National NSP Consultation Forum
Research Briefing

This document summarises key research and policy literature, along with data gathered from the Pre-Forum Survey, on current challenges and possible solutions to improving the health and human rights of people who inject drugs via Needle & Syringe Programs (NSP). The document is intended to provide a foundation for dialogue at the Forum on the future of NSP in Australia, and to focus discussion on the best use of federal funds to improve and expand NSP going forward.

1. The State of the Nation: Hepatitis C, HIV, people who inject drugs and NSP

People who inject drugs (PWID) are at particular risk of contracting hepatitis C and some risk of HIV. The Needle and Syringe Program (NSP) plays a pivotal role in reducing this risk and decreasing harm to PWID in general. This section explores current data on hepatitis C and HIV prevalence, and the role of NSP in preventing and treating these blood-borne viruses.

Hepatitis C

Hepatitis C continues to be a significant public health issue in Australia and is one of the most commonly reported notifiable diseases.[1] In Australia, **most new hepatitis C infections are related to sharing of contaminated injecting equipment and the population groups most affected are people who inject drugs, people in custodial settings and Aboriginal and Torres Strait Islander people.** Approximately 90 per cent of new and 80 per cent of existing hepatitis C infections are attributed to unsafe injecting drug use.[2]

New diagnoses of hepatitis C have been gradually increasing in the Aboriginal and Torres Strait Islander (ATSI) population over the last five years – from a population rate (per 100 000) of 130 in 2008, to 166 in 2012. This compares to a decreasing rate in non-Indigenous people for the same time period, from 51 per 100 000 to 40 per 100,000. These new diagnoses of hepatitis C in Aboriginal and Torres Islanders have most commonly occurred in those aged between 20 and 49 years of age. Transmission continues to occur predominantly among people with a history of injecting drug use, and data from the Australian Needle Syringe Program Survey also reports that **hepatitis C prevalence has been higher among Aboriginal and Torres Strait Islander survey respondents compared to non-Indigenous participants for most years**.

Further, **the prevalence of hepatitis C infection among male inmates of prisons is estimated to be 35-47 per cent, and 50-70 per cent in women**.[3]

[1] In 2012, an estimated 230,000 people were living in Australia with chronic hepatitis C infection, including 58,000 with moderate to severe liver disease. While prevention remains the cornerstone of Australia's response to hepatitis C, recent advances in antiviral treatments have the potential to significantly improve the rate of cure (*Fourth National Hepatitis C Strategy, Department of Health*, 2014).

[2] *Fourth National Hepatitis C Strategy, Department of Health*, 2014

[3] *Fourth National Hepatitis C Strategy, Department of Health*, 2014

HIV

In 2004 – 2013, **approximately 6 per cent of HIV notifications in Australia were in people with a history of injecting drug use, of whom more than half were men who also reported sex with men**.

Exposure to HIV was attributed to heterosexual contact and injecting drug use in 9% and 1%, respectively, of diagnoses of newly acquired HIV infection.[4]
HIV prevalence among people who inject drugs attending needle and syringe programs has remained low (at 1 – 2% during 2004 – 2013) (Figure 30) but in the subgroup of homosexual men, prevalence was 33% in 2013.[5] A higher proportion of infections in Aboriginal and Torres Strait Islanders was attributed to injecting drug use: 13 per cent versus 2 per cent.[6]

At present, five national policy strategies guide our understanding, treatment and prevention of hepatitis C, HIV, and other blood-borne viruses. Three are most relevant to the future of Needle & Syringe Programs (NSP): *The Fourth National Hepatitis C Strategy 2014-2017*; *The Fourth National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy 2014-2017*; the *Second National Hepatitis B Strategy 2014-2017*; and *the Seventh National HIV Strategy 2014-2017*. Each strategy sets goals and targets for treatment and prevention based on current evidence. These are guided by objectives.

