

# South Australian Prisoner Blood Borne Virus Prevention Action Plan 2017-2020

Department for Correctional Services  
Department for Health and Ageing



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of South Australia



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# Foreword

Blood borne viruses (hepatitis B, hepatitis C and HIV) are a significant public health issue for all Australians, but particularly so for prisoners who experience a far greater burden of blood borne virus infections than the general population.

The first *South Australian Prisoner Blood Borne Virus Prevention Action Plan 2017-2020* (Action Plan) demonstrates a commitment between health, correctional, and community services to collaborate and coordinate efforts to improve the overall health and wellbeing of prisoners, people leaving the prison system, and the general community of which the majority of prisoners re-join.

This commitment supports and indeed should be considered a key component of the Department for Correctional Services' vision for "a safer community by protecting the public and reducing re-offending", and mission to "contribute to public safety through the safe, secure and humane management of offenders and the provision of opportunities for rehabilitation and reintegration"<sup>1</sup>.

The Action Plan supports the *Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings 2008*, which were developed to promote standardised evidence-based approaches to hepatitis C in prison settings across Australia. It also supports the principles and objectives within the suite of six national strategies with blood borne virus targets.

Whilst acknowledging challenges to the prevention and management of blood borne viruses in correctional settings, the Action Plan comprises practical medium to long-term objectives addressing these health issues in this high prevalence setting. A requisite to achieving these objectives, the Action Plan also formalises the partnership, and establishes governance processes between the Department for Health and Ageing and the Department for Correctional Services.

We commend the many participants who took part in the consultation process to develop this Action Plan for their generosity and their dedication to minimising the personal and social impact of blood borne viruses in South Australia, and amongst the South Australian prisoner populations.

**Hon. Jack Snelling M.P.**  
**Minister for Health**



**Hon. Peter Malinauskas M.P.**  
**Minister for Correctional Services**



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# Introduction

The first *South Australian Prisoner Blood Borne Virus Prevention Action Plan 2017-2020* (Action Plan) outlines the State's collaborative approach to reduce the impact of hepatitis B, hepatitis C and human immunodeficiency virus (HIV) in South Australian prisons and, accordingly, within the broader community to which people released from prison return.

Partnerships are imperative to build an effective statewide response to blood borne viruses (BBV) within the prison system. Prevention, testing, treatment and management of BBVs amongst South Australian prisoner populations is the shared responsibility of state government agencies, primary health services, public hospitals, Aboriginal health services, and non-government organisations. Activities in the Action Plan reflect the integration, teamwork and goodwill required to implement the necessary cross-departmental systems and processes needed to achieve stipulated goals.

Funded within existing resources, most undertakings build upon current relationships and work activities to create new capacity to address items in the Action Plan. Other activities may require new funding streams to achieve objectives, and to meet performance indicators and output measures.

# 1. Overview

This section describes the purpose of this Action Plan, the priority areas for action, and the priority populations. Furthermore, it highlights the national and state policy frameworks informing this Action Plan, identifies high-level goals and objectives, and defines the roles and responsibilities of the parties involved.

## 1.1 Purpose of this Action Plan

This Action Plan is a statewide document that:

- > commits to local strategies and actions required to progress the targets of the state and national BBV strategies
- > identifies current, and proposes new, relationships and joint activities required to undertake stipulated actions
- > defines local performance indicators, output measures, and lines of governance required to monitor the effectiveness of the actions.

## 1.2 Priority action areas

The priorities outlined in this Action Plan are:

Action area 1: Prisoner BBV education and workforce development for staff working in correctional settings

Action area 2: Testing, vaccination, treatment, care and support of prisoners living with BBVs

Action area 3: Implementation of evidence-based harm reduction strategies

Action area 4: Governance and partnerships to enable and monitor actions.

## 1.3 Priority populations

Whilst there are groups within prison populations that are at highest risk of BBVs, imprisonment itself is an independent risk factor for hepatitis C infection<sup>2</sup>. Therefore, the priority populations for this Action Plan reflect two overlapping groups:

- > people who are incarcerated
- > people living in the community who are in contact with prisoners upon release, and therefore at higher risk of BBV infection.

## 1.4 Aboriginal people

A number of actions (specifically in Action area 1) relate to improving access to BBV services for Aboriginal people in prison. Aboriginal people are vastly overrepresented in the Australian justice system, representing only 2% of the population aged over 18 in the Australian community, but 27% of the prisoner population<sup>3</sup>. Frequently attributed to higher rates of incarceration, and the resultant risks in this environment, as well as disproportionate representation within the injecting community, Aboriginal people constitute 8.3% of the total population living with chronic hepatitis C<sup>4,5</sup>. These interconnected issues (incarceration, injecting drug use, and hepatitis C) are attributable to historical trauma, socio-economic disadvantage, marginalisation, disconnection to land, mistrust of and lack of access to health services, and racism experienced by many Aboriginal people in Australia<sup>6</sup>.

## 1.5 Prison workforce

In addition to prisoners, this Action Plan also targets the prison workforce including:

- > SA Prison Health Service staff
- > non-government organisation staff
- > correctional officers
- > workers providing pre and post-prison services
- > any other staff within the Department for Correctional Services (DCS).

## 1.6 Policy framework

This Action Plan is guided by six national strategies designed to reduce the transmission of BBVs in Australia, and minimise the associated morbidity, mortality, and the personal and social impacts of these viruses.

The six national strategies with BBV targets<sup>i</sup> are:

- > *The Fourth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2014-2017*
- > *The Second National Hepatitis B Strategy 2014-2017*
- > *The Fourth National Hepatitis C Strategy 2014-2017*
- > *The Seventh National HIV Strategy 2014-2017*
- > *The Third National Sexually Transmissible Infections Strategy 2014-2017*
- > *The National Drug Strategy 2010-2015.*

Of particular note, the *Fourth National Hepatitis C Strategy 2014-2017* acknowledges as an achievement the *Hepatitis Australia Consensus Statement: Addressing Hepatitis C in Custodial Settings*, and emphasises the need to reduce BBVs in prisons:

“Custodial settings have the potential to be a focal point for hepatitis C testing, education and treatment. While hepatitis C treatment services are available for prisoners in some custodial settings, they are not consistently available nationally.

Continuity of care for people in custodial settings can be challenging as hepatitis C treatment requires coordination between justice and health systems.”

This Action Plan also comprises actions, performance indicators and/or output measures to assist in the implementation and monitoring of national prison based guidelines. This includes *The Standard Guidelines for Corrections in Australia 2012*<sup>7</sup>, in which the DCS is a signatory, and the *Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings 2008*<sup>8</sup>, in which the Department for Health and Ageing (SA Health) and DCS are both signatories.

Within South Australia, this Action Plan is one of a suite of related state Implementation and/or Action Plans, which complement the national strategies, including:

- > *South Australian Hepatitis B Action Plan 2014-2017*<sup>9</sup>
- > *South Australian Hepatitis C Implementation Plan 2016-2018*<sup>10</sup>
- > *South Australian HIV Implementation Plan 2016-2018*<sup>11</sup>
- > *South Australian Alcohol and Other Drugs Strategy 2017-2021*<sup>12</sup>

This Action Plan also contributes to a number of other commitments and initiatives of the South Australian Government including the:

- > *Aboriginal and Torres Strait Islander Companion Document to the Statewide Cancer Control Plan (2011-2015) and Cancer Care Pathway*<sup>13</sup>
- > *Aboriginal Health Care Plan 2010-2016*<sup>14</sup>
- > *South Australia's Health Care Plan 2007-2016*<sup>15</sup>
- > *South Australia's Strategic Plan*<sup>16</sup>
- > *Strong Foundations and Clear Pathways: Women Offender Framework and Action Plan 2014-2019*<sup>17</sup>.

Finally, this Action Plan follows recommendations in the *Australian Immunisation Handbook 10th Edition* about hepatitis B vaccinations for high risk populations<sup>18</sup>.

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<sup>i</sup> See Appendix A: Adult prisoner related national targets



## 1.7 Goal and objectives

### Goal

The goal of this Action Plan is:

- > to reduce the transmission of, and morbidity and mortality caused by BBVs, and to minimise the personal, clinical and social impact of BBVs for prisoners in South Australia.

### Objectives

Consistent with the objectives of the BBV related national strategies, this Action Plan intends to:

- > reduce the proportion of prisoners with undiagnosed BBVs
- > achieve high levels of hepatitis B vaccination for prisoners who are not immune
- > reduce risk behaviours associated with transmission of BBVs
- > reduce rates of newly acquired BBV infection
- > improve the health of prisoners living with BBVs through access to clinical services, treatment, education and support.

## 1.8 Roles and responsibilities of parties to this plan

A coordinated cross-departmental partnership between SA Health and DCS, coupled with collaboration and cooperation between a range of community, health and correctional partners and key stakeholders, is essential to achieve the stipulated goals and objectives of this Action Plan.

SA Health and DCS equally oversee this Action Plan through two governance groups:

- > The South Australian Sexually Transmissible Infection and Blood Borne Virus Advisory Committee (SASBAC), chaired by the Chief Public Health Officer in relation to SA Health actions.
- > The Department for Correctional Services Statewide Performance Group, chaired by the Deputy Chief Executive in relation to Department for Correctional Services actions.

Responsibilities of key partners to this Action Plan are as follows:

### Joint DCS and SA Health working group

A joint DCS and SA Health working group will be established to oversee and facilitate collaboration on implementation of Action area 3, Strategy 6 (p.43), and any other action determined by SASBAC and/or the DCS Statewide Performance Group as requiring high-level collaborative deliberation.

### Communicable Disease Control Branch, SA Health

- > development and oversight of the implementation of statewide BBV health policy and action plans
- > disease surveillance and investigation
- > supply vaccine for at-risk adults under the SA Health Access to Free Hepatitis B Vaccine policy<sup>19</sup>
- > administration of funding to non-government organisations
- > liaising with the Commonwealth and other state and territory health departments
- > facilitation of the mid-term review and final evaluation of this Action Plan.

### Department for Correctional Services

- > facilitation of access to health service providers including through both in-reach services and transport to external services
- > facilitation of education for custodial staff
- > facilitation of consultation with prisoners through Prisoner Needs Committees
- > facilitation of education and awareness-raising for prisoner populations.

### **SA Prison Health Service, SA Health<sup>ii</sup>**

- > provision of hepatitis B vaccination
- > provision of BBV related testing, treatment, care and support
- > provision of medication assisted treatment for opioid dependence (MATOD)
- > referral of prisoners with BBVs to specialist services
- > referral of prisoners living with, or at risk of acquiring, BBVs to post-release services.

### **Drug and Alcohol Services South Australia, SA Health**

- > advises on a whole-of-government approach to prevent the use of illicit drugs and the misuse of licit drugs
- > advises on policy relating to tobacco, alcohol and other drugs
- > provides or brokers a range of prevention, intervention and treatment programs across the State with a particular focus on high risk groups and behaviours
- > advises on evidence-based practice, including provision of guidance and advice regarding primary prevention of BBVs among people who inject drugs
- > implementation of relevant sections within Action area 3, Strategy 6.

### **Central Adelaide Local Health Network**

- > implementation of statewide/local policy and programs
- > provision of specialist services including in-reach services
- > delivery of post-release health services.

### **Other Local Health Networks**

- > implementation of statewide/local policy and programs
- > provision of specialist services including in-reach services
- > delivery of post-release health services.

### **Non-government organisations**

- > provision of information and support to individuals and groups
- > referrals to clinical and support services
- > provision of prisoner development and education
- > provision of workforce development and education
- > provision of peer support
- > provision of health promotion including prevention education
- > provision of specialised guidance enabling agencies to provide culturally safe services for specific priority populations, including Aboriginal people, people born in high prevalence countries, and people who inject drugs.

### **South Australian Health and Medical Research Institute**

- > collaboration with stakeholders to set future research agenda
- > development of new evidence and dissemination of research findings
- > attract research funding.

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ii At Mt Gambier Prison, the Department for Correctional Services is responsible for prisoner health care. At the time of writing this document, DCS had subcontracted G4S Custodial Services to provide these services.

## 2. Background

This section outlines the prevalence of BBVs in Australian prisons, and provides a summary of HIV, hepatitis B and hepatitis C. It also underlines the relevance of the national approach to drugs in Australia, including its application within the prison system. Finally, as the most prevalent BBV within the Australian prison system, this section discusses the prisons important role in addressing hepatitis C as a public health issue.

### 2.1 Prevalence of blood borne viruses in Australian prison populations

The prevalence of BBVs is disproportionately high amongst people in custodial settings. Currently, the prevalence of chronic hepatitis C, chronic hepatitis B and HIV within the community is approximately 1%, 1% and 0.1% respectively. By contrast, approximately 30-40% of the prison population are living with hepatitis C, 3-4% of the prison population are living with hepatitis B, and 0.2% of the prison population are living with HIV<sup>20</sup>.

The high rate of BBVs in correctional settings reflects the large number of people entering prison on drug-related offenses and/or with drug dependence issues<sup>21</sup>. The prevalence also reflects transmissions occurring within prisons, which is predominately attributed to sharing injecting drug equipment<sup>22,23</sup>. A recent study in NSW verified this phenomena through identifying and confirming transmission events of hepatitis C occurring between people who inject drugs whilst in prison. This study established direct evidence of ongoing hepatitis C transmission within a prison setting<sup>24</sup>. Other risk factors for BBV transmission within prisons include sharing tattooing and piercing equipment, unprotected sex, and physical violence<sup>25,26</sup>.

### 2.2 National approach to drugs: Harm minimisation

Since 1985, the Australian Government has operated within a harm minimisation framework to address illicit and licit drug use in Australia. In recognition of the high rates of drug use amongst prisoner populations, the strategic document guiding this national approach, the *National Drug Strategy*, identifies prisoners as a priority population.

Associations between incarceration, the uptake of drugs, risky drug use behaviours, BBVs and socio-economic disadvantage are well established<sup>27,28</sup>. Incarceration is a significant potential harm associated with the use of illicit drugs, resulting primarily from the criminalisation of many forms of drug use, and the use of criminal proceeds to support drug dependence<sup>20</sup>.

Minimising harms associated with drug use is the primary goal of the overarching national framework. The Framework employs three approaches ('the three pillars of harm minimisation') to reach this objective; supply reduction, demand reduction and harm reduction. It is argued the former two approaches, especially supply reduction, receive overwhelming precedence in prison settings<sup>29</sup>.

**Supply reduction** initiatives aim to prevent, stop, disrupt or otherwise reduce the production and supply of illicit drugs. Supply reduction also aims to control, manage and regulate the availability of licit drugs. Predominantly undertaken by law and border enforcement agencies or within the prison system by correctional officers, this approach broadly involves detecting and seizing illegal drugs, preventing illegal drug manufacture and sale, obstructing organised crime, and licensing and policing access to licit drugs through efforts such as prescription medications and, in the community, the sale of alcohol and tobacco<sup>21</sup>.

**Demand reduction** programs aim to prevent the uptake, or delay the onset, of drug use; reduce the misuse of licit and use of illicit drugs; and support people to address or manage drug dependence<sup>21</sup>. Overall, these initiatives seek to reduce the demand for drugs in Australia, meaning there are fewer consumers of drugs and fewer drugs consumed. The scope of this approach is wide reaching, and includes drug education; public awareness campaigns; drug and alcohol counselling; withdrawal and rehabilitation services; and taxation and regulation of controlled substances. Demand reduction initiatives within South Australian prisons include drug treatment services such as withdrawal services for prison entrants, drug and alcohol programs, drug-free units, and medication assisted treatment of opioid dependence (MATOD). Due to limitation on available resources, health services within prisons are largely confined to providing support during the withdrawal phase<sup>30</sup>.

MATOD is a noteworthy demand reduction initiative offered in all South Australian prisons (including Mount Gambier Prison), whereby people dependent upon heroin or other opioids are prescribed a legal longer-lasting substitute. Approximately 9% of all prisoners receive MATOD at any one time<sup>29</sup>. People admitted into prison who are already on MATOD for opioid dependence are assessed for continuation of the program whilst in prison<sup>29</sup>. These programs reduce illicit opioid use, risky injecting behaviours, and crime<sup>31</sup>, including amongst people who continue to inject drugs<sup>32</sup>. A study found people who remain on MATOD upon leaving prison reduce their risk of re-incarceration by 20%<sup>33</sup>.

