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HIV, policing and the law

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AFAO is the national federation for the HIV community response, providing leadership, coordination and support to the Australian policy, advocacy and health promotion response to HIV/AIDS. Internationally, AFAO contributes to the development of effective policy and programmatic responses to HIV/AIDS at the global level, particularly in the Asia Pacific region.

AFAO's aims are to:

- Advocate on behalf of its members at the federal level, thereby providing the HIV community with a national voice;
- Stop the transmission of HIV by educating the community about HIV/AIDS, especially those whose behaviour may place them at high risk;
- Assist its members to provide material, emotional and social support to people living with HIV;
- Develop and formulate policy on HIV issues;
- Collect and disseminate information for its members;
- Represent its members at national and international forums; and
- Promote medical, scientific and social research into HIV and its effects.

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This edition of *HIV Australia* explores the nexus between HIV prevention, policing practices and the law. As many contributors make clear, legal and public health responses to HIV are intrinsically linked. Contributors outline the importance of this relationship, and stress the need to address laws and policing practices that undermine harm reduction approaches and create barriers to HIV prevention, treatment and care.

The edition canvasses a broad range of topics – from the application of criminal law, and how this can impinge upon the health and human rights of people with HIV and affected communities, through to care and support programs for people as they transition in and out of the criminal justice system.

Some articles highlight programs and resources supporting police and prisoners to better understand blood borne virus (BBV) exposure risks and BBV-related stigma. Others look at the reform of stigmatising laws, and initiatives to improve policing policies and practices.

A major issue threaded throughout this edition is the continued inertia surrounding the implementation of a needle-syringe program in any Australian prison. This is a key gap in Australia's evidence-based policy response to BBVs, which urgently needs to be addressed.

***HIV Australia* online includes additional content not published in the printed edition. Read more of *HIV Australia* at www.afao.org.au**

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Why are we waiting? The urgent need for NSPs in Australian prisons

By Angella Duvnjak, Nicole Wiggins and Sione Crawford

There are currently no needle and syringe programs (NSPs) operating in any Australian prisons. This is despite a growing body of international research clearly demonstrating that NSPs have been shown to be safe, beneficial and cost-effective within a variety of prison settings.^{1,2}

The continuing high rates of blood borne viruses (BBVs) among prisoners support an urgent need to introduce NSPs into the Australian prison system. Australia cannot afford to continue to avoid the serious implications of not implementing prison-based NSPs, both to protect prisoners' health and human rights, and to limit the spread of BBVs as individuals are released back into the community.

Prisons and BBVs: a growing problem

Current data indicate that Australia's prison population is on the rise, with an increase of 7% in just one year, (from 33,789 to 36,134 people between 30 June 2014 and 30 June 2015).³

Prisons have been shown to be high-risk environments for the transmission of BBVs, including HIV and hepatitis C (HCV), and prisoners are named as a priority population in Australia's *Fourth National Hepatitis C Strategy 2014–2017*⁴ and the *Seventh National HIV Strategy 2014–2017*.⁵

The Hepatitis C Strategy outlines the high prevalence of hepatitis C in prisons, with two-thirds of female and one-third of male prisoners testing positive for hepatitis C. The Strategy also highlights that Aboriginal and Torres Strait Islander people are

disproportionally affected, with 43% of those in custody being hepatitis C positive.

These alarming figures are reflected in successive National Prison Entrants Blood Borne Virus and Risk behaviour surveys⁶, which report that the prevalence of hepatitis C is over thirty times higher among prisoners than the general community; it is not surprising therefore, that prisons are widely referred to as 'incubators for disease'.

Because most prisoners serve short-term sentences (averaging six months to two years), the potential for BBVs to spread from prison settings into the wider community is clear.

Contextualising BBV risks – inside and out

It is well known that incarceration is an issue that disproportionately impacts Aboriginal and Torres Strait Islander people, who account for more than a quarter of adult prisoners despite representing around 2% of the Australian population.⁷

Criminalisation of drug use also results in the mass incarceration of people who use drugs. Illicit drug offences represent the second most common offence for custodial sentences in Australia.⁸ Over the past year there has been a 17% increase in prisoners sentenced for illicit drug offences.⁹

Outside of the prison environment, community-based NSPs demonstrate overwhelmingly high success rates in reducing the spread of BBVs¹⁰, with nine out of ten people who inject drugs (PWID) reporting use of clean needles for all or most of their injections in the month prior to coming into prison¹¹.

Upon entering the Australian prison system, however, access to this basic, evidence-based, harm reduction strategy is non-existent, severely limiting an individual's ability to access sterile injecting equipment. The vast majority of injecting episodes inside prisons therefore occur with shared injecting equipment – a practice identified to be one of the most effective ways to transmit HIV and HCV.¹²

Injecting and sharing syringes in the prison context may appear foolish to people without any experience of drug dependence and/or prison, but the harsh realities of prison life make stopping drug use inside prison difficult for many people.

Prison drug rehabilitation programs – where they exist – can have long waiting lists, and methadone as a drug substitution therapy is not available in all settings and is only suitable to those who are opioid dependant.¹³ The most common drug injected in prison is in fact amphetamine, with the prison entrants' survey showing 59% of prisoners reporting it as the last drug injected.¹⁴

Injecting drug use within prisons is a practice dominated by specific cultural norms unique to the prison context. Those most vulnerable, such as young people and new prison entrants, are at particularly high risk of becoming HIV- or hepatitis C-positive, as Marcus, a 34 year old ex-detainee, explains:

'Whoever is the most senior, whoever's done the most time, they'll go [inject] first. [It] runs more on politics you know, it's just the way it is. If it's a young up and coming bloke, even if he owns the fit, he'll go last – like the end of the food chain.'

All the ones [syringes] I've used inside [were] "cut down"¹⁵ (they're easier to transport and bring in) ... The guy with the fit, who's in charge he mull'd up [mixed the drugs with water], divided it up in his head, and shot everyone up. He goes first – let's say five lines, and then on to the next guy who gets five lines and the next gets his five lines. Sometimes there might've been a bit of a running the tip under the tap [to remove blood residue between users], but not always. So you've got to trust him, not only to not miss [the vein], and not just to get everyone's shot [amount of drug] right, but that he hasn't got something [hepatitis C or HIV], and that the guy before you and the guy before him doesn't have something.'

Source: Poeder, F. (ed). (2013).¹⁶

Boredom and frustration can also lead people to (re)commence injecting drug use while incarcerated.

Whatever the reason for choosing to inject, a BBV infection that will impact on the rest of the person's life is a high price to pay for drug use while incarcerated. Time spent in prison should not result in a lifelong sentence of impaired health.

The evidence is clear – so why are we waiting?

There is a wealth of evidence supporting the provision of needles and syringes as the gold standard for harm reduction when it comes to injecting drug use and the prevention of BBV transmission. Prison-based NSPs have been successfully operating internationally for more than 20 years, and international evidence has shown that prison NSPs:

- are feasible and affordable across a wide range of prison settings
- are effective in decreasing syringe sharing among PWID, thereby decreasing the risk of BBV transmission (HIV, HCV) between prisons and from prisoners to prison staff
- are not associated with increased attacks on prison staff or other prisoners
- do not lead to increased initiation of drug consumption or injection
- contribute to workplace safety
- can successfully coexist with other drug prevention and drug dependence treatment programs.

Source: Stöver and Nelles. (2003).¹⁷

Following an exhaustive review of the evidence, the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommended in 2007 that 'prison authorities in countries experiencing or threatened by an epidemic of HIV infections among PWID should introduce and scale up NSPs urgently'.¹⁸

These key international bodies have added their voices in support of NSP programs in prisons citing the basic requirement to respect the human right to health. The former UN Special Rapporteur on the right to health, Anand Grover stated: 'If harm reduction programmes and evidence-based treatment are made available to the general public, but not to persons in detention, that contravenes international law'.¹⁹ Others go further to argue that the right to health and freedom from torture and ill treatment are indivisible particularly in prison settings, thereby requiring governments to take *proactive* steps to safeguard the health of prisoners.²⁰

Despite all of the above, Australia remains stuck in a frustrating status quo. The recent 'close encounter' with a trial program in the ACT was effectively derailed at the final hurdle.^{21,22} Those of us concerned about BBVs in Australia need to urgently take stock of this situation and look towards next steps in this seemingly never ending battle to ensure that prisoners are not denied the most basic of human rights; having the means, and being given the opportunity, to protect their own health.

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It's time: a case for trialling a needle and syringe program in Australian prisons

By **Mark Stoové**

Australia's decisive and early harm reduction response to HIV is internationally lauded. Alongside the sustained efforts led by the Australian gay community to prevent the sexual transmission of HIV, Australia's early implementation, expansion and ongoing maintenance of a national needle and syringe program (NSP) stands as one of our most significant and enduring achievements in reducing the local impact of HIV.

The profound and lasting impact of NSPs has resulted in Australia having one of the lowest rates of HIV among people who inject drugs (PWID) in the world.¹ Between 2000 and 2009 alone, NSPs were estimated to have directly averted 32,050 new cases of HIV and 96,667 cases of hepatitis C.² These results have had an immeasurable impact on the lives of individuals, as well as an immense economic benefit, saving approximately \$1.28 billion in healthcare costs.³

Australia's strategic response to illicit drug use is founded on three pillars of harm minimisation: reducing drug supply through law enforcement; reducing drug demand through dependence treatment programs; and reducing drug harms through harm reduction interventions. Although the majority of Australia government spending focuses on the first

of these areas, bolstering law enforcement responses⁴ – a strategy proven to be far less cost effective than treatment⁵ – our broad, three-pronged harm minimisation approach has placed Australia in a demonstrably better position than countries that rely almost exclusively on law enforcement.

In the US for example, where a ban on federal funding for NSPs by Congress in 1989 (in accordance with a drug war ideology)⁶ was only recently lifted, the estimated prevalence of HIV among people who inject drugs (PWID) is ten times higher than in Australia⁷. This correlation between NSP coverage (or lack of it) has been observed in relation to divergent HIV epidemics among PWID globally.⁸

Prison-based NSPs: the missing piece of the puzzle

The public health case for prison-based NSPs is incontrovertible. The ongoing criminalisation of drug use and the routine incarceration of people for drug-related crime means that PWID are grossly over-represented in Australian prison populations. PWID are the primary hepatitis C risk population in Australia⁹, and are also at elevated risk of acquiring HIV compared to the general population¹⁰.

While NSPs are readily accessible in the community, inmates within correctional facilities are denied access to clean needles and syringes. This key gap in Australia's NSP coverage amounts to a significant deficit in harm reduction policy and practice, which continues to undermine Australia's response to blood borne viruses, both in and outside of the prison system.

Despite drug interdiction strategies and a generally restrictive environment, injecting drug use continues to occur in prison.^{11,12} It is little wonder that a lack of access to sterile injecting equipment in prison contributes to significant rates of intraprisson hepatitis C transmission.¹³

Aside from the clear public health imperatives of providing prison-based NSPs, incarcerating people with drug dependence in environments with high rates of BBVs and where injectable drugs are available, but prohibiting access to clean injecting equipment represents a fundamental breach of basic human rights. This approach contravenes international law stating that prisoners must be able to access the same standard of health care as available in the wider community.¹⁴

Prison NSPs are endorsed by major Australian health and medical peak bodies, including the Australian Medical Association, Australasian Society for HIV, Viral Hepatitis and Sexual Health

Medicine (ASHM), the Public Health Association Australia (PHAA), the Royal Australasian College of Physicians, and the Australian Ministerial Advisory Committee on Blood-Borne Viruses. Prison NSPs are also endorsed by major global bodies like the United Nations General Assembly, World Health Organization (WHO), UNAIDS (the Joint United Nations Programme on HIV/AIDS) and the United Nations Office on Drugs and Crime (UNODC).

Despite these endorsements and a strong disease prevention and harm reduction rationale, Australia is not alone in its reluctance to implement and maintain prison NSPs. The first (albeit informal) prison NSP commenced in Switzerland in 1992, followed by pilot programs in Germany in 1996 and Spain in 1997. Only 13 countries have established prison NSPs, often as pilots operating for a limited time and across a limited number of sites. Currently, only eight countries maintain prison NSPs¹⁵, while 90 operate community-based NSPs¹⁶.

Arguments against

So what are the key concerns that prevent prison NSP implementation? An overriding concern driving Australian debates has been that prison NSPs present an occupational health and safety risk to prison staff. This issue has been flagged repeatedly by the Community and Public Sector Union (CPSU) as justification for their opposition to the long proposed prison-based NSP at the Alexander Maconochie Centre in Canberra.^{17,18}

While the safety of prison staff is a legitimate concern, international experience has shown that introducing prison NSPs does not in fact increase occupational risk. Careful consideration of prison operational environments and appropriate systems to control and monitor the location of injecting equipment has meant that, across nearly 25 years of international experience, prison NSPs have not been associated with increased attacks on prison staff or other prisoners. Furthermore, there have been no safety problems reported that relate to syringe disposal.¹⁹

Strategies to enhance occupational safety have revolved primarily around one-for-one exchange (whereby used injecting equipment must be returned

in exchange for new equipment) and implementing strategies that ensure prison management and staff know who is in possession of injecting equipment, and where injecting equipment is located. Conditions for accessing prison NSPs have included directives that equipment may only be stored in specific locations when not being used, and that prisoners must disclose the location of injecting equipment (including if they are carrying injecting equipment on their person).²⁰

In addition to learning from the successful management of occupational health and safety risks in international prison NSP models, it is important to acknowledge the risks posed by current circumstances in which injecting drug use occurs in Australian prisons. In the absence of NSPs, uncontrolled and clandestine exchange of reused injecting equipment between prisoners is the norm. In this situation, officers carrying out searches are at a clear risk of a needlestick injury.

A survey of Australian prison officers conducted in 2006 reported that two-thirds had ever found needles and syringes during prison searches and that seven percent (n=17) had experienced a needlestick injury, most commonly during searches.²¹ Relative to the status quo, controlling the number and location of needles and syringes in prison through a formal prison NSP program is highly likely to enhance the occupational safety environment in Australian prisons.

Another commonly cited objection to prison NSPs is that such programs sanction, or even encourage continued drug use and may therefore undermine the effectiveness of prison drug treatment programs. The notion that NSPs cannot co-exist with prison treatment services, or align with longer-term abstinence goals, ignores the fact that NSP and drug treatment services are already well integrated in the community, and that the typical trajectory for people using drugs involves changing patterns of drug use, including periods of self-imposed cessation.

Furthermore, evaluations of international prison NSPs have found no evidence of increased drug use or the amount of drugs entering correctional settings. On the contrary, some evaluations have found that a prison NSP can increase demand for drug treatment due to contact with NSP staff and services.^{22,23}

Meanwhile, the argument that financial investments required for prison NSPs would be better spent on drug treatment programs ignores the fact that current responses to drug use in Australia's correctional system overwhelmingly favour treatment programs and strategies that reduce demand and supply. The almost total absence of evidence-based harm reduction interventions in prison is therefore at complete odds with Australia's long-standing harm minimisation strategy.

It is also important to note that none of these arguments have been evoked to oppose the operation of NSPs in the wider community.

It's time for an honest dialogue on prison-based NSPs

One of the few drug harm reduction interventions currently in place within Australia's prisons is the provision of bleach to clean used needles and syringes, which is available to prisoners in all correctional facilities. Ironically, the suggestion by those opposed to prison NSPs that they condone drug use in prison also logically applies to bleach programs. Unfortunately this duplicity leaves prisoners relying on an only partially efficacious approach to preventing blood borne virus transmission.²⁴

In Australia, the workplace and programmatic concerns about prison NSPs have been largely prosecuted by the CPSU. But sitting above this resistance is the reality that prison NSPs are highly unlikely to be a political winner for any government. To implement a prison NSP, governments must be willing to either push through on the basis of public and prevention health evidence (as the ACT government has tried to do over recent years) or engage in a longer-term strategy of engaging in an honest dialogue with the community about drugs in prison. Such a discussion would need to include the overarching issues associated with the ongoing criminalisation of drug use and the incarceration of people for drug-related offences. No Australian government has yet embarked on this endeavour in any meaningful way.

During the 2010 International AIDS Conference in Vienna, Mercedes Gallizo Llamas, the General Secretariat of Penitentiary Institutions in Spain, was asked about strategies that were successful in gaining political support

for prison NSPs.²⁵ Her response was simple. Politicians need to be made aware that no prison system in the world is drug-free and that drugs in their prisons are therefore not their political failure. Recognition that drugs in prison are an inevitable product of criminalising drug use and incarcerating drug users is a precondition to engaging in a mature conversation about how to reduce drug harms in prison.

While a full and frank political debate about drugs in Australia's prisons is yet to emerge, the one Australian jurisdictional government that has at least shown leadership on prison NSPs from a public health and prevention perspective is the ACT government. A long process that emerged from the public support for a prison NSP trial at the Alexander Maconochie Centre (AMC) from successive ACT Chief Ministers, Jon Stanhope and Katy Gallagher, is now drawing to a close. As part of a Deed of Agreement that brought to an end a long-running enterprise bargaining agreement (EBA) stalemate between the ACT government and the CPSU that centred on the prison NSP trial²⁶, a process is now underway to develop a prison NSP model that can be feasibly implemented at the AMC. A NSP Working Group has been tasked with developing a NSP model to be voted on by AMC staff, with majority support needed for the trial to proceed (in accordance to the Deed of Agreement). The Working Group has sought and received submissions detailing the potential operations of a prison NSP that pays due consideration to legal and operational issues as well as the health, safety and welfare needs of staff and detainees.