Taken together, **the key goals and targets of the National Strategies include**:

- To reduce the number of hepatitis C infections by 50 per cent.
- To work towards virtual elimination of HIV transmission by 2020.
- To sustain the virtual elimination of HIV amongst PWID, and maintain effective prevention programs targeting sex workers and for PWID.
- To reduce the risk behaviours associated with the transmission of HIV and hepatitis C, including the proportion of PWID who re-use someone else's equipment
- To decrease the number of PWID with undiagnosed HIV infection
- In Aboriginal and Torres Strait Islander people and communities, to increase the use of sterile injecting equipment for every injecting episode; and to increase the number of people with HIV, hepatitis C and hepatitis B receiving antiviral treatment.
- To increase the number of people receiving antiviral treatment for hepatitis C by 50% each year of the Strategy.
- To increase hepatitis B vaccination coverage of priority populations.

These goals and targets are informed by **objectives** which include:

- to reduce the burden of disease attributed to chronic hepatitis C and HIV

[4] *Seventh National HIV Strategy, Department of Health*, 2014
[5] Of 3 249 men and 2 034 women with a history of injecting drug use who were tested for HIV antibody at metropolitan sexual health centres in 2004 – 2013, 7 males (0.2%) and one woman (0.2%) was diagnosed with HIV infection. (McDonald et al, 2014.)
[6] *Seventh National HIV Strategy, Department of Health*, 2014

- to increase access to appropriate management and care for people with hepatitis C and HIV, and
- to eliminate the negative impact of stigma, discrimination, legal and human rights issues on people's health.

The role of Needle & Syringe Programs (NSP)

It is well established and widely agreed that NSPs are "the frontline of BBV prevention among people who inject drugs"[7]. As such, data on NSP provision offers an important window on the current state of prevention and the prospects for greater prevention. The Annual NSP Survey data report 2009-2013 reports the following:[8]

- The proportion of respondents aged less than 25 years decreased from 11% in 2009, to 8% in 2013. The low proportion of people in the survey who reported initiation of injection drug use in the previous five years (around 13% in 2013) and the low proportion of survey respondents aged younger than 20 years (around 2% in 2013) suggests that there has been a decrease in the prevalence of injecting drug use among young people in Australia.
- The proportion of new initiates (less than 3 years since first injection) increased from 5% in 2010 to 7% in 2013. Almost half (49%) of new initiates in 2013 reported last injecting performance and image-enhancing drugs (PIEDs).
- HCV antibody prevalence has increased: from 50% in 2009 to 54% in 2013. HCV antibody prevalence was highest among respondents aged 35 years or more and among those who first initiated injecting drugs more than ten years prior to survey participation in all years 2009 to 2013.
- Injecting frequency has decreased: the proportion of respondents reporting daily or more frequent injection in the month prior to the survey decreased from 50% in 2009 to 44% in 2013
- **Over the period 2009 to 2013, prevalence of re-use of needles and syringes (including re-use of one's own syringes), receptive sharing of needles and syringes and receptive sharing of ancillary equipment remained stable. In 2013, 24% of respondents reported re-use of needles and syringes, 16% reported receptive sharing of needles and syringes and 33% reported receptive sharing of ancillary equipment.**
- The proportion of respondents testing HIV antibody positive was low in all years 2009 to 2013, though HIV antibody prevalence increased from 1.2% in 2009 to 2.1% in 2013. Methamphetamine was the most commonly reported drug last injected among HIV antibody positive respondents in all jurisdictions. In 2013 the median age of HIV antibody positive respondents was 44 years, and respondents first injected a median of six years prior to survey participation.
- The proportion of people seen at NSP who reported having injected drugs for five years or less was stable in 2009-2013 at around 11%. Within this group, hepatitis C prevalence declined from 21% in 2011 to 14% in 2013.[9]

Overall, it is well accepted that NSP save lives and money.[10]

[7] AIVL, 2010.

[8] In 2013, 50 NSP services participated in the ANSPS and 2,407 NSP attendees completed the survey. The response rate was 44%. (Iverson et al, 2014).