**Harm reduction** approaches aim to reduce adverse health, social and economic consequences of licit and illicit drug use<sup>21</sup>. These initiatives necessarily acknowledge that drug use and drug misuse occur despite supply and demand reduction efforts. Accordingly, the programs work towards reducing harms and promoting safer drug use practices. Examples of harm reduction initiatives in the community include drug diversion programs that direct people who are found with small quantities of illicit drugs into treatment services rather than the criminal justice system; smoke-free zones; sobering-up facilities; and community clean needle programs (CNP).

## 2.3 Clean needle programs

Introduced in Australia in 1986 in response to the emergence of HIV, CNP are internationally recognised as the primary harm reduction initiative in the prevention of BBV transmissions. The programs provide free and legal access to sterile injecting equipment and sharps disposal facilities to people who inject drugs (PWID). One of the leading responders to HIV amongst PWID internationally, Australia was an early adopter of CNP services and promptly increased the size and geographical scope of the programs<sup>34</sup>. These actions are credited for the low prevalence (less than 1%<sup>35</sup>) of HIV amongst PWID in Australia compared to nations that were slower to implement CNP services, or those with no, or far less comprehensive services<sup>33,iii</sup>.

It is estimated that CNP averted 32,050 new HIV infections and 96,667 new hepatitis C infections in Australia in the years 2000-2009<sup>36</sup>, and that for every dollar invested in CNP, more than four dollars are returned in healthcare savings<sup>35</sup>. Economic analysis has shown that CNP averted HIV and hepatitis C infections saved the Australian healthcare system \$220 million during this period, and a projected \$950 million in future costs<sup>37</sup>.

Amongst other benefits, studies also indicate CNP encourage access to health services (including drug dependence treatment) by people who would otherwise avoid contact with services due to the unlawful nature of their drug use<sup>38</sup>.

## 2.4 Prison clean needle programs

No prison clean needle programs (prison-CNP) currently operate in Australia, despite international evidence of the benefits and efficacy of these programs. Most notably, lessons from prison-CNP find the programs have reduced BBV transmissions; reduced sharing and reuse of injecting equipment; and reduced instances of needle-stick injuries amongst staff. Furthermore, there have been no recorded cases of needles provided by prison-CNP being utilised as weapons; no observable increases in the use of drugs (injecting or otherwise); and despite early reservations, prison staff have accepted and supported CNP after a short period of time<sup>28,39</sup>. Currently, eight countries host CNP in prisons (elsewhere known as prison needle and syringe programs). In Spain, where CNP operate in every prison nationwide, the first ten years of the program saw the overall prevalence of HIV amongst prisoners reduce by more than half, and the prevalence of hepatitis C fall from 40% of the prison population to 26%<sup>40</sup>. Combined implementation of MATOD, prison-CNP services and, more recently, 'treatment as prevention' (discussed in section 2.13), is the most effective means of mitigating hepatitis C transmissions in prisons<sup>23,41</sup>.

iii Historically, CNP were established in response to the emergence of HIV, which was officially identified in 1984. The prompt implementation of CNP are internationally attributed to the low rates of HIV amongst Australian PWID (approximately 1-2% prevalence). However, the prevalence of hepatitis C amongst PWID is approximately 57%. Hepatitis C is more infectious than HIV, and was officially identified many years after it had already become widely prevalent amongst PWID. Officially identified in 1989, retroactive tests of blood samples from 1971 revealed the virus had already reached wide dispersal amongst PWID. Therefore, hepatitis C had greater capacity (through increased infectiousness), and more time, to unknowingly transmit within injecting communities. CNP have prevented significant rates of hepatitis C transmissions; made significant savings in health care costs; and are credited with maintaining stable rates of hepatitis C amongst PWID, without which higher rates would exist. Studies argue a reduction in hepatitis C prevalence will require a collaborative approach that includes harm reduction programs, such as CNP and MATOD, coupled with widespread treatment, which is now possible through the new highly effective and tolerable treatments for hepatitis C.

## 2.5 Prevalence of injecting in Australian prison populations

The Kirby Institute's annual *Australian Needle and Syringe Program Survey National Data Report 2011-2015* found that 10-12% of PWID in the community had spent time in prison during the 12 months preceding each survey, and of those, approximately one in three continued to inject drugs while in prison<sup>42</sup>. Whilst it is estimated that 1.5% of the Australian population have ever illicitly injected drugs<sup>43</sup>, the *2013 National Prison Entrants' Blood Borne Virus Survey* indicates that of the 793 Australian prisoners surveyed when entering prison:

- > 44% of those screened had (at some point) injected drugs and, of those, 67% had injected within the past month.
- > 86% of PWID had done so for more than three years, indicating the prisoner population is characterised by drug dependence and long-term use.
- > 90% of people who had injected drugs reported using clean needles for 'all' or 'most' of their injections in the month prior to entering prison, indicating their familiarity with and access to community CNP.

Injecting equipment is currently considered contraband throughout all prisons in Australia, leading to a scarcity of sterile injecting equipment amongst the prisoner population. It is reported that prisoners find it more difficult to smuggle injecting equipment into prisons than drugs, and that used injecting equipment is far cheaper to acquire than sterile equipment in these environments<sup>22,44</sup>. These factors promote, and even necessitate, sharing and reuse of injecting equipment, especially amongst those who are most economically disadvantaged.

## 2.6 Individual risk mitigation and decision making

Recent research finds re-use and sharing of needles and syringes are highly selective and strategic acts that occur when prisoners feel they have no alternatives<sup>45</sup>. The final decision to borrow or share with another person occurs as a last resort and is often made in conjunction with complex and highly resourceful protective practices attempting to mitigate risk to self and to others, for example:

- > sharing with people that they have a close personal relationship with
- > sharing with someone whose BBV status is believed to be known, and the same as their own<sup>iv</sup>
- > sharing on the condition that the recipient takes responsibility for 'cleaning' before reuse.

For the individual, entering prison adds a whole new set of complexities impacting their decisions to re-use and share injecting equipment. Complexities such as:

- > the lack of access to sterile injecting equipment
- > the fact that injecting equipment is only available as contraband
- > the new social and power relationships that may exist between prisoners
- > the inherent risks associated with BBV status disclosure.

One recent Australian study also reports there have been instances where prisoners attempt to acquire used intra-muscular injecting equipment from sharps disposal units in the health centre due to the assumption they were less likely to contain infected blood<sup>22</sup>.

These factors reduce options available to prisoners to mitigate risk in relation to sharing injecting drug equipment.

iv As there are numerous hepatitis C genotypes and subtypes, people already living with hepatitis C are at risk of acquiring a mixed infection (two distinct variants of the hepatitis C virus) if they share injecting equipment with someone else living with the virus. A recent study suggests mixed infections may have implications for treatment outcomes with the new direct acting antiviral treatments (Cunningham et. al. 2015).

## 2.7 Drug incidents in South Australian prisons in 2014/15

As reported in the 2014/15 DCS Annual Report, there were 1,102 'drug incidents' in South Australian prisons during the 2014/15 financial year<sup>46</sup>. In this instance, the definition of a 'drug incident' includes various circumstances, such as the discovery of illicit drugs or drug use paraphernalia (including items such as injecting equipment or burnt tin foil); the discovery of misuse of prescription medications; and instances whereby visitors attempt to smuggle illicit drugs or drug use equipment into the prison<sup>47</sup>. Increases in 'drug incidents' in the 2014/15 financial year are attributed to increased and targeted supply reduction measures and technologies.

**Table 1: Drug incidents within South Australian prisons in 2014/2015**

Prison	No. of incidents
Adelaide Remand Centre	17
Adelaide Pre-Release Centre & Adelaide Women's Prison	39
Cadell Training Centre	29
Mobilong Prison	66
Mount Gambier Prison	76
Port Augusta Prison	51
Port Lincoln Prison	35
Yatala Labour Prison	789
<b>TOTAL</b>	<b>1,102</b>

## 2.8 HIV

HIV is both a BBV and a sexually transmitted infection (STI). It is less infectious than viral hepatitis (hepatitis B and hepatitis C)<sup>48</sup>, but as with hepatitis C, it has no preventative vaccine. In the community, HIV prevention strategies include condom use, CNP services, post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), education, MATOD, and a range of strategies aimed at achieving high rates of testing and treatment.

Antiretroviral treatment (ART) for HIV serves a number of purposes. Firstly it is crucial in preventing HIV progressing to acquired immunodeficiency syndrome (AIDS), thereby extending a person's lifespan to within normal limits. Secondly, treatment dramatically reduces HIV viral load. A number of peer reviewed studies now demonstrate that a person with a sustained undetectable HIV viral load is virtually non-infectious<sup>49,50,51</sup>. Thus, 'treatment as prevention'<sup>52</sup> is an internationally accepted concept that drives new infection rates down through targeted programs that achieve high rates of diagnosis, early treatment and ongoing adherence to treatment. Whilst HIV treatment is available in Australian prisons, prisoners living with HIV may avoid treatment due to fears over compromised confidentiality, stigma and violence<sup>53</sup>.

Rates of HIV in Australian prison systems are similar to rates in the wider Australian community; however activities that carry a risk for HIV transmission, such as sharing injecting equipment, unprotected sex and unsterile body art increase the risk of ongoing, unchecked transmission in the absence of the highly effective harm reduction strategies available to the wider community. Studies have demonstrated that outbreaks of HIV do occur within Australian prisons<sup>54,55</sup>, which has onward public health implications for the wider community<sup>56</sup>. Prisoners and the prison workforce who experience a possible exposure to HIV should be eligible to receive HIV PEP. HIV PEP decreases the chances of the person acquiring the virus, but must be taken within 72 hours of the exposure<sup>57</sup>.

## 2.9 Hepatitis B

Compared to over 1% prevalence within the wider Australian population, hepatitis B disproportionately affects prisoner populations with approximately 3-4% of prisoners living with the virus<sup>19</sup>. Hepatitis B is both a BBV and a STI. For unvaccinated people, it is the most infectious of the BBVs discussed in this Action Plan with a 6-30% chance of transmission through percutaneous exposure (depending upon factors such as viral load)<sup>47</sup>. However, in adults, unlike children and babies, the risk of developing lifelong chronic hepatitis B is low<sup>v</sup>. In approximately 95% of cases, adults will develop an immune response to the hepatitis B virus that will clear<sup>vi</sup> the virus from their body within approximately six months of infection<sup>58</sup>. It should be noted, studies indicate clearance rates may be lower amongst PWID<sup>59</sup> and the current treatment for hepatitis B does not cure the virus.

Natural clearance coupled with an extensive vaccination program in Australia, lessens the prevalence of chronic hepatitis B occurring through risky activities undertaken during adulthood. Therefore, hepatitis B has not reached the same prevalence within the prison system as hepatitis C (approximately 30-40%), although the virus still represents disproportionate risk and prevalence in this environment. People who do experience a possible exposure to hepatitis B may be eligible to receive hepatitis B PEP. Hepatitis B PEP decreases the chances of the person acquiring the virus, but must be taken within 72 hours of the exposure<sup>60</sup>.

The majority of chronic hepatitis B infections in Australia are amongst people born in endemic countries (56.1% of cases) including Asian regions, Pacific regions and sub-Saharan African nations<sup>59</sup>. Of people born within Australia, the priority populations include people from Aboriginal communities (9.3%), within which it is likely the virus has been present for thousands of years<sup>61</sup> and for whom the majority of infections occurred prior to the infant vaccination program<sup>62</sup>; people who inject drugs (5.7%); and men who have sex with men (4.4%)<sup>63</sup>. People in prison who identify with these categories are at a higher risk of living with the virus.

Whilst there is no cure for chronic hepatitis B, treatment reduces the risk of progressive liver damage, cirrhosis and liver cancer. Recent research suggests that just four years of treatment for hepatitis B reduces the risk of cancer by more than half<sup>64</sup>. However, it is estimated that nearly half of all people in Australia living with chronic hepatitis B remain undiagnosed<sup>63</sup>, and therefore many of them are not connected to care.

Treatment for hepatitis B is only provided at certain phases of the virus, and therefore, people living with chronic hepatitis B require regular monitoring (at least every six months) to determine the phase of their virus. Continuity of care is highly important within the prison system as in the wider community, as liver damage can worsen through interrupted treatment<sup>57</sup>.

## 2.10 Hepatitis B vaccine distribution

The most effective means of protection against hepatitis B; the provision of hepatitis B vaccinations, is highly important within both the prisoner population and the prison workforce. Furthermore; within an environment with significant rates of hepatitis C, vaccination against hepatitis B is crucial in the prevention of co-infection, which is associated with accelerated progression of liver disease<sup>58</sup>.

In South Australia, prisoners require a test to determine if they are susceptible to hepatitis B infection. If so, they are offered free hepatitis B vaccine available under the SA Health High Risk Hepatitis B Immunisation Program<sup>65</sup>. Funded by DCS, hepatitis B vaccinations are also available and recommended for correctional officers. For adults, the vaccination consists of three doses over six months, which provides lifelong protection to the majority of people<sup>vii</sup>.

v In the worldwide context, the vast majority of chronic hepatitis B infections occur perinatally in high prevalence countries. This means the virus is transmitted from a mother living with hepatitis B to her child around the time of birth. In Australia, all babies born to mothers with hepatitis B should be provided immunoglobulin and a vaccination with 12 hours of birth to significantly reduce, from approximately 95% to 5%, the chance of developing chronic hepatitis B.

vi Low levels of hepatitis B DNA remains in people who acquire hepatitis B but clear the virus within approximately six months. Although a person who clears the infection in six months is considered to have recovered from hepatitis B, in cases where the person goes on to experience severe immunosuppression, such as during chemotherapy, the virus may reactivate.

vii There are processes to follow for people who are non-responders to the three-course dose of the hepatitis B vaccination. These people generally require additional doses of the vaccine. For people who cannot achieve immunity via vaccination even after receiving additional doses, the availability of Hepatitis B PEP should be noted. If these people experience a possible exposure to the virus, they should seek hepatitis B PEP within 72 hours of the exposure, which will lessen their chances of infection. For more information, please see: ASHM, 2014. *B Positive: All you wanted to know about hepatitis B: A guide for Primary Care Providers*. 2nd edition. Darlinghurst: NSW.



Incarceration also presents an opportunistic time to complete vaccination schedules. As stated in the *South Australian Prison Health Service Model of Care*, prisoners often report they have not received the three-doses necessary to complete the full course of hepatitis B vaccination, and therefore complete the series of vaccinations during their time in prison. This confers benefits to the wider community upon a patient's release by reducing the risk of transmission through high risk behaviours, such as intravenous drug use and needle sharing<sup>29</sup>.

## 2.11 Hepatitis C

Classified as a BBV only (although sexual transmission can occur if blood is present<sup>66</sup>), hepatitis C is the most prevalent of the known BBVs within Australian prisons. Approximately 30-40% of the prison population in Australia are living with hepatitis C<sup>19</sup>, compared to 1.8% prevalence amongst the general population<sup>67</sup>.

Although transmission risks are similar for all BBVs within a prison setting, a number of factors increase the prevalence of hepatitis C in these environments. Largely, it is the association between unsterile injecting as the primary route of transmission for hepatitis C, drug dependence, and incarceration. Accounting for approximately 80% of overall infections, and over 90% of new infections, sharing injecting drug equipment is the primary route of transmission for hepatitis C within Australia<sup>68</sup>.

Compounding the risk of acquiring the virus, hepatitis C does not have a preventative vaccination like hepatitis B, and it is more infectious than HIV<sup>47</sup>. Furthermore, approximately 75% of people (of all ages) infected with hepatitis C develop a chronic infection<sup>69</sup>. This means they will require treatment to be cured of the virus, or risk developing a lifelong infection.

## 2.12 New hepatitis C treatment regimens

The rationale for providing treatment for prisoners living with hepatitis C is to:

- > achieve a sustained virological response (a cure) which will prevent further transmissions to other prisoners and to members of the community on release. This is known as 'treatment as prevention'.
- > reduce the future costs of managing hepatitis C related liver disease, including liver transplants and liver cancer, in the individual being treated and others who would have otherwise been infected through onward transmission.

