: increased resourcing to disrupt the trafficking of contraband, increased alcohol and other drug services inside prison and upon release, provision of tattooing and piercing services for inmates, the introduction of rapid testing for hepatitis C, and greater research on the current rate and methods transmission of hepatitis C in prisons across Australia.¹¹⁴
- 5.83 Data received indicated that 39 per cent of men and 20 per cent of women in prisons reported getting tattoos whilst in prison while 14 per cent of women reported having piercings done in prison.¹¹⁵
- 5.84 The CPSU also advocated that current hepatitis C education strategies in prisons are not effective, commenting:
- [Prisoners] are provided with two minutes to read a booklet. They have many more worries on their mind than reading a booklet and therefore, once they enter the domestic part of the prison, they are untrained. They are uneducated on hepatitis C, hepatitis B and HIV. We should start with education when prisoners come into the prison.¹¹⁶
- 5.85 A number of organisations were of the view that harm-minimisation, supply-reduction and demand-reduction strategies, if introduced in isolation of the other two strategies, would not be successful. The Public Health Association of Australia stated that it is 'not an either/or, nor is it sequential'.¹¹⁷ This was echoed by Hepatitis Australia, further commenting that NSPs cannot be positioned 'as the answer'.¹¹⁸
- 5.86 Rather, Hepatitis Australia advised that an NSP must be part of a 'suite of interventions... this has to be looked at as a whole... it is about providing the best possible protection of health for prisoners and custodial officers, and for the community by extension'.¹¹⁹ The National Drug Research Institute agreed and recommended that a 'raft of measures' is needed to prevent hepatitis C transmission in prison, including: drug and alcohol

113 Mr John Didlick, Hepatitis ACT, *Committee Hansard*, Canberra, 4 May 2015, p. 5.

114 Community and Public Sector Union, *Submission 101*, p. 6.

115 Mr Stuart Loveday, Hepatitis NSW, *Committee Hansard*, Canberra, 4 May 2015, p. 13.

116 Mr Andrew Smith, Western Australian Prison Officers' Union, *Committee Hansard*, Canberra, 4 May 2015, p. 8.

117 Adjunct Professor Michael Moore, Public Health Association of Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 8.

118 Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 8.

119 Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 8.

treatment, drug-free units, needle and syringe programs, and the ability to clean needles and syringes.¹²⁰

Treatment

- 5.87 Correctional settings were described as an ‘ideal opportunity’ to undergo treatment for hepatitis C.¹²¹ Hepatitis ACT reported that the view of some prisoners is that the correctional setting is a ‘great opportunity’ to undergo treatment as ‘life on the outside can be too complex or hectic to maintain a course of daily treatments or there are other priorities; or... because the treatment side effects are better dealt with in prison away from the demands of everyday life’.¹²²
- 5.88 Despite this, in 2013 only 231 treatments for hepatitis C were conducted in Australian prisons.¹²³ The Australasian Society for HIV Medicine stated that, with 30 000 people entering Australian prisons each year, there is ‘potential to treat 9 000 people’.¹²⁴ While hepatitis C treatment services are available in some custodial settings in Australian jurisdictions, this is not consistent nationally.¹²⁵
- 5.89 There are a number of barriers to commencing treatment for hepatitis C in prison, including variable sentence length, frequent movement of prisoners between different prisons, limited communication between and within custodial settings, and the lack of specialist providers.¹²⁶ However, new interferon-free treatments, with shorter treatment periods of six to twelve weeks, create new opportunities for prisoners with shorter custodial sentences to commence and complete hepatitis C treatments.¹²⁷
- 5.90 Professor Alex Thompson described prisoner movement from one prison to another as ‘enormously challenging’ for prison treatment clinics. Professor Thompson explained that:

120 Dr Susan Carruthers, National Drug Research Institute, *Committee Hansard*, Canberra, 4 May 2015, p. 24.

121 Dr Susan Carruthers, National Drug Research Institute, *Committee Hansard*, Canberra, 4 May 2015, p. 14; Associate Professor Mark Andrew Stoové, Private Capacity, *Committee Hansard*, Canberra, 4 May 2015, p. 14; Mr Troy Wright, Community and Public Sector Union, *Committee Hansard*, Canberra, 4 May 2015, p 20-21.

122 Mr John Didlick, Hepatitis ACT, *Committee Hansard*, Canberra, 4 May 2015, p. 16.

123 Australasian Society for HIV Medicine, *Submission 58*, p. 11.

124 Australasian Society for HIV Medicine, *Submission 58*, p. 11.

125 Australian Government, *Fourth National Hepatitis C Strategy 2014–2017*, July 2014, p. 23.

126 Australasian Society for HIV Medicine, *Submission 58*, p. 11

127 Dr Susan Carruthers, National Drug Research Institute, *Committee Hansard*, Canberra, 4 May 2015, p. 14; Associate Professor Mark Stoové, Private Capacity, *Committee Hansard*, Canberra, 4 May 2015, p. 14; Australasian Society for Infectious Diseases, *Submission 11*, p. 6.