The features of the successful prison NSP models implemented internationally can be brought to bear on the process underway in the ACT. International experiences indicate clearly and unambiguously that an effective balance can be reached to deliver a program that is effective in reducing injecting drug-related harms, maintains the good working order of a prison and protects the health and safety of staff and prisoners.²⁷ With only a limited number of international jurisdictions currently operating prison NSPs, the ACT is now in a position to show genuine international leadership by becoming the first jurisdiction in the English-speaking world to introduce

a prison NSP. This would be the first significant innovation in drug harm reduction policy and practice in Australia for well over a decade, invoking memories of a time when Australia once led the world in drug harm reduction policy and practice.

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The role of the police in the HIV response: the Law Enforcement and HIV Network (LEAHN)

By **Nick Crofts and Melissa Jardine**

Police are the first responders to a range of complex situations involving criminal, civil or public health related issues, some of which may relate to HIV. Law enforcement, HIV and public health are therefore inextricably linked; however many law enforcement agencies do not perceive these connections.

The Global Commission on HIV and the Law 2012 report clearly outlines the need for reform of policing practice, and the opportunity to recruit police as partners, facilitators and even leaders in HIV prevention strategies.

One significant recommendation in the report¹ is that reform of policy and law must go hand in hand with reform of law enforcement practices and implementation of policy and law by police; critically, these are different activities requiring different focuses. The report also states: 'In many countries, the law (either on the books or on the streets) dehumanises many of those at highest risk for HIV.'²

Police are the key group translating 'law on the books' to 'law on the street' (or often acting without reference to the law at all). Police routinely enforce the criminalisation of activities such as drug use or sex work, meaning that law enforcement practices are one of the major determinants of the risk environment for people at greatest risk of HIV. In many situations police may use existing law to meet more pressing community or political pressures. It is therefore essential that police are engaged as partners in the HIV response and supported to change their approach.

The Law Enforcement and HIV Network (LEAHN) was established to ensure that law enforcement officers and agencies are equipped to support a human rights based response to HIV in their jurisdictions. Set up by police, LEAHN is an international network of people involved in HIV prevention, particularly those working in law enforcement and public health. LEAHN facilitates knowledge sharing,

advocacy and peer education enabling police and public health professionals to share advice and experiences about HIV prevention and harm reduction programs.

Achieving cultural change

One of the biggest remaining challenges, as LEAHN sees it, is the need to reform police culture.

Policing 'culture' is subject to a variety of influences that are difficult for an outsider to discern. In many countries, this culture is male-oriented and male-dominated, self-protecting, and embodies the prejudices and attitudes of the wider society. Changing behaviours is secondary to changing the culture; culture, through peer influence, is often a far stronger determinant of behaviour than police training.

Implementing training within police academies on human rights, harm reduction policing, and the necessity for a partnership approach to addressing HIV – all this is good and necessary,

but is not in itself sufficient to change police behaviours. The closed culture which a new police officer enters after leaving the academy determines many aspects of his or her behavior on the job; and if this is not a culture supportive of human rights and partnerships in the HIV response, the training will be quickly forgotten. Similarly, short-term or one-off training workshops have little impact if the participants return to an unchanged culture and work environment.

To engage police in the response to HIV, it is necessary to understand the world from their point of view, to appreciate the multiple pressures on them, and to ask ‘what’s in it for them?’ Too often, advocacy to police from the HIV sector sounds to them like ‘help us do our job’; the usual police response is ‘we’re too busy doing our job’ (as they perceive it to be).

Police agencies worldwide are undergoing budgetary cutbacks; everywhere, they are subject to the same mantra: ‘focus on the traditional role of policing, that of identifying and catching criminals; ignore the marginal activities such as partnering with public health’. What this imperative forgets is that police have always had a critical partnership role in public health – in road trauma, violence and other crime prevention, dealing with mental health crises and many other issues; this role is not marginal, it is central to the police mandate. The fact that this role is under-recognised and under-rewarded means that police do not immediately understand that their partnership role in HIV prevention and care is part of a normal and central contribution police make to a healthy and safe society.

In many countries, there are structural drivers of counter-productive police

behaviours, such as low pay and status and inadequate training. The global move towards professionalisation of police is founded on the understanding of the critically important role they have, in partnerships, across the widest range of health and welfare issues, and that if they are adequately paid and trained they will be more amenable to learning new roles and attitudes – and more accountable.

None of this is to be read as excusing adverse police behaviours in relation to people and communities at risk of HIV; rather, without an understanding of the drivers of this behavior, attempts to change it will be unsuccessful.

Creating police allies in the global response to HIV

In our experience, there are three common erroneous strains of thought among many civil society, non-government organisations (NGOs) and agencies involved in the HIV response, which may affect their willingness to work with police:

1. that police are merely passive implementers of the law; so that if the law is reformed, police attitudes and behaviours towards most at risk (MAR) communities will automatically fall in line.
2. that police are the enemy, and that their behaviours are not amenable to change without confrontation, and/or
3. that training and sensitisation of police is adequate to change police behaviour towards MAR communities.

‘Police can be your worst enemy, or your best friend’ is a truism to the HIV program manager. While in many situations, police are the enemy of a human rights based approach to HIV prevention and care

among vulnerable populations, this is not always the case. In some instances, changes in police behaviours have been in advance of law reform, through partnership with the HIV sector and beneficial exercise of discretion.

Some HIV programs around the world have been able to work with police, rather than against them, to help ameliorate hostile policing practices which are key drivers of HIV risk (among many other risks to MAR communities). An example of such achievements is a more sensitive approach to patrolling near needle-syringe program outlets, with standard operating procedures in some jurisdictions now recommending no targeting of needle exchanges. Similarly, in Ghana, police not only stopped harassing women carrying condoms as sex workers, but have begun carrying condoms themselves for distribution to sex workers.³ Such approaches are by no means universal, but the list of positive examples is growing.⁴

The Global Commission on HIV and the Law clearly recognises the potential positive role of police, and the urgent need to harness this force to the cause of HIV prevention:

‘The legal environment – laws, enforcement and justice systems – has immense potential to better the lives of HIV-positive people and to help turn the crisis around.’ (p. 7)⁵

‘There are instances where legal and justice systems have played constructive roles in responding to HIV, by respecting, protecting and fulfilling human rights. To some such an approach may seem a paradox – the AIDS paradox. But compelling evidence shows that it is the way to reduce the toll of HIV.’ (p. 9)⁶

Given this background, LEAHN was established to help build informed, trained and supportive police forces as strong allies in the fight against HIV.

LEAHN provides a crucial infrastructure that connects police to the HIV sector and communicates harm reduction best practice within the domain of law enforcement. In some ways, police and security forces are a hard to reach key population – despite being identifiable through their uniforms, they may not see themselves as ‘at-risk’ or as important actors in the HIV response. LEAHN, therefore, plays a dual role: it channels

... police have always had a critical partnership role in public health – in road trauma, violence and other crime prevention, dealing with mental health crises and many other issues; this role is not marginal, it is central to the police mandate.

health and safety information among law enforcement officers to prevent transmission risk through needle-stick injury or unsafe sexual behaviours, and acts as a conduit between police and key populations to repair strained relations and build mutually beneficial trust for effective implementation of HIV prevention services.

The impact of peers

Culture change in a closed culture is best achieved through peer-led interventions, such as modeling and peer education to create a sustainable and supportive environment, which LEAHN helps to create. Key to LEAHN's success is a network of serving or retired police or law enforcement officers (known as Country Focal Points – CFPs) who provide the impetus to connect to their peers and the HIV sector.⁷ LEAHN is expanding, with 20 CFPs representing different countries. The CFPs have produced a video in which they explain why they see police engagement in the HIV response as critical.⁸

As peers, CFPs are a credible and authoritative source of information about best practice harm reduction approaches, facilitating information sharing between senior and junior officers and specialist and general police. This work takes place in a range of ways, including training sessions, face-to-face discussions, internal policy review and via social media channels. The CFP cultivates all these opportunities and nurtures the learning process.

The network facilitates information sharing within and across countries, highlighting examples where police and law enforcement have been key partners in harm reduction, and turning examples of best practice into tools which can be used as impetus for police in other countries to adopt harm reduction approaches. Such examples may even convince

non-government organisations that it is worthwhile engaging with police, where it may have otherwise been deemed too difficult or dangerous.

Some police keenly see the benefits of harm reduction and are early adopters of new practices, while others require ongoing persuasion. In the latter case, the LEAHN peer network provides essential infrastructure to buttress messages which challenge ineffective practices and unhelpful norms in order to convince officers to change their old habits.

LEAHN, through its International Police Advisory Group, has published a Statement of Support by police for harm reduction approaches to policing vulnerable populations.⁹ This Statement has been signed by over 10,000 police worldwide, and continues to accrue more support. It was launched by a delegation of police from LEAHN at the UN Commission on Crime Prevention and Criminal Justice in Vienna in April 2013. It carries a strong message – informing police that this approach is not foreign to policing practices, but is in fact policy among many police agencies already, and has enormous support among police peers and colleagues. It also informs the HIV community that there are many police ready and willing to engage in a partnership to confront not only HIV but the underlying human rights issues affecting MAR communities.

Conclusion

There is a pressing need for more sustained engagement with police around HIV prevention and care; it needs to be better framed as culture change, and integrated with global movements to professionalise policing. It is our hope that through the work of LEAHN, HIV health professionals and communities most affected by HIV can work together help to achieve positive change within the police force.

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The logo for HIV Australia, featuring the word "HIV" in large, bold, blue capital letters above the word "AUSTRALIA" in smaller, bold, blue capital letters, all set against a black background.

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Watching the Detectives: a successful policy intervention in Victoria

By Paul Kidd

Despite three decades of education and awareness-raising, misconceptions persist about the risk posed by people living with blood borne viruses (BBVs) in occupational settings. These misconceptions most often surface in health care, sporting and emergency services environments, often in response to genuine and well-intentioned concerns for ensuring a safe work environment.

In early 2015, Living Positive Victoria (LPV) was approached for advice on a draft Victoria Police (VicPol) policy that would have had the effect of restricting people with HIV, hepatitis B or hepatitis C infection from serving as sworn police officers in Victoria. This article describes the successful policy intervention the organisation was able to undertake, which resulted in the draft policy being dropped from consideration.

LPV was contacted by a member of the VicPol policy review group, who provided us with a draft Victoria Police Manual document entitled 'Recruitment and Management of Employees with Blood Borne Transferable Diseases'. The document set out proposed procedures to be employed where a prospective VicPol recruit or serving member was diagnosed

with a BBV. The policy would have required recruits and serving police to: mandatorily disclose any diagnosis with a BBV; undergo 'ongoing medical risk assessments' by the police medical officer, including compulsory blood testing; and, where the medical officer so advised, potentially be refused employment (in the case of prospective recruits) or be placed on 'restricted non operational or alternative duties' (in the case of serving members).

The policy was contextualised in terms of meeting VicPol's obligations to provide a safe working environment for its employees and minimising any risk to members of the public. It acknowledged the responsibility of VicPol to provide 'an equitable, diverse and fair workplace' as well as its obligation to comply with anti-discrimination laws. These are laudable aims; however it was immediately apparent the proposed policy overstepped what would be reasonable or appropriate measures to achieve them.

Occupational transmission of BBVs

Police work is by its nature high-risk compared to many other professions, and serving police face significant occupational

health and safety risks as part of their role, including possible assault, homicide, and mental health conditions arising out of stress, fatigue and trauma, as well as exposure to communicable diseases.¹ The risk of occupational transmission of BBVs in police settings has not been conclusively quantified, but transmission via this route is exceedingly rare. More data are available relating to the risk of transmission in healthcare-related settings, which confirm the low level of risk for occupational exposure generally.^{2,3}

Numerous procedures and guidelines for minimisation of risk of occupational exposure exist, ranging from the use of protective barriers such as gloves and face masks to the implementation of post-exposure protocols including post-exposure prophylaxis (PEP) in the case of possible HIV exposure. Overseas studies have shown strong evidence for the efficacy of PEP when used by police following blood exposure, but it is rarely used in this context due to the low level of risk of occupational exposure.^{4,5}

The draft policy included a requirement that all VicPol members who have been diagnosed with a BBV disclose this to their manager; it proposed to institute

a program of ‘compulsory annual/ongoing testing’ for members who did so. The police medical officer would then make a determination of the member’s suitability for duty based on the ‘level of risk’ determined from viral load and other clinical markers. We considered this a particularly troubling aspect of the policy: there is no scientific basis for restricting duties based on HIV, hepatitis B or hepatitis C viraemia. We argued that the requirement for members to disclose their BBV status, and to undergo mandatory testing, represented an unacceptable intrusion into the privacy of police employees with no epidemiological or scientific justification.

Lawfulness of the draft policy

Discrimination on the basis of disability (which includes chronic infection with a BBV) is unlawful under both Victorian and Commonwealth law, except in cases where an exception or exemption applies.

In Victoria, Part IV of the *Equal Opportunity Act 2010* (Vic) (‘EOA’) prohibits discrimination against employees and prospective employees on the basis of disability.⁶ The EOA applies to Crown authorities including Victoria Police.⁷ The Act provides for a number of exceptions to the law, including the scenario where the (prospective) employee’s disability requires the employer to make adjustments to work practices or the workplace in order to accommodate the disability, and where such adjustments cannot reasonably be made.⁸ As there was no applicable exception or exclusion that applied, the draft policy was prima facie unlawful under the EOA.

Discrimination is also prohibited under federal law via the *Disability Discrimination Act 1992* (Cth) (‘DDA’). In similar terms to the EOA, the DDA prohibits discrimination in employment and hiring based on the (prospective) employee’s disability⁹, except where the employer can show the disability would prevent the employee carrying out ‘the inherent requirements of the particular work’¹⁰, or where the adjustments needed would cause ‘unjustifiable hardship’ to the employer¹¹.

The draft policy was apparently drafted with the ‘inherent requirements’ test from the DDA in mind, using this phrase to describe the assessment of the member’s suitability for duty to be made by the

police medical officer (although in other parts of the document the requirement was that the member be ‘non-viraemic’).

The ‘inherent requirements’ test was considered by the High Court in 1999 in *X v Commonwealth*.¹² That case concerned an Australian Defence Force recruit who was discharged following a positive HIV diagnosis. Gummow and Hayne JJ (Gleeson CJ and Callinan J agreeing) held that the test should be applied taking into account the particular circumstances: in this case, deployment to battlefield was a necessary part of the employment of an ADF member, and an inherent requirement of that role was the ability to undergo battlefield injury and medical treatment without endangering others with infection (ie. to ‘bleed safely’). The High Court accepted the Commonwealth’s argument that the dismissal was lawful as it attracted the s 21A exemption.¹³

In our response to the draft policy, LPV argued that it was highly unlikely a court would support an exemption to the DDA on similar grounds: the availability of emergency medical treatment across Victoria, the personal protective equipment issued to all VicPol members, and the availability of PEP in cases of percutaneous exposure, all militate against the application of any exemption.

A final aspect of our response was the application of the *Victorian Charter of Human Rights and Responsibilities* (‘the Charter’).¹⁴ While the Charter gives rise to no actionable rights per se, it obliges all public authorities to act in a way that is compatible with the rights set out within it. We argued that the proposed policy was incompatible with the right to equality before the law and the right to privacy, set out in sections 8 and 13 of the Charter respectively.

Conclusion

This was a successful policy intervention for Living Positive Victoria. We were advised that the proposal to restrict employment of sworn police with BBV infections had been dropped from further consideration in response to our submissions.

Our experience in this matter shows that discrimination against people with HIV remains a live issue, despite the strong legislative protections in place across

Australia, and the Charter protections for human rights in Victoria and the ACT. We were able to successfully assist the state police service with achieving a policy outcome consistent with both anti-discrimination law obligations and current medical science. Greater formal and informal contact between HIV sector agencies and police and other emergency services can help achieve similar outcomes elsewhere.

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The problem with Section 79: the call to amend HIV disclosure laws in NSW

By **Scott Harlum**

The Public Health Act is a key piece of NSW legislation which impacts the lived experience of people living with HIV. For many years, Positive Life NSW has advocated for a number of key changes to the Act to reflect the current reality of HIV as a chronic manageable health condition, to better support efforts to end HIV transmission and to acknowledge prevention of HIV transmission is a shared responsibility regardless of sero-status.

With charges under the Crimes Act laid against a man relating to the alleged infection of another man in January, and, more recently, unrelated accusations against a sex worker extradited to Western Australia, Positive Life will again advocate for change to the Public Health Act as part of a required review of the legislation.

Despite an update in 2010, Positive Life argues some sections of the Public Health Act need change, and even removal from the Act to protect the interests of people living with HIV, reduce stigma and discrimination and enhance HIV prevention and testing in the broader community. A key example is the removal of Section 79, known as the 'disclosure provision'.

Section 79 requires anyone who knows they have a sexually transmissible infection (STI) including HIV to inform a person before they have sex, and for that person to voluntarily accept the risk of acquiring that infection. In NSW, if you are HIV-positive and don't disclose your status before sex you are guilty of an offence under the Act. The requirement to disclose your HIV status before sex hasn't changed from the 1991 version of the Act, except for the inclusion of a 'reasonable precautions' provision.

This provision provides a defence to prosecution if 'reasonable precautions' have been taken during sex to prevent transmission. However, the definition of 'reasonable precautions' remains unclear and this amendment falls short of the current reality of HIV. Removing Section

79 will provide a more comprehensive approach to the rights and responsibilities of the community regardless of sero-status.

With today's HIV treatments, if a HIV-positive person is on treatments and has an 'undetectable viral load', the chances of condomless sex resulting in HIV infection are extremely low. However under the current Section 79, without change to the law or a court deciding that an undetectable viral load is a 'reasonable precaution', a person with HIV could still be committing an offence under the Act for not disclosing their status before sex.