[9] McDonald et al, 2014.

[10] Department of Health and Ageing, 2002; Department of Health 2009.

2. Achieving our goals through NSP

NSP are therefore critical to achieving the goals of the national strategies, and any other policies that are pertinent to improving the health and human rights of PWID. This section discusses the strengths, problems and barriers as regards NSP in reducing harm to PWID, particularly in decreasing incidence of hepatitis C and HIV.

In advance of the National Consultation Forum, AIVL surveyed 158 key stakeholders on their experiences, observations, ideas and priorities for improving, via NSP, the health and human rights of people who inject drugs.[11] There was broad agreement on the strengths of NSP in Australia at present, as well as the problems and barriers faced by the sector in improving and expanding NSP.

Survey respondents tended to agree that NSPs work well when they are:

- 24 hour
- Provide unlimited equipment
- Provide a range of equipment

Further, survey respondents felt that Australian NSPs were doing well in the areas of:

- Providing a welcoming and non-judgemental service
- Reducing harm
- Availability of equipment
- Peer staff and peer educators
- Accessibility, particularly in providing free or low-cost equipment

Survey respondents also agreed with the literature that:

- Some vulnerable groups of people are at greater risk of hepatitis C and HIV, especially Aboriginal and/or Torres Strait Islander PWID and people in custodial settings
- The rate of new hepatitis C infections is unacceptably high
- The rates of re-use of injecting equipment (one's own or someone else's) amongst people who inject drugs has remained unacceptably high (between 21-24% for more than five years)

[11] 158 responses: 6 from NT, 43 from QLD, 45 from NSW, 15 from ACT, 26 from VIC, 3 from TAS, 8 from SA, 12 from WA; 63% inner metro, 11% Outer metro, 19% regional centre, 5% rural, 2% remote; 8% researcher/academic; 13% peer/PWID; 13% peer worker in peer-based DUO or network; 30% NSP worker; 36% other – these identifications included people who occupy some or all of these categories at any one time; people who work for Aboriginal, youth, AOD, sexual health, health promotion organisations with some relationship to PWID; and policy makers/funders. NSP workers included peer-based NSP in a drug users organisation, NSP in another type of non-government organisation, government operated NSP, pharmacy-based NSP, other health/medical/social service and government department or research organisation. Peer groups worked with: People living in metro/city areas 70%; rural, regional, remote 50%; ATSI 54%; Women 52%; CALD 37% ; young people 44%; Older PWID 61%; PWID amphetamine-type substances 68%; PWID heroin 66%; PWID opioid pharmaceuticals 63%; people in prison or recently released from prison 48%.

- Distributing more equipment can reduce the risk of hepatitis C and HIV. This includes providing people with the range of equipment that they need, as well as having more equipment available to people at the time when they need it
- Current programs have not eliminated the need to reuse injecting equipment
- Access to information and equipment is urgently needed among people new to injecting[12]
- Peer distribution is an important way of providing clean equipment

Focus on sharing 1

We know that a key driver of hepatitis C acquisition among people who inject drugs is the sharing or reuse of someone else's equipment. Respondents to the pre-Forum survey broadly agreed with the research on sharing: naming access to equipment (including issues related to having to purchase equipment, and access to sterile equipment in rural and regional locations), knowledge of the risks of sharing, and personal and social relationships as key factors for intervention to reduce the rates of sharing. As Australian researchers Suzanne Fraser, Carla Treloar, and Joanne Bryant observe, "most hepatitis C transmission occurs through the sharing of equipment used for injecting drugs (including) between sexual partners. The social, relational, and intimate aspects of sharing are key to understanding how to reduce it.[13]

In a review of existing literature on sharing, Treloar concluded that once threshold coverage of sterile equipment is reached, other factors are important in driving sharing rates, including interpersonal relationships, levels of experience with injecting (with new/young injectors more likely to be at risk of unsafe behaviours, depression and distress and perceived discrimination[14].