... to date there has not been a facility for their treatment to be transferred, so it leads to interruptions in treatment, if not cessation of treatment. It emphasises the need for a state based holistic approach, where a person can be started on treatment in their resident prison, and, if they need to move to another prison, it can be seamlessly continued.¹²⁸

- 5.91 The NSW prison system was highlighted by a number of participants as delivering an improved treatment model for prisoners.¹²⁹ In NSW, a recent pilot program of hepatitis C treatment in custodial settings demonstrated 'the feasibility and effectiveness of a nurse-led model of care'. NSW Health explained:

A NSW Health pilot of hepatitis C treatment in correctional facilities demonstrated the feasibility and effectiveness of a nurse-led model of care. Despite a high proportion of individuals who reported current illicit drug use or had a psychiatric disorder(s), almost 80% of patients were able to commence treatment with phone or teleconference involvement by specialists. The treatment success rate and safety was comparable to that in specialist settings. The effective implementation of this model requires comprehensive training and ongoing support for participating nurses as well as specialist support. NSW Health supports a continued focus and expansion of nurse-led treatment in correctional facilities.¹³⁰

- 5.92 Professor Alex Thompson noted that the treatment model in NSW is being used as a model in Victoria, where St Vincent's Hospital is delivering a centralised service for the entire prison-population in Victoria, using nurse-led models of care and telemedicine. Professor Thompson stated that this model will make it possible to 'dramatically increase treatment rates'.¹³¹
- 5.93 In addition to models of care, the availability of treatment in prison is impacted by the 'availability of resources'.¹³² The CPSU similarly noted

128 Professor Alex Thompson, Director, Department of Gastroenterology, St Vincent's Hospital, *Committee Hansard*, Melbourne, 21 January 2015, p. 15.

129 Professor Michael Levy, Australian National University, *Committee Hansard*, Melbourne, 21 January 2015, p. 10; Mr Stuart Loveday, Hepatitis NSW, *Committee Hansard*, Sydney, 22 January 2015, p. 30; Professor Alex Thompson, St Vincent's Hospital, *Committee Hansard*, Melbourne, 21 January 2015, p. 15; NSW Health, *Submission 94*, p. 3; Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 19.

130 NSW Health, *Submission 94*, p. 4.

131 Professor Alex Thompson, St. Vincent's Hospital, *Committee Hansard*, Melbourne, 21 January 2015, p. 15.

132 Mr Stuart Loveday, Hepatitis NSW, *Committee Hansard*, Canberra, 4 May 2015, p. 19.

that the healthcare provided to prisoners is limited by resources and the prioritisation of those resources: 'when corrections departments feel the financial pinch, it is their non-custodial operations that probably get hit a bit earlier than the custodial operations'.¹³³ The CPSU emphasised that recent expansions in prison populations and resulting overcrowding, has increased the risk of the transmission of blood-borne viruses and placed prisoners' health services under significant pressure.¹³⁴

Post-Release Support

- 5.94 The continuity of treatment for prisoners entering prison and returning to the community following prison was another key issue for this high-risk population. Professor Margaret Hellard described prisons as 'a revolving door' as a result of the average duration of time spent in prison being 'only seven months'.¹³⁵
- 5.95 Professor Michael Levy stated that in the ACT's Alexander Maconochie Centre, a prisoner will not commence treatment if they are scheduled to return to the community before the treatment's end as there had been issues with as it was difficult for a patient to comply with treatment requirements after release.¹³⁶
- 5.96 The Victorian Department of Health and Human Services confirmed that 'given the length of current therapy for hepatitis C and the number of shorter sentence lengths, many [clinically] eligible prisoners do not receive treatment due to issues with continuity following release'.¹³⁷ However, the Victorian Department of Health was of the view that new treatments 'represent an opportunity to markedly increase the number of prisoners receiving curative treatment for hepatitis C while in prison'.¹³⁸ Improvements in therapies as well as post-release care delivery and referral was also raised by HepatitisWA and the Public Health Association of Australia.¹³⁹

133 Mr Troy Wright, Community and Public Sector Union, *Committee Hansard*, Canberra, 4 May 2015, p. 20.

134 Mr Troy Wright, Community and Public Sector Union, *Committee Hansard*, Canberra, 4 May 2015, p. 15; Ms Catherine Davies, Assistant Branch Secretary (Victoria) CPSU-SPSF Group, *Committee Hansard*, Canberra, 4 May 2015, p. 2.