Until recently, interferon-based therapies were the standard treatment for hepatitis C. They involved prolonged treatment times of between six to 12 months and a number of potential, and even likely, adverse side effects. During the era of these treatments, uptake in Australia remained low with only 1-2% of people living with the virus receiving treatment each year<sup>70</sup>.

In March 2016, new direct acting antiviral (DAA) treatments were listed on the Pharmaceutical Benefits Scheme (PBS). With the advent and availability of DAAs, duration of hepatitis C treatment considerably reduced, with most people only requiring 12 weeks of therapy, and tolerability has significantly increased, with most people experiencing no or minor side effects. Furthermore, the new treatments result in higher rates of sustained virological response (SVR), with cure rates of more than 90%<sup>40</sup>.

With these marked improvements, DAAs have created a crucial opportunity to significantly increase treatment numbers, reduce the viral pool, and contribute to the World Health Organization's (WHO) global target of elimination<sup>viii</sup> of hepatitis C by 2030. As with any infectious disease, elimination requires the continued presence of measures to prevent reestablishment of transmission, as people cured of hepatitis C, or who spontaneously clear the virus, do not have immunity and can therefore be reinfected if they are re-exposed<sup>40</sup>.

The availability of DAAs have significantly increased access to treatment in Australia, with more people accessing treatment in the five month period following the PBS listing of the new medications (March-July 2016) than the cumulative number of the previous three years<sup>71</sup> (see Figure 1).

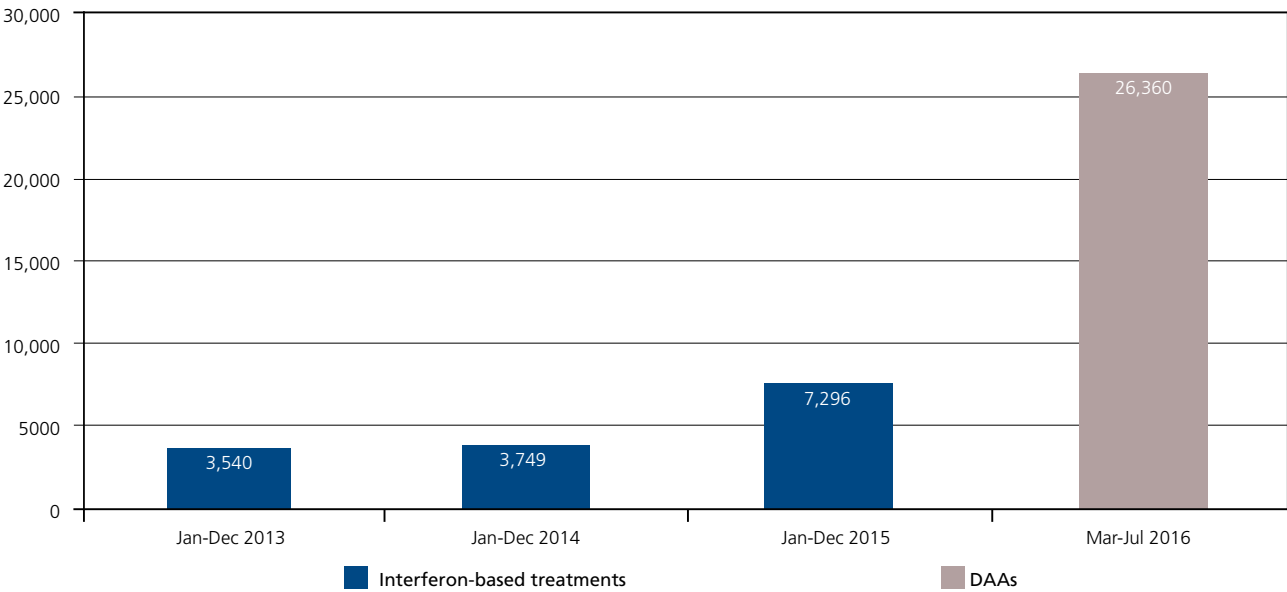
viii Elimination is defined as a reduction of hepatitis C transmissions to zero through targeted and deliberate efforts within specifically defined areas.



As well as those who were discouraged due to the duration and side effects of the previous treatments, DAAs provide an opportunity to treat many patients previously considered too complex or unwell to treat (e.g. people on short custodial sentences, people with significant cirrhosis and in poor health, people with co-morbid mental health issues).

Whilst healthcare for prisoners is usually funded by respective state and territory governments, the Commonwealth Government is currently funding the new medications for prisoner populations, highlighting the importance of treating this priority population. For details of prisoner DAA access, please see Figure 3: South Australian prisoner hepatitis C treatment access according to specified time periods and treatment type.

**Figure 1: Hepatitis C treatment access in Australia according to specified time periods and treatment types**



Data source: The Kirby Institute, Hepatitis B and Hepatitis C in Australia: Annual Surveillance Report Supplement, 2016.

### 2.13 Hepatitis C treatment as prevention

Through achieving high rates of treatment, the overall prevalence of the virus decreases and subsequently reduces the number of people from whom the virus can transmit. This is known as ‘treatment as prevention’, and requires targeted treatment towards people who currently engage in risky activities<sup>72</sup>.

Studies find this approach will have the greatest impact over the long term if targeted towards settings associated with the highest risk of transmission such as prisons<sup>40</sup>. It is also argued that treatment of prisoners with the aim of preventing transmissions is essential to reducing the overall burden of this disease<sup>27</sup>. With ongoing access to a high prevalence environment with a number of marginalised people and/or current PWID who may otherwise be isolated from both testing and treatment services, prisons play an important public health role in preventing hepatitis C transmissions in the community<sup>73</sup>.

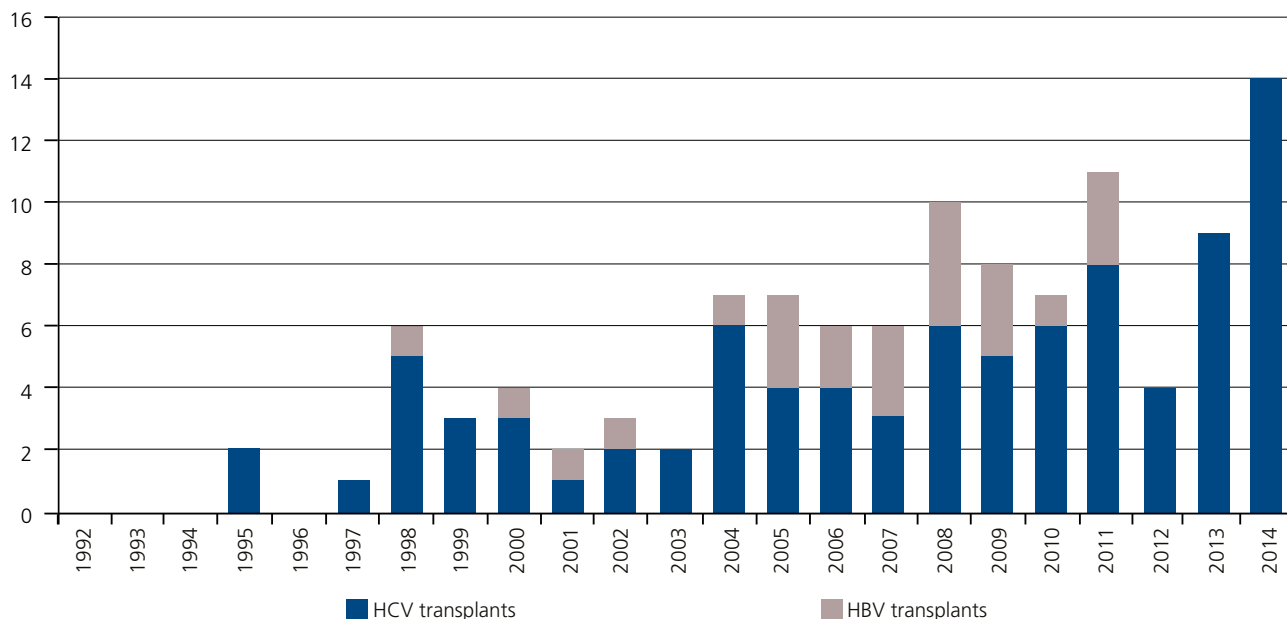
Without engaging in preventative approaches, including ‘treatment as prevention’, prisons are environments that concentrate, amplify, and subsequently perpetuate onward transmission of hepatitis C and other BBV into the community<sup>74</sup>. Furthermore, the significant and expanding reservoir of hepatitis C virus inside prisons is also an occupational hazard for correctional officers. Through implementing evidence-based prevention strategies, increasing testing, supporting the provision of education, and offering treatment to every infected prisoner, workplace safety is improved<sup>38,75</sup>.

## 2.14 Liver disease

Viral hepatitis is the leading cause of primary liver cancer in Australia, and liver cancer is now the fastest increasing cause of cancer death in the country<sup>76</sup>. Modelling of primary liver cancer projections by the Australian Institute of Health and Welfare<sup>77</sup> for 2011-2020 predicts a doubling in the number of new cases in Australia, primarily attributed to viral hepatitis (see Appendix C: National primary liver cancer). Only possible since the advent and availability of DAAs, widespread treatment provision of DAAs has the capacity to curtail this increasing burden of liver disease<sup>69</sup>.

Current data from the South Australian Liver Transplant Unit, Flinders Medical Centre, presented in Figure 2 below, reveals a sharp increase in the number of patients receiving liver transplants due to viral hepatitis.

**Figure 2: Hepatitis B and hepatitis C related liver transplants in South Australia, 1992-2014**  
(Total = 112)



Data source: SA Liver Transplant Unit, Flinders Medical Centre, 14 August 2015.

Of the total of 112 hepatitis B and hepatitis C related liver transplants in South Australia since 1992, five patients were Aboriginal people.

Modelling published by the University of New South Wales estimated the cost (2008 Australian dollars) of liver transplants to the health system at:

- > \$120,000 per transplant; and
- > \$13,300 per annum thereafter<sup>78</sup>.

### 3. Specialist hepatitis nursing support

A needs-assessment conducted in Australian prisons found accessibility to specialist hepatitis nurses and consultants was the most frequently recommended approach to improving viral hepatitis services in the prison system<sup>74</sup>. In 2016, two separate nursing models of care were released that, in part, seek to improve services for prisoners living with viral hepatitis in South Australia.

#### 3.1 South Australian Prison Health Service Model of Care

The role of SA Prison Health Service (SAPHS) is the provision of primary health services to adults incarcerated in state<sup>ix</sup> run adult correctional facilities in South Australia.

Endorsed in September 2016, the South Australian Prison Health Service Model of Care<sup>74</sup> (SAPHS MoC) guides the delivery of health services by a multidisciplinary team within the corrections environment, and solidifies strong links with external care providers. Specifically, in relation to BBVs in the prison system, the SAPHS MoC states “the reduction in BBVs including hepatitis B, hepatitis C and HIV in prisons is a public health priority. The responsibility for prevention, testing, monitoring, treatment and management of BBVs in the SA prison population is shared amongst various government agencies including SA Health, the Department for Correctional Services and non-governmental services. SAPHS plays a pivotal role in coordinating BBV care for patients including linking patients to relevant hepatitis/HIV services when leaving the prison system”. Prison health services also have specific BBV Link Nurses to lead the process in addressing BBVs in the prison system.

Impacting BBVs in DCS prisons, the SAPHS MoC states that prison health services provide the following services:

- > Ensures that medication is issued in a responsible and professional manner;
- > Ensures staff and prisoners have necessary equipment and training to implement best practice infection prevention and control measures, with a particular focus on education around BBVs due to high prevalence amongst prisoner populations;
- > Ensures staff and prisoners receive education about Standard Precautions, and are encouraged to follow these procedures at all times, with the assumption that all blood and bodily fluids are potentially infectious;
- > Ensures prisoners are offered testing for relevant communicable diseases, including viral hepatitis and HIV, and staff members have access to testing as required;
- > Ensures all prisoners and staff members living with communicable diseases have access to counselling and referral to relevant services as required;
- > Provide evidence based immunisation including those to prevent BBVs;
- > Provide the authority for duly qualified medical practitioners to provide medication assisted treatment of opioid dependence;
- > Ensures that requests from any prisoner are dealt with in accordance with the relevant legislation, policy and ethical standards on patient confidentiality.

The SAPHS MoC also establishes links with non-governmental pre- and post-release BBV support services, including SHINE SA, MOSAIC Blood Borne Viruses Support Services (Relationships Australia South Australia) and Hepatitis SA.

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<sup>ix</sup> This does not include Mount Gambier Prison, which is privately owned.

### 3.2 Nursing Model of Care: For Viral Hepatitis Management in South Australia

Endorsed by SA Health in August 2016, the *Nursing Model of Care: For Viral Hepatitis Management in South Australia*<sup>79</sup> (2015 revision) details work that will be undertaken by the Viral Hepatitis Support Nurses within the prison system.

The Viral Hepatitis Support Nurses support the work of SAPHS, particularly the BBV Link Nurses identified in each prison. While the prisoner's primary, day to day health care is provided by SAPHS staff, the Viral Hepatitis Support Nurses working in partnership with the RAH Viral Hepatitis Centre may provide expert advice to support pre-treatment work up and treatment monitoring by BBV Link Nurses. They may also provide direct services such as FibroScan®, specialist liaison, in-reach clinics and the education and mentoring of SAPHS clinical staff.

Importantly, as well as hepatitis C, it should be noted that the Viral Hepatitis Support Nurses may also assist in managing chronic hepatitis B infections.

Viral Hepatitis Support Nurses may work in partnership with the RAH Viral Hepatitis Centre in decisions to refer to specialists or GPs outside the RAH Viral Hepatitis Centre. This referral decision may include considerations such as minimising patient waiting times, or the long term clinical/psychosocial needs of the patient.

## 4. Support services

The following services are actively supporting the implementation of this Action Plan. Some are able to provide in-reach services within prisons, and all are able to provide support and/or provide referrals to prisoners post-release.

### **Aboriginal Health Council of South Australia (AHCSA)**

AHCSA's Aboriginal Viral Hepatitis Coordination Program and Sexual Health Program build capacity and coordinate links in relation to viral hepatitis and sexual health within Aboriginal Community Controlled Health Services. The Aboriginal Viral Hepatitis Coordination Program also coordinates treatment pathways with the Viral Hepatitis Nursing Support Program to facilitate service access for Aboriginal people; and provides guidance to agencies working to address viral hepatitis to ensure appropriate services for Aboriginal people.

Phone: 8273 7200

Website: [ahcsa.org.au](http://ahcsa.org.au)

### **Clean Needle Programs**

Drug and Alcohol Services South Australia (DASSA), SA Health coordinates the Clean Needle Program in South Australia. Services are provided at a range of sites in metropolitan and country South Australia.

Phone Alcohol and Drug Information Service: 1300 131 340

Website: [www.sahealth.sa.gov.au/dassa](http://www.sahealth.sa.gov.au/dassa)

### **Clean Needle Program Peer Projects (program of Hepatitis SA)**

The CNP Peer Projects Program is staffed by workers who have personal experience and knowledge of injecting drug use. This service provides peer education about safer injecting to PWID at a number of CNP sites in South Australia. CNP Peer Educators also provide information and referrals in regards to hepatitis B, hepatitis C and HIV.

Phone: 1800 437 222

Website: [hepatitissa.asn.au](http://hepatitissa.asn.au)

### **Hepatitis SA**

Hepatitis SA provides information, education and support services to South Australians affected by hepatitis B and hepatitis C. All services are free and include the Prison Hepatitis Helpline (prisoners dial '8' for a free 10 minute phone-call with Hepatitis SA), Hepatitis SA Helpline (1800 437 222), face to face information sessions (prior bookings required), support groups, community and workforce education sessions, printed resources, and online information including a website and online hepatitis library.

Phone: 1800 437 222

Website: [hepatitissa.asn.au](http://hepatitissa.asn.au)

### **MOSAIC Blood Borne Viruses Support Services, Relationships Australia South Australia**

MOSAIC Blood Borne Viruses Support Services provides free and confidential counselling, case management support, advocacy and problem solving support, as well as information and referrals to other relevant community or health services, to people affected by HIV or viral hepatitis.

