National Needle and Syringe Programs Strategic Framework 2010-2014

ISBN: 978-1-74241-394-5
Online ISBN: 978-1-74241-395-2
Publications Approval Number- D0191

The report was produced by the Victorian Department of Human Services and funded by the Australian Government.

TABLE OF CONTENTS

ACRONYMS ____ *4*

FOREWORD ____ *5*

1. EXECUTIVE SUMMARY ____ *6*

2. BACKGROUND ____ *8*

2.1 Blood Borne Viruses and NSPs ____ **11**

2.2 Practice Context ____ **12**

2.3 NSPs - A Successful Public Health Response ____ **14**

2.4 Challenges for the Program ____ **15**

3. NEEDLE AND SYRINGE PROGRAMS (NSPs) ____ *17*

3.1 NSP Service Provision ____ **17**

3.2 NSP Outlet Descriptions ____ **18**

4. FUTURE DIRECTIONS FOR THE PROGRAM ____ *21*

4.1 Actions - Key Result Areas for the Program ____ **21**

4.1.1 Key Result Area 1 - National Standards ____ **22**

4.1.2 Key Result Area 2 - Increased Availability ____ **22**

4.1.3 Key Result Area 3 - Improved Data Collection ____ **22**

4.1.4 Key Result Area 4 - Peer Education ____ **23**

4.1.5 Key Result Area 5 - Core Training For NSP Workers ____ **23**

4.1.6 Key Result Area 6 - Improved Referral To Health And Welfare Services ____ **24**

4.1.7 Key Result Area 7 - Improved And Expanded Evidence Base For NSPs ____ **24**

4.2 Future Challenges to the Program - Understanding The Gaps, Risks And Limitations 24

5. PRIORITY ACTIVITIES AND INDICATORS FOR ACTIONS ____ *27*

6. MONITORING AND REVIEW ____ *29*

GLOSSARY ____ *30*

BIBLIOGRAPHY ____ *35*

APPENDIX A ____ *39*

ACRONYMS

AIHW – Australian Institute of Health and Welfare

AIVL – Australian Injecting and Illicit Drug Users League

ANCD – Australian National Council on Drugs

Anex – Association for Prevention and Harm Reduction Programs Australia

AOD – alcohol and other drugs

BBV – blood-borne virus

CALD – culturally and linguistically diverse / cultural and linguistic diversity

COAG – Council of Australian Governments

DoHA – Australian Government Department of Health and Ageing

HBV - hepatitis B virus

HCV – hepatitis C virus

HIV/AIDS – human immuno-deficiency virus/acquired immuno-deficiency syndrome

IRID – injecting related injury and disease

IDRS – Illicit Drug Reporting Survey

IDU – injecting drug user

NDSHS – National Drug Strategy Household Survey

NSP – Needle and Syringe Program

STI – Sexually Transmissible Infection

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNODC – United Nations Office of Drugs and Crime

WHO – World Health Organization

FOREWORD

The aim of the National Needle and Syringe Programs Strategic Framework 2010-2014 (the Framework) is to articulate what the Australian Needle and Syringe Program (the Program) offers as a public health program and what it aspires to achieve nationally. The Framework aims to provide guidance to governments and administrators planning the future development of the Program by setting policy directions and identifying program goals as appropriate for respective jurisdictions.

Formally established in Australia since 1987 the Program has evolved during its more than 20 years of existence. In each jurisdiction the Program has acquired distinct characteristics reflecting the relevant legislation, government policies, health system structures and dedicated funding, as well as patterns of injecting drug use that are particular to that State or Territory. The Program has been integrated with different health infrastructures and responded to differing emerging priorities.

This diversity presents a challenge for the development of a national strategic framework. However, there are goals and imperatives for the Program that are common across jurisdictions.

Throughout this document, the abbreviation 'NSP' refers to an outlet or service that provides IDUs access to injecting equipment, sometimes for sale. 'The Program' is the term used to refer to the constellation of NSP outlets and service modalities that collectively comprise Australian NSPs.

This document seeks to articulate the benefits of the Program and set broad policy directions for the Program for the period 2010-2014

1. EXECUTIVE SUMMARY

This Framework is designed to strengthen the links between services and across jurisdictions to ensure a coherent and evidence-based approach to the provision of services. It seeks to enhance the public health benefits of the Program both for IDUs and the Australian community by:

- articulating the aims of Australian Needle and Syringe Programs (NSPs); and
- outlining the key result areas for the Needle and Syringe Program (the Program) for the period 2010-2014.

The Program also seeks to enable IDUs access to other health and related services.