135 Professor Margaret Hellard, Burnet Institute, *Committee Hansard*, Melbourne, 21 January 2015, p. 15.

136 Professor Michael Levy, Australian National University *Committee Hansard*, Melbourne, 21 January 2015, p. 14.

137 Victorian Department of Health and Human Services, *Submission 96*, p. 3.

138 Victorian Department of Health and Human Services, *Submission 96*, p. 3.

139 Mr Frank Farmer, HepatitisWA, *Committee Hansard*, Perth, 10 March 2015, p. 7; Ms Melanie Walker, Public Health Association of Australia, *Committee Hansard*, Canberra, 4 May 2015, pp 17-18.

Access to Medicare Benefits Schedule and Pharmaceutical Benefits Scheme

5.97 A number of organisations suggested extending prisoners access to services available on the Medicare Benefits Schedule and therapies listed on the Pharmaceutical Benefits Scheme.¹⁴⁰ Under current arrangements where prison health is a state and territory issue, prisoners automatically lose access to Medicare and the Pharmaceutical Benefits Scheme upon entering a custodial-setting. The Department of Health explained:

The provision of pharmaceuticals and medical treatment within a prison is state and territory responsibility. PBS medicines are not dispensed in state prisons. The cost of those drugs is met by the state and territory governments themselves.

Notwithstanding these general provisions, the Commonwealth has approved access under provisions within the PBS to the Highly Specialised Drugs Program for prisoners in each state and territory. This recognises the need to provide access to medicines used to treat HIV/AIDS and hepatitis B and C in particular.¹⁴¹

5.98 Both Hepatitis Australia and the Public Health Association of Australia stated that, although they support listing new treatments on the general schedule (to encourage greater access to those medications in the general community as recommended by the PBAC), this will limit access to treatment for prisoners.¹⁴²

5.99 In effect, costs of providing new treatments to prisoners will shift to state and territory governments and 'will undoubtedly exacerbate hepatitis C treatment access issues within prisons'.¹⁴³ The Public Health Association of Australia emphasised that when state and territory governments are 'forced to cap their corrections budget', prisoners' health services is likely to be more difficult to provide.¹⁴⁴

5.100 To address this problem, Hepatitis Australia advocated that 'it may be possible to make a dual listing under section 100 and the general schedule'.¹⁴⁵ More broadly, Hepatitis Australia stated that these current arrangements do not facilitate 'national consistency in health care for

140 Ms Melanie Walker, Public Health Association of Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 3.

141 Department of Health, *Submission 20.3*, p.1.

142 Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 15; Ms Melanie Walker, Public Health Association of Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 19.

143 Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 15.

144 Ms Melanie Walker, Public Health Association of Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 19.

145 Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 15.

prisons', and recommended a review of prisoner access to Medicare and PBS-listed pharmaceuticals whilst in prison.¹⁴⁶

- 5.101 The Public Health Association of Australia similarly suggested the introduction of 'Medicare access for prisoners and equity in treatment across Australia in terms of opioid substitution treatment, alcohol and drugs, and hepatitis C.'¹⁴⁷ Hepatitis NSW made a similar recommendation, which further commented that prisoner health should be placed on the agenda for the Council of Australian Governments Meeting.¹⁴⁸

Concluding Comment

- 5.102 The Committee acknowledges the statement in the *Fourth National Hepatitis C Strategy*, that health care in Australia should be 'accessible to all based on need... Whether related to geographic location, gender, sexuality, drug use, occupation, socioeconomic status, migration status, language, religion or culture'.¹⁴⁹ The Committee welcomes the identification of priority demographics in the *Fourth National Hepatitis C Strategy*.

Injecting Drug Users

- 5.103 The Committee acknowledges the role of NSPs in reducing the transmission of hepatitis C among injecting drug users in the general community setting. Evidence received emphasises the value of providing health services for injecting drug users outside of the traditional primary and tertiary care models. The Committee believes that the introduction of rapid point of care testing, especially in community-based settings could assist in increasing the diagnosis rate of hepatitis C, as well as providing an environment where treatment options can be more easily discussed.
- 5.104 Offering treatment for those with a hepatitis C infection through community-based settings should continue to be encouraged, in addition to considering ways of extending these services in rural and remote areas.

Aboriginal and Torres Strait Islanders

- 5.105 The Committee acknowledges the information it received about the higher proportion of hepatitis C infection amongst Aboriginal and Torres Strait

146 Ms Helen Tyrrell, Hepatitis Australia, *Committee Hansard*, Canberra, 4 May 2015, p. 15.

147 Adjunct Professor Michael Moore, Public Health Association of Australia, *Committee Hansard*, Canberra, 4 May 2015, pp 24-25.