Phone: 1300 364 277 or 1800 182 325 (country callers)

Website: [www.rasa.org.au](http://www.rasa.org.au)

### **PEACE Multicultural Services, Relationships Australia South Australia**

PEACE Multicultural Services is a statewide service that provides support and assistance to people from culturally and linguistically diverse (CALD) communities. Specifically, the service assists CALD people at risk of, or affected by HIV, STI, viral hepatitis, and other related issues, such as gambling.

Phone: 1300 364 277 or 1800 182 325 (country callers)

Website: [www.rasa.org.au](http://www.rasa.org.au)

### **RDNS SA HIV Enhanced Primary Care Coordination Program**

The RDNS SA HIV Enhanced Primary Care Coordination Program provides coordinated care and support to people with HIV and AIDS in South Australia.

Phone: 1300 364 264

Website: [www.silverchain.org.au/sa](http://www.silverchain.org.au/sa)

### **SAMESH (a program of SHINE SA and Victorian AIDS Council)**

SAMESH (South Australia Mobilisation + Empowerment for Sexual Health) provides support, education and training about sexual health and HIV for men who have sex with men and people living with HIV in South Australia. SAMESH also provides condoms, HIV point of care testing (Rapido!), and resources to their priority populations.

Phone: 7099 5300

Website: <http://www.samesh.org.au/>

### **South Australian Sex Industry Network**

The South Australian Sex Industry Network (SIN) provides peer support, education, information, advocacy and referral services for sex workers in South Australia.

Phone: 8351 7626

Website: [www.sin.org.au](http://www.sin.org.au)

### **SHINE SA**

SHINE SA provides education, clinical services and counselling to the community about sexual, reproductive and relationship health and wellbeing. Amongst other services, SHINE SA provides clinical services at three SAPHS prison sites, and operates a Sexual Healthline.

Phone: 1300 794 584

Sexual Healthline: 1300 883 793 or country callers 1800 188 171

Website: [www.shinesa.org.au](http://www.shinesa.org.au)

## 5. Other considerations for blood borne virus prevention in prisons

### 5.1 Telemedicine

All South Australian prison sites have portable telehealth units connected to the SA Digital Telehealth Network. The use of telemedicine in conjunction with APRI (aspartate aminotransferase to platelet ratio index) testing, and other relevant blood tests, will remove a significant barrier to accessing the new treatments for many prisoners. Those with low APRI scores ( $>1.0$ ) and no clinical signs of cirrhosis, may be permitted to attend specialist appointments via telehealth services, and may not require travel to an appointment. Prisoners with higher APRI scores will likely need to attend a face-to-face appointment, especially in cases where portable FibroScan® equipment is unavailable and/or where medical staff decide a face-to-face specialist appointment is necessary<sup>29</sup>.

### 5.2 Condom access

In Australia, access to condoms in prison was first provided in New South Wales, occurring in 1996 following a class action by prisoners<sup>80</sup>. Currently, access and supply is inconsistent within South Australian prisons. Ensuring access is readily available in all South Australian prisons is important as HIV and hepatitis B are sexually transmissible viruses, and there is a heightened risk of hepatitis C transmission amongst men who have sex with men (MSM) who are living with HIV<sup>81,82</sup>. Research about condom access in prisons finds condoms are more likely to be used if they are made available, and condom access does not increase rates of consensual sex, sexual assault, or threats of sexual assault<sup>79</sup>.

### 5.3 Exploring feasibility of rapid testing in the prison system

Non-invasive rapid tests for BBVs within prison increase case-finding, testing rates, and the likelihood of prisoners, especially those with short sentences, receiving their results<sup>73</sup>. Exploring their feasibility within the prison system is recommended<sup>72</sup>.

### 5.4 Opt-out testing for blood borne viruses

Prisons have a unique opportunity to engage highly marginalised populations into a health service. Achieving high rates of testing for BBVs within this population is an important public health objective. It is recommended that BBV tests are offered routinely on entry to the prison, 6-12 months thereafter and upon release<sup>73</sup>. 'Opt out' testing involves an individual being advised that a BBV test will be undertaken unless they actively refuse, compared to an 'opt in' approach whereby testing is offered to all prisoners who then decide whether they will take the test. Studies suggest both of these testing approaches are valid and possible within prison systems, although the 'opt out' approach results in higher testing numbers<sup>73</sup>. The aim of implementing an 'opt out' approach is to not only increase testing numbers, but to consequently increase the number of people accessing treatment for hepatitis C; and vaccination or management for hepatitis B. For any testing approach, consideration is required towards gaining informed consent<sup>83</sup>; fear of stigma and discrimination; pre and post-test counselling; and available resources<sup>73</sup>.

## 5.5 Programs addressing violence in South Australian prisons<sup>45</sup>

In 2014-15, programs addressing violence, including sexual violence, within DCS prisons included:

- > **Violence Prevention Program:** An intensive, group-based treatment program for prisoners and community based offenders who are assessed as having a medium to high risk of violent re-offending. The program is run over a period of approximately nine months and is approximately 260 hours in duration.
- > **Sexual Behaviours Clinic:** A specialised therapeutic group program that provides treatment to offenders who have been convicted of a sexual offence (against either adult or child victims) and who have been assessed as being moderate to very high risk of sexual re-offending. The program runs for approximately 230 hours and is delivered over a nine month period.
- > **Sexual Behaviours Clinic-me (SBC-me):** An intensive, group-based treatment program for adult male sexual offenders who have been identified as having a mild to borderline level of intellectual disability, or cognitive deficits, that would preclude them from participating in mainstream therapeutic programs. The program is run over a 14 month period and comprises approximately 300 group-based hours.

## 5.6 Clean barbering equipment

Please see the SA Health *Guideline on the Public Health Standard of Practice for Hairdressing*<sup>84,85</sup>. When shared amongst people, electric hair-clippers should always be used with the clipper attachment (often plastic). The clipper attachment can then be cleaned with the recommended disinfectant, and the clipper body can be wiped down with the recommended disinfectant<sup>84,86</sup>. If a clipper attachment is unavailable, or correct cleaning cannot occur, a personal razor should be used.

## 5.7 Tattooing and body art

Compliance with Australian infection control standards for tattooing and body art reduces the risk of transmission of hepatitis C in custodial settings<sup>8</sup>.

## 5.8 Boxing gloves

If boxing gloves are shared amongst prisoners, single-use or clean personal protective inserts should consistently be worn<sup>87</sup>.

## 5.9 Safe forms of disinfectant

*The Hepatitis C Prevention, Treatment and Care: Guidelines for Australian Custodial Settings* support the provision of safe forms of disinfectant and bleach in prisons for decontaminating spills, surfaces or equipment, where no other safer alternative is available<sup>8</sup>.



## 6. Unique challenges of custodial environments

Prisons are highly dynamic environments with an ongoing thoroughfare of prisoners entering and leaving the system, and being transferred to other prisons, court appearances and medical appointments. This presents unique challenges in relation to the treatment of chronic illnesses, such as:

- > **Frequent transfers between prisons.** This contributes to difficulties in achieving complete and accurate clinical handover, and may disrupt continuity of care.
- > **Delays to treatment.** Depending on disease stage, some prisoners require specialist consultation or diagnostic procedures (such as FibroScan® - used to assess liver scarring) which may not be available within prisons. This requires prisoners to attend public hospital appointments with external escorts.
- > **Disincentives to treatment for the individual.** Whilst essential, security measures used for external escorts to public hospital appointments (such as handcuffing, no notification to prisoner in advance of appointment time and no information given to prisoner on destination) are disincentives for a number of prisoners<sup>x</sup>. The expansion of telemedicine and access to portable FibroScan® are expected to reduce the need for external appointments.
- > **Continuity of care on release.** Short sentence lengths and the volume of turnover of prisoners, many directly from the court, challenge the capacity to provide continuity of care<sup>xi</sup>.
- > **Accommodation and access pressure.** High density accommodation with temporary security lock-downs, as a result of enacting surge capacity procedures, can create challenges at many stages of chronic disease management. These issues impact on many of the factors listed above, such as transporting prisoners to medical appointments<sup>88,89</sup>.

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x Feedback provided by prisoners to clinical staff at the Royal Adelaide Hospital.

xi See Appendix E: Data tables – Table E5

## 7. Blood borne viruses in South Australian prisons

This section provides summary information<sup>xii</sup> related to service delivery within prisons, namely:

- > estimated number of people with BBVs in prisons
- > number of prisoners being treated for BBVs
- > numbers of BBV tests performed on prisoners
- > number of hepatitis B vaccines distributed to prisons
- > number of prisoners receiving information and education related to BBVs
- > number of correctional officers receiving information and education related to BBVs
- > number of incidents where prison officers have been exposed to a BBV transmission risk.

This section also discusses the likely gaps in current service delivery and the challenges and opportunities involved for both departments in further developing services within prisons.

### 7.1 People with blood borne viruses in South Australian prisons

Based on the daily average number of prisoners<sup>xiii</sup> and ASHM's prevalence estimates<sup>19</sup>, at any point in time the total number of people living with a BBV in South Australian prisons ranges from 869-1,160. This comprises 79-105 (3-4%) people living with hepatitis B, 788-1,050 (30-40%) people living with hepatitis C, and 2-5 (0.1-0.2%) people living with HIV (for more detail, see Table E2, pg. 52).

### 7.2 Prisoner blood borne virus treatment snapshots

Summarised below are the estimated numbers of prisoners accessing treatment for BBVs in South Australia<sup>xiv</sup>.

#### 7.2.1 HIV treatment

Of the 2-5 people estimated to be living with HIV in prisons at any one time, it is estimated that all<sup>xv</sup> were accessing treatment for the virus as at October 2016.

#### 7.2.2 Hepatitis B treatment

Of the 79-105 people estimated to be living with hepatitis B in prisons at any one time, less than five<sup>xvi</sup> were accessing treatment for the virus as at October 2016. Treatment for hepatitis B is provided only at certain phases of the viral infection (based on viral load and extent of liver damage). Australia's *Second National Hepatitis B Strategy 2014-2017* recommends that at least 15% of people living with chronic hepatitis B (i.e. those that satisfy the clinical guidelines) should be receiving treatment at any given time<sup>90,91</sup>. This means approximately 16 people<sup>xvii</sup> in South Australian prisons should be accessing treatment for hepatitis B at any one time. All people living with chronic hepatitis B require regular monitoring (at least every six months) to determine the current phase of the virus in their body<sup>57</sup>. People receiving treatment also require regular monitoring<sup>57</sup>.

xii Additional data and/or breakdowns by prison site are available as Appendices.

xiii As per data provided by DCS regarding 2014/15.

xiv Estimates for the number of prisoners accessing treatment for HIV and hepatitis B are provided via a snapshot of people accessing treatment in October 2016. Estimates for the number of prisoners accessing treatment for hepatitis C are provided via snapshot of people accessing treatment in September 2016, as the specialist responsible for a large number of hepatitis C prescriptions for South Australian prisoners was not available for the entirety of October 2016.

xv As per estimate from SAPHS, October 2016.

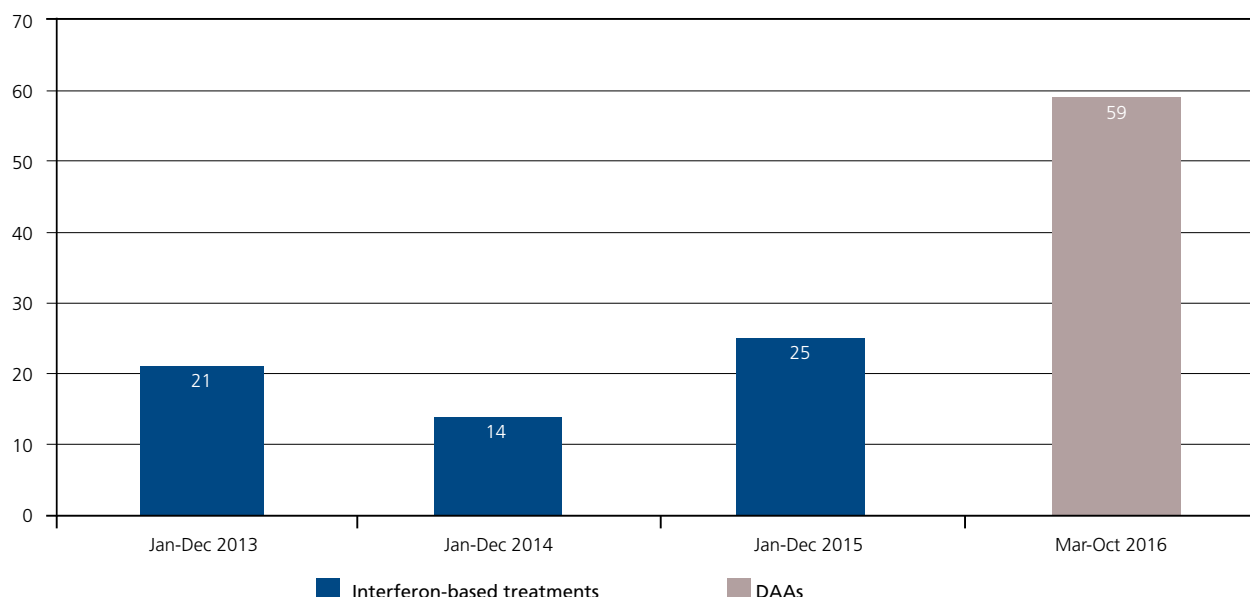
xvi As per estimate from SAPHS, October 2016.

xvii This figure was determined by calculating 15% of the estimated 105 people living with hepatitis B in South Australian prisons.

### 7.2.3 Hepatitis C treatment

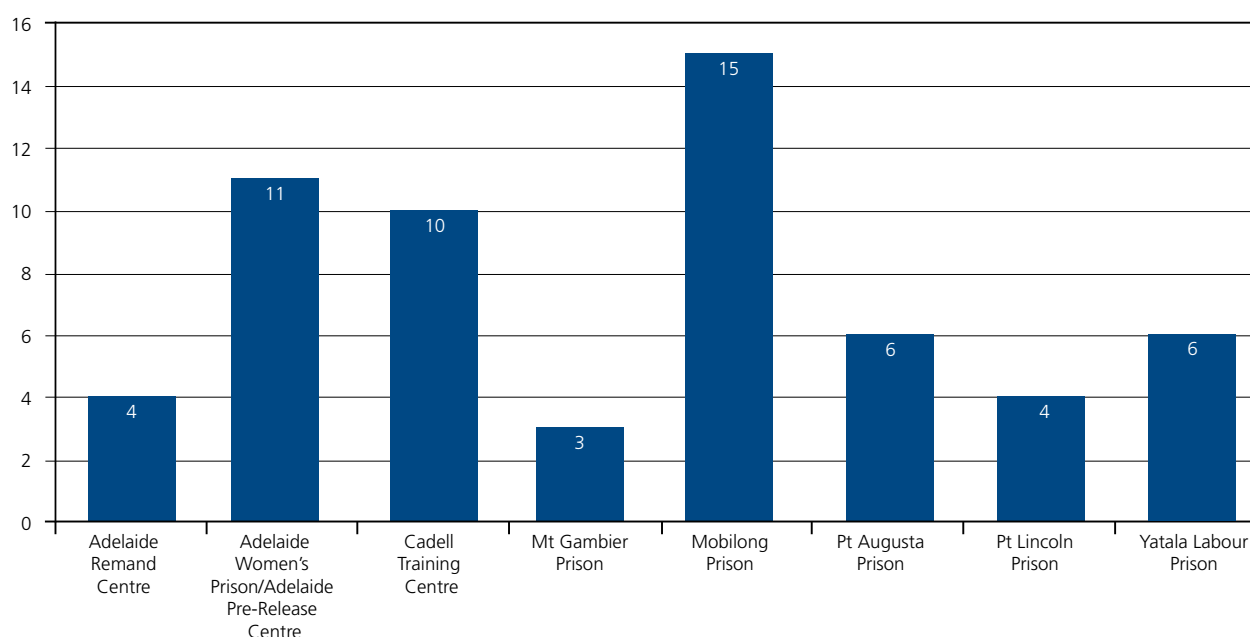
Of the 788-1,050 prisoners living with hepatitis C in prisons at any one time, 13<sup>xviii</sup> were accessing treatment in September 2016. Since being listed on the PBS in March 2016, availability of DAAs to prisoners (and the wider community) has coincided with significant increases in access to hepatitis C treatment in prisons. The number of prisoners who accessed treatment for hepatitis C in the eight month period following the listing of DAAs on the PBS (March-October 2016) was equivalent to the aggregate total for the previous three years combined (see Figure 3 and Figure 4).