Under Section 79, criminalising HIV discourages testing and encourages anonymous sex. Put simply, if you don't know you have HIV you cannot be found guilty of an offence under the Act for not disclosing your status. Equally, anonymous sex reduces your chances of being identified for prosecution. In an era where more than 90% of people with HIV are on treatment and have an undetectable viral load, people who are infected with HIV but unaware of their status are more of a risk for transmission than people on treatment with a suppressed viral load.

Fear of prosecution inhibits honesty with sexual partners and medical providers, so Section 79 may actually increase the transmission of HIV and other STIs, rather than decrease it. An honest and open relationship with our doctor is crucial to maintain good health regardless of our sero-status. For example, contracting an STI such as gonorrhoea is a risk for anyone who is sexually active, and if the symptoms are hidden, we don't know we've picked up an STI. If we can't speak openly about the sex we have, it's likely we won't be tested for STIs and instead transmit any unknown infection to others.

Under Section 79, forced disclosure of our status as a person with HIV can encourage HIV-related stigma and discrimination, both real and perceived.

Disclosure of our status as a person with HIV can, in rare circumstances, lead to violence. More often forced disclosure leads to rejection, loss of control over who knows of our status, discrimination on the basis of our status, or the premature ending of relationships.

Section 79, as it stands, does not account for PrEP (pre-exposure prophylaxis). Today, many HIV-negative people are already importing PrEP, and following last year's World AIDS Day announcement of an expanded PrEP trial in NSW¹, many more will be taking PrEP for HIV prevention as the trial is rolled out in the coming months. A benefit of PrEP is it encourages HIV-negative people to take control of their own health and reduce their own risk of acquiring HIV. Reducing HIV transmission is a shared responsibility and Positive Life believes this principle should be reflected in the Public Health Act.

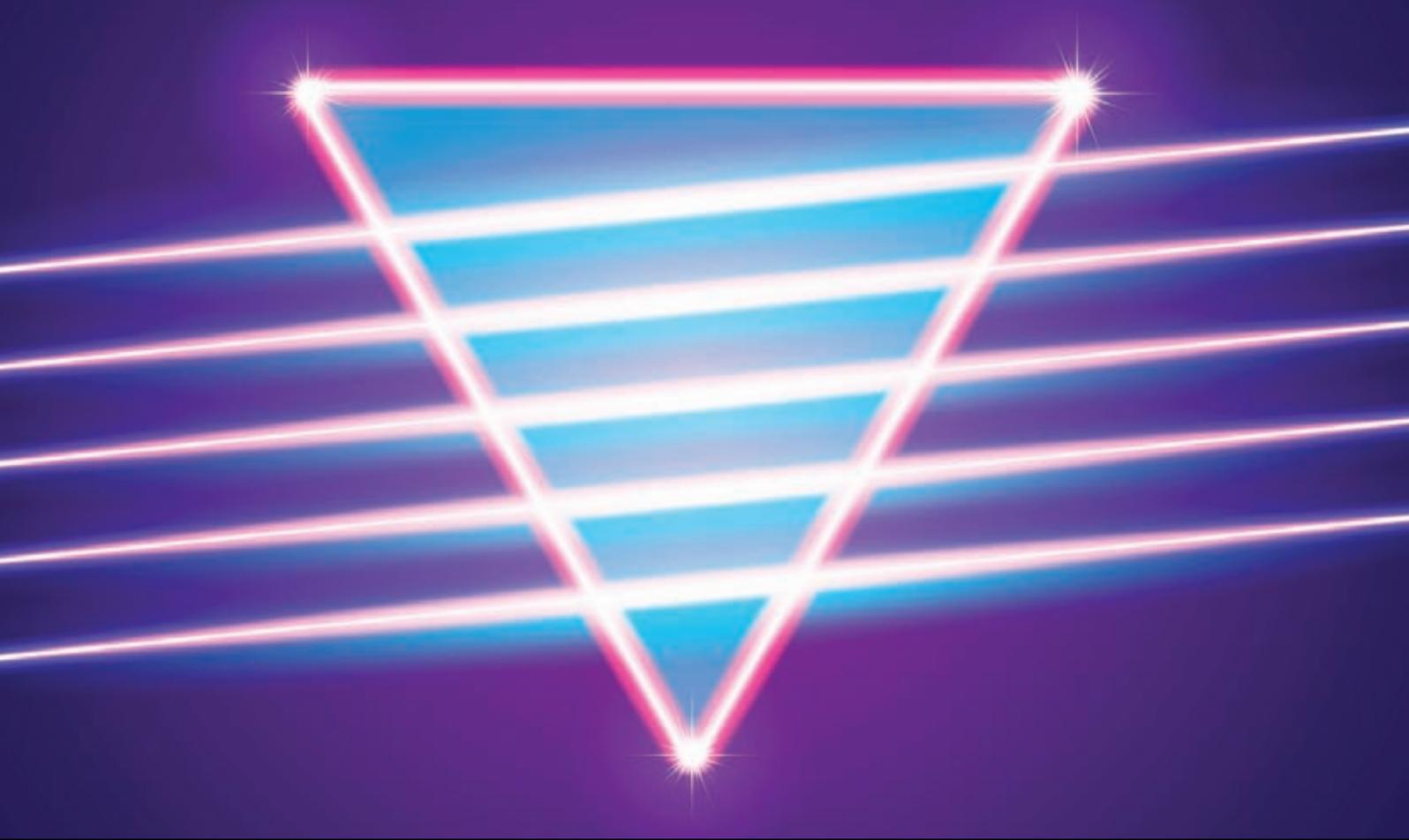
With the coming review of the Public Health Act, Positive Life will share more about other changes we believe should be made to the Act to reflect the modern reality of HIV as an ongoing manageable health condition. In the meantime, if you have questions or comments about our proposed changes to HIV disclosure requirements in the Act, please make contact on 1800 245 677 (freecall) or email contact@positivelife.org.au

This is an edited version of an article first published by *Gay News Network* (GNN) on 8 March 2016. The original article is available at: <http://gaynewsnetwork.com.au/checkup/checkup-opinion/hiv-disclosure-in-nsw-the-problem-with-section-79-20619.html>

Reference

- 1 EPIC-NSW (the Expanded PrEP Implementation in Communities in NSW Study) will enrol 3,700 people at high risk of acquiring HIV. For information see: <http://endinghiv.org.au/nsw/stay-safe/epic/>

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Back to the future? HIV, spitting and perceptions of risk

By Linda Forbes and Michael Frommer

Warning: this article may evoke a spooky, back to the 1980s feeling ... a past/future Australia where councils seriously proposed draining swimming pools frequented by gay men to protect swimmers from ‘catching AIDS ...’. But this is not a story of past ignorance; it’s about recent developments, policy challenges, and a very serious question: how do we preserve hard won legal protections against HIV-related discrimination and laws that stigmatised people with HIV?

Introduction

In 2014 the South Australian (SA) and Western Australian (WA) parliaments passed legislation providing for forced testing for blood borne viruses (BBVs) of people who are considered to have potentially exposed police, hospital staff or emergency workers to a BBV. In both states, the laws were introduced following concerted advocacy on the part of police unions. This article looks at what drove the introduction of these laws, discusses implementation issues, and proposes some policy solutions.

Before looking at the detail, let’s be clear: police officers face challenging and dangerous situations daily, and it is perfectly understandable that an officer who has been bitten, jabbed, bled on or spat at will want workplace policies in place to minimise the risk of contracting an infectious disease as a result of potential exposure.

The problem is that for HIV and other BBVs, these new forced-testing laws represent a knee-jerk response that:

- (a) undermines Australia’s best-practice policy framework for addressing BBV risks to public health in a way that responds to actual risk, and
- (b) does nothing to educate the public or police about BBV transmission and exposure risk, or allay unfounded fears and stigmatisation of people living with BBVs in the community.

It is the view of the Australian Federation of AIDS Organisations (AFAO) that these laws in fact serve to reinforce misinformation about how BBVs are transmitted; heighten police officers’ anxieties; and fuel community stigma

associated with HIV and other BBVs. The concerns raised in this article focus on HIV, but the basic issues apply for all BBVs.

South Australia

In the lead up to the 2014 South Australian election, the Police Association of SA successfully lobbied the SA Labor Government for laws to provide that a person who assaults a police officer can be required to undergo blood tests to check for ‘communicable diseases’ – including HIV and other BBVs. This resulted in Labor announcing its intention to pass such a law if re-elected. The SA Premier and Attorney-General’s media statement announcing the proposed legislation described it as ‘a new community safety measure’ designed to ‘protect those who protect us’.¹

The re-elected Labor Government subsequently fulfilled its promise, with the *Criminal Law (Forensic Procedures) (Blood Testing for Diseases) Amendment Bill 2014*.² The Opposition, the Police Association and the Law Society of SA were all at one with the government on the issue,

agreeing that the legislation would provide 'peace of mind' to police who might have been exposed to a BBV or communicable disease. The SA Opposition not only supported the measure but proposed to broaden its scope to include firefighters, paramedics, emergency service workers, surf lifesavers, nurses, midwives, doctors and hospital emergency department staff.³

Representations made to the SA Attorney-General, including from AFAO, argued strongly against the legislation, went unheeded and in 2015 the Bill was passed.

The SA legislation provides for forced testing for 'communicable diseases', including HIV and other BBVs where a person is 'suspected of a prescribed serious offence' (this covers assault, causing harm and serious harm), and 'it is likely that' a person engaged in 'prescribed employment' came into contact with, or was otherwise exposed to, 'biological material of the person as a result of the suspected offence'. People in 'prescribed employment' are:

- (a) police officers
- (b) emergency workers
- (c) medical practitioners in a hospital
- (d) nurses or midwives in a hospital, and
- (e) people providing assistance or services in a hospital.

Under the legislation, a senior police officer determines whether it is 'likely' that exposure occurred, and can order that an alleged offender provide a blood sample for BBV testing. The scope of this legislation is extremely broad, allowing for testing to be carried out 'whether or not the person is in lawful custody', and clarifying that these amendments apply 'whether the relevant offence was committed before, on or after the commencement of the law'.

Western Australia

And so to the west ... and another election commitment. In October 2014,

the WA Parliament passed the *Mandatory Testing (Infectious Diseases) Act 2014*⁴, its intended purpose being:

'to help ensure that a police officer or other public officer who, in the course of duty, is exposed to the risk of transmission of certain infectious diseases receives appropriate medical, physical and psychological treatment ...'

Under the legislation, persons reasonably suspected of having transferred bodily fluids to a police officer (or other public officer) may be required to test for BBVs/specified STIs. Other than for children/incapable persons, the decision to require a person to test is made by a 'senior police officer'.

It is particularly concerning that the guidelines supporting the implementation of this legislation enable the police to 'request to override' an attending doctor's recommendation as to the need for testing.⁵ This extraordinary process prioritises the expertise of police over attending doctors when making decisions about testing, and begs the question of what infection and disease expertise do WA Police have that is more relevant than that of a medical professional?

As in South Australia, the introduction of the legislation was the result of concerted police union advocacy, with similar hyperbole providing fodder for sensationalist media reports. A WA News report in March 2014 says it all when quoting WA Police Union Boss George Tilbury:

*'Members have told harrowing stories about withdrawing from family and friends because they feared they would infect them ... This legislation will allow for the taking of blood samples from the offender which helps in diagnosis, clinical management and treatment of the exposed police officer.'*⁶

Peppered with inaccuracies and factual errors, the report uses the same emotive language as we heard from SA, when Police Association of SA president Mark

Carroll stated: 'Incubation periods for serious diseases such as hepatitis C and HIV mean that police and their families must endure the horrible stress of waiting months before their health is cleared'.⁷

Misguided rationale

The rationale presented for introducing these laws has been variously stated as 'protecting' the police, and helping to address officers' anxieties while they wait for their own test results.

The legislation fulfils neither rationale. A fundamental flaw is the broad-brush approach of both the SA and the WA legislation, covering various BBVs and contagious diseases; and covering various types of exposure to bodily fluids, ranging from contact with saliva, to blood co-mingling, including during an assault. Rather than serving to address real exposure risks faced by police officers, this broad coverage reinforces misplaced anxieties and common misconceptions about modes of transmission of HIV – as is apparent in the media statements about the laws.^{8,9}

Government, opposition and trade union policy announcements and associated media have served to perpetuate the common misunderstanding that HIV can be transmitted through contact with saliva, such as through spitting. This will reinforce rather than allay general anxiety about the risk of contracting a BBV, both among police and the wider community.

What if there has been an actual exposure risk?

In cases of actual potential exposure risk, the rationale for forcibly testing the source of the potential exposure is misconceived. If a positive BBV result is returned for an offender, it cannot establish whether a police officer has contracted a BBV unless they are themselves tested, allowing for the relevant BBV window periods. While a positive result may unduly alarm the officer, a negative test result from the offender is not conclusive, given that they may have seroconverted but still be in the test window period.

The new laws also group BBVs together. It is unclear whether in each instance an assessment will be made about the likelihood of transmission associated with each different BBV, or whether a full 'set' of tests will be run regardless of risk.

It is particularly concerning that the guidelines supporting the implementation of this legislation enable the police to 'request to override' an attending doctor's recommendation as to the need for testing.

The best-practice approach for any police officer who has had an actual potential exposure to a BBV – e.g. they’ve been jabbed with a blood-filled syringe – is to get immediate access to post-exposure prophylaxis (PEP) and ongoing support, including accurate information resources and referral to professional and expert counselling.

The logistics of forcibly obtaining a blood sample

The legislation does not meet the threshold criteria for compulsory testing set by the National HIV Testing Policy, which states:

‘Informed consent is required for HIV testing, except for rare occasions when a legal order is made for compulsory testing or in emergency settings.’
(Section 3.0)¹⁰

In both SA and WA, a ‘senior police officer’ will be able to order forced testing of a person. The senior police officer is not required to obtain external scientific or medical expert opinion on HIV transmission risk.

The legislation fails to specify how testing will be enforced where a person refuses to be tested. The WA Act states that: ‘A police officer may apprehend and detain the suspected transferor for as long as is reasonably necessary to enable determination of the application’. This suggests that a person may be held indefinitely while they continue to resist forced testing.

Alternatives to forced testing

In AFAO’s view, the SA and WA legislation should be repealed, or at least substantially amended to require that exposure risks for particular BBVs and contagious conditions are taken into account when determining whether a test is to be required. Clear processes for supporting police who have been exposed to risk need to be developed, as laid out in ASHM’s guiding document, *Police and Blood-Borne Viruses*.¹¹ In the meantime, robust procedural protocols are needed, both to limit application of these laws and ensure that overriding protections and rights of appeal in other legislation are observed.

The need for federal leadership

There is a risk that these laws may be replicated around the country, with police

unions in other jurisdictions making calls for similar ‘protection’.¹²

The Commonwealth has an overarching responsibility to identify and respond to jurisdictional issues of national significance. The SA and WA laws clearly flout the Seventh National HIV Strategy¹³, and established national policy guidelines which state that BBV testing must be voluntary and with informed consent; however, the Commonwealth has to date taken a hands-off approach, arguing that these are jurisdictional issues.

This perspective ignores the real potential for further policy replication across the jurisdictions – particularly given the political expediency of responding to ongoing pressure from state police unions regarding what is painted as a law and order issue. The legislation has been presented by governments as workforce protection without regard to actual BBV transmission risks, and without proper consultation with jurisdictional health departments. In SA and WA it seems that political expediency overrode expert advice. The result is that we are now seeing the introduction of laws based on misguided understandings of HIV transmission risk that were rife in 80s, but are now well and truly discredited.

Once in place, the repeal of such laws is notoriously difficult. The National HIV Strategy notes the importance of entering into ‘a respectful dialogue with other sectors to discuss impacts of wider decisions on the health of priority groups’.¹⁴ It’s time for the Commonwealth to establish ‘a respectful dialogue’ with WA, SA and the police unions to reform the laws now in place, and prevent the replication of bad laws around the country.

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Police work and blood borne viruses (BBVs): providing information and guidance about risks and responsibilities

By Karen Seager

Introduction

ASHM (Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine) is a professional, not-for-profit, member-based organisation. It supports its members, sector partners and collaborators to generate knowledge and action in clinical management, research, education, policy and advocacy in Australasia and internationally.

For some years, ASHM has been producing a series of profession-based booklets tailored to meet the specific needs of particular workforce groups in relevant blood borne virus disciplines. Initially the series focused primarily on hepatitis C and was targeted at primary care providers, generally doctors and nurses. In 2008, ASHM expanded the suite of resources to include booklets for other professional groups. These new booklets focused on paramedics and BBVs, and general practitioners and HIV.

By 2010, through research and surveys in various workplace settings, ASHM had identified a growing need for basic information about hepatitis B, hepatitis C and HIV right across the community.

Interest in resources and information was no longer limited to primary care providers caring for people with a blood borne virus. Other groups that have an occupational risk of exposure to BBV infections, such as the police and correctional officers, were seeking more information about BBVs. In response to the growing demand for information, ASHM developed the booklets *Police and Blood-Borne Viruses (BBVs)* (2008) and *Correctional Officers and Blood-Borne Viruses* (2010), both of which were updated in 2015. ASHM has also produced booklets on BBVs for pharmacists, aged care workers and professional interpreters and translators.

Police and BBVs: resource rationale

Members of law enforcement agencies, such as the police, often undertake work where exposure to blood and body fluids can occur. While the risks of such exposure vary according to particular circumstance, police officers may be exposed to infectious agents including BBVs while conducting searches and arrests or during the collection of bodily samples.¹

Although there is increased occupational risk of BBV exposure for police officers, it is important to stress that the risk is arguably less than for other emergency service providers such as paramedics or hospital workers. Also, if exposure does occur, it tends to be less serious. Nevertheless, it is understandable that police officers may express concern about the occupational risks of contact with BBVs, highlighting a clear need for access to accurate information about BBV transmission and exposure risks.