Following the emergence of HIV/AIDS, Australia was at the forefront of the public health response passing legislation to enable legal distribution of needles, syringes and other injecting equipment to IDUs since 1987. The Program has demonstrably prevented higher levels of HIV/AIDS infection in Australia than are currently present.

The prevention of HCV amongst IDUs has proven more difficult. This is partly related to the high prevalence of HCV in the IDU community prior to the commencement of the Program, the greater transmissibility of the virus, HCV resistance to current methods of cleaning injecting equipment, continued sharing, and re-use of injecting equipment. In addition, IDUs often come into contact with NSPs and other prevention services after they have commenced injecting and when they may already be infected with HCV.

Approximately 160,000 Australians are living with chronic HBV (Gidding et al 2007). The majority of these people were born overseas. Other high risk groups for HBV include IDUs, Indigenous Australians, and people participating in high-risk sexual activity.

The Program seeks to facilitate access for IDUs to preventive care as well as primary health services. IDUs are a group who often experience poor general health and medical problems associated with injecting.

Based on the risks of injecting, the Framework identifies seven key result areas for the period 2010-2014:

1. National standards;
2. Increased availability;
3. Improved data collection;

4. Peer education;
5. Implementation of national core training areas for NSP workers;
6. Improved access to referral to health services; and
7. Improved and expanded evidence base for NSPs.

More information about the development of the Framework is provided at Appendix A.

2. BACKGROUND

The aims of the Program in Australia are to protect the health, social, and economic wellbeing of the community through the priority focus on the following:

- human immuno-deficiency virus (HIV);
- hepatitis C virus (HCV);
- hepatitis B virus (HBV) ;
- injecting related injury and disease (IRID); and
- facilitating IDU access to other health and related services.

NSPs are situated within the harm reduction component of the National Drug Strategy. Since 1999, the Australian Government has continued to affirm its support for NSPs under the National Drug Strategy through the COAG Illicit Drug Diversion Supporting Measures Relating to NSPs. The measures aimed to:

- increase education, counselling and referral services through NSPs; and
- diversify existing NSPs to increase the accessibility of NSPs through pharmacies and other outlets and provide information and training.

Across jurisdictions Commonwealth funding provided under this initiative has represented a substantial proportion of government funding for NSPs.

The Ottawa Charter for Health Promotion (WHO, 1986) frames Australia's approach to HIV/AIDS and viral hepatitis and establishes an overarching international policy basis for the Framework. The Ottawa Charter defines health promotion as the process of enabling people to increase control over and thereby improve their health. It provides a holistic approach to thinking about health and wellbeing as well as to planning health promotion activities that improve health outcomes for individuals and populations.

The WHO Constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" (WHO, 2006). Both the Ottawa Charter and the WHO Constitution play a key role in informing the context and principles of the Program in Australia.

A number of Australian Government strategies and policies directly inform the practice of NSPs. These include the:

- *National Drug Strategy: Australia's Integrated Framework 2004-2009;*
- *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2004-2009;*
- *National Amphetamine-Type Stimulant (ATS) Strategy 2008-2011.*
- *The Sixth National HIV Strategy 2010-2013;*
- *The First National Hepatitis B Strategy 2010-2013;*
- *The Second National Sexually Transmissible Infections Strategy 2010-2013;*
- *The Third National Hepatitis C Virus (HCV) Strategy 2010-2013; and*
- *The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013.*

It is noted that while a number of these strategies are near their end date, the development of new strategies to replace those that have expired is underway in most instances.

The *National Drug Strategy: Australia's Integrated Framework 2004–2009* (the National Drug Strategy) seeks to "improve health, social and economic outcomes through preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in society" (Commonwealth of Australia, 2004). The National Drug Strategy outlines and endorses an approach encompassing:

- harm reduction strategies aiming to prevent anticipated harm and reduce actual harm to individuals and communities;
- supply reduction strategies to disrupt the production and supply of illicit drugs and to control and regulate licit substances; and
- demand reduction strategies to prevent the uptake of harmful drug use through education and other prevention activities and to reduce drug use through treatment and rehabilitation activities.

From 1 July 2009 funding previously provided for health programs is included in the new broad banded Healthcare Specific Purpose Payment. Consistent with the Intergovernmental Agreement on Federal Financial Relations (IGA) the expenditure of these funds on healthcare programs is a matter for each State and Territory. Under the IGA all payments are provided directly from the Commonwealth Department of the Treasury to the State/Territory Treasury.