**Figure 3: South Australian prisoner hepatitis C treatment access according to specified time periods and treatment type**



Data source: Royal Adelaide Hospital, Viral Hepatitis Centre.

**Figure 4: Number of South Australian prisoners accessing hepatitis C DAA treatment between March-October 2016**



Data source: Royal Adelaide Hospital, Viral Hepatitis Centre.

xviii As per data provided by Royal Adelaide Hospital, Viral Hepatitis Centre, October 2016.

### 7.3 Blood borne virus tests performed on prisoners in South Australia

In DCS prisons, some prisoners are offered BBV testing on entry. Whilst data related specifically to testing on entry is unavailable, Table 2 summarises the total number of BBV tests performed on prisoners for a 12 month period from 1 July 2014 to 30 June 2015. This data is for all tests completed, some of which were on entry and some during a prisoner's term. Therefore, some prisoners may have been tested more than once. Similarly, the total prisoner admissions include people who have been admitted more than once during the year.

**Table 2: Number of BBV tests performed on prisoners and the number of positive results between 1 July 2014 - 30 June 2015**

Test	Number of tests	Number of positive tests*	% Positive**	Total prisoner admissions	Testing level (tests/total prison admissions)
Hepatitis B	964	28	3%	5,725	17%
Hepatitis C	1,301	273	21%	5,725	23%
HIV	1,286	10	1%	5,725	22%
<b>TOTAL</b>	<b>3,551</b>	<b>311</b>			

Data source: Test counts - SAPHS/SA Pathology Report as at June 2015; Total prisoner admissions – DCS 2014/2015.

Note Aboriginality unavailable as not collected on Pathology Request form.

\* The number of tests may be greater than the number of individuals, as tests may be carried out more than once per year for an individual, which is often the case for individuals who disclose drug use.

\*\* %positive differs from ASHM prevalence estimates in Section 2.1. Table 2 represents tests performed over a year by various staff, and was not collected using scientific methods.

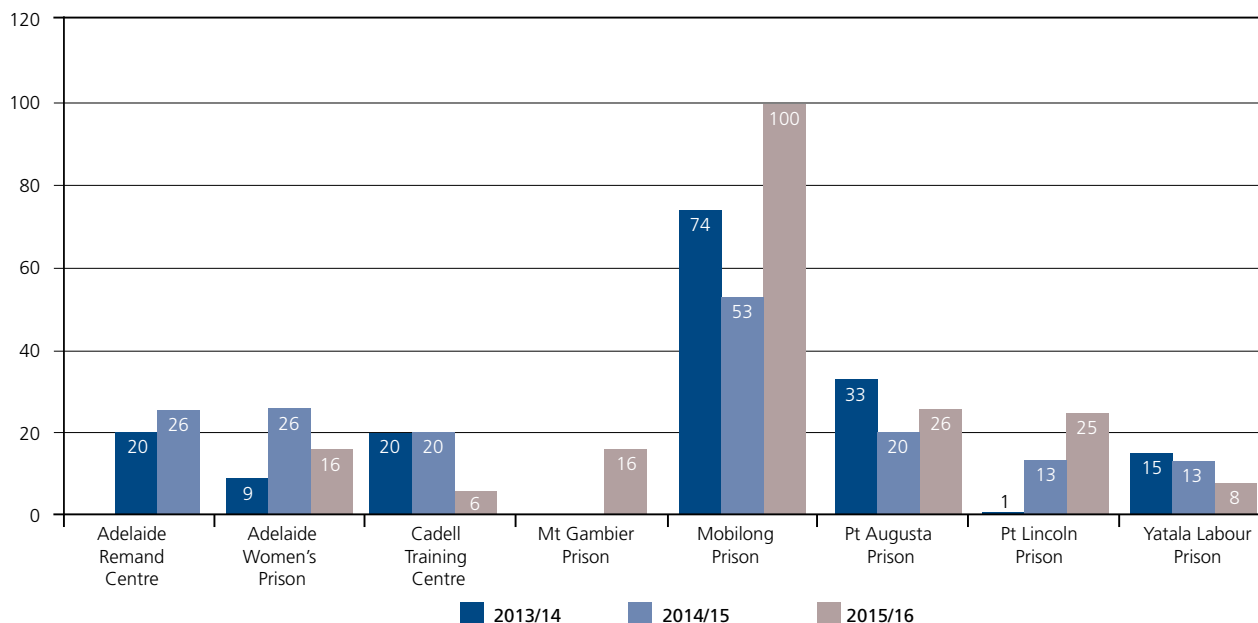
### 7.4 Hepatitis B vaccines distributed to South Australian prisons

In South Australia, prisoners require a test to determine if they are susceptible to hepatitis B infection, and if so, they are offered free vaccine available under the SA Health High Risk Hepatitis B Immunisation Program<sup>64</sup>. For adults, the vaccination consists of three doses over six months, which provides lifelong protection to majority of people<sup>xix</sup>.

There is no data available on the number of individuals achieving vaccination coverage, Figure 5 presents the total number of vaccines distributed to each prison (divided by three<sup>xx</sup>), in the last two financial years as a proxy for the number of people receiving vaccination.

xix There are processes to follow for people who are non-responders to the three-course dose of the hepatitis B vaccination. These people generally require additional doses of the vaccine. For people who cannot achieve immunity via vaccination even after receiving additional doses, the availability of hepatitis B post-exposure prophylaxis (HBV PEP) should be noted. If these people experience a possible exposure to the virus, they should seek HBV PEP within 72 hours of the exposure, which will lessen their chances of infection. For more information, please see: Australasian Society of HIV and Viral Hepatitis Medicine, 2008. B Positive: All you wanted to know about hepatitis B: A guide for primary Care Providers. Darlinghurst: NSW.

**Figure 5: The number of doses of hepatitis B adult vaccine distributed to each prison in 2013/14 to 2015/16**

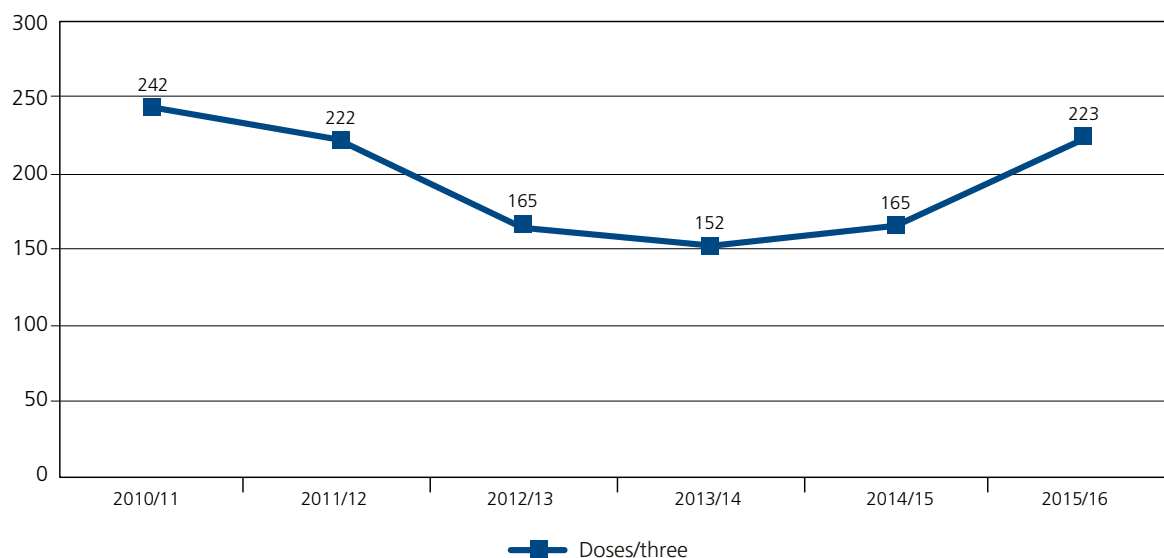


Data source: SA Health, Immunisation Section, Communicable Disease Control Branch on 7 July 2015 and 31 October 2016.

Note: Data has been divided by three as the vaccine is given in three doses, however it should be noted that some prisoners may be completing their vaccination schedule, rather than commencing it from the first dose.

Across the state, the number of hepatitis B vaccines being ordered by prisons declined from 242 in 2010/11 to 152 in 2013/14, before rising to 223 again in 2015/16 (Figure 6).

**Figure 6: Total number of doses of hepatitis B adult vaccine (HBVAXII) distributed to prisons from 2010/11 to 2014/15**



Data source: SA Health, Immunisation Section, Communicable Disease Control Branch on 7 July 2015 and 31 October 2016.

Note: Future vaccines intend to use two dose accelerated schedule.

## 7.5 Prisoner blood borne virus education

Table 3 summarises the total number of prisoners attending education sessions related to viral hepatitis in the periods 2013/14, 2014/15 and 2015/16 as a percentage of the average number of prisoners. Sessions aim to increase awareness of transmission risks and myths, testing, treatment, stigma and discrimination, disclosure, hepatitis B vaccination, harm reduction practices and available services.

**Table 3: Number of prisoners attending viral hepatitis education sessions from 2013/2014 to 2015/2016**

Prisons	13/14 attend. no.	14/15 attend. no.	15/16 attend. no.	Daily AVG prisoners 14/15	% of daily AVG attended education in 14/15	Admissions in 14/15
Adelaide Remand Centre	-	-	-	308	-	-
Adelaide Women's Prison / Adelaide Pre-Release Centre*	73	72	142	235	30%	-
Cadell Training Centre	-	29	17	190	15%	-
Mt Gambier Prison	-	120	51	326	33%	-
Mobilong Prison	-	100	102	353	28%	-
Port Augusta Prison	-	71	51	493	14%	-
Port Lincoln Prison	-	66	49	172	38%	-
Yatala Labour Prison	8	-	-	548	-	-
<b>TOTAL</b>	<b>81</b>	<b>458</b>	<b>412</b>	<b>2,625</b>	<b>17%</b>	<b>5,725</b>
Change on 2013/14	+377 (465% increase)					
Change on 2014/15	-46 (10% decrease)					
<b>% OF ADMISSIONS</b>						<b>8%</b>

Data sources: Hepatitis SA and the Department for Correctional Services. Data on Aboriginality is unavailable.

\* As they are located at the same site, figures from Adelaide Women's Prison and Adelaide Pre-release Centre are combined.

Table 3 illustrates that between 2013/14 and 2014/15 there was a significant increase (from 81 to 458) in the total number of prisoners accessing education sessions on viral hepatitis conducted by Hepatitis SA. Although the number slightly decreased (to 412 prisoners) in the 2015/16 financial year, this figure still represents a marked increase since concerted efforts were made to specifically target this priority population. However, the highest recorded rate of enrolment in these education sessions (458 in 2014/15) still only represents 17% of the daily average (2,625) number of prisoners, and 8% of the total number (5,725) of individuals admitted to prison during this financial year.

Currently, the decision to provide prisoner BBV education is determined by each prison. In 2014/15 and 2015/16, no BBV education sessions were held in Yatala Labour Prison. In the same financial years, the Adelaide Remand Centre did not provide any group education sessions to prisoners, however it should be noted that 28 prisoners received one-on-one education from the Hepatitis SA Treatment Peer Education Team<sup>xx</sup>. It should also be noted that MOSAIC Blood Borne Viruses Support Services provides counselling and case management services in Adelaide Women's Prison and Mobilong Prison, as well as to people on parole or home detention.

<sup>xx</sup> One-on-one peer education services are also provided at Adelaide Pre-Release Centre

## 7.6 Prison expos

To raise awareness about viral hepatitis and available services (including the Prison Hepatitis Helpline), Hepatitis SA also attends prison health expos. In the 2014/15 financial year, the organisation attended expos at Mobilong Prison and Port Lincoln Prison, and engaged with 300 and 120 prisoners respectively. In the 2015/16 financial year, the organisation attended expos at the Adelaide Remand Centre and Port Lincoln Prison, and engaged 63 and 120 prisoners respectively.

## 7.7 Prison officer information and education

In May 2015, Hepatitis SA commenced work with DCS to pilot the provision of viral hepatitis education to DCS staff, including those within Central Office. Since completion of the pilot, education continued to expand in 2015/16. During this period, 572 DCS staff attended education sessions, which equates to approximately 48% of workers. It should be noted that SAPHS, Hepatitis SA, and the Viral Hepatitis Support Nurses have also provided education sessions to a number of nurses within the prison system, using these sessions to inform prison health staff of new hepatitis C treatments.

Table 4 below summarises the total number of DCS staff that attended an education session in the period 2014/15.

**Table 4: Number of DCS staff attending viral hepatitis information/education sessions from May-June 2015 and July-June 2015/2016**

Location	2014/15	2015/16
Central office	16	94
Fort Largs Academy (new recruits)	25	117
Adelaide Remand Centre	20	44
Adelaide Women's Prison	0	66
Cadell Training Centre	0	17
Mobilong Prison	13	47
Port Augusta Prison	0	103
Port Lincoln Prison	0	39
Yatala Labour Prison	0	0
<b>TOTAL</b>	<b>74 (6% of staff)*</b>	<b>572 (48% of staff)*</b>

Data sources: Hepatitis SA and the Department for Correctional Services.

As the education session was tailored to DCS correctional staff, education was not provided to Mount Gambier Prison correctional staff as this is a privately owned prison.

\* Total number of corrections staff: 2014/15 1,070; 2015/16 1,172. These are approximate figures as they do not include other operational services staff in community corrections or central office; offender development staff; or administrative staff that may work across prison sites.

## 7.8 Prisoner to correctional officer transmission risk

As of June 2015, DCS reported seven occupational health and safety (OHS) incidents that involved blood during the period 1 July 2014 to 30 June 2015. None of these OHS incidents related to drug injecting equipment and of the seven incidents with blood involved, none were assessed by DCS as a risk of transmitting a BBV to a correctional officer.

## 8. Access to usual care

The term 'usual care' in this Action Plan means the full spectrum of medical and public health interventions that are routinely available to people in the general community or practised by clinicians when providing care and treatment.

In 2013, the World Health Organization's (WHO) Joint United Nations Programme on HIV/AIDS, (UNAIDS) published a policy brief titled *HIV Prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*. This policy brief outlined 15 interventions that constitute the essential components of a response to HIV within prisons or other closed settings<sup>92</sup> and includes activities such as information provision, hepatitis B vaccination, counselling, treatment, preventing sexual violence, access to clean needles and sterile tattooing, and reducing risk to correctional officers (See Appendix B: Summary of WHO UNAIDS HIV prevention interventions).

Outside of prison, the South Australian community has access to a similar suite of interventions as those that the WHO identifies as constituting 'usual care' for BBVs. These interventions form a set of evidence-based public health harm reduction strategies, which include easy access to the following:

- > testing targeted to high risk populations
- > hepatitis B vaccination targeted to high risk populations
- > information and education
- > promotion and provision of MATOD
- > free sterile injecting equipment and sharps disposal facilities
- > bleach for cleaning injecting equipment (as a last resort in the absence of single-use sterile injecting equipment)
- > sterile tattooing and piercing services
- > clean toothbrushes, razors and hair-clippers
- > antiviral treatments
- > HIV and hepatitis B post-exposure prophylaxis<sup>xxi</sup>

Where feasible and given the highly dynamic environment, this Action Plan aims to align the health services offered to prisoners with the 'usual care' available in the community.

### 8.1 Summary of gaps in usual care

While some prisoners do have access to harm reduction education, testing and treatment, many of the major public health interventions are not provided in South Australian prisons. Table 5 outlines each of the elements of medical and public health interventions that are accessed by people in the community and reports on the current status for prisoners.

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xxi Post-exposure prophylaxis is preventive medical treatment (antiviral HIV or hepatitis B medication) started immediately after exposure in order to prevent infection and the development of disease. There is no post-exposure prophylaxis available for hepatitis C.