Accordingly, ASHM has produced a resource designed to provide information and guidance to police officers about BBVs, including how the viruses are spread, how to protect against infection and what to do if there is a possible exposure. The booklet, *Police and Blood-Borne Viruses*, includes information about exposure risks, BBV transmission, BBV prevention methods, and appropriate emergency management following exposure to a blood borne virus.

ASHM believes it is crucial for police officers to understand the true potential risk of infection – blood exposure, needle-

stick injury, and sexual contact (without a condom) – and that they also have a clear understanding of what behaviours do not present a risk of infection.

Importantly, police officers must also have a thorough understanding of an individual's rights relating to BBV disclosure. ASHM advocates that standard infection control procedures should be maintained at all times, regardless of a person's suspected or actual BBV status. This approach ensures that people with a BBV do not face unnecessary stigma and discrimination, while also ensuring police officers are protected during the course of their regular duties.

Broad content areas

Police officers and Blood-Borne Viruses was developed to provide basic information on BBVs, dispel myths, and outline key facts about hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV). It was first published in 2008, and was subsequently updated in 2010 and 2015.

The resource discusses the prevalence of each virus within the community and explains the similarities and differences between these viruses. Importantly, the booklet clearly outlines how the viruses are transmitted, how to protect against possible infection, and what steps to take in the event of a possible exposure. The 2015 updated edition also contains brief information on prevention of transmission, treatment, and environmental risk management.

Although the primary focus of the booklet is about how police officers can mitigate their occupational risk and protect themselves from possible infection, another critical area outlined is legislation designed to protect and uphold the rights of people living with a BBV infection.

This includes an individual's right to confidentiality regarding BBV status, as well as the right to access treatment and medical care while being held in police custody. The booklet stresses that police officers must not record a person's suspected BBV status – or other confidential information, such as sexual orientation – on police records unless it is directly relevant to a crime for which the individual has been arrested.



Police and Blood-Borne Viruses



Depending on their duties, Police Officers (Officers) may be exposed to blood or body fluids in the course of their work. This means Officers have an occupational risk of contact with blood-borne viruses.

This resource is written for Officers across Australia. It contains basic information about blood-borne viruses (BBVs) including how the viruses are spread, how to protect against infection and what to do if there is a possible exposure.

The booklet was developed to provide information and guidance. It does not replace policies and procedures of policing agencies. Where State or Territory detail is needed, Officers should check their local policies and procedures.

The Facts

The three major BBVs – hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV) – are different viruses, but they are all spread by blood. Hepatitis B and HIV can also be passed on in other body fluids.

All these infections can be prevented.

They can all be treated, but if left untreated, in some people, they may lead to serious health problems. See Table 1 for The Facts About hepatitis B, hepatitis C, and HIV.

Police officers are also advised that there is no need to isolate individuals with, or suspected of having, a BBV infection. Furthermore, the booklet highlights the importance of not discriminating against any individual based on the notion that they might have a BBV. Officers are further advised to follow local policies and procedures relating to the provision of medication, and access to medical care, for those who are held in custody.

Where disease testing orders may be in place, officers are advised not to wait for the outcome of such testing before seeking their own risk assessment from an appropriately qualified health professional. Waiting for an individual's test result is not necessary and may delay treatments that need to be started as soon as possible.

Throughout the booklet, key messages are highlighted and clear subject headings

allow officers to find relevant information quickly and easily.

Development process

For each resource that ASHM develops, an Advisory Group is established to guide the project. An Advisory Group for each edition of the *Police and Blood-Borne Viruses* booklet was convened comprising representatives from state and territory police agencies, representatives from Australia and New Zealand Policing Advisory Agency (ANZPAA) Safety Committee, Australian Federal Police and the Police Federation of Australia.

This Advisory Group also included doctors, nurses, trainers, and police officers nominated by their agencies who had some responsibility for the health and safety of officers in their jurisdiction. In addition to this advisory group, ASHM clinical

advisors reviewed the content to ensure clinical accuracy and relevance. Funding was provided by the Commonwealth Department of Health. The booklet was accepted by police services in all jurisdictions and endorsed by ANZPAA.

Jurisdictional differences

During the development process, discussions highlighted a range of procedural differences that exist in each state and territory. These differences can be quite significant, or relatively minor, and stem mainly from differences in state and territory laws. As an example, some states and territories have prohibited the use of torches during a mouth inspection, while others haven't.

One highly contentious difference was the 2014 introduction of mandatory testing laws for communicable diseases, including BBVs. The passage of this legislation meant that individuals accused of certain offences (offences differ in each jurisdiction) in South Australia and Western Australia are subject to mandatory testing. This allows for the testing of an individual who has spat at, or bitten, an officer. Currently, Western Australia and South Australia are the only states and territories to have adopted this legislation.

It is important to note that although the booklet acknowledges there are jurisdictional differences between agencies, it does not attempt to argue the appropriateness of them. The booklet was developed only to provide essential information on BBVs for police officers, and is not an advocacy tool. As a national resource, it is beyond the scope of the booklet to address precise jurisdictional differences that exist; police officers are advised to consult their local process and procedural documentation, where necessary, and to follow the relevant protocols.

Police officers living with a BBV

The booklet also provides information for police officers who themselves have a BBV infection. It is recommended that all officers know their own status with regard to BBVs. Knowing their status means they can get the right care for themselves. Having a BBV infection does not prevent officers from performing their usual duties. All officers are advised to adhere to standard infection control precautions, regardless of their BBV status. Doing so will protect them and others from a possible exposure to a BBV.

Like most other workplaces, officers are not required to inform their employer about their BBV status and the employer must not discriminate against their employees on the basis of their BBV status. Police officers have the same rights to confidentiality and privacy as anyone else and these rights need to be protected and respected.

The booklet contains contact details of helplines and other resources that are specifically designed to support police officers in the event of an exposure to, testing for, diagnoses of, and treatment for a BBV infection, regardless of how or where the exposure occurred. Officers are not compelled to use these specific services and have the right to choose their own medical practitioner. However, the helplines are available 24 hours a day (with the exception of Tasmania) and can provide immediate confidential advice and support in the event of an accidental exposure. If officers choose not to utilise the specific helplines, they are advised to contact the emergency department at local hospitals who can provide services such as counselling, risk assessments, testing and immediate treatment if it is deemed necessary by a qualified health professional.

Take up and feedback

Since the booklet *Police and Blood-Borne Viruses* was first published in 2008, over 10,000 hard copies have been distributed (including 2,000 copies of the 2015 version) through police services in each state and territory. The booklet is used as a training resource with each new intake in Police Academy Training Institutes around the country. It has become essential reading for police officers during recruitment and training, as well as being made available once they are deployed to a police station. Interest in the resource has also been shown in New Zealand, where it contributed to the development of a resource tailored to the New Zealand context.

In 2011, an associated e-learning module based on the booklet was developed in response to requests for more support material. The module highlights the key messages from the booklet but primarily focuses on standard procedures for infection prevention and what to do in the event of an accidental exposure.

The module is a mix of information, interactive activities and mini quizzes, and takes about 20 minutes to complete. The module, which can be accessed at any time, is used as an additional tool during officer training or as a revision exercise at a later date.

The module is available through the training section of the ASHM website and access is not restricted to police officers.

Copies of *Police and Blood-Borne Viruses* are available free of charge in all jurisdictions. The booklet can also be downloaded from the ASHM website at: <http://www.ashm.org.au/resources/Pages/978-1-920773-39-7.aspx>

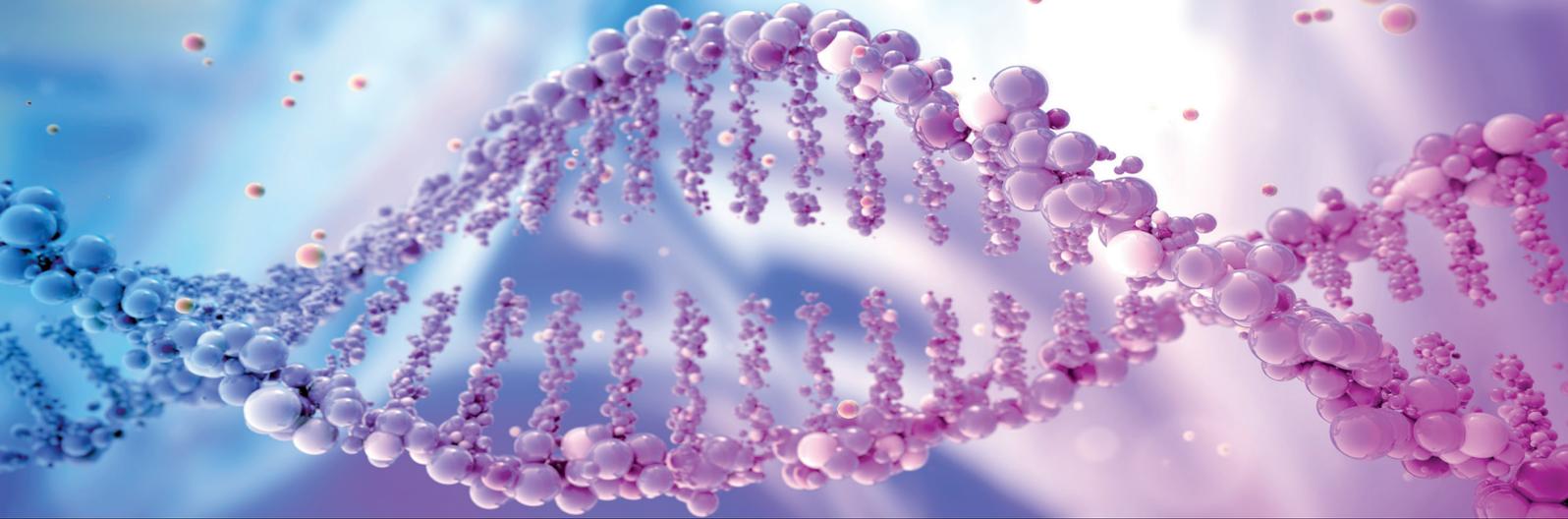
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Phylogenetic analysis as expert evidence in HIV transmission prosecutions

By Paul Kidd

Modern criminal prosecutions rely increasingly on the use of evidence from forensic science. Such evidence can help establish the identity of offenders, place defendants at the crime scene, or support a prosecution narrative. In cases involving the alleged criminal transmission of HIV, a key challenge for the prosecution is proving a causal link between the HIV infection of the complainant and that of the accused. No forensic test exists that, by itself, can establish such a causal link beyond reasonable doubt. Prosecutors in some cases have nonetheless been able to introduce into evidence phylogenetic analyses that purport to show a non-definitive, but inferential, link between the infections.

This article examines the use of HIV phylogenetic analysis in three Australian criminal trials. It argues that courts in Australia appear to accept forensic evidence uncritically. As the forensic methodology used in phylogenetic analysis is inherently limited, it argues there is risk of miscarriage of justice where this type of evidence forms a substantial part of the prosecution case.

HIV phylogenetic analysis

Phylogenetic analysis is a methodology within the field of molecular virology that compares partial DNA or RNA sequences extracted from different sources to infer evolutionary relationships between them.^{1,2,3,4} By identifying shared genetic sequences, an evolutionary 'gene tree' is constructed based on a hypothesis about the relatedness of the samples via a common ancestor.^{5,6,7,8} Phylogenetics

is a well-established scientific discipline, but one that is more commonly used to study viral dynamics within populations of organisms, rather than to suggest direct virological links between specific individuals.⁹

In criminal cases where HIV transmission is alleged, phylogenetic analysis of proviral DNA extracted from human blood is sometimes admitted in court as evidence of causation (i.e. 'person A infected person B'), despite significant concerns about its reliability and validity. As with DNA profiling, phylogenetic analysis can definitively rule out a connection between cases, but cannot prove a connection beyond reasonable doubt.^{10,11}

Like DNA profiling, phylogenetic analysis compares selected gene sequences from the accused (A), the complainant (B), and a number of unrelated controls, to determine a probability that the two samples are related. In no circumstances can the process show the direction of infection, so this is always inferred (A infected B). Nor can it rule out other routes of infection, such as that a third person (C) infected both A and B, that A infected C who infected B, and so on.¹²

Unlike DNA profiling, which typically uses databases with hundreds of thousands or millions of control samples to minimise error, phylogenetic studies typically use only a handful of control samples.¹³ The selection of these controls then becomes highly significant, as the inclusion of even one or two inappropriate controls may seriously distort the reliability of the analysis.¹⁴

A key criticism of forensic phylogenetics is that the process proceeds from a hypothesis of guilt. The analysts, who are typically not forensic specialists but research virologists or geneticists, take as their starting point a presumed relationship between the accused and the victim's samples, and a presumed direction of infection.¹⁵ This introduces a degree of bias from which it has been argued the evidence cannot recover.¹⁶

Phylogenetic evidence is subject to the so-called 'CSI effect', the phenomenon whereby juries give undue weight to forensic science evidence.¹⁷ When combined with the sensation and scandal that typically accompanies HIV-related criminal prosecutions, the willingness of juries to accept such evidence is likely to be amplified by the desire to punish behaviour that carries an extreme stain of moral obloquy.

Viral forensics in Australian HIV cases

In Australia, a small number of cases involving alleged HIV transmission have employed phylogenetic analysis evidence. Three of these are described briefly below.

In F's Case¹⁸, a 51-year-old Victorian man was convicted of three counts of conduct endangering life¹⁹ for having unprotected intercourse with three people with a disability, two of whom had tested HIV-positive. He was sentenced to eight years' jail, but tragically committed suicide in prison the day after being sentenced.²⁰ At his trial, experts testified that phylogenetic

analyses linked his HIV infection with that of the complainants. According to a newspaper report, 'DNA tests confirmed the strain to be the same as that carried by [F].'²¹

The technical process used in F's Case was subsequently detailed by the investigators involved.²² They employed forensic methods originally developed for analysis of a US dentally-acquired HIV cluster²³ to compare three samples taken from the accused with samples collected from four subjects whose sero-positive status was presumed to be linked (three of whom had sex with F, and the other a partner of one of the first three), and 15 'randomly selected' controls.

A critical reading of their article highlights a number of issues. Only 15 control samples were used. One of the controls was a strong match for F, and was later discovered to have frequented the same sex-on-premises venue as him, raising questions about the degree of randomisation in the selection process. While the resulting phylogenetic tree does suggest a relationship between F and the victims, it also showed a weaker, but still strong, relationship with the controls.²⁴

In Rowland²⁵, a 30-year-old Western Australian man was sentenced to 10 years' jail after he was found guilty of causing grievous bodily harm to a 12-year-old boy he allegedly infected with HIV²⁶. The prosecution case relied in part on phylogenetic analysis, with a University of Western Australia immunologist testifying that DNA tests linked the HIV infection of the two parties.²⁷

In Richards²⁸, a 34-year-old Brisbane man was acquitted of charges related to the infection of an 18-year-old man. This was despite a geneticist testifying there was a '100 per cent probability' that Richards had infected the man.²⁹

Phylogenetic analysis was by no means the only evidence of causation led by the prosecution in any of these cases, and it is not suggested that any miscarriage of justice occurred. None of the three cases went on appeal, and in the absence of published reports, it is difficult to determine what weight was given to the expert evidence or on what basis it was admitted. But the fact that such evidence was admitted at all demonstrates a willingness by the courts to consider evidence that has limited probative value

(because it cannot definitively establish causation) and has never been subject to independent scientific validation.

Admissibility of phylogenetic analyses

Expert evidence is admissible in Australian courts under an exception to the 'opinion rule' that permits an opinion to be given by a person with 'specialised knowledge' where the opinion is based wholly or substantially on that knowledge.^{30,31} The law conspicuously does not impose a requirement that evidence be reliable, or that the methodology used be subject to scientific validation or acceptance. Phylogenetic analysis as used in criminal trials has never been subjected to any form of independent validation or error rate quantification.

The established view is that the role of the judge in a criminal trial is to adjudicate questions of law, not fact, and that questions as to the reliability of forensic science evidence are best left to the jury. According to this view, any concerns from the defence on such matters should be ventilated during cross-examination and via the calling of rebuttal experts.³² While this view has theoretical merit in terms of its reinforcement of the separate and complementary roles of judge and jury, in practice it creates an uneven playing field. The state has significantly greater forensic resources to call on, and studies have found that cross examination of experts has little or no effect on juries, who tend to accept prosecution experts' evidence without question.³³

The Universal Evidence Acts do provide a mechanism for the exclusion of evidence where its probative value is outweighed by its prejudicial effect.³⁴ Yet this safeguard has had 'no discernible effect' on the courts' willingness to admit opinion evidence.³⁵ A recent Victorian case gives some hope that the ground is shifting, but there is a long way to go.³⁶ In the UK, after a trial involving phylogenetic analysis collapsed, prosecutorial guidelines now limit the use of the technique.^{37,38}

Conclusion

HIV phylogenetic analysis is a forensic technique that has significant scientific limitations: it cannot prove a link between two samples to the required criminal standard; it provides no information about the direction of infection; it employs too

few control samples; it proceeds from a hypothesis of guilt; and it has never been independently scientifically validated. Nonetheless, evidence based on this science has been placed before magistrates and juries as 'proof' of facts which the scientific foundations of the technique cannot reliably support. Problematically, Australian evidence law provides no mechanism for the exclusion of evidence based on flimsy science, preferring to leave often ill-equipped jury members to determine what weight the evidence should be given.

While the number of Australian cases employing phylogenetic evidence has to date been quite small, there is considerable cause for concern. When combined with the moral scandal that typically surrounds HIV transmission prosecutions, phylogenetic analysis risks being given such undue weight that it could result in a serious miscarriage of justice. Prosecutors and the judiciary should be wary of allowing such evidence to be put before juries, especially where the evidence of transmission from accused to complainant is otherwise weak; and defence counsel should work strenuously to ensure juries are made aware of the inherent limitations of the technique.