Within this, it is well understood that 'peer distribution'- where NSP workers distribute injecting equipment to drug users in a range of environments, including in the homes of dealers and other places where people are scoring and using together – is likely to reduce the rates of equipment sharing and therefore hepatitis C and/or HIV infection.[15]

After considering the strengths of NSP at present, survey respondents felt that significant barriers to improving and expanding NSP include:

1. Attitudes of the media and community to drug users and injecting drug use
2. Not enough NSP outlets
3. Limits on amounts of injecting equipment, in particular:
    - The cost of equipment
    - The range: items like butterflies, sterile water, filters are not always available
4. Opening hours too restrictive

[12] ACT Human Rights Commission, 2013.
[13] Fraser et al, 2014.
[14] Treloar, 2014
[15] NUAA, 2009.

5. Laws and attitudes that prevent peer distribution
6. Problems with location of NSP outlets, in particular:
    - This is a big problem for Aboriginal people
    - There is a need for more consultation with Aboriginal people
7. Resistance from pharmacies
8. Information re opening hours, location, what equipment available
9. Police surveillance and focus from police
10. NSP workers asking too many questions
11. Confidentiality
    - This is a particular barrier in rural areas
    - Secondary outlets also need to work on confidentiality
12. NSP worker's attitudes (to users as well as to peer user colleagues)
    - NSP workers *not* asking questions (i.e., and thus not opening up pathway to treatment)
    - Secondary outlets seem particularly prone to discriminatory attitudes
    - Need consumer participation

Survey respondents also commented on the lack of access to NSP in prison, the need to reduce unsafe sharing, the increase in use of NSP for people injecting steroids, the important and sometimes undermined role of peer workers, experiences of other prejudice such as racism and homophobia, the need for tailored programs for Aboriginal people, the interface with treatment including AOD services and the need for primary health care, and the potentially prohibitive salary costs in running an NSP.

Some comments from the survey respondents:

> "*Great support and compassion for peers (clients). Yet lack of support or empathy for staff or volunteers who are peers – insidious judgements by non-peer workers toward peer workers*"
>
> "*Banning supply of winged infusion sets and larger syringes (in NSW) primarily used for injecting methadone. Limiting equipment to PIED users. Both of these policies are discriminatory and are based on what drug someone is using, not their level of risk*."
>
> "*For Aboriginal people in rural areas, there are not enough options. Often in NSW NSP outlets are emergency at hospitals or other locations which are not located close to Aboriginal communities. Rural areas need more tailored service provision - outreach, through AMSs, more vending machines & 24 hour access. Also need to have good programs around collecting disposed syringes, increasingly becoming an issue in rural areas & impacts negatively on NSP*."
>
> "*Being stigmatised, denied safe injecting equipment in prisons in NSW, lack of reintegration services when exiting prisons*"

Focus on sharing 2

Respondents to the Pre-Forum survey identified a number of drivers of equipment sharing and a series of possible solutions:

Issue	*Number of respondents*	*Potential solutions*
Equipment - availability, volume, type		
Availability of equipment	14	
Out of hours access to (free) equipment	21	Flexible service models: · All gov health services operate secondary NSP · Drive through NSP · 24/7 NSP · Chutes · VM/ADM · Mobile · On foot outreach · Distribute via servos · Online access/postal access
Need for peer distribution	10	Currently being piloted in NSW and Victoria
Volume of equipment	10	Mobile NSP
Butterflies and big barrels	2	
Lack of NSP in prisons	4	
Knowledge and information regarding hepatitis C prevention		
Lack of knowledge re: safe injecting, hepatitis C, (personal) shame	15	· Education via NSPs · Social media · Campaigns · Education in schools
Education of new injectors re prevention	1	
More info needed on injecting technique	1	
Lack of knowledge re hepatitis C transmission, safe injecting technique among NSP workers	1	
Service models		
Location of NSP	7	App re location
Not enough NSPs	1	
Poor self-care	1	Care of own health/primary health care