The National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009 (the CAP) was developed through public consultation to help provide a nationally coordinated and integrated approach to reducing drug-related harm among Aboriginal and Torres Strait Islander people. The CAP was prepared in consultation with those working to address Indigenous alcohol and other drugs misuse - the Intergovernmental Committee on Drugs, the Australian National Council on Drugs, Aboriginal and Torres Strait Islander people in every State and Territory, the National Aboriginal Community Controlled Health Organisations, and a broad range of other key stakeholders. The CAP is endorsed by the Ministerial Council on Drugs and is one of the eight priority areas for action within the National Drug Strategy. The CAP sits between the National Drug Strategy and the individual national action plans. It is not prescriptive but rather sets the national direction, encouraging careful attention to the needs of Aboriginal and Torres Strait Islander peoples. The CAP provides an opportunity for communities, non-government organisations, Aboriginal and Torres Strait Islander community-controlled organisations and all levels of government to pursue strategies that are specifically relevant to Aboriginal and Torres Strait Islander peoples and appropriate to their circumstances, needs and aspirations.

The Sixth National HIV Strategy 2010–2013 (Commonwealth of Australia, 2010a) acknowledges the success of the early introduction and maintenance of NSPs in preventing an HIV epidemic among IDUs in Australia. The strategy recognises that rates of HIV among injecting drug users are sensitive to even small adjustments in the availability of injecting equipment and supports the resolution of problems in relation to the quality, coverage and accessibility of NSPs.

The Third National Hepatitis C Strategy 2010 –2013 (Commonwealth of Australia, 2010b) recognises that the majority of hepatitis C transmission occurs through unsafe injecting drug use practices. Access to sterile injecting equipment and harm reduction services, including NSPs, contribute to reducing this transmission.

The hepatitis C strategy identifies priority action areas including to:

- increase access to sterile injecting equipment, particularly in priority populations;
- enhance the capacity of the NSP workforce to engage with people with or at risk of hepatitis C infection and provide targeted education and health promotion interventions; and

- conduct a feasibility study into providing the full range of hepatitis C prevention interventions in custodial settings throughout Australia with the view to piloting the provision of prison-based NSPs.

The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013 (Commonwealth of Australia, 2010c) includes a priority action area focused on increasing primary prevention activities to reduce the transmission of HIV and viral hepatitis among Aboriginal and Torres Strait Islander people who inject drugs this includes access to NSPs.

The National Hepatitis B Strategy 2010–2013 (Commonwealth of Australia, 2010d) identifies people who inject drugs as a population of interest for the prevention of hepatitis B transmission. Many people who have chronic hepatitis B and inject drugs, have hepatitis C co-infection. The hepatitis B strategy recognises the need for increased awareness of hepatitis B prevention through a range of interventions, including safe injecting.

Actions recommended under the *National Amphetamine-Type Stimulant (ATS) Strategy 2008–2011* include resourcing and supporting NSPs to provide information and education to reduce risk of HIV and blood-borne virus transmission (such HCV). This includes strategies to enhance access to NSPs by various groups including Indigenous people and young people who are affected by ATS use. NSPs are identified as important to providing information on treatment options and how to access treatment.

2.1 Blood Borne Viruses and NSPs

The sharing of injecting equipment poses the greatest risk of exposure to BBV's.

Hepatitis C

*Approxima*tely 83 per cent of HCV infections have resulted from unsafe injecting drug use practices. In Australia in 2006 it was estimated that approximately 264,000 people had been exposed to HCV and had HCV antibodies with around 197,000 living with chronic hepatitis C. The estimated number of new cases of HCV infection has declined from 16,000 per annum in 2001 to 10,000 in 2005. The majority (65 per cent) of people with HCV are aged between 20 and 39 years and 35 per cent of national notifications of HCV are in women.

While 25 per cent of HCV infections clear spontaneously within two to six months 75 per cent develop into chronic infections. Chronically infected persons will continue to be able to transmit the virus including those who experience no noticeable illness or symptoms. After 20 years, between 5 and 10 per cent of infections will have resulted in cirrhosis of the liver, with 2 to 5 per cent progressing to liver failure or a form of liver cancer known as hepatocellular carcinoma.

Human immuno-deficiency virus

In Australia it is estimated that about 13 per cent of people with HIV also have HCV. HIV shares major routes of transmission with both HCV and HBV. People who inject drugs are at particularly high risk for HCV and HIV co-infection.

While HIV was not established in the Australian IDU population when NSPs were introduced, the prevalence of HCV was already high. HCV is a more robust virus than HIV and is transmitted more efficiently though blood-to-blood contact. Approximately 80 per cent of current HCV infections and 90 per cent of new infections are attributable to unsafe injecting practices (Commonwealth of Australia, 2005b). This explains IDUs being identified as a priority population within *The Third National Hepatitis C Strategy*.