**Table 5: Items considered usual care and prevention strategies in the community vs those accessed by prisoners**

Usual care and/or prevention strategy	Status for SA prisoners
Promotion and provision of hepatitis C testing amongst target groups (to confirm case, and determine transmission risk, management and treatment approach).	Approximately 23% of prisoners currently receive BBV testing. <sup>xxii</sup>
Access to information and education (to minimise transmission risks, increase treatment uptake and increase adherence to medication and safe practices).	BBV education sessions for prisoners are provided by Hepatitis SA. Sessions were attended by 81 participants in 2013/14, 458 participants in 2014/15 and 412 participants in 2015/16. The peak figure recorded in 2014/15 represented 8% of total admissions for that financial year.
Promotion and provision of medication assisted treatment for opioid dependence to reduce injecting and crime rates upon release.	Available in all South Australian prisons (including Mount Gambier Prison). Approximately 9% of all prisoners receive MATOD at any one time <sup>29</sup> .
Access to clean toothbrushes, razors and nail clippers (to reduce the risk of transmission).	Items are provided as requested at a cost to prisoners. However, prisoners report they do not always have the funds to purchase these items.  Prisoners have access to one razor at a time, and must exchange their old razor to access a new one.
Access to clean barbering equipment i.e. hair clippers or razors (to reduce the risk of transmission).	Hair clippers are shared, but access to cleaning materials is provided.  Prisoners have access to one razor at a time, and must exchange their old razor to access a new one.
Access to free sterile injecting equipment, disposal facilities, and related peer education.  South Australia currently has approximately 85 community CNP, six syringe vending machines and 220 pharmacy CNP.  Hepatitis SA CNP Peer Educators provide peer education services at a number of metropolitan CNP sites in South Australia.	Not available.
Access to bleach.	Not available.
Access to sterile tattooing and piercing.	Not available.
Access to condoms and lubricant.	Not available in all prisons, nor readily accessible.

continued

xxii See Table 2: Number of BBV tests performed on prisoners between 1 July 2014 - 30 June 2015 and number of positive results.

Usual care and/or prevention strategy	Status for SA prisoners
Access to antiviral medications (to reduce viral load and transmission risk)	<p>Since DAA medications became available for South Australian prisoners, treatment uptake for hepatitis C in this population has increased significantly. As the most prevalent BBV in this environment, large numbers of prisoners require treatment.</p> <p>HIV treatment is available. Based on prevalence estimates and reported treatment uptake in the South Australian prison system, it is estimated that there are currently similar numbers of people living with HIV as there are people accessing treatment for HIV in this setting.</p> <p>Hepatitis B treatment numbers are low in the South Australian prison system. At the time of publication fewer than 5 people in prison were accessing treatment. This is significantly lower than the state and national targets for hepatitis B treatment uptake would indicate for this setting.</p>
Access to hepatitis B vaccination (free under various programs for priority populations)	Free hepatitis B vaccinations are available under the SA Health High Risk Hepatitis B Immunisation Program
Access to HIV and hepatitis B post-exposure prophylaxis at major hospitals in the case of blood exposure	Available through admission to hospital Emergency Departments.

Sources: Department for Correctional Services, Royal Adelaide Hospital, SA Prison Health Service and Hepatitis SA.

## 8.2 Opportunities

Opportunities exist to close the gap between the services available to prisoners and services available to the general community, including:

- > enhance screening and hepatitis B vaccination for prison entrants
- > develop new models of in-reach specialist care, including the use of telemedicine services, to reduce the need for prisoners to be transported to hospital outpatient clinics
- > develop protocols for connecting prisoners with Viral Hepatitis Support Nurses on entry to prison, and upon release in the community
- > develop protocols to effectively manage the treatment of people living with hepatitis B in the prison system
- > improve testing and vaccination record keeping processes
- > enhance the role and skill base of SAPHS nurses to include the management of viral hepatitis
- > offering advanced BBV training to GPs consulting at SAPHS
- > increase the number of prisoner education sessions to raise awareness of transmission risks, increase willingness to be treated, and reduce isolation from support services upon release
- > offer training to SAPHS staff on HIV and hepatitis B PEP
- > offer workforce development with correctional officers to enable greater engagement in the development of shared protocols to improve BBV management in prison and on-release
- > further increase access to diagnostic procedures (for example FibroScan®)
- > ensure consistent access to condoms and lubricant across all prisons in South Australia
- > fully examine over the course of the Action Plan the enablers and barriers in policy, evidence, health and safety, and legislation toward implementing the full suite of harm reduction strategies available to the wider SA community
- > increase clinical and community capacity to facilitate the above.

## 9. Implementation and monitoring

### 9.1 Governance and monitoring

Overall monitoring of this Action Plan will be undertaken by:

- > The SA Health South Australian Sexually Transmissible Infection and Blood Borne Virus Advisory Committee (SASBAC)
- > The Department for Correctional Services Statewide Performance Group.

Progress reports will be jointly prepared twice a year by the Implementation Group (DCS and SA Health). Responsibility for coordination of this process will be shared between DCS and SA Health, alternating between each party.

Collection of performance indicators and/or output measures will contribute to a mid-term stocktake and final review of this Action Plan.

In 2018, the mid-term stocktake will be conducted jointly by DCS and SA Health.

The aim of the stocktake report is as follows:

- > provide a brief on any major changes to the epidemiological, social, economic, clinical and political context through an environmental scan
- > broadly describe the successes, difficulties and learnings gained from the first part of the implementation process
- > assess the degree of completion of each of the priority action areas and related strategies
- > report on available performance indicators and/or output measures
- > recommend an updated set of priorities for the remaining life of this Action Plan
- > describe an agreed process for the final review of this Action Plan.

### 9.2 Joint DCS and SA Health working group

A joint DCS and SA Health working group will be established to oversee and facilitate collaboration on implementation of Action area 3, Strategy 6 and any other action determined by SASBAC and/or the DCS Statewide Performance Group as requiring high-level collaborative deliberation and coordination.

# 10. Detailed strategies and actions

The priority action areas of the *South Australian Prisoner Blood Borne Virus Prevention Action Plan 2017-2020* are:

Action area 1: Prisoner blood borne virus education and workforce development for staff working in correctional settings

Action area 2: Testing, vaccination, treatment, care and support of prisoners living with blood borne viruses

Action area 3: Implementation of evidence-based harm reduction strategies

Action area 4: Governance and partnerships to enable and monitor actions.

The following tables detail the South Australian strategies, actions, output measures, timelines, lead agencies and partners of the *South Australian Prisoner Blood Borne Virus Prevention Action Plan 2017-2020*.

In these tables, lead agencies are listed against each action. The role of the nominated lead agency is to provide leadership in ensuring the implementation of the specified action.

## Action area 1: Prisoner blood borne virus education and workforce development for staff working in correctional settings

Strategy	Action	Performance indicator and / or output measure	Lead agencies and partners
1. Build capacity of prisoners to prevent BBV transmission in the prison setting.	a. Provide prisoner education on BBV prevention that includes: <ul style="list-style-type: none"> <li>&gt; testing</li> <li>&gt; vaccination for hepatitis B (HBV)</li> <li>&gt; treatment options including benefits of early treatment</li> <li>&gt; transmission risks</li> <li>&gt; keeping safe in prison</li> <li>&gt; post-exposure prophylaxis (HIV and HBV)</li> <li>&gt; living with BBVs post-release</li> <li>&gt; reducing stigma and discrimination and empowering priority populations</li> <li>&gt; disclosure.</li> </ul>	i. Number of prisoners attending education sessions. ii. Sessions evaluated to determine level of effectiveness, and assess participant knowledge.	Lead: Hepatitis SA Department for Correctional Services (DCS) SA Health, SA Prison Health Service (SAPHS) MOSAIC BBVs Support Services (MOSAIC) South Australian Sex Industry Network (SIN) Aboriginal Health Council of SA (AHCSA) Other non-government organisations (NGO) providing pre and post-release services
	b. Engage with and resource Aboriginal Elders and other Aboriginal Health Workers (including Aboriginal Health Practitioners, Aboriginal Sexual Health Workers and Aboriginal Liaison Officers) to raise prisoner awareness and knowledge on BBV prevention and safer sexual practices.	i. Number of Aboriginal prisoners provided education/information. ii. Sessions evaluated to determine level of effectiveness, and assess participant knowledge.	
	c. Consult Aboriginal Elders and other Aboriginal Health Workers (including Aboriginal Health Practitioners, Aboriginal Sexual Health Workers and Aboriginal Liaison Officers) about training packages delivered to Aboriginal prisoners.	i. Number of consultations between in-reach prisoner training providers and Aboriginal Elders and other Aboriginal Health Workers	Lead: AHCSA Hepatitis SA SHine SA Other NGOs providing pre and post-release training services
	d. Aim to employ Aboriginal Health Workers within prison health services.	i. Number of Aboriginal Health Workers employed within prison health services.	Lead: SAPHS
	e. Provide cultural competence training to non-Aboriginal health workers and correctional officers.	i. Number of non-Aboriginal health workers and correctional workers undertaking cultural competence training. ii. Sessions evaluated to determine level of effectiveness, and assess participant knowledge.	Lead: DCS AHCSA

continued

## Action area 1: Prisoner blood borne virus education and workforce development for staff working in correctional settings

Strategy	Action	Performance indicator and / or output measure	Lead agencies and partners
	f. Provide resources that specifically cater to the needs of the prisoner, ensuring they are sensitive to the prisoner's culture, literacy level, and/or comprehension of the English language.	<ul style="list-style-type: none"> <li>i. Number and name of resources deemed suitable for the prisoner population distributed to individual prisoners and prisons.</li> <li>ii. Number and name of resources tailored specifically to the needs of Aboriginal people and people from CALD backgrounds distributed to individual prisoners and prisons.</li> </ul>	Joint Lead: AHCSA and PEACE Multicultural Services (PEACE) Hepatitis SA SHine SA DCS SAPHS
	g. Ensure prisoners and/or correctional officers who are responsible for cleaning up blood and other body fluids are trained and resourced to follow standard precautions.	<ul style="list-style-type: none"> <li>i. Policies, procedures, training and equipment in place.</li> </ul>	DCS SA Health
	h. Deliver health promotion and prevention activities	<ul style="list-style-type: none"> <li>i. Number of prisoners provided education.</li> <li>ii. Sessions evaluated to determine level of effectiveness, and assess participant knowledge.</li> </ul>	Lead: SAPHS DCS SHine SA Other NGOs providing pre- and post-release services
	2. Build capacity of correctional officers (both custodial and community) to prevent BBV transmission in the prison setting.	<ul style="list-style-type: none"> <li>a. Provide education to correctional officers (including community correctional officers) on BBV prevention that includes:               <ul style="list-style-type: none"> <li>&gt; testing vaccination for HBV</li> <li>&gt; treatment options including benefits of early treatment</li> <li>&gt; transmission risks</li> <li>&gt; keeping safe at work</li> <li>&gt; post-exposure prophylaxis (HIV and HBV)</li> <li>&gt; living with BBVs</li> <li>&gt; reducing stigma and discrimination and empowering priority populations</li> <li>&gt; disclosure.</li> </ul> </li> <li>b. Promote the Australian Institute of Social Relations' online learning course Blood Borne Viruses: An Orientation to correctional officers.</li> </ul>	Lead: Hepatitis SA DCS SAPHS Other NGOs providing pre and post-release services
		<ul style="list-style-type: none"> <li>i. <i>Blood Borne Viruses: An Orientation</i> online learning course promoted to correctional officers.</li> </ul>	Lead: Relationships Australia South Australia (RASA) Hepatitis SA

continued

## Action area 1: Prisoner blood borne virus education and workforce development for staff working in correctional settings

Strategy	Action	Performance indicator and / or output measure	Lead agencies and partners
3. Build capacity of healthcare workers to prevent BBV transmission in the prison setting.	<p>a. Provide healthcare worker education on BBV prevention that includes:</p> <ul style="list-style-type: none"> <li>&gt; testing including national policies</li> <li>&gt; vaccination for HBV</li> <li>&gt; treatment options including benefits of early treatment</li> <li>&gt; transmission risks</li> <li>&gt; keeping safe at work</li> <li>&gt; post-exposure prophylaxis (HIV and HBV)</li> <li>&gt; living with BBVs</li> <li>&gt; reducing stigma and discrimination &amp; empowering priority populations</li> <li>&gt; disclosure</li> <li>&gt; referral of prisoners living with BBVs, or at risk of acquiring BBVs, to post-release services.</li> </ul>	<p>i. Number of healthcare workers attending BBV education sessions.</p> <p>ii. Sessions evaluated to determine level of effectiveness, and assess participant knowledge.</p>	<p>Lead: SAPHS</p> <p>Hepatitis SA</p> <p>Other NGOs providing pre and post-release services</p>
4. Build capacity of community workers (in contact with prisoners) to prevent BBV transmission in the prison setting	<p>a. Provide community worker education on BBV prevention that includes:</p> <ul style="list-style-type: none"> <li>&gt; testing</li> <li>&gt; vaccination for HBV</li> <li>&gt; treatment options</li> <li>&gt; risk behaviours</li> <li>&gt; keeping safe at work</li> <li>&gt; post-exposure prophylaxis (HIV and HBV)</li> <li>&gt; living with BBVs</li> <li>&gt; reducing stigma and discrimination &amp; empowering priority populations</li> <li>&gt; disclosure</li> <li>&gt; referral of prisoners living with BBVs, or at risk of acquiring BBVs, to post-release services.</li> </ul>	<p>i. Number of sessions held with community workers that have contact with prisoners attending BBV education sessions.</p> <p>ii. Sessions evaluated to determine level of effectiveness, and assess participant knowledge.</p>	<p>Lead: Hepatitis SA</p> <p>SHine SA</p> <p>Other relevant NGOs providing pre and post-services</p>

continued

## Action area 2: Testing, vaccination, treatment, care and support of prisoners living with blood borne viruses

Strategy	Action	Performance indicator and / or output measure	Lead agencies and partners
1. Increase voluntary testing in prisoners.	a. Implement an 'opt out' approach to voluntary testing for all BBVs, with consideration for ethical issues noted in section 5.4 and with the aim of increasing access to hepatitis C (HCV) treatment; HBV management and HBV vaccination.	i. Process to implement 'opt out' approach is developed. ii. Number of BBV tests conducted (including any confirmatory and/or viral load testing).	Lead: SAPHS DCS Aboriginal Community Controlled Health Services (ACCHS)
	b. Improve record-keeping of tests undertaken.	iii. Evidence of increase to HCV treatment, HBV management, and HBV vaccination. iv. Evidence of work towards improved testing record-keeping.	
	c. Explore use/feasibility of existing and emerging testing technology for prisoners such as rapid testing for short-stay prisoners.	i. Evidence of feasibility assessment of utilising existing and emerging testing technology for prisoners explored. ii. Number of BBV tests undertaken utilising new technologies.	Lead: SAPHS DCS

continued



## Action area 2: Testing, vaccination, treatment, care and support of prisoners living with blood borne viruses

Strategy	Action	Performance indicator and / or output measure	Lead agencies and partners
2. Increase access by prisoners to blood borne virus management and care.	<p>a. Increase proportion of prisoners being referred to care and support pathways:</p> <ul style="list-style-type: none"> <li>&gt; increasing referrals for pre-treatment assessment and treatment</li> <li>&gt; increasing referrals to other support services</li> <li>&gt; increasing attendance at Prison Health Clinics</li> <li>&gt; improving access to medicines at early stages of disease</li> <li>&gt; reducing barriers to commencement and continuation of medications within, and upon exit of, the prison system.</li> </ul>	<p>i. Number of SAPHS BBV Link Nurse shifts worked per fortnight per prison</p> <p>ii. Number of Viral Hepatitis Support Nurse led clinics conducted per month per prison.</p> <p>iii. Number of prisoners commenced on HCV, HBV and HIV treatment in prison (including record of Aboriginal background of each prisoner commenced on treatment, if applicable).</p> <p>iv. Number of prisoners referred to MOSAIC, Shine SA (SAMESH) Counselling Service, RDNS SA or PEACE.</p> <p>v. Number of prisoner calls to the Hepatitis SA and Shine SA helplines with BBV related queries.</p>	<p>Lead: SAPHS</p> <p>DCS</p> <p>Viral Hepatitis Support Nurses</p> <p>HIV Nurses (RDNS SA, Central Adelaide Local Health Network (CALHN))</p> <p>Primary Health Networks</p> <p>RASA</p> <p>Hepatitis SA</p> <p>Shine SA</p> <p>ACCCHS</p>
	<p>b. Support linkage to care for prisoners with a BBV post-release.</p>	<p>i. A model supporting linkages to care developed between health sector stakeholders.</p>	<p>Lead: SAPHS</p> <p>DCS</p> <p>Viral Hepatitis Support Nurses</p> <p>HIV Nurses (RDNS SA, CALHN)</p> <p>AHCSA</p>