Issue	*Number of respondents*	*Potential solutions*
Reaching marginalised sub-populations		
Need to target young people	4	
Some populations are more marginalised: women, Aboriginal people, people from CALD backgrounds	1	
Supportive legal and community environment		
Stigma and discrimination against people who inject drugs	13	Includes attitudes from NSP staff, especially secondary NSP and pharmacy staff; as well as mainstream community
Police attitudes and policing	5	
Legal barriers	3	Law reform
Peer cultures and relationships		
Peer cultures that encourage sharing Peer Cultures unaware of risk	2	
Intimacy and trust cause people to relax/not prioritise prevention	5	
Miscellaneous		
Some people assume that they already have hepatitis C so no prevention	1	
Needs to be discussion at point of supply	1	
People who inject meth/ice prone to poor decision making	2	
Immediacy of drug use	5	
Poor mental health	1	
Equipment that can be reused will be reused		Need for retractables

3. What could be done differently in the NSP to achieve these goals?

Whilst NSP has played a critical role in reducing harm and preventing hepatitis C and HIV, in 2014 there are clear opportunities for improvement in further reducing harm to people who inject drugs. Many individuals, organisations and programs are considering and trialling innovations to increase the effectiveness of NSP.

Around 60 per cent of respondents to the pre-Forum survey said they were aware of work being done **at present** to address the barriers and opportunities in improving and/or expanding NSP.

Examples include:

- Service interface, co-location or add-on programs.

  "*Our NSP is enhanced by offering referrals (including to the programs within our organisation; care and support and Aboriginal sexual health) and offers brief interventions in the form of providing safer using information and other health information, advocacy, and help with obtaining legal information, advice or assistance. We also utilise peer workers within the NSP and other programs. This is greatly helped by the fact that the NSP is not run as a stand-alone program - it is run in conjunction with other programs within the organisation*."

- Provision of Naloxone on site.

- Peer distribution:

  "I would estimate that nearly 50% of NSP clients are collecting equipment for others as well as themselves - informal peer distribution. We have a client who is a dealer who takes large amounts of everything we stock and provides it to his customers"

- Peer networking: programs cited included NUAA Peer Link and hepatitis SA peer education program.

- Police training:

  "*some services provide education sessions to new police graduates to inform them of the value and place of NSPs*"

- Prison NSP: currently being progressed in the ACT.

- Rapid testing:

  "[We're] developing a pilot project involving rapid Hep C testing for remote areas, on release for prisoners, and those who may fall through the "Cure Crack" in some other way. This is still being put together in a way to suggest the best possible outcomes."

- Research/data collection: e.g., current UNSW study, 'Understanding and preventing hepatitis C in sexual relationships' is focussed on equipment sharing/reuse.

- Training for pharmacy providers and users: e.g., through the Pharmacy Guild in QLD.

- A triage system for NSP clients:

  "Triaging PIEDS users to pharmacy program versus NSPs."

- Vending machines, such as in NSW:

  "*Maybe if we had them here [Victoria] people would get the equipment they need more often because they could access the machine 24 hours and it's anonymous.*"

- 'Public image' work to reduce public concern, e.g. 'syringe sweeps' to 'clean up' areas where there is nowhere to dispose of syringes.

- Postal distribution:

  "*WASUA has a postal service and the Geraldton exchange will supply outlying regions via clients/peer distribution."*

On the specific question of **increasing accessibility to NSP for Aboriginal and/or Torres Strait Islander PWID**, research tells us that the following may be useful:

- General Service improvements: continuing improvement in the number and location of NSP outlets, longer hours of operation including evenings and weekends, wider use of vending machines, offering IDUs some choice of services where possible, flexibility in amount and types of equipment offered.
- Training in cultural competence and safety for mainstream NSP workers.
- Consultation by NSP planners and service providers with relevant Indigenous organisations, Indigenous communities and Indigenous IDUs themselves
- Employment of Indigenous staff (Peer) where this is considered appropriate.
- Expansion and improvement of NSP services in regional and rural areas - in particular including ongoing training for people providing services through secondary outlets and pharmacies.
- Increased user of mobile and outreach services.
- Use of posters, sign, brochures and the like which indicate that service providers are Indigenous-aware and Indigenous-friendly.[16]