Hepatitis B

In Australia it is estimated that between 90,000 and 160,000 people are chronically infected with HBV. The majority were born overseas predominantly in the Asia-Pacific region. Refugees and migrants from the Mediterranean, Eastern Europe, Africa, and Latin America also have high rates of HBV infection. Other groups at higher risk of HBV infection include Indigenous Australians, people participating in high-risk sexual activity, and people who inject drugs.

People with chronic HBV have a significantly increased risk of developing liver cancer. Treatment aims to stop or reduce the rate of multiplication of the HBV and decrease the risk of serious liver disease developing later in life. Medications rarely cure HBV infection but adult vaccination against HBV is effective in preventing transmission.

2.2 Practice Context

Legislation enabling the legal distribution of needles and syringes to IDUs is a State and Territory responsibility and has been enacted in all jurisdictions. However this legislation

can vary significantly impacting upon NSP service delivery and governance in each jurisdiction. Carefully negotiated adjustments to policing procedures and operational guidelines facilitating IDU access to harm reduction services have been crucial to the success of the Program.

Local government urban planning processes also contribute to the Program context by affecting the location and operation of NSP outlets.

There is well-documented evidence that greater availability and use of injecting equipment reduces the incidence of HIV, HCV and HBV among IDUs. The following documents form part of the evidence-base for the Program and describe good practice:

- *Evidence for action technical papers: Effectiveness of sterile Needle and Syringe Programming in reducing HIV/AIDS among injecting drug users* (Wodak and Cooney, 2004);
- World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) *Guide to Starting and Managing NSPs* (2007);
- Return on Investment in Needle and Syringe Programs in Australia (2002); and
- Return on Investment 2: Evaluating the Cost-Effectiveness of Needle and Syringe Programs in Australia (2009).

These documents provide evidence for the effectiveness, sustainability and population health benefits of NSPs and identify the essential qualities of NSPs in the prevention of BBV transmission as flexibility, ease of access, responsiveness, and monitoring.

Depending on the State or Territory administration of the Program, NSP responsibilities may reside with the mental health, alcohol and drugs, public health or BBV/STI program area. Although originally introduced to prevent HIV transmission and later HCV transmission some NSPs have evolved to provide a range of services addressing identified needs of the client group. Some of the overall diversity of NSP service provision can be seen to reflect the varied placement of the Program within jurisdictional health departments.

Similarly, jurisdictional differences in health sector infrastructure have offered varying opportunities for the placement of NSP services. Another area of significant difference is the degree and way in which community pharmacies have been engaged in the Program. Pharmacy NSPs range from independent retail services to those participating in jurisdictional pharmacy schemes.

Other important factors influencing the development of jurisdictional programs have been the differing patterns of injecting drug use experienced across jurisdictions and the funding allocations applied to the Program over time. A number of regular national research studies influence policy and strategy at all levels. These studies include the

- *Australian NSP Survey;*
- *Illicit Drug Reporting System; and the*
- *National Drug Strategy Household Survey*.

2.3 NSPs - A Successful Public Health Response

The value of the Program as an evidence-based public health response to the risk of BBV transmission associated with injecting drug use is substantial. NSPs have been endorsed by the WHO, the UNAIDS, and the UNODC as an essential public health response to ensure "that drug users have their own injecting equipment and do not share it with others, that the circulation time of used needles and syringes is reduced, and that used equipment is disposed of safely" (WHO, 2004).

Australia's first NSP was trialled in New South Wales in 1986 with the provision of NSP services becoming New South Wales Government policy in early 1987 and the remaining states and territories implementing NSPs soon after via primary, secondary and pharmacy outlets (Dolan et al., 2005). This occurred following the discovery of HIV and the potential threat that this virus posed to the Australian community. The establishment of NSPs throughout Australia would not have been possible without bipartisan political support which continues to be an important element in the continuing existence and operation of NSPs.

In Australia the Program is the single most important and cost-effective strategy in reducing drug-related harms among IDUs. Australian Governments invested $130 million in NSPs between 1991 and 2000 resulting in the prevention of an estimated 25,000 HIV infections and 21,000 HCV infections, with savings from avoided treatment costs of up to $7.8 billion (Health Outcomes International et al., 2002). In the decade 2000-2009, the gross funding for NSPs was $243 million. This investment yielded healthcare cost savings of $1.28 billion; a gain of approximately 140,000 Disability-Adjusted Life Years (DALYs); and a net cost saving of $1.03 billion. During this time, NSPs have averted 32,061 new HIV infections and 96,918 new HCV infections (NCHECR, 2009).

Historically some communities have been resistant to the establishment of NSPs, even though Dolan et al. (2005) note that based on international and national evidence the Program does not:

- encourage more frequent injection of drugs;
- increase recruitment of new IDUs;
- increase crime or violence; or
- increase the number of discarded needles and syringes in public places.