148 Mr Stuart Loveday, Hepatitis NSW, *Committee Hansard*, Canberra, 4 May 2015, p. 25.

149 Australian Government, *Fourth National Hepatitis C Strategy*, p. 10.

Islanders, and the lower treatment rate. The Committee also acknowledges the added complications many Aboriginal and Torres Strait Islanders experience in seeking treatment, including being co-infected, having high incarceration rates, and also limited access to treatment for varying reasons.

- 5.106 The limited data available on Aboriginal and Torres Strait Islander hepatitis C infection rates does not easily enable the identification of trends for comparison purposes across years. There is however evidence of an increase in new diagnoses of hepatitis C among Aboriginal and Torres Strait Islanders, and it is clear that to address this issue requires a national response.
- 5.107 The Committee welcomes developments in outreach to Aboriginal and Torres Strait Islanders living with hepatitis C, and notes the way hepatitis C testing and treatment is being offered through several Aboriginal community controlled health services. The success of these programs should be used to set the standard for hepatitis C treatment in Aboriginal and Torres Strait Islander communities.

Culturally and Linguistically Diverse Backgrounds

- 5.108 Stigma and discrimination about hepatitis C varies within migrant communities, and culturally specific treatment and outreach should be encouraged as best practice. To this end, there is room for more of a focus on culturally sensitive communication between medical practitioners and people from diverse backgrounds who are living with hepatitis C.
- 5.109 Linguistic issues and access to interpreters, especially for smaller linguistic communities is still limited in Australia. Through its inquiry, the Committee heard evidence of people with a positive diagnosis for hepatitis C keeping it a secret from their immediate family, and changing their behaviours to reduce physical contact. The Committee believes that providing adequate resources to ensure that culturally and linguistically appropriate information provision in relation to hepatitis C is a basic way of improving the lives of migrant people living with an infection.

People in Custodial Settings

- 5.110 The Committee heard a considerable amount of evidence on hepatitis C in custodial settings. The Committee understands that prisons are a segregated environment where there is a higher risk of hepatitis C infection than the general community.
- 5.111 The Committee was concerned by the limited reliable data available on hepatitis C infection and transmission rates in Australian prisons.

Estimates vary significantly; nonetheless, the rate of hepatitis C infection is higher within prisons than in the general population.

- 5.112 The Committee heard there was no consistent approach to determining prisoner health on incarceration. Developing a consistent national approach to determining prisoner health would assist in measuring hepatitis C in custodial settings.
- 5.113 The introduction of a national surveillance system for hepatitis C infection should also be a priority. Such a system would enable better responses to hepatitis C infection in prisons, as well as providing a way of treating those who wish to seek treatment.
- 5.114 Rapid point of care testing in the custodial setting would also assist in determining the status of prisoners upon entry, as well as checking their HCV antibody status while incarcerated.
- 5.115 The Committee acknowledges the challenges faced by prisoners seeking treatment. Prisoner movement between facilities, the regimented environment, long treatment regimes, and accessing treatment all make it more difficult for a prisoner seeking to undergo treatment for hepatitis C.
- 5.116 The Committee received a considerable amount of information on the introduction and operation of NSPs in prisons. The Committee notes recent developments in relation to NSPs in the Australian Capital Territory and believes the outcome of this debate will inform the broader debate on this matter throughout Australia.
- 5.117 At present, there are five national strategies for blood-borne viruses and sexually transmissible infections. The Committee considers that the development of a sixth strategy focused on custodial settings may assist in addressing the challenges of blood-borne viruses in prisons.
- 5.118 A further benefit of developing a dedicated strategy is that once it has been finalised, the implementation and success of the strategy can be assessed, as is the case with the existing strategies. Measuring progress will also improve Australia's national data set on prisoner health more generally, and more specifically the prevalence of prison-acquired hepatitis C.
- 5.119 As an initial step towards this goal, the Committee believes that the Australian Government should raise the issue of prisoner health, focussing on hepatitis C with its state and territory counterparts at the earliest opportunity, including at a future meeting of the Australian Governments Health Council. At this meeting, the Committee also believes that achieving national standards in prisoner health-delivery should be made an overall priority.

Recommendation 6

5.120 The Committee recommends that the Department of Health work with States and Territories to produce culturally and linguistically specific information for migrant groups with higher rates of hepatitis C infection to inform them about hepatitis C including: transmission methods, testing and treatment options.

Recommendation 7

5.121 The Committee recommends that the Department of Health work with States and Territories to develop strategies to address the high prevalence rates of hepatitis C in the Aboriginal and Torres Strait Islander population.

Recommendation 8

5.122 The Committee recommends that the Department of Health work with State and Territory health and corrections agencies to:

- 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

5.123 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.

Recommendation 10

- 5.124 **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.**

Steve Irons MP
Chair

23 June 2015