Developing the role of NSPs in BBV diagnosis, assessment and treatment

- There is also significant potential for the NSP to contribute to the achievement of the goals and targets of the Strategies in relation to uptake of testing, monitoring and treatment for BBVs.
- The period to 2017/2018 will see a significant transition in the treatment options for hepatitis C, with treatment regimens of the future offering greater efficacy and substantially improved tolerability. The potential to cure greater numbers of people with hepatitis C, and stabilise the prevalence of advanced liver disease among those who have had hepatitis C long-term, will require a much wider range of services to be actively involved in diagnosing, monitoring and referring people.
- In addition, access to primary health care remains a pressing issue for a proportion of NSP clients, in particular those with chronic and complex needs[17]. Improving access to primary health care can contribute to improving the baseline wellbeing of individual clients, build engagement with the mainstream health system, and may be a pre-cursor to individuals considering treatment for hepatitis C.
- The NSP is ideally located to address a broader range of health issues among people who inject drugs. This is in no small part due to the existing access that NSPs provide for clients with high unmet need and low service access, as well as the trust that NSP clients have in NSP workers[18].
- There is the potential for NSPs to adopt a more comprehensive service model for addressing the health needs of people who inject drugs and indeed across Australia a small number of primary outlets already offer either enhanced care (focussed on BBVs) or primary care for people who inject drugs.
- Under this model, those (primary) NSPs unable to provide enhanced care or primary health care from within their existing staffing and funding could conceptualise their role as providing the infrastructure for other health

[16] Urbis, 2008.
[17] Treloar, C (2014)
[18] Treloar, C (2014)

initiatives to be conducted with this client population. Other services could then be targeted to provide outreach clinics within the NSP facility.

- Such an approach could significantly improve access to health care, particularly among those NSP clients with complex/chronic needs and low service access. Achieving this will, however, require a recasting of the role of the primary NSP, and a significant program of both workforce development and partnership development.

What enables innovation in NSP?

Survey respondents identified a number of key elements which 'enable' innovative solutions such as those described above, such as:

- The strong, active role of peers in service design and service provision, and the connection of the NSP to user communities:

"*Peerworkers don't do well in boxes and tend to think outside them.*"

Within this, peer distribution itself was also regularly cited as an enabler of innovation.

- Vending machines were also considered enablers – perhaps due to their role in engaging people with the NSP through that mode of access to equipment.
- Extended, secondary and or co-located NSPs – this can create an environment for new information and new ideas.
- Ongoing staff training and public education – this arguably makes space for innovation, by freeing up time that might otherwise be spent having to be reactive to misinformation and prejudice.
- Use of social media:

"*Improvements in our online and social networking presence, profile, and functionality*."

- Structural support from funders, decision-makers, organisational management, and partnerships:

"High level support within government. Strong leadership. Advocacy by community based organizations. Partnerships and collaboration. Funding."

4. What needs to happen at a systemic level?

There are persistent systemic barriers to improving the work of NSP in supporting the health and human rights of PWID. Law reform, policy implementation, community education and workforce development all contain systemic solutions to the goals discussed above regarding hepatitis C, HIV, and injecting drug use. In particular, there is wide scope for repeal and reform of laws that prevent NSP from supporting drug users to improve their health and realise their human rights. This section reviews some of the key systemic issues in maintaining and improving NSP.

The many legal remedies for expanding NSP have been summarised by the ACT Human Rights Commission, as follows:[19]

[19] ACT Human Rights Commission, 2013.