2.4 Challenges for the Program

Despite the success of the Program a number of challenges remain.

Variability

NSPs vary across jurisdictions — in legislation, policy and practice guidelines; geographic spread; existing Program infrastructure; injecting populations and patterns of injecting drug use. This variability can particularly impact on:

- the range, type, cost and quantity of equipment distributed;
- geographic access to services;
- confidentiality of access; and
- access at different times of the day and week.

Therefore, this variability may potentially impede the full public health benefits of the Program.

Populations

IDUs who do not access the Program present another key challenge. In order for everyone to benefit equally from the preventative effect of the Program, groups that need to be specifically targeted in education and outreach campaigns include IDUs who:

- are aged under 25 years;
- have been injecting for less than three years;
- are from Indigenous backgrounds;
- are from CALD backgrounds;
- have a history of imprisonment;
- are men who have sex with men;
- are people who inject steroids;
- are peer distributors; and
- are currently in prison.

These groups have been identified in the national strategies mentioned earlier.

Workforce development

A significant challenge for the Program is workforce development. People who staff secondary and pharmacy NSPs do not undertake NSP duties as their main role. These workers may not have had the opportunity to obtain NSP qualifications or training and therefore may not be aware of the public health benefits of the program; the importance of making clients feel comfortable in accessing the service; or may be unable to provide referral or other services when required. Training and education for workers in secondary NSPs and pharmacies is critical to the success of the Program.

The workforce staffing individual NSPs need to have an appropriate level of knowledge about the effects of injecting drug use on health and wellbeing and be skilled to provide NSP services confidently and effectively.

The Program experiences considerable workforce turnover on an annual basis. Investment in training must be constant to address the orientation and further training needs of new personnel.

Evidence and Community

Evidence informing the Program must be robust and diverse. A current challenge for the Program as a whole is to be informed by, and responsive to, input from both service users and IDUs who do not currently access the Program.

The Program needs to establish strong links with people and organisations to improve community understanding of the public health benefits of the Program (Körner and Treloar, 2004:Treloar and Körner, 2005). Groups or organisations identified through the development of the Framework as being of particular importance include police, corrections and the media.

Funding

Available funding is a key challenge to developing national consistency in service quality and in reducing the incidence of HIV, HCV, HBV and IRID.

3. NEEDLE AND SYRINGE PROGRAMS (NSPs)

3.1 NSP Service Provision

NSPs in Australia are delivered via a mix of models that vary considerably across jurisdictions. The Program is comprised of three outlet types:

- primary NSPs;
- secondary NSPs; and
- pharmacy NSPs.

The Program is delivered through a number of service modalities which are not provided in every jurisdiction. The service modalities include:

- fixed sites;
- vending machines; and
- outreach and mobile response services

The following table summarises the mix of NSP models by jurisdiction in 2009. This information has been sourced from consultations with representatives from State and Territory Governments. The consistency of these figures may be influenced by variations in the manner in which jurisdictions classify and therefore count NSPs.

Table 1: NSP outlets by jurisdiction 2009

Jurisdiction	Primary NSP	Secondary NSP	SVMs	Outreach	Pharmacy NSP
ACT	2	6	5	2	29
NSW	33	270	110	11	445
NT	3	10	0	0	12
QLD	15	125	23	0	438
SA	1	80	0	5	180
TAS	6	20	3	0	66
VIC	11	128	0	25	932
WA	2	101	5	2	440
TOTAL	73	740	146	45	2,542

Note: These figures are estimates

3.2 NSP Outlet Descriptions

Primary NSPs

Primary NSPs are services dedicated to the provision of an extended range of injecting equipment and other services to IDUs. They deliver information and education on issues relating to injecting drug use and health, and make referrals to a range of health and social services, including drug treatment services. Primary NSPs liaise with a range of local stakeholders including police, other criminal justice service providers, and local government, health and community services.

Some primary NSPs may provide additional services such as primary health care, counselling and the provision of an extended range of consumables sometimes on a cost-recovery basis. Primary NSP services vary according to funding and local needs.

Secondary NSPs

Secondary NSPs operate within an existing health or community service so that staff providing the NSP services do so in addition to the other roles for which they are primarily employed.

Secondary NSPs may provide the same range of services as primary NSPs but typically have a limited capacity to deliver services in addition to injecting equipment and disposal facilities.

Pharmacy NSPs

Pharmacy NSPs are community retail pharmacies that distribute a range of injecting equipment. Pharmacy NSPs may be supplied injecting equipment and disposal containers free of charge for either sale or distribution to NSP clients.

While the Pharmacy Guild of Australia supports the Program, and the Pharmaceutical Society of Australia has published professional practice standards for pharmacy NSP delivery, the provision of pharmacy NSP services is at the discretion of individual proprietors.