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Recently been exposed to HIV?

ACT FAST.





Equity inside and out? HIV, treatment access and prisoners

By Michael Frommer and Tony Maynard

Many people believe that under the Medicare system, all Australians are provided with universal access to health services and pharmaceuticals. However, prisoners have always been excluded from Medicare coverage, with all prison health care provided by state and territory governments.

While human rights law states that all prisoners have the right to health care equivalent to that provided to the general community¹, concerns have been expressed by some researchers about the adequacy of medical services and care available within correctional facilities, compared with services available under Medicare². This article explains the rationale for excluding prisoners from accessing Medicare, and then examines how this plays out for people with HIV and other blood borne viruses (BBVs) who are incarcerated.

Before Medicare

Prior to the introduction of Medicare, publically-funded health services were provided by state and territory governments. This was consistent with

the division of responsibilities for service provision between state and federal governments.

Australia's universal health care system, originally called Medibank, was adopted in 1975 and then removed with the change of government. The universal health care system was reborn in 1984, with the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) centrally administered under the Health Insurance Act 1973.

An amendment to the *Health Insurance Act* states that 'Medicare benefit is not payable in respect of a professional service ... under an arrangement with ... an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory.' As prisons are state established entities, prisoners are not eligible for Medicare subsidised services.

The question that arises is whether, without access to Medicare-subsidised services, prisoners with HIV and other BBVs are receiving inferior access to services. First, a quick snapshot of background numbers/demographics.

Prison population demographics

Australia's prison population is increasing in both numbers and rates. The most recent figures quoted in the Australian Institute of Health and Welfare report, *The Health of Australia's Prisoners 2015* show that 187.3 per 100,000 adults were in custody during 2013–14, up from 172.4 in 2012–13.³

As of 30 June 2014, there were 33,170 prisoners in Australia but over the entire year, more than 50,000 moved through the prison system.

The Australian prison population is primarily male (92%), and more than two thirds of detainees (68%) are 40 years of age or younger (compared with around 38% in the wider community).⁴

Aboriginal and Torres Strait Islander people are significantly overrepresented in Australian prisons, comprising just 2% of the general population but making up 27% of the prison population.⁵ The reasons for this over-representation are complex, with entrenched social and economic disadvantage being among the key drivers.

Blood borne viruses in prisons

All prisoners are offered screening for BBVs and STIs on entry. This voluntary policy has been in place since 1999 when it replaced the mandatory testing policies of the 1990s; however, anecdotal reports suggest that due to fear of disclosure, many prisoners decline to be tested.

Stigma and discrimination also discourage HIV-positive prisoners from disclosing their status, therefore reliable statistics on the number of people living with HIV in Australia's 94 prisons are scant. The numbers are estimated from *The Health of Australia's Prisoners 2015* 'snapshot' analysis of prison entrants. The report uses data obtained from the National Prisoner Health Data Collection (NPHDC), conducted over a two weeks period in 76 out of 91 public and private prisons in all Australian states and territories.⁶

In 2015, this 'snapshot' found that of 501 entrants who were tested, none tested positive for HIV, a result unchanged since 2010. Clearly this is not a reflection of the actual numbers who are incarcerated. At any given time there are believed to be 30 to 40 HIV-positive prisoners in NSW prisons alone. This shows that Australia, as a high-income country, has significantly lower rates of HIV infection among prisoners than do neighbouring middle and low income countries.

In the case of hepatitis C, the situation is markedly different. Up to two-thirds of females screened for hepatitis C on entry to Australian prisons are found to be HCV positive, compared to around one-third of male prisoners.⁷

For Aboriginal and Torres Strait Islanders in prison, the rates of hepatitis C are much higher. Figures cited in the National Hepatitis C Strategy state that 43% of Aboriginal and Torres Strait Islander people in custodial settings have hepatitis C, compared with 33% of non-Indigenous detainees.⁸

Treatment for BBVs in prisons should be provided in line with International frameworks from the United Nations (UN) and the World Health Organization (WHO) and supported by national principles in Australia, which state that prisoners have the right to access an equivalent standard of healthcare as available in the wider community, irrespective of their legal situation.⁹

People in offshore detention

Due to restrictions on accessing information regarding the wellbeing of people detained offshore on Nauru, Manus and Christmas Island, it is hard to get a precise picture of how detainees with HIV and other BBVs are faring, including their ability to access treatment.

There have been, however, several anecdotal reports of poor or even completely non-existent access to appropriate HIV care and support. One informant, who worked with detainees on Nauru as a case manager, stated that HIV health care must be seen in the context of the general impoverished state of health care available in detention. He stated, 'The guys I see just say "I get sick, I feel unwell, I go to the doctor," and sometimes they have to book an appointment, sometimes it takes a long time. Sometimes there are no doctors on the island, and then they just get a Panadol, some painkillers ... no specialised treatments.' He was certain that none of the three HIV-positive people who he saw were receiving ARVs.

John-Paul Sanggaran was a medical officer at Christmas Island detention centre. He expressed concern to AFAO about a host of problems he observed, which led to substandard health care, including for people with HIV. An individual newly diagnosed with HIV might need specialist psychological services to deal with the ramifications of the diagnosis, but this support, he states, is not available in a remote offshore detention centre. He described these environments as generally uncaring and unsupportive, with significant stigma attached to the virus, made worse by religious beliefs and moral judgements among asylum seekers. A particularly disturbing example of problematic treatment was where an individual diagnosed with HIV while on Christmas Island was housed in White compound, which is a behavioural management unit. An individual may be placed in the White compound if deemed to be 'non-compliant' by centre management, due to aggressive behaviour, or if they are considered at risk of harm from others.

For people in immigration detention, where the overall health landscape is dire, at the very least individuals should receive counselling upon diagnosis and have reliable access to antiretroviral medications. While the public debate around immigration detention is extremely contentious, coordination among partners in the non-government sector (NGO) sector and direct advocacy to government should be pursued.

In some states and territories, the state or territory Department of Health provides prison health services, but in others such as NSW and Victoria, these services are provided by the Department of Justice or Corrections. Public/sexual health nurses are employed in all prisons except for the most remote rural ones, so screening, care and treatment are widely available.

Health education programs are the most widely used strategy for reducing the spread of BBVs in prisons, but while prisoners are informed about the risks of infection and transmission, they are not consistently provided with the means to reduce their risk of acquiring BBVs. Harm minimisation measures such as opioid substitution programs, and dental dam/condom dispensers are available in many prisons; however needle and syringe programs are not provided anywhere.

Access to services

HIV

Due to the voluntary nature of participation in BBVs and STIs screenings for prison entrants, it is not possible to determine exact numbers of people with HIV in prisons, nor the subset of this population who have difficulties accessing appropriate medication.

Anecdotal reports indicate that because of the stigma and prejudice associated with HIV infection, some prisoners forego medications to protect themselves from being identified and thus being subjected to discrimination. For example, an infectious diseases nurse in Victoria informed the National Association of People With HIV Australia (NAPWHA) that very few of the prisoners living with HIV attend the health clinic because they are afraid their status

will be leaked, and as a result they will suffer harassment and sometimes violence from other prisoners.

NAPWHA is aware of one case in NSW where an HIV-positive prisoner had to be moved to another jail after he was bashed, when it leaked out that his daily visits to the clinic were to pick-up his HIV medications.

In the Northern Territory (NT), we understand that occasionally a person with HIV may experience a day or two without being able to access treatment when first admitted to prison; however this is not generally a problem. Sometimes there are issues with getting prison nurses in the NT to use correct blood tubes for viral load and CD4 counts, but this is simply due to a nurse's lack of familiarity with these tests. To avoid the problem, sexual health coordinators usually label and send the tubes out to the nurses. There are no reported problems with arranging medical appointments, provided that a letter is sent to the administrative person at the prison with one or two weeks' notice.

Access to treatment in prison is a mixed picture. It is a concern if prisoners who know their status conceal this information and don't take medication while in prison to avoid stigma and discrimination from staff or other inmates. NAPWHA, however, has not been made aware of any systemic problems in relation to HIV-positive people accessing medication in prison. We thus believe that while stigma remains a concern, people living with HIV who are prepared to disclose their HIV-positive status are generally able to access treatment in prison.

Hepatitis C

The *Fourth National Hepatitis C Strategy 2014–2017* and the *Fourth National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy 2014–2017* recognise prisoner populations as priority populations for hepatitis C.

Uptake of treatment for hepatitis C has historically been low in both the community and in prison, due to the considerable side-effects associated with interferon in the treatment regimens. Prisoners' access to treatments has also been patchy. In 2013, The National Prison Entrant Bloodborne Virus Survey found that only 11 (9%) of inmates with hepatitis C had reported receiving HCV treatment (up from 5% in 2010), including five Aboriginal prison entrants.¹⁰ This suggests an urgent need to further increase hepatitis C treatment uptake among prisoners.

From March 1, 2016, the new interferon-free direct acting oral antivirals (DAA) became available to all Australians with hepatitis C, including those in prison. These drugs have very high cure rates following a 12–24 week course. Given the high rates of HCV in Australian prisons, providing access to these treatments will have a significant impact. In NSW, for example, it's estimated that between 500 and 600 prisoners will be able to access treatment and be cured of their hepatitis C infection.¹¹

Conclusion

People in prisons generally receive adequate HIV treatment and support,

despite not being able to access Medicare-subsidised services. However, with high rates of hepatitis C and injecting and a lack of needle exchanges, further spread/transmission of hepatitis C is likely, along with the potential for HIV transmission. There is a great need for comprehensive BBV prevention, including introduction of needle and syringe programs, as well as adequate access to sexual health prevention measures.

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People in prisons generally receive adequate HIV treatment and support, despite not being able to access Medicare-subsidised services. However, with high rates of hepatitis C and injecting and a lack of needle exchanges, further spread/transmission of hepatitis C is likely, along with the potential for HIV transmission.



Hepatitis C and Aboriginal and Torres Strait Islander people: closing the gap

By **Heather McCormack**

When we talk about closing the gap in relation to Aboriginal and Torres Strait Islander people, we often have very siloed ideas of what that means: there's over-incarceration, the health gap and the education gap, for example. But viral hepatitis, and particularly hepatitis C, is one of those areas where it all links together in a horrible cycle that ends up disproportionately affecting Aboriginal people's health.

The over-incarceration of Aboriginal people means that more of us are in an environment where there are very high rates of hepatitis C. We're more likely to inject drugs and share equipment when we do inject drugs, and our historic disconnection from the health sector means that people aren't getting treatment and aren't being monitored. We're also often disconnected from health messages that educate drug users to inject safely, due to educational disparity and geographical distance.

Colonialism and racism play a big role, too. Even today people claim that over-incarceration occurs because Aboriginal people commit more crimes. That is wrong. The evidence suggests Aboriginal people are more likely to be searched for drugs, more likely to be arrested if they do

have drugs on them, and more likely to be sent to prison if they are arrested.

Conservative estimates state that 30–50% of people in the criminal justice system at any one time have, or have had, hepatitis C.^{1,2} Ex-prisoners tell stories of one needle being shared between 10 to 20 people again and again and again. If you were trying to design the ideal environment for hepatitis C transmission, you would come up with something that looks a lot like our prison system – a high number of people incarcerated for drug-related crimes, who currently inject drugs but who are then denied access to sterile injecting equipment.

About 90% of new hepatitis C infections come from shared injecting equipment.³ A lot of people now understand not to share needles, but hepatitis C is a startlingly infectious disease and can be passed on by traces of blood on things like tourniquets and swabs. So if people don't know not to share absolutely anything related to injecting, they can still transmit the disease.

In that remaining 10%, things like backyard tattooing and piercing and prison tattooing – which we know happens frequently in the Aboriginal community – are a big risk factor.

There is a persistent myth that Aboriginal people share injecting equipment because of the culture of sharing. That is just not the case. The real reason is a combination of lack of access to sterile equipment and low health literacy. We know when people are given the information and capacity to look after their own health they do, and Aboriginal people aren't any different to that.

Anecdotal evidence suggests that Aboriginal people using drugs are more heavily policed than non-Aboriginal drug users. We have heard of people accessing needle syringe programs (NSPs) and being targeted by police doing that, even though that's not supposed to be a thing that police do.

We also know that a lot of Aboriginal people are reluctant to access NSPs where they may be recognised by members of their communities as someone who uses drugs. There are some places, especially regional and remote areas, where there just aren't NSPs. Aboriginal medical services that have implemented NSPs find that some people don't access it because that's where they get all their healthcare needs met and they don't want their healthcare providers to know they use

drugs. Some of the services are countering this by putting vending machines in places where they can't be seen but there is still more work to be done.

I cannot be any clearer that the single easiest way to reduce hepatitis C transmission would be to introduce needle and syringe programs in prisons. The statistics for hepatitis C in prisons are staggering. People don't stop injecting when they go into prison, and they don't stop injecting when they come out of prison. We know that some people actually start injecting when they go into prison. While prisoners are no more or less valuable than any other member of the community, it is also a way of passing that infection into the general population.

Owing to myriad complex factors, we tend to cycle people through prison in repeated short sentences, and that includes a number of marginalised people not being offered bail. Drug treatment programs in NSW, however, are only available to prisoners who are incarcerated for a minimum of six months. In practice, this means we are effectively imprisoning many people for using substances illicitly, but telling them they're not in prison long enough to be treated for dependency on those substances. With no NSPs in prisons, this puts inmates at huge risk of hepatitis C transmission.

Hepatitis C: Three key messages

1. Get tested. If you've ever injected drugs, even just once, even a long time ago; if you've had a tattoo or a piercing; if you've lived with someone who had hepatitis B or C, you should go and get an easy blood test at your GP, your public health nurse, an Aboriginal health service, or a sexual health clinic. The results are entirely confidential, and apart from a few exceptional cases, you don't have to tell anyone if you have hepatitis.

2. If you're living with hepatitis B or C, get a liver check. Nowadays this check is easy, there's no probing or cutting, it's the equivalent of an ultrasound that can tell you how damaged your liver is. Based on that, you can make decisions about treatment and lifestyle modifications.

3. Ask your doctor about treatment. New medications for hepatitis C are now available. They are more effective than previous treatments and have fewer side effects. In terms of hepatitis B, there are already effective treatments that can help to prevent progression to serious liver disease. Talk to your doctor about the best option for you today.

This article was originally published by *The Guardian* on 27 July 2015 in partnership with IndigenousX, as part of Hepatitis Awareness Week. The original article is available at: <https://bit.ly/1EBd5ri>

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THINK YOU MIGHT HAVE BEEN RECENTLY EXPOSED TO HIV?

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Straight outta WA: tracing the success of a state-wide prison-based BBV education program

By **Matthew Armstrong**

People entering the Australian criminal justice system experience extreme health inequities compared to the broader population, with elevated risks for communicable and chronic disease, high levels of drug and alcohol addiction, and little to no prior contact with healthcare services outside of the prison setting.^{1,2}

Given that these elevated risks are well known, and that prisoners are named as a priority population in Australia's national HIV and hepatitis C strategies^{3,4}, prison health care services and programs provide a critically important avenue for access to BBV and sexual health screening and education.

The HIP HOP Program

The Health In Prison Health Outta Prison (HIP HOP) Program is a two-part health information education package, operating across all prisons in Western Australia (WA), specifically designed to suit the needs of people in prison settings.

The program is funded by the Department of Corrective Services; HepatitisWA currently holds the

contract to provide HIP HOP within all metropolitan prisons and youth detention centres, as well as the Bunbury, Karnet and Wooroloo Prisons. In other regional areas, the program is facilitated by the Department of Corrective Services themselves, or contracted out to other local service providers.

The two-hour program is compulsory for all prisoners. It is designed to effectively target offenders during different stages of their incarceration, from prison entry through to release. Both state and national public health principles have been incorporated into the education methodology.

Its primary aim is to reduce the incidence of BBVs, sexually transmissible infections (STIs) and drug-related harm by providing a dedicated safe space for prisoners to receive accurate information about these topics, and to discuss their own experiences and concerns with health educators and peers. The program is aimed at:

- increasing awareness among prison populations in relation to BBVs

and STIs, by facilitating discussion on topics including prevalence, transmission, prevention, risk behaviours, testing, vaccination and treatment options

- increasing understanding of the concept of harm reduction in relation to BBVs, the effectiveness of needle and syringe programs (where available), and ensuring personal safety when outside of prison
- increasing awareness in relation to 'blood awareness' and health and safety issues
- decreasing stigma around people living with BBVs, and understanding the psycho-social impact of living with a BBV
- increasing awareness of the BBV and STI testing and treatments services available to prisoners, and how to access HepatitisWA's services.

The HIP HOP Program covers a wide range of topics, including detailed information on specific BBVs and STIs, their natural outcomes, liver health, the importance of healthy lifestyle, available

treatments and testing pathways in prison. It also covers the concept of harm minimisation, harm reduction strategies, and prison-specific transmission and prevention strategies.

The birth of HIP HOP

The first Sexual Health and Blood-borne Virus Program in WA was formed in response to an incident of HIV transmission in a prison setting. The incident generated sufficient concern among prison staff and inmates to mobilise a six-month pilot program, held at two maximum security prisons.

The workshops were two hours long, with initial participants being handpicked to ensure the most suitable and influential prisoners took part. Feedback from participants and staff indicated that the program was seen as effective and highly valued, and it went on to become an officially tendered contract.

Following on from the success of these pilot workshops, in 1997 a new BBV and sexual health education program was created, called the Keeping Safe Project. The project was fully funded by the Department of Corrective Services, and was co-facilitated by the Hepatitis C Council of WA (now rebranded as HepatitisWA) and the WA AIDS Council.