1. review and repeal legislation in each jurisdiction prohibiting peer distribution of injecting equipment;
2. review of unintended negative impacts of associated legislation including self-administration and aiding and abetting legislation on peer distribution of injecting equipment,
3. all jurisdictions to implement NSP in prisons in line with available evidence and as part of a comprehensive approach to BBV prevention among prisoners;
4. review relevant legislation and policy to improve the regulatory processes in relation to NSP service planning and approval at the local level,
5. review and repeal policy and legislative inconsistencies in relation to safe disposal in all jurisdictions and ensure IDU are properly informed of any changes,
6. review and address the potential for mandatory reporting requirements to directly and indirectly impact on access to NSP and injecting equipment

The Commission also notes that key actions for policy reform include:

7. strengthen partnerships between local councils, police and neighbourhood drug action teams to support greater understanding and support for NSP services;
8. all NSP staff to be provided with training on risk-benefit analysis in relation to mandatory reporting requirements, BBV prevention and building and maintaining positive client/staff rapport with a highly marginalised clientele.
9. Review budgetary frameworks to account for NSP's return on investment:

"*Current budgetary frameworks do not allow for current spending (such as removing limits on equipment distribution) to be offset by future savings in other areas (such as reduced costs of clinical care for people with hepatitis C-related liver disease)*."[20]

The pre-Forum survey consistently ranked stigma, prejudice and discrimination as the key barrier to their work in improving the health and human rights of people who inject drugs. Stigma also remains the strongest factor identified in research reports and other evidence documents. Legal and policy action remains intertwined with public morality. To this end, drug user communities have proposed measures to educate and inform the local community as well as media and political decision-makers; an AIVL position paper on this issue has previously recommended that:

- Member organisations take advantage of relevant local forums and events to raise awareness of stigma and discrimination associated with people who inject drugs
- Member organisations lobby jurisdiction-based communications and media authorities to take a firmer stand on the stigmatisation of people who inject drugs
- Member organisations educate their members of parliament in how the current jurisdiction-based drug control laws negatively affect the health and wellbeing of people who inject drugs on a daily basis.[21]

[20] ACT Human Rights Commission, 2013.
[21] AIVL, 2011.

Conclusion

- The Strategies set ambitious but attainable goals and targets in addressing blood-borne virus prevention, diagnosis, management and treatment among people who inject drugs.
- The Needle and Syringe Program has a central role in achieving those goals and targets.
- The NSP currently functions as a key site of access to people who inject drugs, many of whom have patchy access to the mainstream health system. However, access to the NSP and/or to sterile equipment is still not adequate among some sub-populations of people who inject drugs and these populations will require a tailored response.
- Achieving the prevention goals of the *Fourth National Hepatitis C Strategy* will require focussed attention on increasing the volume of equipment being provided across Australia, and improving the availability of equipment at the times when individuals are most in need.
- This will build on the existing network of NSPs, diversity the services involved in NSP, and will also require a more comprehensive approach to peer distribution.
- However, equipment provision is necessary but not sufficient. A broader program of work can and should be undertaken, including in particular peer education, and health promotion. There is also significant evidence pointing to the contribution of depression and distress in sharing rates, but limited evidence as to effective responses to those issues.
- In addition, achieving the vaccination, testing, monitoring/management and treatment goals, targets and objectives of the four relevant national strategies will require a reconceptualising of the role of the NSP. In particular, there is potential to use the NSP as the infrastructure by which other health services – ranging from primary health care to hepatitis C treatment (in the post-interferon world).
- In order for the above to be realised, there is also a need for more focused work on building supportive environments, which includes addressing stigma and discrimination directed at people who inject drugs, including stigma and discrimination in NSP and health care settings; addressing legislative barriers to distribution of sterile equipment and the criminalisation of drug use; and addressing the harm reduction needs of people in custodial settings.
- There will also need to be a focus on building and sustaining capabilities over time: partnerships between people who inject drugs, peer-based or drug-user organisations, NSP workers, program managers, policy makers, researchers and clinicians will be critical; as will workforce development.
- The achievements of the Australian NSP are substantial. It is now time for the next phase of its development.

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