As with other NSPs, pharmacy NSPs may collect data, and offer disposal facilities, information and referral. Some pharmacy NSPs also dispense opioid substitution treatment.

Pharmacy NSPs are the most common type of NSP outlet and account for approximately 10–5 % of national needle and syringe distribution (NCHECR, 2009).

Service Modalities

Fixed Sites

Fixed site services account for the majority of NSPs. This means that services are provided from a designated building and operate within identified hours. Some fixed sites operate 24 hours a day.

Fixed site NSPs are located in a variety of settings, the most common of which are hospitals, pharmacies or community health services.

Vending Machines

Syringe Vending Machines (SVMs), also known as Needle Dispensing Machines (NDMs), are self-contained units that dispense injecting equipment mostly for a small

fee. There are several styles and models that are usually nondescript stand-alone or wall-mounted metallic units. Unlike snack, beverage or cigarette vending machines they do not advertise their contents. SVMs may operate after NSP service hours or provide 24-hour access to injecting equipment.

Outreach/Mobile NSPs

These services may operate from a vehicle (such as a car, van or bus) or in a small number of cases utilise a 'foot outreach' model. This involves NSP staff carrying backpacks or driving a vehicle to deliver injecting equipment, safe disposal containers and educational information. These services may operate on a specific timetable and be present at designated locations at scheduled times or may respond directly to requests such as by phone. They often operate outside of normal business hours.

4. FUTURE DIRECTIONS FOR THE PROGRAM

In the Development of the Needle and Syringe Strategic Framework 2010-2014, a number of key result areas have been identified. In particular:

- NSPs should be geographically accessible to all IDUs and be culturally and socially accessible;
- the Program should endeavour to reduce harm by preventing IRID and overdose so that hospital admissions and demands on a range of health services are reduced and serious disability and death are averted;
- Program services should be non-judgemental and accept the lived experience of IDUs some of whom may be marginalised as a result of their injecting drug use and associated activities;
- the Program should represent a comprehensive population health intervention. Consequently, quality improvement of services is required on a regular and independent basis. Evaluation results would inform the evidence base for effective NSP practice;
- the NSP workforce should be skilled in offering evidence-based services and engaging with IDUs. The availability of a consistent and high standard level of education and training of all NSP workers will maintain a professional and effective workforce;
- the Program encompasses a large network of health and welfare providers; and
- the Program effectively engages with the public. It is essential that the Program is supported by the public community including other services such as law enforcement, all levels of government, health service providers, researchers and AOD service providers.

4.1 Actions - Key Result Areas for the Program

The Key Result Areas for the period 2010-2014 under this Framework document are:

1. National standards
2. Increased availability
3. Improved data collection
4. Peer education
5. Implementation of national core training areas for NSP workers
6. Improved access to referral to health services
7. Improved and expanded evidence base for NSPs

The suggested actions relate to the key result areas indicated in the following section.

4.1.1 Key Result Area 1 - National Standards

Action – Aim to develop national standards to guide NSP practice for future implementation

The development of national standards for NSPs would ensure consistent quality of service provision across all services, regardless of service type, modality, location or time of day. There are currently no such national benchmarks or processes in place.

The development of national standards should be informed by the adoption of a National Minimum Data Set for NSPs to ensure consistency across jurisdictions and to enable improved service planning and identification of service gaps.

4.1.2 Key Result Area 2 - Increased Availability

Action – Aim to increase the availability of needle and syringe equipment by increasing NSP hours and sites. This includes needle dispensing machines and less restrictive policies in relation to the amounts and range of injecting equipment available at NSPs

In order to effectively meet the purpose of the Program, and realise optimal public health benefits, IDUs need to be able to access NSPs according to need. The quantity and type of equipment that is provided to service users should maximise the opportunity for BBV and IRID prevention. Equipment distributed should be appropriate for the type of drug being injected and the circumstances in which injection is likely to take place.

All jurisdictions need to increase geographic access to NSPs. The co-location of many NSPs with existing health and community services improves geographical coverage. Increased access requires further exploration particularly regarding hours of access, as service availability outside normal business hours is a key challenge. Increased availability also includes the exploration of models to expand coverage in diverse communities.

4.1.3 Key Result Area 3 - Improved Data Collection

Action – Aim to improve data collection and reporting systems which will allow a better understanding of who is accessing NSPs and the gaps in current NSP service delivery

While jurisdictions comply with the annual collection of a nationally consistent data set on NSPs the quality and amount of data collected at NSPs varies across jurisdictions. While every effort is made to provide an anonymous service collection, analysis of de-identified data is an important indicator for the Program in relation to demographics, distribution methods, drug use, and harms that may result. Data collection will inform opportunities for improvement of the Program.