State government funding enabled education workshops to be held at six metropolitan prisons and one semi-regional prison. Unlike the pilot program, participation in the Keeping Safe Project was compulsory for all prisoners. Despite some operational and attitudinal resistance during the program's implementation, the workshops went ahead successfully and received very positive anecdotal feedback from participants.

A formal evaluation, conducted in 2005, indicated a perception among inmates that the Keeping Safe workshops were seen as being relevant only for people who inject drugs and men that have sex with men; this had the potential to stigmatise those taking part and to discourage others from joining the program. To make the workshops appear more accessible, the scope of the project was broadened out to include additional BBV risk behaviors such as participation in blood sports and fights.

In addition, the project redesign focused more on a model of 'problem solving' rather than 'information giving'. The new program also created separate target messages for both entering and exiting the prison system.

The redesigned program was rebadged as Health In Prison Health Outta Prison (HIP HOP), and launched in 2006. The program continues successfully to this day as the primary BBV and sexual health education program operating at every prison in Western Australian.

Prisoners and BBV risk

The continuation of funding for this highly successful program has been in part due to the Department of Corrective Services acknowledging that they are one of the biggest notifiers of viral hepatitis infection in WA.⁵ This is due largely to the high proportion of individuals who have a history of injecting drug use prior to entering a correctional facility.⁶

It is currently estimated that 91% of all new hepatitis C infections in the community are attributed to people sharing drug injecting equipment.⁷ Research has shown it is possible that up to 55% of prisoners have a history of injecting drug use⁸, and that a further 34% of prisoners with a history of injecting

drugs will continue to inject while in prison⁹. Of those prisoners, potentially up to 90% will share drug injecting equipment while in prison¹⁰.

It is also recognised that prisoners may engage in other BBV risk behaviours, such as unsterile tattooing and body art, violent and ritualistic behaviours, unsafe sexual practices and unsanitary hygiene practices. It is currently estimated that the hepatitis C prevalence amongst Australian prisoners is between 23–47%, and even up to 70% for female prisons in some studies¹¹.

Program evaluation and feedback

Over the last six months, HepatitisWA has facilitated 200 HIP HOP workshops across the metropolitan prisons, reaching approximately 1,580 prisoners. Feedback from prisoners remains very positive. The results of our evaluations have shown that at the completion of training almost all prisoners (98%) could identify the major forms of hepatitis C transmission, and also identify effective prevention strategies for BBVs and STIs. In addition, a high percentage of prisoners thought the workshop had assisted them in feeling confident in protecting themselves (98%). Also, the majority of participants (87%) indicated they would be willing to undertake an STI and BBV screening as a result of the workshop.

Although primary prevention is the main aim of the program, it is very difficult to measure any long-term impact on rates of infection. It is currently not mandatory for testing to be conducted on prisoners entering or exiting the prison system, so we can only speculate on the impact the information provided through HIP HOP has on rates of high risk behaviours (such as sharing injecting equipment).

Anecdotally, we often receive reports from previous participants claiming the course has helped them make informed decisions about taking risks while incarcerated. Discussion around prevention and harm reduction during the sessions can be very lively, and the safe space we create during the workshop enables participants to openly discuss their attitudes towards their current and future behaviours.

Sometimes the candid nature of this discussion shows us that we have provided enough information for prisoners to choose to abstain from high risky

Over the last six months, HepatitisWA has facilitated 200 HIP HOP workshops across the metropolitan prisons, reaching approximately 1,580 prisoners. Feedback from prisoners remains very positive.

behaviours; however, this is not always the case. Some prisoners are open to admitting that they will continue to take risks despite the information we have provided, and the reasons for this are varied and complex.

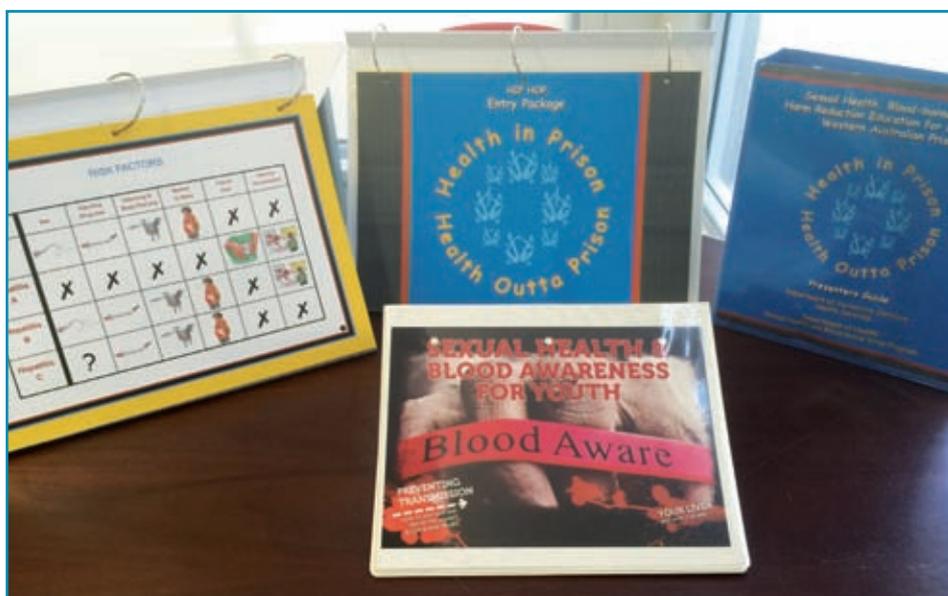
Although all prisoners have access to BBV education and information regarding the harms associated with sharing injecting equipment, anecdotal evidence suggests injecting drug use rates in prisons remains high. There is much evidence to show that in the absence of access to sterile injecting equipment prisoners will continue to inject, putting themselves and others at risk of BBV transmission, such as hepatitis C. Such infections have the potential to develop into a life threatening condition decades later. This is why the advent of new hepatitis C treatments, which became available to both prisoners and the general community through the pharmaceutical benefits scheme (PBS) from 1 March 2016, are so vitally important.

These new treatments have few side effects and provide a cure in up to 90% of cases. It is possible that if managed effectively, access to the new treatments could eradicate hepatitis C in the future. Unfortunately the availability of treatments in isolation will not solve the problem of hepatitis C in the community or in prisons. The factors that contribute to the rapidly growing prevalence of hepatitis C in Australian prisons also need to be addressed. The solution must also include the provision of opiate replacement therapies and access to prison-based needle and syringe programs in tandem with treatment.

The West Australian Department of Corrective Services is to be congratulated for implementing a comprehensive prevention and harm reduction program like HIP HOP, as well as the provision of safe sex equipment, in all prisons. What is now urgently needed is the political will to implement needle and syringe programs within all Australian prisons.

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Pictured top: Holly Beasley (BBV Coordinator from Department of Corrective Services), Jaqueline Del Bravo (all prisons), Amada Siebert (Boronia and Bandyup prisons), Glenn Thomas (Hakea prison), Sue Bosley (Casuarina and Banksia Hill), Rodney Hatch (Woorloo, Karnet, and Bunbury prison), and Matt Armstrong (Program Coordinator); and **above:** HIP HOP resources used by program facilitators and participants.

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The Connections Program: a NSW integrated approach to care and engagement for prisoners with a history of illicit drug use

By **Stephen Ward**

Introduction

Justice Health and Forensic Mental Health Network (JH&FMHN) is responsible for the provision of health services for people in contact with the forensic mental health and criminal systems throughout New South Wales. The Connections program is managed by JH&FMHN. It takes an assertive approach to release planning and post-release follow-up, assisting illicit drug users with the transition from prison back to the community.

Most participants in the program have extensive criminal histories with multiple incarcerations. They also tend to have complex medical and social situations which, together with drug dependence, contribute to a history of poor engagement with community-based services. This often results in multiple hospital presentations and higher levels of mortality.

Prior to the establishment of Connections in September 2007, patients with illicit drug problems leaving custody were generally provided with appointments to attend community health services with limited practical assistance available. NSW Health funding has resulted in Connections successfully providing coordinated state-wide comprehensive pre- and post-release assistance to about

800 adults leaving custody each year. Between September 2007 and December 2015, more than 6,600 participants have been assisted by Connections, of whom 18% (1,179) were female and 28% (1,873) identified as Aboriginal and/or Torres Strait Islander. During the same period, 3.5% (229) had ongoing blood borne virus treatment arranged post release.

Connections has developed strong working relationships and pathways with Population Health in the correctional and community environments; this ensures that patients receiving, or who require specialist treatment services for a blood borne virus have access to treatment as required. This can be as simple as assisting with the referral process, or transporting and attending an appointment with a participant and then ensuring the participant has adequate storage facilities for medications and accommodation in place. Connections staff are based throughout NSW so regardless of a patient's geographic location, Connections can provide appropriate support to facilitate access to treatment as required.

Program pathway

The Connections program operates within the JH&FMHN Drug and Alcohol Directorate, and the participation of adult patients in custody is voluntary. It

is one of a small number of JH&FMHN programs that operate within both the correctional and the community environments. The program coordinates release planning and links patients with relevant health and welfare service providers post-release.

Connections is available at all Adult Correctional Centers throughout NSW and there is no exclusion criteria based on location or criminal history. Referrals come from a variety of sources including health staff, correctional staff, family, friends and legal representatives. Following referral, all participants complete a comprehensive assessment and start the process of release planning. The Connections Clinical Support Workers (CSWs) then begin working and advocating with health and welfare staff within the custodial and community environments, to ensure that participants are as prepared as possible for release and their needs are appropriately addressed.

CSWs are based throughout NSW and have developed strong networks and local relationships, which together with formal agreements with community based services, have resulted in a comprehensive and coordinated approach to release planning. Some CSWs are co-located with the Local Health Network and

other community-based staff, which has enhanced continuity and the smooth transfer of care.

People released from custody often have complex needs and limited coping skills, requiring an assertive approach to engagement that is not available within existing community drug and alcohol service provision. All Connections participants are assertively followed up in the community by an allocated CSW for a period of four to twelve weeks, addressing identified needs through existing community-based services. Some participants need minimal assistance, while others require more intensive support e.g. workers attending appointments with participants in order to advocate or support, especially at initial appointments and during crisis intervention, etc. All participants are also assisted in accessing a case manager in the community if needed, with a handover of care arranged prior to ending Connections engagement.

Model of care and aims

The Connections program is focused on social justice and social inclusion, delivering coordinated care to integrate people back into their community. The program aims are to improve the engagement of participants with a variety of health and welfare services to enhance health, reduce drug related deaths and reduce the rate of return to custody. External evaluation of this approach to pre and post-release engagement has demonstrated its success and positive outcomes.

The service operates within the principles of The Personal Strengths Model of Care, as outlined by Rapp (1993)¹. This practical social work model from the USA was initially developed to assist patients with mental health problems leaving institutions, and then later modified for working with people with substance misuse problems. The underlying principle of the model is that everyone has the capacity to grow and learn, and a practical and consistent assertive approach will enhance positive changes and the engagement of participants.

Assistance provided

Connections participants are provided with a comprehensive assessment four weeks prior to release and a release plan is then developed in collaboration with the patient to meet their identified health

and welfare needs. Following release, participants require very different levels of support and the Connections program is very flexible in its approach to assist with the transition back to the community. Some patients may have existing community supports and may just require telephone contact and direction. One of the more common types of feedback Connections receives from participants is that it was good to have someone to talk to, who understood what they were going through and did not make judgments on their ability to achieve planned goals.

Other participants have much more complex needs, and these individuals are sometimes released early with little or no planning for their release in place. JH&FMHN have no control over when someone is released and this can occur for a variety of reasons. As a result a participant may be in a situation where they are homeless, have little if any identification, have no money or access to food and are in need of a lot of immediate practical help. Connections CSWs can assist by transporting participants to service providers if required, and can advocate for access to ensure their initial basic needs are met and the conditions for the foundations of community integration are in place.

Connections has developed strong links with service providers and put in place agreed processes between government and non-government health and welfare services throughout NSW that have resulted in improved and enhanced access to services. This ensures that follow up appointments with primary health, drug and alcohol services, mental health services and specialist physical health services are in place with release, and that ongoing medication regimes are arranged prior to release. Practical assistance provided includes obtaining identification, accessing housing, education, employment, food, clothing and transporting patients to health and welfare appointments as appropriate while actively advocating and negotiating access to services.

Program evaluation and Connections' contribution to the NSW targets 'NSW 2021'

Goal 11: Keeping people healthy

A 2009 evaluation of Connections completed by the National Drug and

Alcohol Research Centre (NDARC) found that completing Connections was associated with improved health among participants. A further internal analysis found participants who remained engaged during the four weeks follow up period reported significantly improved general health ($p < 0.001$), mental health ($p < 0.01$) and social functioning ($p < 0.001$).

In NSW between 1988–2002, the conservative death rate for a prisoner within four weeks post release was 104 (2.2%); within the first year this increased to 721 (14.9%).² Since 2007, Connections are aware of 38 (0.6%) deaths of participants compared to an expected 147 (2.2%) deaths within the first four weeks of release.

Goal 12: Increase patient satisfaction

Over 87% of respondents (2,435) reported being better prepared for release and 86% (2,395) reported having an easier transition to the community as a result of Connections, with over 97% ($n=2,707$) reporting that they were satisfied or very satisfied with the help received from Connections.

Participant quotes:

- 'If I wasn't on Connections I would have kept going after the lapse and would have not cared.'
- 'You're there to help with anything. We use (sic) to get release papers but now it's different we get Connections.'
- 'This is one of the best things, should have happened years ago, there would be less people in gaol.'
- 'You do the job not like some services, they are all just talk.'
- 'I think I have a chance of staying out of gaol.'

Goal 13: Reduce the number of people who are homeless:

Connections developed numerous close working relationships and partnerships with both government and non-government organisations, ensuring that participants have greater opportunities to obtain stable accommodation. When accommodation is identified, Connections assertively works with an array of welfare services to obtain furniture, clothing, food and the basic necessities. Connections was Highly Commended in the 2012 National Homelessness Service Achievement Awards.

Goal 17: Reduce the recidivism rate

Recidivism is defined by the Attorney General's Department as returning to custody within two years following release from prison. NSW Governments have recently been targeting a reduction in recidivism. A 10% reduction by 2016 was a goal of the 2006 State Plan. In the more recent NSW 2021 plan, the government has a target of 5% reduction in re-offending by 2016 and a below average Australian recidivism rate.

In December 2015, a review of data found that prior to Connections participation only 9% (473) of people released from custody reported managing to remain in the community for two years or more before returning to custody. Following Connections participation, 33% (1,712) of participants had continued to remain in the community at two year's review. Programs specifically designed to reduce recidivism have difficulty achieving reductions in recidivism. The significant change in recidivism following Connections participation would suggest that a flexible health-based approach to assertive support is worth further external analysis.

External recognition

The Connections program has received recognition for the outstanding results it has achieved in improving health outcomes as well as reducing return to custody rates. It has previously been a finalist in the NSW Premier's Awards, the NSW Health Awards and the National Homelessness Awards. In 2013, Connections was a winner of both the National Drug and Alcohol Awards and the National Crime and Violence Prevention Awards. In 2014, it was Highly Commended at the Treasury Managed Fund Awards in the Innovation Category.

Conclusion

As a result of working within a broad definition of health and including the social determinants of health, Connections has implemented a whole of government approach to transitional care. The outcomes achieved by the Connections program continue to contribute to a number of NSW and Commonwealth Government strategies.

In the 2014/15 financial year there were 15,003 discharges from NSW adult correctional centre. The Connections

program has a current capacity to assist 800 of those discharges (5% of the total) with the potential demand for the program far exceeding current resources.

The outcomes of the Connections program are currently being externally researched by the University of Technology Sydney following a recently allocated grant from the National Health and Medical Research Council.

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From ‘Evening Boys’ to ‘Evening Girls’: shifting the dynamic between transgender sex workers and the police

By Jackie McMillan and Chantell Martin

‘My work history stems back 30 years before decriminalisation came into place, and things back then weren’t as good as they are today. Police brutality and physical violence from the people passing by on the streets was unacceptable. As a transgender sex worker we were beaten by the police if we spoke out against them, and what they use to do to us.’ – Transgender sex worker.

Since 1995, sex workers in New South Wales have been fortunate to have been able to operate in a decriminalised work environment. As the above quote makes clear, the decriminalisation of sex work has direct and immediate impacts on the safety and wellbeing of sex workers.

Conversely, the myriad effects of laws criminalising sex work put sex workers’ safety, health and wellbeing at risk. Criminalisation forces sex work underground, fosters dangerous work place environments, and acts as a barrier deterring sex workers from accessing health services, for fear of prosecution.¹ These effects are magnified for sex workers who experience additional marginalisation, whether because of gender, sexuality, drug use or cultural background.

Given that it’s not unusual for sex workers, particularly transgender sex workers, to engage in sex work for many years, the wealth of experience that NSW-based sex workers have, as both subjects and observers of changing legislative frameworks, law enforcement policies and attitudes to policing, is particularly unique.

Chantell Martin, a transgender sex worker working with the Sex Workers Outreach Project (SWOP) in NSW, has seen first-hand the negative impacts of sex work criminalisation. She looks back to the 90s, recalling how transgender sex workers were routinely targeted by police: ‘As a street-based transgender sex worker, I saw a lot of bad things happen, and not just to me but to others as well. At the

time, corruption was rife within the police force in Kings Cross. Trans sex workers caught on the street would be rounded up, and what money we had on us was taken away. Then we would be put in the back of a paddy wagon and driven way out past Parramatta and dropped off in the middle of nowhere and told to find our own way back to Kings Cross.

‘We were never going to have a voice in that turbulent environment. Prior to 1995, we only had each other on the streets. Our strong camaraderie was unbreakable; however it wasn’t enough to save some of us from suicide or overdose. The heavy burden of being outcast by family, told never to return: “You are no longer my child”; plus the added dilemma of having no home, no security and no one to protect us, was just too much for some. Suicide often became the only alternative.’