continued

## Action area 2: Testing, vaccination, treatment, care and support of prisoners living with blood borne viruses

Strategy	Action	Performance indicator and / or output measure	Lead agencies and partners
	c. Implement procedures in updated nursing models of care (see 3.1 and 3.2); including the enhancement of linkages into prisons by Viral Hepatitis Support Nurses; the formation of mentoring relationships between the Viral Hepatitis Support Nurses and SAPHS BBV Link Nurses; and improving access to FibroScan®.	<p>i. Qualitative feedback provided to governing bodies about the implementation of the <i>Nursing Model of Care: For Viral Hepatitis Management in South Australia</i> in regards to HCV and HBV management of prisoners.</p> <p>ii. Governance bodies to provide leadership in determining solutions to identified issues in undertaking actions relating to prisons in the <i>Nursing Model of Care: For Viral Hepatitis Management in South Australia</i>.</p> <p>iii. Mentoring relationships developed between SAPHS BBV Link Nurses and the Viral Hepatitis Support Nurses.</p> <p>iv. Processes to manage HBV in prison developed.</p>	Lead: SAPHS Viral Hepatitis Support Nurses
	d. Increase number of prison GPs with s100 prescriber accreditation for HBV and HIV, and prison GPs who are experienced in the treatment and management of patients with HCV.	<p>i. Number of prison GPs currently with s100 prescriber accreditation for HBV and HIV, and the number of prison GPs currently experienced in the treatment and management of HCV established.</p> <p>ii. s100 prescriber training opportunities disseminated to prison GPs.</p>	Lead: SAPHS SA Health, Communicable Disease Control Branch (CDCB)
3. Optimise health risk assessment for correctional officers at risk.	a. Work in partnership to develop an evidence-based risk assessment protocol for correctional officers at risk of BBV transmission through occupational exposure.	i. Protocol reviewed and any subsequent recommendations evaluated.	Lead: DCS CDCB

continued

## Action area 2: Testing, vaccination, treatment, care and support of prisoners living with blood borne viruses

Strategy	Action	Performance indicator and / or output measure	Lead agencies and partners
4. Increase access to HBV vaccination.	<p>a. Increase the number of HBV vaccinations provided to prisoners who are susceptible.</p> <p>b. Improve testing and vaccination record-keeping.</p>	<p>i. Number of prisoners tested on entry to check susceptibility to HBV.</p> <p>ii. Number of prisoners fully vaccinated for HBV (by Aboriginality), and evidence of vaccination-status recorded in prison health records.</p> <p>iii. Number of distributed doses of HBV vaccine to prisons in South Australia.</p>	<p>Lead: SAPHS</p> <p>CDCB</p>
5. Increase access to HIV and HBV post-exposure prophylaxis (PEP).	a. HIV and HBV PEP available for staff and prisoners.	<p>i. Evidence of HIV and HBV PEP procedures for both correctional staff and prisoners.</p> <p>ii. Number of incidents where BBV testing and HIV or HBV PEP may be indicated.</p> <p>iii. Number of instances where HIV and/or HBV PEP is provided to correctional staff or prisoners.</p>	<p>Lead: SAPHS</p> <p>DCS</p>
6. Develop a joint BBV health response procedure to incidents of suspected BBV exposure through injecting, tattooing or other risk behaviours by prisoners.	a. Provide access to timely counselling, education, testing and treatment for people exposed to the risk of acquiring a BBV whilst in prison.	<p>i. A joint BBV health response procedure for incidents of suspected BBV exposure developed and implemented.</p> <p>ii. Number of incidents involving a confirmed BBV transmission risk.</p>	<p>Lead: DCS</p> <p>SA Health</p> <p>Hepatitis SA</p> <p>SHine SA (SAMESH)</p> <p>MOSAIC</p>

continued

### Action area 3: Implementation of evidence-based harm reduction strategies

Strategy	Action	Output Measures	Lead agencies and partners
1. Provide access to safe forms of disinfectant for cleaning equipment that presents a significant risk of spreading BBVs.	a. Provide access to safe forms of disinfectant for cleaning equipment.	i. Access to safe forms of disinfectant for cleaning equipment to reduce risk of spreading BBVs provided. w	Lead: DCS SA Health Hepatitis SA SHine SA (SAMESH)
2. Provide access to clean shaving equipment and toothbrushes	a. Provide free, clean shaving equipment and toothbrushes to each prisoner.	i. Free, clean personal shaving equipment and toothbrush provided to each prisoner.	Lead: DCS SA Health
3. Provide access to clean barbering equipment	a. Provide access to free and clean barbering equipment (see section 5.6).	i. Access to free and clean barbering equipment provided.	Lead: DCS SA Health Hepatitis SA
4. Provide access to condoms and lubricant.	a. Provide access to free condoms and lubricant.	i. Access to free condoms and lubricant provided, and readily available.	Lead: DCS SAPHS
5. Reduce sexual and other violence.	a. Continue to implement strategies to reduce sexual and other forms of violence.	i. In 100% of incidents of sexual violence, STI testing is offered, and, if indicated, HIV or HBV PEP is offered.	Lead: DCS SAPHS

continued

### Action area 3: Implementation of evidence-based harm reduction strategies

Strategy	Action	Output Measures	Lead agencies and partners
6. Explore options for reducing needle sharing and needle reuse by prisoners	a. Continue to support increased access to evidence-based harm reduction strategies and drug treatment programs, including peer education and medication assisted treatment for opioid dependence (MATOD) programs in prison, and referral to CNP and other programs (on release).	i. Evidence of increased access to harm reduction strategies and programs for prisoners	Joint Lead: DCS and SA Health (SAPHS, Drug and Alcohol Services SA (DASSA) and CDCB) Hepatitis SA
	b. Establish a joint DCS and SA Health working party, comprised of membership from the SA Health South Australian Sexually Transmissible Infection & BBV Advisory Committee (SASBAC) and the DCS Statewide Performance Group, to fully examine over the course of this Action Plan the enablers and barriers in policy, evidence, health and safety and legislation toward implementing the full suite of harm reduction strategies available to the wider South Australian community in prison settings.	i. Joint working party with terms of reference established by May 2017. ii. Report with recommendations for strengthening harm reduction strategies in prisons, with a focus on reducing needle sharing and needle reuse by prisoners, prepared for the Minister for Health and Minister for Correctional Services during the course of this Action Plan.	Joint Lead: DCS and SA Health (SAPHS, DASSA and CDCB)
	c. In consultation with stakeholders, review further evidence-based harm reduction strategies for prisoner populations, including pre and post-release, and identify barriers to evidence-based harm reduction strategies.	i. Report with recommendations prepared and submitted to the joint DCS and SA Health working party	Lead: DASSA SAPHS CDCB DCS
	d. Barriers to evidence-based harm reduction strategies addressed.	i. Removal of barriers to evidence-based prevention activities.	Lead: DCS DASSA SAPHS CDCB

continued

### Action area 3: Implementation of evidence-based harm reduction strategies

Strategy	Action	Output Measures	Lead agencies and partners
7. Improve uptake of treatment in regards to HBV, HCV and HIV, whilst monitoring the impact.	a. Maintain high levels of treatment for HIV; and improve treatment uptake for HBV and HCV.	i. Number of prisoners on treatment for HBV, HCV and HIV	Lead: SAPHS Viral Hepatitis Support Nurses DCS
	b. Monitor clinical and access criteria as appropriate to increase treatment numbers and reduce transmission risk.		

continued

#### Action area 4: Governance and partnerships to enable and monitor actions

Strategy	Action	Output Measures	Lead agencies and partners
1. Establish site based performance measures for BBV prevention in prisons	a. Develop site based performance measures.	i. Incorporation into corporate performance monitoring systems.	Joint responsibility: SA Health and DCS NGO partners
2. Improve reporting outputs and indicators related to reduction of BBVs in prisons.	a. Develop a joint monitoring report.	i. Monitoring report template developed.	Joint responsibility: SA Health and DCS
3. Jointly monitor this Action Plan through SA Health and DCS governance processes.	a. Monitoring to be conducted by: 1) DCS Statewide Performance Group; and 2) SASBAC.	i. A jointly prepared <i>South Australian Prisoner Blood Borne Virus Prevention Action Plan 2017-2020: Monitoring Report</i> .	Joint responsibility: SA Health and DCS
4. Participate in the strengthening of national surveillance reporting and improving understanding of burden of disease in South Australian prisons.	a. Improve reporting when required which may relate to: > incidence > testing > vaccination > disease related mortality.	i. Annual provision of BBV (HBV, HCV, HIV) notification data by prison location. ii. Annual provision of data by prisons reporting mortality related to a BBV, notified by prison. iii. Provision of required data for the <i>National BBV &amp; STI Surveillance and Monitoring Plan</i> .	CDCB
5. Develop evidence-based responses and evaluate the impact of programs; and improve understanding through research and promote balance in research.	a. Support rigorous research and evaluation of BBV related interventions.	i. Number of research projects supported by prisons.	Lead: SA Health DCS SAHMRI
6. Evaluate health promotion, testing, treatment, care, support and education and awareness programs and activities to ensure they are effective.	a. In addition to strategies 3 and 5 (above), ensure NGO activities are included in the <i>South Australian Prisoner Blood Borne Virus Prevention Action Plan 2017-2020: Monitoring Report</i> .	i. NGO activities reported.	Joint Lead: SA Health and DCS All NGO partners

# Appendices

## Appendix A: Adult prisoner related national targets

### National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2014-2017 (BBV related targets only)

- > Increase use of sterile injecting equipment for every injecting episode
- > Increase the number of people with HIV, hepatitis C and hepatitis B receiving antiviral treatment

### National Hepatitis B Strategy 2014-2017

- > Increase hepatitis B vaccination coverage of priority populations
- > Increase to 80% the proportion of all people living with chronic hepatitis B who are diagnosed
- > Increase to 15% the proportion of people living with chronic hepatitis B who are receiving antiviral treatment

### National Hepatitis C Strategy 2014-2017

- > Reduce the number of new hepatitis C infections by 50%
- > Increase the number of people receiving antiviral therapy by 50% each year

### National HIV Strategy 2014-2017

- > Reduce sexual transmission of HIV by 50% by 2015
- > Sustain low general population rates of HIV in Aboriginal and Torres Strait Islander people and communities
- > Sustain the virtual elimination of HIV amongst sex workers
- > Sustain the virtual elimination of HIV amongst people who inject drugs
- > Sustain the virtual elimination of mother-to-child HIV transmission
- > Increase treatment uptake by people with HIV to 90%
- > Maintain effective prevention programs targeting sex workers and for people who inject drugs.



## Appendix B: Summary of WHO UNAIDS HIV prevention interventions

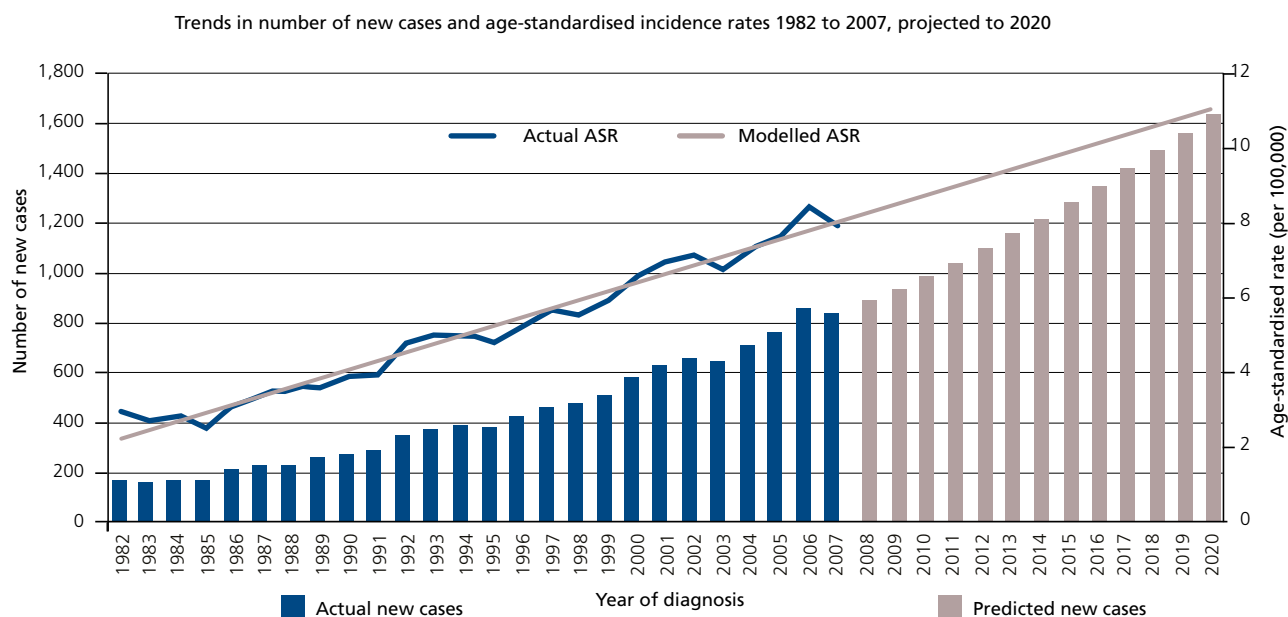
In 2013, the World Health Organization's Joint United Nations Programme on HIV/AIDS (UNAIDS) published the policy brief *HIV Prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*. This brief recommended:

1. information, education and communication
2. condom programmes
3. prevention of sexual violence
4. drug dependence treatment, including opioid substitution therapy
5. needle and syringe programmes
6. prevention of transmission through medical or dental services
7. prevention of transmission through tattooing, piercing and other forms of skin penetration
8. post-exposure prophylaxis
9. HIV testing and counselling
10. HIV treatment, care and support
11. prevention, diagnosis and treatment of tuberculosis
12. prevention of mother-to-child transmission of HIV
13. prevention and treatment of sexually transmitted infections
14. vaccination, diagnosis and treatment of viral hepatitis
15. protecting staff from occupational hazards.

## Appendix C: National primary liver cancer projections

The following graphs are adapted from the Australian Institute of Health and Welfare, *Cancer incidence projections: Australia, 2011-2020* published by the Australian Government. They refer only to primary liver cancer.

Figure 3.9a: Liver cancer (C22), males, Australia: actual 1982-2007 and projected to 2020

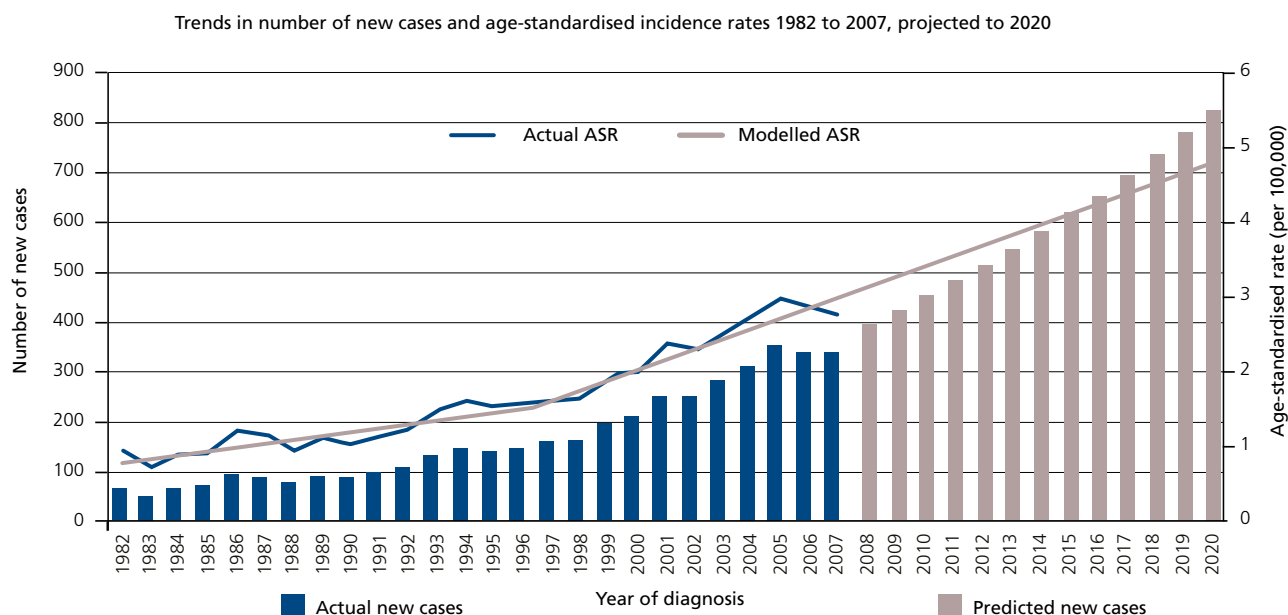


(a) Rates are expressed per 100,000 males.