It should be noted that the National Health Care Agreements require jurisdictions to continue to collect and supply the nationally consistent NSP data annually, pending the *development of the NSP National Minimum Data Set.*

4.1.4 Key Result Area 4 - Peer Education

Action – Aim to strengthen the evidence base for peer education

Improved service delivery through the involvement of peers in both the areas of education programs and service delivery. An exploration of models that examine peer education including culturally sensitive service provision to culturally diverse groups should be undertaken.

4.1.5 Key Result Area 5 - Core Training For NSP Workers

Action – Aim to develop and implement a nationally consistent training model for NSP workers

While training of the NSP workforce occurs in a variety of ways across jurisdictions there is no national standard that ensures that people who provide NSP services have been appropriately trained. The availability of a consistent and high standard of education and training of all NSP workers will maintain a professional and effective workforce.

Core training and education of NSP staff should be consistent for staff who work in primary, secondary, and pharmacy NSPs. Training would allow NSP staff to feel skilled and supported to effectively engage with IDUs. This would include an understanding of drug use, a non-judgmental attitude, and a strong knowledge of the broader service system.

A nationally consistent approach to workforce training and development would enhance the quality of service provision.

4.1.6 Key Result Area 6 - Improved Referral To Health And Welfare Services

Action - NSPs should offer referral to other appropriate health and welfare services

NSPs are an important point of contact for referral to other healthcare services designed to meet the needs of IDUs (Dolan et al., 2005). The Program is "in a unique position to make contact with and advise people using drugs, including acting as a gateway to treatment and counselling when requested or appropriate" (ANCD 2002). Referral opportunities for prevention, health promotion, treatment, welfare, and housing should be available on all occasions of service and be undertaken both proactively and in response to service user request. The establishment of links with local health services will support opportunities for referrals.

4.1.7 Key Result Area 7 - Improved And Expanded Evidence Base For NSPs

Action – Aim to regularly assess the effectiveness of NSPs through evaluation of the direct and indirect effects of NSPs and their impact on the prevention of drug related harm.

The Program is supported by evidence and is supportive of innovative practice. The Program assists in building the evidence base through data collection and participation in research activities. The Program incorporates the principles of evidence-based practice. This means that the best available evidence informs the delivery of services, with practitioners using the best available evidence, moderated by client circumstances and preferences, to improve the quality of clinical judgments and facilitate cost-effective care. Improving the evidence base of the Program will inform best practise in the prevention of BBVs and STIs.

4.2 Future Challenges to the Program - Understanding The Gaps, Risks And Limitations

The Program has a number of future challenges, risks and limitations.

Challenges

- To ensure its long term sustainability, the long term challenge for the NSP sector is managing the process of integrating the Program into all relevant areas of health.

- As a population health strategy which aims to reduce IRID, morbidity and mortality, NSP provision should be fully integrated into the practice of a range of disciplines including but not limited to: Mental Health (including homeless populations), Alcohol and Other Drug, Youth Work, Indigenous Health, Sexual Health, and Pharmacy.

- At a policy level, injecting drug use and the Program needs to be fully integrated into policies relating to injection safety and generalised sharps management.

- Consideration should be given to aligning jurisdictional legislation and regulations pertaining to the Program.

- There should be increased integration of community pharmacy needle and syringe provision into jurisdictional NSPs, both at the grassroots and policy levels.

- Given their particular epidemiology, IDU with mental health problems, young injectors, indigenous IDU and gay injectors all represent specific challenges to the Program.

Risks

- Needle stick injury and the unsafe disposal of sharps in public may fuel community opposition to NSP provision. This is often accentuated by a lack of political will and understanding at the local level.

- Injecting drug use in prison and the absence of NSPs in prisons represents a gap, a risk and a limitation in all jurisdictions and requires urgent attention.

- The capacity of the Program to effectively reduce the spread of HCV represents a critical risk. It also highlights a general lack of understanding of the limitations of the Program and a tendency within health service delivery and health planning to abdicate responsibility for HCV prevention to the Program alone.

Limitations

- Workforce development issues especially training; the lack of specific recognised qualifications; and the lack of career pathway, limit the growth and development of the sector.

- A lack of adequate clinical capacity adversely impacts on the Program and limits its efficacy.

- There needs to be greater clarity regarding the limitations of the NSP and the corresponding responsibility that other sectors have to engage with injecting drug use within their target populations.

- The Program has not yet attained full integration within the health sector, therefore it is dependent on and limited by budgetary constraints.