However a big change was coming for the street-based sex workers of NSW. First there was the 1994 Royal Commission into the New South Wales Police Service. Then, in 1995, NSW became one of the first global jurisdictions to complete the process of decriminalisation. The

implementation of the decriminalised framework, driven in part by the desire to remove police as the regulators of the sex industry, reduced the corruption that had come to light during the Inquiry.

One of the key effects of decriminalisation was that it allowed sex workers to go to the police with complaints or allegations about their work, without fear of being punished for being a sex worker. Of course, this didn't happen straight away. It took the work of a visionary Commander to improve the relationship with transgender sex workers and NSW Police to the point where reporting crime was more than just possible in abstract terms. Chantell explains: 'To build and create a better relationship between sex workers and the police, a brilliant Commander from the Kings Cross Police would come down on to William Street (the main street-based working area for transgender sex workers) and introduce himself, and his officers, to us all. He did this once a week in person and his officers did the beat every night, for months.'

'At first this confused us,' continues Chantell, 'as we were so used to being hurled nasty names from the police as they drove past us while on patrol. They'd say: "Evening boys" to which we would reply: "Evening girls". The Commander put a stop to that – no more were his officers allowed to verbally abuse us.'

Chantell explains that the same Commander also initiated monthly meetings with sex workers in a William Street café called PJ's, run by St Johns Church. 'At that meeting, the Commander would talk to us about any updates and feedback from the residents in the area and he would ask us how his officers were treating us,' Chantell says. 'By involving sex workers in the conversation as valued stakeholders in their local area, this Commander began to shift the dynamic between sex workers and police.'

'Within a year, our relationship with the police had become a lot better than it had ever been in the past. If we had problems with yobboes from out west giving us a hard time or throwing bottles at us, all we had to do was let the police know when they did their rounds and that would be the end of the yobboes.'

'We ended up by working together to maintain safety, not only for sex workers, but for the whole community in that area.' Chantell explains that such successes also eventually led to Kings Cross Police assigning a particular Crime Prevention Officer, (unofficially) dubbed the 'Sex Worker Liaison Officer', with whom sex workers could more easily converse when there was a problem.

Today NSW is in its twenty-first year of sex work decriminalisation. To this day, decriminalisation of sex work remains the best regulatory system for sex workers because it allows sex work to be treated as what it is: work; and it removes the barriers to engagement with regulation and regulatory bodies that are produced by alternative systems of legalisation, licensing, regulation and criminalisation.

In 2012, The Kirby Institute's report to government, *The Sex Industry in New South Wales: A Report to the NSW Ministry of Health*², declared the NSW sex industry 'the healthiest sex industry ever documented,' and advised the government to scrap the few remaining laws related to the industry. The report stated that sex work decriminalisation has: '... improved human rights, removed Police corruption [and] netted savings for the criminal justice system ... International authorities regard the NSW regulatory framework as best practice.'

The decriminalisation of sex work in NSW is held up as an example of world's best practice. This framework for regulation is evidence-based and backed by the World Health Organization, the United Nations Programme on HIV/AIDS (UNAIDS), literature cited in the leading medical journal *The Lancet*³, and most recently, Amnesty International⁴. Aside from NSW, New Zealand is the only other jurisdiction globally that has a decriminalisation framework in place for the regulation of the sex work industry.

Condoms are now used in over 99% of anal and vaginal sex undertaken in the NSW sex industry.⁵ The rates of STIs among female sex workers in NSW are lower than that for other sexually active females in NSW. Demand and pressure to perform unsafe sex has also fallen.⁶ Even more significantly, there has not been any recorded case of HIV transmission due to commercial sex work in NSW. This, along with the low rates of STIs among

sex workers has only been achievable since decriminalisation, representing a positive public health outcome that is acknowledged internationally as being world leading.

Decriminalisation is also a fiscally sensible practice. According to evidence presented by *The Lancet* at AIDS 2014, the decriminalisation of sex work would have the greatest impact on the HIV epidemic globally, reducing HIV by up to 46% in the next decade, and would result in cost savings of tens of millions of dollars.⁷

However with *The Lancet HIV & Sex Workers* July 2014 edition emphasising that 'police harassment (without arrest) can directly influence HIV acquisition risk'⁸, it's clearly not enough to simply rely upon a change of legislation, even one as significant as decriminalisation, to ensure the relationship between marginalised communities and law enforcement remains strong. Sex worker peer organisations play a key role in advocating for the needs of sex workers and ensuring such legislation is respected. Building upon the work begun by the visionary NSW police Commander, SWOP maintains a focus on strengthening the relationship between sex workers and police to prevent HIV.

The informal meetings held in cafés during the early years of decriminalisation have been replaced with official community meetings, like the Kings Cross Community Safety Precinct Committee (CSPC) hosted by Kings Cross Police, and interagency meetings like the Kings Cross Police Interagency. By sitting on the Kings Cross Police Interagency, alongside health agencies like Kirkeaton Road Centre and legal services like Inner City Legal Centre, SWOP is able to ensure that issues raised by sex workers, including transgender sex workers (who make up 7.93% of sex workers SWOP saw in 2013–14), are dealt with appropriately.

By attending meetings in traditional sex working areas across the state, where NSW Police are present, SWOP is able to take the voices of sex workers and our service users into these high level conversations. SWOP Outreach Officers, such as Chantell, represent street-based sex workers on a range of issues from unjust move-on orders, to the poorly thought out locations of Random Breath

Testing (RBT) vehicles in traditional sex working areas, which scares away clients. SWOP has also designed and presented training to help ensure effective communication between the police and the sex industry at a number of Local Area Commands, in locations that regularly see street-based sex workers. SWOP has offered to roll this training out to all Crime Prevention Officers across the state in 2016.

The twenty years of decriminalisation has seen the gradual but steady improvement of sex workers' health, capacity and working conditions. The ripple down effect of police treating transgender sex workers with respect, starting with that initial Commander, was enormous. By being treated as worthy of respect, transgender sex workers saw themselves as worthy of respect, and became better able to advocate for that respect in all aspects of their lives.

Chantell explains that this respect was also reflected in the attitudes of health care service providers: "Trans sex workers were also given full access to health services without being discriminated against because of gender, or what we do for work."

She says that the health and safety of sex workers immediately improved as a result of sex work decriminalisation, and workplace environments improved too: 'Sex work became better because I no longer had to fear being bashed by the police whenever I saw them. My health improved because I was able to access more help from the health clinics in the area. And [when I] report sexual assault to the police today, they seem to be a lot more respectful to transgender sex workers.'

These human rights gains are incredibly significant, and form the cornerstone of our shared goal to end HIV transmission in NSW by 2020. Such achievements also illustrate why we must never be complacent about the key relationships between sex workers and the police.

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INTERNATIONAL FEATURE Harm reduction and drug policy in ASEAN: an uneasy but critical partnership for health and human rights

By Gloria Lai

At a high-level meeting of Association of Southeast Asian Nations (ASEAN) countries, held in Malaysia in October 2015¹, ministers yet again reiterated their commitment to rid the region of drugs:

*'While some drug-related support services may be implemented, ASEAN is committed to a zero-tolerance approach to realise its regional vision of a Drug-Free ASEAN, so as to provide our people and communities with a society free from drug abuse and its ill-effects.'*²

Consistent with ASEAN's prior work plan on drugs, 'some drug-related support services' likely refers to drug use prevention and rehabilitation, while the aim of achieving 'a society free from drug abuse' directly contradicts the provision of harm reduction measures for people who use drugs.

ASEAN's unwavering commitment to achieving a drug-free region has justified the brutal criminalisation and punishment of people who use drugs, along with unbalanced investment in law enforcement at the expense of health and harm reduction interventions, thereby fuelling HIV and hepatitis epidemics among people who inject drugs in the region.^{3,4} Over a decade after harm reduction

programs were introduced in several countries throughout South East Asia, ASEAN's drug policy makers clearly have not shifted their stance in support of them. Yet efforts to build collaboration between law enforcement, harm reduction, civil society and communities of people who use drugs have taken root in certain localities throughout the region. In the context of global shifts away from criminalisation and punishment, such developments provide further evidence of the need for ASEAN to update their policies in response to drug use.

ASEAN's contradictory approach to HIV and drug use

As with many other parts of the world, drugs are regarded first and foremost as a security threat to South East Asia. In its drug strategy and work plan, ASEAN portrays drug markets as a key security concern, and as a cause of individual suffering weakening 'the social fabric of nations', direct and indirect economic costs to governments, along with criminal activities that could threaten the stability of states.⁵ The 1998 *Joint Declaration for a Drug-Free ASEAN* outlines a broad strategy for eradicating the production, trafficking and use of controlled drugs in the region by 2020. In 2000, to highlight

the urgent need to tackle expanding drug markets for use and supply, the target year for achieving a drug-free region was brought forward to 2015.^{6,7}

Regional policy makers adopted the *ASEAN Work Plan on Combating Illicit Drug Production, Trafficking and Use (2009–2015)* (the Work Plan)⁸ to set out agreed priorities for eradicating supply through the 'elimination' of syndicates involved in the production and trafficking of drugs and their precursors, and for reducing the prevalence of drug use, primarily through preventative education programs. The ASEAN Senior Officials on Drug Matters, comprising senior officials from agencies with responsibility for drug-related issues from each member state, has responsibility for coordinating, monitoring and evaluating implementation of the Work Plan.

Despite high levels of HIV prevalence among people who inject drugs throughout the region (see Table 1), there is only one mention of HIV/AIDS in the entire ASEAN Work Plan on drugs: as a component of preventative education programs for the general population and people who use drugs. The Work Plan does not refer to the comprehensive package of interventions advised by the World Health Organization (WHO),

Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Office on Drugs and Crime (UNODC) to provide HIV prevention, treatment and care services for people who inject drugs, including opioid substitution therapy (OST) and needle/syringe programs (NSP) (re-affirmed and expanded upon to include overdose prevention in the *Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations* published by the WHO in 2014).^{9,10} Nor does it refer to the *ASEAN Declaration of Commitment: Getting to zero new HIV infections, zero discrimination, zero AIDS-related deaths*, which includes a commitment by ASEAN governments to reduce transmission of HIV among people who inject drugs by 50 per cent by 2015.¹¹ Such commitments are critical given the high rates of HIV prevalence among people who inject drugs in ASEAN.

While several countries in ASEAN provide OST and/or NSP as key harm reduction interventions, the availability and accessibility of these critical measures throughout the region is inadequate.¹² The Declaration states that ASEAN countries commit to implementing and expanding ‘risk and harm reduction programmes, where appropriate and applicable, for people who use drugs’.¹³ However, as mirrored at national level in most countries throughout the region, there appears to be no integration between the ASEAN entities working on respectively HIV and drug policy, despite clear recognition of the need for it by the ASEAN Task Force on AIDS.¹⁴

Given the framing of drugs as primarily a security concern, policymakers struggle with responding to the health and human rights concerns that relate to drugs. Such concerns arise from the implementation of drug policies that focus overwhelmingly on criminalisation and punishment, rather than from the use of drugs itself, as noted in a paper released by the International Drug Policy Consortium in 2013:¹⁵

- widespread human rights violations, including abusive practices by police against people who use drugs, and the use of compulsory drug detention and rehabilitation centres that have been condemned by United Nations agencies^{16,17,18,19}
- punitive and stigmatising measures in response to drug use, including

Table 1: HIV prevalence among people who inject drugs in ASEAN countries²⁰

Country	Numbers of people who inject drugs (estimate)	Adult HIV prevalence among people who inject drugs (%)*
Philippines	14,000	44.9
Indonesia	74,326	36.4
Cambodia	1,300	24.8
Myanmar	83,000	23.1
Thailand	40,300	19
Malaysia	170,000	16.6 (male)
Vietnam	271,506	10.5 (male)
Singapore	10,000–20,000	1.5

* The HIV prevalence rates among people who inject drugs in some cities are significantly higher than national prevalence rates, for example, 56% in Jakarta (Indonesia). The HIV prevalence rates among people who inject drugs in Brunei and Lao PDR are not known.

- compulsory registration, criminal conviction, imprisonment and detention, and denial or inadequate provision of life-saving harm reduction measures such as OST, NSP and overdose prevention, and
- disproportionate sentences and penalties for drug-related activities, including lengthy imprisonment sentences for low-level, non-violent offences, and use of the death penalty.^{21,22}

It is confounding that ASEAN policy makers insist on following the same drug strategies despite the extensively damaging consequences for public health and human rights. It is even more baffling that they continue to reiterate the same objectives and approaches despite clear evidence of their failure to eliminate, or even reduce, the use and supply of drugs. Available data on regional drug trends in the past decade show that there has been no significant reduction in the overall use and supply of drugs, but instead expanding markets, particularly for synthetic drugs such as methamphetamine.^{23,24}

Engaging public health and law enforcement

In the lead up to the UN General Assembly Special Session on the world drug problem this year, an increasing number of countries and UN agencies have called for a shift towards a public health approach to drugs. This includes the US, which has traditionally led the global ‘war on drugs’.²⁵ The United Nations (UN) Secretary General Ban Ki Moon

has repeatedly supported the removal of criminal sanctions for people who use drugs, and called on member states to:

‘... consider alternatives to criminalization and incarceration of people who use drugs and focus criminal justice efforts to those involved in supply. We should increase the focus on public health, prevention, treatment and care, as well as on economic, social and cultural strategies.’²⁶

Several UN agencies have also issued recommendations for the removal of criminal penalties for drug use and possession for personal use, (decriminalisation), including UNAIDS^{27,28}, UN Development Program²⁹, WHO³⁰, the Office of the High Commissioner on Human Rights³¹, UN Women³², and the UN Special Rapporteur on the Right to Health^{33,34}. Similarly, the United Nations Office on Drugs and Crime stated in 2013 that people who use drugs should ‘not [be] treated as criminals’ and has called for a shift from a ‘sanction-oriented to a health-oriented approach to drug use and dependence’.³⁵

While ASEAN governments recognise that drug policy requires a public health dimension, they have been reluctant to take decisive steps in shifting from criminalisation and punishment to health and harm reduction as their primary response to drug use. Some countries have adopted measures that contribute towards such a shift, for example Malaysia established Cure and Care centres offering drug treatment and OST services on a

voluntary basis in 2010³⁶, Thailand's drug agency adopted harm reduction as part of its national drug strategy in 2014³⁷, and Indonesia adopted a multi-agency regulation on instituting procedures for diverting people who use drugs away from prison to rehabilitation centres in 2014³⁸. In addition, collaboration between harm reduction services and police has been established in some jurisdictions to enable access by people who use drugs without fear of arrest, for example:

- Cambodia – a local NGO (KHANA) and the Ministry of Interior introduced the Police Community Partnership Initiative at HIV 'hotspots' in Phnom Penh, where police are encouraged to refer people who inject drugs to harm reduction services instead of arresting them (where there is no evidence of drug trafficking).³⁹
- Thailand – an informal truce was negotiated between non-government health service providers and local law enforcement officers in Narathiwat Province, following a series of capacity building and sensitisation workshops. Local law enforcement officers agreed to apply greater discretion in avoiding arrest and instead, refer people who use drugs to health services.⁴⁰

However, these developments supporting greater access to harm reduction measures remain tenuous, contentious, and at risk of lapsing (or worse, reversal) if they are not formally instituted with legislative and policy reforms that remove criminal and other punitive sanctions against people who use drugs. In particular, the entrenched policy in most ASEAN countries of compulsory detention in so-called rehabilitation centres for people arrested for drug use is a significant barrier to access to harm reduction measures and must end, particularly as extensive abuse occurs at these centres.^{41,42,43,44,45}

Governments need to invest instead in the development and provision of evidence-based health and harm reduction services, along with ensuring an enabling legal and policy environment that supports voluntary access to those services by people who use drugs.^{46,47}

As rates of drug use continue to rise, and the availability of drugs expand, ASEAN governments must ensure that their drug policy and harm reduction responses are

well-equipped for protecting the health, welfare and lives of their citizens. Such an approach is particularly critical for the development of post-2015 strategies on drug control, health and HIV (many ASEAN strategies ended in 2015, including its drug strategy).⁴⁸

As governments prepare for the UN General Assembly Special Session on the world drug problem in April 2016 in New York, the hope of many civil society organisations and communities is for agreed outcomes that are relevant in managing the contemporary realities of drug markets. Glossing over the needs for drug policy reform and harm reduction interventions by recycling unrealistic drug-free strategies will not meet that expectation.

Note: the issues in this article are discussed in other publications by the International Drug Policy Consortium, including:

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Living Well: Women with HIV

By **Sally Cameron and Finn O’Keefe**

The Australian Federation of AIDS Organisations (AFAO) recently celebrated the inaugural National Day for Women Living with HIV (9 March), launching a new resource for HIV-positive women.

The resource has been adapted from a ground-breaking booklet *Treat Yourself Right*, first produced by AFAO in 2000 and revised and reprinted in 2001 and 2007. The latest iteration of the resource has been rebranded and relaunched as *Living Well: Women with HIV*.

Women make up about 10% of people living with HIV in Australia, and gender differences can have a significant impact on the progression of HIV infection, how it is best treated and the range of side effects experienced. Consequently, there is strong demand from HIV-positive women for specific resources for women to supplement the many resources which assume a male audience as their default.

Treat Yourself Right was unique as one of only a few resources written specifically for HIV-positive women in the Australian context. Although it has been out of print for many years, the resource remains highly regarded by Australian and international people living with HIV (PLHIV) organisations and networks. It has been commended by the International Council of Women, and has been adapted for use by New Zealand’s Positive Women, who produced a localised version for HIV-positive women in New Zealand.