(b) Age-standardised rates are age-standardised to the Australian population as at 30 June 2001.

Source: Australian Cancer Database (2007)

Figure 3.9b: Liver cancer (C22), females, Australia: actual 1982-2007 and projected to 2020



(a) Rates are expressed per 100,000 females.

(b) Age-standardised rates are age-standardised to the Australian population as at 30 June 2001.

Source: Australian Cancer Database (2007)

## Appendix D: South Australian liver cancer projections

The following table and graph are extracts from the *SA Hepatocellular Carcinoma (HCC) Cancer Care Pathway*<sup>93</sup> (draft July 2013).

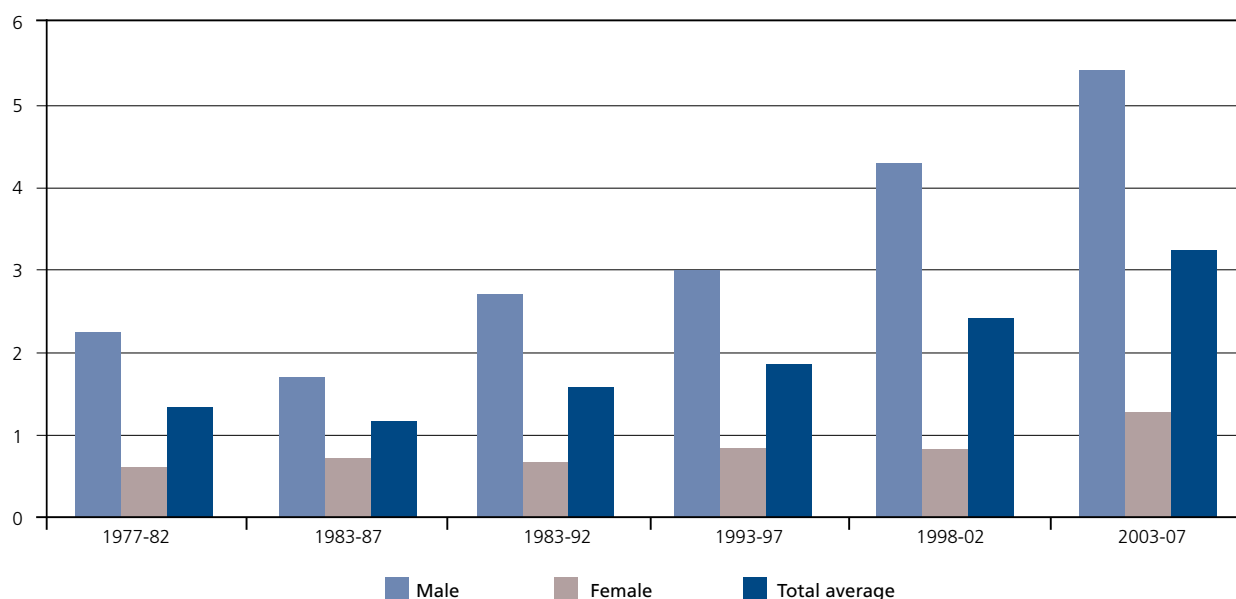
Table 1 and Figure 3 show the annual age-standardised incidence per 100,000 of HCC in South Australia. This data demonstrates there has been a 143% increase in incidence between the period of 1977-82 (1.33 cases per 100,000) and the period 2003-2007 (3.3 cases per 100,000). Another important observation is the much higher incidence of HCC in males, with 77% of all HCC occurring in males.

**Table 1: Annual incidence of HCC per 100,000 population by calendar year and sex-age standardised**

	1977-82 (n=89)	1983-87 (n=75)	1988-92 (n=109)	1993-97 (n=141)	1998-02 (n=199)	2003-07 (n=288)	Total (1977-2007)
<b>Males</b> (n=693)	2.24	1.71	2.69	3.02	4.29	5.42	3.20
<b>Females</b> (n=208)	0.61	0.71	0.67	0.85	0.83	1.28	0.82
<b>TOTAL</b> (n=901)	1.33	1.16	1.57	1.85	2.39	3.23	1.9

Note: adapted from Luke C et al, APJCP, 2010

**Figure 7: Annual incidence of HCC per 100,000 population by calendar year and sex-age standardised**



Note: adapted from Luke C et al, APJCP, 2010

## Appendix E: Data tables

**Table E1: Number of BBV tests performed on prisoners in South Australia and number of positive results, 1 June 2014 to 31 May 2015**

Test	Count	Positive	% Positive
Hep B	964	28	3%
Hep C antibody	1,301	273	21%
HIV	1,286	10	1%
<b>TOTAL</b>	<b>3,551</b>	<b>311</b>	

Data source: SAPHS/SA Pathology Report dated 17 June 2015.

**Table E2: Daily average number of prisoners and estimated number of prisoners with a BBV by prison in South Australia, 2015**

Prison site	Daily AVG prisoners 2015*	HBV estimated range (3-4%)**	HCV estimated range (30-40%)**	HIV estimate (.2%)**	Total prisoners living with BBV
Adelaide Pre-release Centre	89	3 - 4	27 - 36	0.09 - 0.18	29 - 39
Adelaide Remand Centre	308	9 - 12	92 - 123	0.31 - 0.62	102 - 136
Adelaide Women's Prison	146	4 - 6	44 - 58	0.15 - 0.29	48 - 65
Cadell Training Centre	190	6 - 8	57 - 76	0.19 - 0.38	63 - 84
Mt Gambier Prison	326	10 - 13	98 - 130	0.33 - 0.65	109 - 144
Mobilong Prison	353	11 - 14	106 - 141	0.35 - 0.71	117 - 156
Port Augusta Prison	493	15 - 20	148 - 197	0.49 - 0.99	163 - 218
Port Lincoln Prison	172	5 - 7	52 - 69	0.17 - 0.34	57 - 76
Yatala Labour Prison	548	16 - 22	164 - 219	0.55 - 1.10	181 - 242
<b>TOTAL DAILY AVERAGE</b>	<b>2,625</b>	<b>79 - 105</b>	<b>788 - 1,050</b>	<b>2.63 - 5.25</b>	<b>869 - 1,160</b>

Data sources:

\* Daily Average Prisoners between 1 July 2014 and 7 June 2015 Report, Department for Correctional Services

\*\* BBV estimates based on ASHM data in Section 2.1

**Table E3: Number of individual prisoners admitted and number of admissions to prison in South Australia, 2014/2015**

Re-admission	Number of individual prisoners	Number of admissions
Admitted once	4,113	4,113
Admitted twice	599	1,198
Admitted three times	105	315
Admitted four times	21	84
Admitted five times	3	15
<b>TOTAL</b>	<b>4,841</b>	<b>5,725</b>

Data source: Department for Correctional Services, 6 July 2015.

**Table E4: Number of individual Aboriginal prisoners admitted and number of admissions to prison in South Australia, 2014/2015**

Re-admission	Number of individual prisoners (Aboriginal)	Number of admissions (Aboriginal)
Admitted once	769	769
Admitted twice	217	434
Admitted three times	40	120
Admitted four times	9	36
Admitted five times	2	10
<b>TOTAL</b>	<b>1,037</b>	<b>1,369</b>

Data source: Department for Correctional Services, 6 July 2015. Note: 1,002 admits were from an 'Unknown' cultural group.

**Table E5: Number of prisoner transfers in South Australia, 2014/2015**

Prison site	Transfers in	Transfers out
Adelaide Pre-release Centre	277	159
Adelaide Remand Centre	134	855
Adelaide Women's Prison	140	163
Cadell Training Centre	615	328
Mt Gambier Prison	680	599
Mobilong Prison	789	438
Port Augusta Prison	0	0
Port Lincoln Prison	291	223
Yatala Labour Prison	1,971	2,397
<b>TOTAL TRANSFERS</b>	<b>4,897</b>	<b>5,162</b>

Data source: Department for Correctional Services, 9 July 2015.

**Table E6: Number of prisoners starting hepatitis C treatment in South Australia, 2011-2015 and March-October 2016**

Prison	2011*	2012*	2013	2014	2015	2016**
Adelaide Remand Centre	-	-	-	1	2	4
Adelaide Women's Prison / Adelaide Pre-release Centre	4	3	6	-	1	11
Cadell Training Centre	2	2	1	-	1	10
Mt Gambier Prison	-	-	1	2	-	3
Mobilong Prison	2	3	8	3	3	15
Port Augusta Prison	5	4	2	4	16	6
Port Lincoln Prison	-	1	1	2	2	4
Yatala Labour Prison	-	-	2	2	-	6
<b>TOTAL PRISONERS STARTING HEPATITIS C TREATMENT</b>	<b>13</b>	<b>13</b>	<b>21</b>	<b>14</b>	<b>25</b>	<b>59</b>
<i>Of the above, number who were Aboriginal</i>	<i>1</i>	<i>0</i>	<i>5</i>	<i>2</i>	<i>5</i>	<i>3</i>

Data source: Royal Adelaide Hospital, Viral Hepatitis Centre.

\* Prison site breakdown unavailable for 2011 and 2012.

\*\* 1 March- 31 October 2016.

**Table E7: Number of doses of hepatitis B adult vaccine (HBVAXII) distributed by prison and by financial year since 1 July 2010, South Australia**

Prison site	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Adelaide Remand Centre	40	10	0	0	60	80
Adelaide Women's Prison/Adelaide Pre-release Centre	49	46	30	28	78	48
Cadell Training Centre	80	90	60	60	60	20
Mt Gambier Prison	24	4	10	0	0	50
Mobilong	146	299	202	222	160	302
Port Augusta Prison	200	175	80	100	60	80
Port Lincoln Prison*	8	12	14	2	38	76
Yatala Labour Prison**	180	30	100	45	40	24
<b>TOTAL DOSES DISTRIBUTED</b>	<b>727</b>	<b>666</b>	<b>496</b>	<b>457</b>	<b>496</b>	<b>680</b>
<b>TOTAL DOSES/THREE***</b>	<b>242</b>	<b>222</b>	<b>165</b>	<b>152</b>	<b>165</b>	<b>226</b>

Data Source: SA Health, Immunisation Section, Communicable Disease Control Branch 7 July 2015.

\* 2015/16 Port Lincoln Prison: 24 of these distributed doses were Engerix.

\*\* 2015/16 Yatala Labour Prison: 10 of these distributed doses were Engerix.

\*\*\* Three doses are required per person to complete the full course of the hepatitis B vaccination.

## Appendix F: Target groups of the National Strategies

Aboriginal & Torres Strait Islander BBV and STI	Hepatitis B	Hepatitis C	HIV
<p>Aboriginal and Torres Strait Islander people</p> <p>Young people</p> <p>People in custodial settings</p> <p>People who live in remote communities</p> <p>People in custodial settings</p> <p>Gay men, other men who have sex with men, and sister girls and transgender people</p> <p>People living with HIV and viral hepatitis</p> <p>People living in the cross-border region of Australia and PNG</p> <p>Sex workers</p>	<p>People from CALD backgrounds, particularly:</p> <ul style="list-style-type: none"> <li>&gt; Asia-Pacific</li> <li>&gt; Sub-Saharan African</li> <li>&gt; Aboriginal and Torres Strait Islander People</li> <li>&gt; Children born to mothers with chronic hepatitis B and children with chronic hepatitis B</li> </ul> <p>Unvaccinated adults at higher risk of infection including:</p> <ul style="list-style-type: none"> <li>&gt; Gay men and other men who have sex with men (MSM)</li> <li>&gt; Sex workers</li> <li>&gt; People who inject drugs</li> <li>&gt; Partners and other household and intimate contacts of people who have acute or chronic hepatitis B infection</li> <li>&gt; People in custodial settings</li> <li>&gt; People with HIV or hepatitis B or both</li> </ul>	<p>People with hepatitis C</p> <p>People who inject drugs</p> <p>People who have injected drugs from:</p> <ul style="list-style-type: none"> <li>&gt; Aboriginal and Torres Strait Islander backgrounds</li> <li>&gt; Culturally and linguistically diverse backgrounds</li> <li>&gt; Young injectors and/or new initiates</li> <li>&gt; Older people</li> <li>&gt; Sex workers</li> <li>&gt; People in custodial settings</li> </ul>	<p>People with HIV</p> <p>Gay men and other men who have sex with men</p> <p>Aboriginal and Torres Strait Islander people</p> <p>People from high prevalence countries and their partners</p> <p>Travellers and mobile workers</p> <p>Sex workers</p> <p>People who inject drugs</p> <p>People in custodial settings</p>

# Acronyms

ACCHS	Aboriginal Community Controlled Health Service
AHCSA	Aboriginal Health Council of South Australia
ASHM	Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine
BBV	blood borne virus
CALD	culturally and linguistically diverse
DAA	direct acting antivirals
DCS	Department for Correctional Services
CALHN	Central Adelaide Local Health Network
CDCB	Communicable Disease Control Branch
DASSA	Drug and Alcohol Services SA
GP	general practitioner
HBV	hepatitis B
HCC	hepatocellular carcinoma
HCV	hepatitis C
HIV	human immunodeficiency virus
NALHN	Northern Adelaide Local Health Network
NGO	non-government organisation
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
HBV PEP	post-exposure prophylaxis to prevent HBV
HIV PEP	post-exposure prophylaxis to prevent HIV
PWID	people who inject drugs
RDNS SA	Royal District Nursing Service SA
SAHMRI	SA Health and Medical Research Institute
SALHN	Southern Adelaide Local Health Network
SA PHS	SA Prison Health Service
STI	sexually transmissible infection
SVR	sustained virological response (cure)
WHO	World Health Organization



# Definitions

## **Aboriginal**

In the context of this report the term Aboriginal is used to mean Aboriginal and/or Torres Strait Islander.

## **Section 100 (s100)**

A section of the *National Health Act 1953* which allows for special supply arrangements to be made by the Minister for Health to ensure appropriate access to a pharmaceutical service to all Australians where general PBS mechanisms are not easily applied. Pharmaceuticals provided under this scheme include all PBS listed medicines with the exception of Schedule 8 and extemporaneous products (i.e. products that need to be manufactured at the pharmacy).

## **Pharmaceutical Benefits Scheme (PBS)**

A scheme through which the Australian Government subsidises the cost of essential prescription medicines.

## **BBV Link Nurse**

BBV Link Nurses are nursing staff of the SA Prison Health Service who have a special interest and responsibility related to the management of prisoners with BBVs.

## **Viral Hepatitis Support Nurses**

The Viral Hepatitis Support Nurses are Clinical Practice Consultants who provide specialist care to people living with hepatitis B or hepatitis C in South Australia, including the provision of in-reach support to people in the prison system. The nursing program aims to increase and facilitate access to treatment and support.

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For more information

**Department for Health and Ageing**

Telephone: 08 7425 7101

[www.sahealth.sa.gov.au](http://www.sahealth.sa.gov.au)

**Department for Correctional Services**

Telephone: 08 8226 9000

[www.corrections.sa.gov.au](http://www.corrections.sa.gov.au)

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