Due to recent developments in antiretroviral (ARV) treatment, new evidence about the preventative benefits of ARV therapy and the rise of electronic media, AFAO’s Health Promotion team undertook a major revision and update of the resource. This process included a survey of key networks of women living with HIV, international scoping of comparable resources, and a technical review of scientific and medical information. Positive women’s networks and service providers

steered the structure of the revised resource and reviewed draft text.

Living Well: Women with HIV offers wide ranging information about living with HIV, disclosing HIV status, having sex, taking treatment, caring for your body, having children, keeping well and getting support. The new-look resource is available as a booklet and, for the first time, as a website.

Having undergone a major makeover, *Living Well: Women with HIV* reflects some of the ways the world of positive women has changed during the last few years. The new name is designed to enhance online access. ‘We wanted a title that was intuitive and pragmatic – something that would show up quickly on any search,’ former AFAO Executive Director Rob Lake explained. ‘The title also recognises the reality that many women with HIV are living great lives, while treatments have provided a sense of long-term optimism,’ Rob Lake said.

Unlike general resources, *Living Well: Women with HIV* addresses many of the specific issues faced by women with HIV including increased risk of thrush, pelvic inflammatory disease (PID), human papillomavirus (HPV), cervical cancer and osteoporosis. HIV may trigger menstrual changes and many ARV treatments reduce the effectiveness of hormonal contraceptives, increasing the likelihood of pregnancy. The resource also addresses issues associated with pregnancy, delivery and breastfeeding.

Development of Living Well benefited enormously from the input of many positive women, but in particular from Femfatales (the National Network of Women living with HIV), Positive Women Victoria and women from Living Positive Victoria. A key input was advocacy to ensure that the resource remained available as a printed booklet as well as a website.

The *Living Well: Women with HIV* website (www.womenlivingwell.org.au) was launched on World AIDS Day 2015. The booklet was launched on 9 March 2016, as part of the inaugural National Day of Women Living with HIV in Australia, organised by Femfatales – a day of coordinated events connecting and supporting HIV-positive women across Australia.¹

Positive Life NSW President Jane Costello spoke at the launch of the booklet, highlighting the importance of having a resource tailored specifically to the needs of HIV-positive women.

‘Women are largely invisible in our HIV response, and women with HIV are a minority who live with inequality, in silence and secrecy,’ Jane Costello said. ‘That inequality, silence and secrecy feeds a climate of stigma and discrimination, as well as an assumption that HIV is simply not an issue for women.

‘If you are a woman living with HIV or you want to know more about some of the specific issues and concerns of women with HIV, I highly recommend this resource to you, and I look forward to seeing the resource distributed widely.’

Copies of the booklet are available to positive women from AFAO, PLHIV organisations and AIDS Councils in each state and territory. A digital download of the booklet is also available from the Living Well website at www.womenlivingwell.org.au/pdfs/living-well-booklet.pdf

Reference

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Is living with HIV the same for women?



IS LIVING WITH HIV THE SAME FOR WOMEN?

LIVINGWELL
Women with HIV

Living with HIV can pose particular challenges for women, including menstrual changes and increased risk of thrush, pelvic inflammatory disease (PID), human papillomavirus (HPV), cervical cancer and osteoporosis (weak bones). Preventative options and treatments are available so it's important to have regular medical check-ups.

Women often juggle many responsibilities – work, running a household, caring for others – which makes managing medical appointments and coping with illnesses/symptoms challenging. Remember, there is support available through your local HIV or PLHIV support organisation.

To find out more about living with HIV and available support services, check out our **Living Well: Women with HIV** website. It contains lots more about living with HIV, telling people, sex, treatment, your body, having children, keeping well and getting support @ www.womenlivingwell.org.au.

Pictured clockwise from top left: *Living Well: Women with HIV* booklet and other campaign collateral; Positive Life NSW President Jane Costello, speaking at the launch of *Living Well: Women with HIV*, 9 March, Sydney; and *Living Well: Women with HIV* campaign materials.

INCREASING KNOWLEDGE ABOUT HIV PREVENTION AND TREATMENT FOR TRANSGENDER PEOPLE

Adapted from an article by Liz Highleyman, produced in collaboration with hivandhepatitis.com for aidsmap.com

Information on the Australian context by Ted Cook from PASH.tm

Transgender women have among the highest rates of HIV infection globally, but little is known about HIV prevalence among trans men, Tonia Poteat of Johns Hopkins Bloomberg School of Public Health said in a plenary lecture on transgender health and HIV at the recent Conference on Retroviruses and Opportunistic Infections (CROI 2016) in Boston – the first ever on this population at CROI.¹ The presentation highlighted that, although a growing number of studies and prevention and treatment programs are addressing transgender populations, the presentation highlighted that more research is needed.

Traditional ‘one-step’ data collection approaches can make it difficult to accurately identify trans people in HIV research. Many investigators have categorised study participants according to either their current gender identity or their assigned sex at birth, both of which can result in misclassification. A ‘two-step’ method that asks about both initial sex assignment and current identity is more accurate and inclusive, (see breakout box, right).

‘The way you ask the question makes a big difference,’ Dr Poteat stressed. For example, the international iPrEx trial of tenofovir/emtricitabine (Truvada) for pre-exposure prophylaxis (PrEP) included transgender women in its population of 2499 men who have sex with men. The initial published iPrEx report² said the study included just 29 trans women, but a later analysis³ used a broader definition – including people assigned male at birth who identified as women, trans or ‘travesti’, and those who identified as men but used feminising hormones – bringing the total up to 339.

Vulnerabilities affecting trans people

A number of factors may make transgender people more susceptible to HIV infection or less likely to use prevention methods or access treatment if they become infected.

‘Two-step’ data collection and the Australian context

In Australia PASH.tm, the sexual health peer network for trans men who have sex with men (trans MSM), have worked with PrEP demonstration project organisers in Victoria, NSW and QLD to ensure that trials are accessible to trans men who have sex with men. PASH.tm submitted recommendations to the NSW PrEP access guidelines review to ensure trans men and women were meaningfully considered and many recommendations were included in the final version.

The current PrEP access guidelines in NSW state that any high risk transgender person should have access to PrEP, however, an inclusion issue remains for trans men who do not engage in receptive anal intercourse but prefer front hole intercourse. There is no research into HIV risk between men who have sex with men (MSM) where non-anal receptive intercourse takes place.

PASH.tm continues to prioritise advocacy on ensuring people with trans experience are counted accurately in HIV and sexually transmissible infection (STI) epidemiology. At present, notification forms capture ‘male’, ‘female’ and ‘transgender’; this approach limits the credibility of data collection because ‘transgender’ is not a gender identity, but rather a gender experience. The two-step approach would help remedy this limitation and PASH.tm released a data collection position statement in December 2015 with practical guidance for improvement, which recommends the following two-step approach to data collection.⁴

1) What is your current gender identity? (select all that apply)

- Male
- Female
- Trans male/trans man
- Trans female/trans woman
- Indigenous Brotherboy
- Indigenous Sistergirl
- Non-binary/gender fluid
- Different identity (please state) _____

This gender identity list is presented as a consulted and focus tested best practice, but also with the recognition that shorter versions can be applied. Male, female, non-binary and a free-text ‘different identity’ should be an absolute minimum data set.

2) What sex/gender were you assigned at birth?

- Male, or
- Female

Intersex infants are not assigned intersex at birth, they are assigned male or female. A third question asking if a person is intersex or has intersex traits is encouraged.

Biological factors include hormone therapy, which has the potential to interact with PrEP or antiretroviral treatment (ART). While no clinically significant interactions have been confirmed between feminising hormones and tenofovir/emtricitabine PrEP or most antiretrovirals, many trans women worry about them and prioritise hormone use.

To date, no randomised clinical trials have looked specifically at PrEP for transgender women or men, but an iPrEx substudy⁵ led by Madeline Deutsch from the University of California at San Francisco’s Center of Excellence for

Transgender Health found that Truvada appeared to protect trans women who took it consistently. No seroconversions occurred among trans women with tenofovir drug levels indicating they took at least four pills per week. However, their level of adherence was lower than that of cisgender gay men in the study, which Deutsch suggested could be due to concerns about PrEP and hormone interactions.

Prior studies have shown that tenofovir reaches higher levels in rectal tissue in men than in cervical or vaginal tissue in women.⁶ This could in part be related to

hormonal differences between cisgender men and women, although some have found that tenofovir levels are lower in cervical-vaginal tissue samples than in matched rectal tissue samples obtained from the same women.

Some researchers hypothesise that exogenous or administered oestrogen may affect tenofovir pharmacokinetics, for example by interfering with creatine kinase phosphorylation of tenofovir disoproxil fumarate to its active form of tenofovir diphosphate. This could mean that trans women taking oestrogen and PrEP will have lower tenofovir levels in rectal tissue than cisgender men, and therefore may need higher doses – a prospect that requires further study. No pharmacokinetic studies have specially focused on transgender men, so there is no definitive answer on the impact that exogenous testosterone has on genital tissue saturation in this population.⁷

Hormones could also potentially cause changes in rectal or vaginal mucosa that increase susceptibility to HIV. Further, sharing needles to inject hormones or fillers such as silicone can transmit HIV and hepatitis B or C. It is not known whether trans women who have genital sex reassignment or affirmation surgery are more vulnerable to HIV infection.

Social and structural factors

Social and structural factors that increase trans people's vulnerability to HIV include stigma, fear of disclosure, sexual networks that include more people with HIV, poverty, lack of employment opportunities which leads many trans women to engage in sex work, homelessness or unstable housing, violence, lack of access to health care or insurance, substance use and mental health issues such as depression.

The limited research that exists internationally regarding the sexual health literacy of trans men indicates low levels of health literacy around HIV, a fear of rejection when negotiating condom use, and a reluctance to access testing services due to a perceived lack of awareness and sensitivity towards transgender people among service providers.

Although many transgender women are eligible for PrEP according to US Centers for Disease Control and Prevention (CDC) or World Health Organization (WHO) guidelines, most are not yet using it and may not be aware of it. One

study found that only about 14% of trans women in San Francisco – a city where PrEP awareness and use among gay and bisexual men are high – had heard of PrEP at the end of 2013.

Dr Poteat reported that among people with HIV using Ryan White HIV/AIDS services, transgender people were less likely than patients overall to remain in care (78 vs 80%) and to achieve viral suppression (74 vs 81%).

A survey of trans women with HIV conducted by the Transgender Law Center found that gender-affirming care and hormone therapy were their top priority, considered more urgent than HIV treatment. But trans women who had the same provider for both hormone therapy and HIV treatment were more likely to stay in care and have an undetectable viral load, demonstrating the benefit of integrated care.

'Transgender women have disproportionate HIV prevalence and incidence due to the interplay of biological and intersectional social factors,' Dr Poteat concluded. 'Gender-affirming approaches are necessary to achieve optimal outcomes.'

To address barriers to care for trans women it is important to 'reduce stigma and prevent secondary trauma including racism, transphobia, economic disadvantage and other structural factors,' she said. 'HIV services we have available, mostly geared towards gay men, do not meet the needs of trans women'

Resources for trans women and men

New resources for trans people have recently begun to appear, including the National Center for Innovation in HIV Care brief *Transgender Women and Pre-Exposure Prophylaxis: What We Know and What We Still Need to Know*⁸ and the booklet *Transcending Barriers for Safer Pleasure*⁹ from Project Inform and Outshine NW. Project Inform's booklet for men who have sex with men, *Is Taking PrEP the Right Choice for You?*¹⁰, has also been updated with inclusive language and information for gay and bi transgender men. There are also other international resources such as *PRIMED² A Sex Guide for Trans Men Into Men*¹¹, *Transmen (THT)*¹², and *brazen – Trans Women's Safer Sex Guide*¹³.

In Australia, sexual health resources for trans men who have sex with men are currently in development by PASH.tm and AFAO. These will include a website, booklet and other associated promotional materials. PASH.tm has also produced a recent PrEP inclusion campaign 'Trans men, PrEP is for us too!'¹⁴

Meanwhile, in Melbourne the Victorian AIDS Council's PRONTO! rapid HIV testing centre now offers expanded STI testing and sexual health services, a PrEP clinic and a two-day-a-week health service specifically for trans and gender diverse communities.

For further information about PASH.tm, including their position statements, visit: <https://www.afao.org.au/PASHtm/pash-tm-media-release-position-statements>

**Adapted from aidsmap.com
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Original article available at: <http://www.aidsmap.com/Transgender-people-are-at-high-risk-for-HIV-but-too-little-is-known-about-prevention-and-treatment-for-this-population/page/3042613/>

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START STUDY SHOWS BETTER QUALITY OF LIFE FOR PEOPLE WITH HIV ON TREATMENT; PROVIDES REASSURANCE ABOUT SIDE-EFFECTS

By Roger Pebody

The Strategic Timing of AntiRetroviral Treatment (START) study has already provided definitive

evidence of the benefit of starting treatment promptly. The trial enrolled 4,685 men and women with HIV who had never taken antiretroviral therapy (ART), were in generally good health and had a CD4 cell count over 500 cells/mm³. Based on random allocation, half the participants started ART immediately, while the other half deferred treatment until their CD4 cell count declined to 350 cells/mm³. Those who deferred treatment knew that they had done so (they were not given a placebo).

As part of the START study, the researchers collected data on health-related quality of life¹, asking study participants to rate their own quality of life on a regular basis. Four measures were used. Participants made a self-assessment of their health, using both a 'visual analogue scale' (marking a score somewhere between 0 to 100 for their current health) and rating their general health as either poor, fair, good, very good or excellent. They were asked about whether pain had recently interfered with their normal work. They were asked how often they had felt calm and peaceful in the past month.

Each time data were collected, the researchers compared the ratings with those given at baseline, at the beginning of the study.

After beginning treatment, people gave higher ratings for their current and general health, while those in the deferred arm gave similar or slightly lower ratings than they did before. Throughout follow-up, all four measures of quality of life were

better rated by the immediate treatment group (p<0.001 for each measure). These differences were modest, but statistically significant.

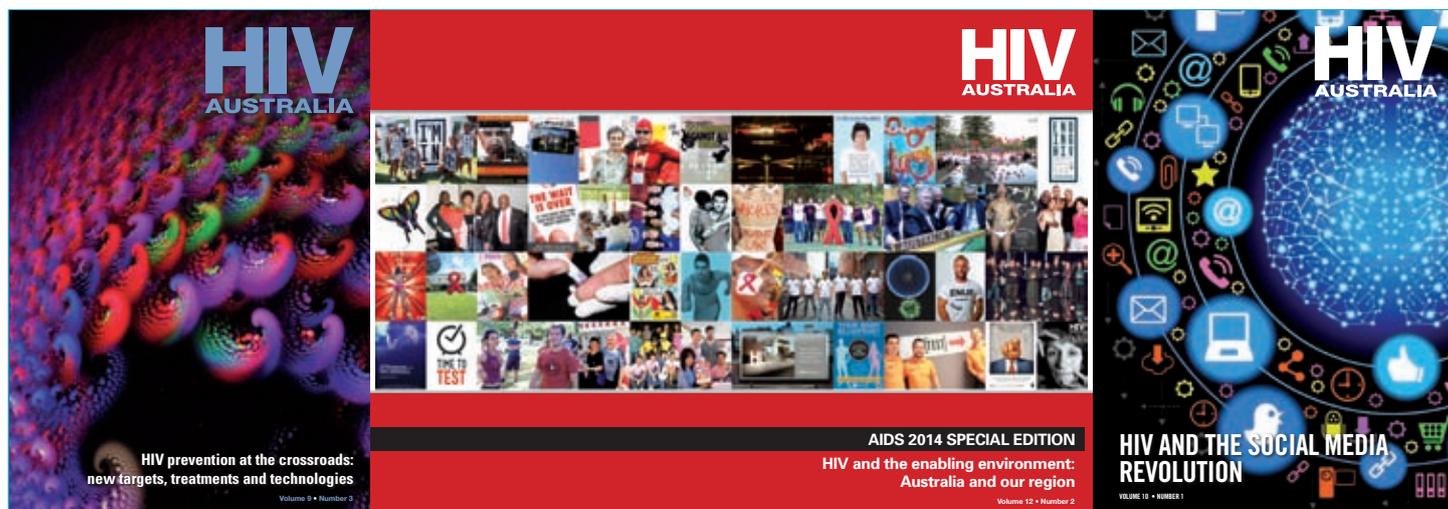
For those beginning treatment earlier, there was a particular improvement in the frequency with which people said they had felt calm and peaceful.

The researchers note that the START study recruited people who were generally in good health and had not yet taken HIV treatment. Maintaining a good quality of life after starting HIV treatment is an important goal for this group, the researchers said. 'These findings provide further support to the superiority of early ART as reported for major clinical outcomes in the START study,' they conclude.

Adapted from aidsmap.com
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Sydney, Australia

<https://www.afao.org.au/events/hiv-health-promotion-conference>

● May

17–19

Asia Pacific AIDS and Co-infections Conference 2016

Hong Kong

<http://www.virology-education.com>

19–20

2016 National Hepatitis Health Promotion Conference

Melbourne, Australia

<http://www.hepatitisaustralia.com/health-promotion-conference-2016/>

28–29

Asian Conference on Hepatitis and AIDS (ACHA) 2016

Nanjing, China

<http://www.virology-education.com>

● July

15–16

HIV Paediatrics Workshop

Durban, South Africa

<http://www.virology-education.com>

● July

17–22

21st International AIDS Conference (AIDS 2016)

Durban, South Africa

<http://www.aids2016.org>

● September

26–27

7th HIV and Aging Workshop

Washington DC, USA

<http://www.virology-education.com>

● November

14–16

2016 Australasian Sexual Health Conference

Adelaide, Australia

<http://www.sexualhealthconference.com.au>

16–18

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