5. PRIORITY ACTIVITIES AND INDICATORS FOR ACTIONS

Key Result Area	Priority Activities	Indicators
1. National standards	▪ The collaborative development of a set of national minimum standards for all NSPs ▪ Timely development of national minimum standards for specific service types ▪ A draft timetable for future implementation and review of standards is developed	▪ Universal minimum standards for Primary, Secondary and Pharmacy NSPs ▪ Individual minimum standards for Primary, Secondary and Pharmacy NSPs ▪ Implementation and review of draft timetable
2. Increased availability	▪ Mapping of current locations, service modalities and operating hours of Primary, Secondary and Pharmacy NSP outlets ▪ Expansion of numbers of NSP outlets and hours of operation to reflect the identified needs within jurisdictions ▪ Investigate the removal of limits on amount of equipment supplied per occasion of service ▪ Expansion of range of equipment made available to service users according to needs identified within jurisdictions	▪ NSP sector map ▪ Data collected to identify access to the Program ▪ Data collected to identify access to the quantity and type of equipment ▪ Reduced incidence and prevalence of sentinel BBVs for all Australians
3. Improved data collection	▪ Review of the nationally consistent data collection tool ▪ Annual analysis of data	▪ Acceptance and use of the nationally consistent data collection tool ▪ Annual data analysed by an independent agency
4. Peer education	▪ Research to be undertaken that examines effectiveness of peer education and peer participation models ▪ Research to be undertaken on peer education in different cultural groups ▪ Research to be undertaken on models of education by peers/non peers that enable culturally sensitive service provision	▪ Evidence on the effectiveness of peer education and participation ▪ Identification of models that enable culturally sensitive service provision to be provided by either peers and/or non-peers where appropriate

Key Result Area	Priority Activities	Indicators
5. Implementation of national core training areas for NSP workers	▪ Development of a national training package for Primary, Secondary and Pharmacy NSP workers that is aligned to the Australian Quality Training Framework ▪ Development of basic, intermediate and advanced levels of training ▪ Implementation of training program across all jurisdictions ▪ Evaluation of national training package	▪ A national training package ▪ A proportion of workers, agreed upon by each jurisdiction, is trained and assessed at each level as competent to provide NSP services ▪ National training package is evaluated
6. Improved access to referral for health services	▪ Staff who provide NSP services are trained in the provision of referrals ▪ Resources that support referrals are available in every Primary, Secondary and Pharmacy NSP ▪ The development of a directory of local services in each jurisdiction	▪ Data collection reflects an increase in referrals ▪ Local service directory in every NSP
7. Improved and expanded evidence base for NSPs	▪ Independent research undertaken on a regular basis to evaluate the population health benefits of the Program ▪ Regular funding of research projects that inform the NSP evidence base	▪ Regular updating of the Return on Investment findings

6. MONITORING AND REVIEW

Evaluation of the Framework is to be based on a national approach that reviews the Strategy's activities and indicators against the Key Result Areas.

The signatories to the National Healthcare Agreements have agreed to continue to collect the NSP Nationally Consistent Data Set pending the development of the National Minimum Data Set. The development of the National Minimum Data Set is seen as a matter that needs to be addressed as a priority to allow for states and territories to report performance measures under this Framework.

Regular review of incidence and prevalence data from the relevant disease surveillance reports for BBVs will also inform the monitoring of progress against indicators identified in this Framework.

Information gathered through monitoring and reporting will be collated in the final year of the Framework implementation period and used to contribute to the identification of key priorities for the next iteration of the National NSP Strategic Framework.

GLOSSARY

Australian Needle And Syringe Program (NSP) Survey
A cross-sectional survey conducted annually by the National Centre in HIV Epidemiology and Clinical Research over a one week period in October each year since 1995. The survey forms the basis of Australia's HIV and HCV surveillance among IDUs and monitors behavioural indices of risk in addition to prevalence of infection.

Best Practice
Integrating the best available evidence with professional expertise to determine the optimal approach or intervention in a given situation with, as appropriate, the service user's informed consent.

Blood-Borne Virus (BBV)
A virus that can be transmitted from an infected person to another person by blood-to-blood contact including through the sharing of injecting equipment.

Custodial Setting
Any of the various facilities in which adults and juveniles can be detained or imprisoned including prisons watch houses, juvenile justice centres, remand and other detention facilities.

Disposal
The provision of individual disposal containers of various sizes to IDUs and bulk disposal facilities for returned containers provided within NSP outlets or often at health facilities. Disposal can be available during operating hours or through secure bin enclosures with 24-hour access. Legislative differences across jurisdictions concerning the definition and disposal of clinical waste can impact on disposal policy and practices.

Drug
A substance that produces psychoactive or physiological effects on the person who consumes the drug. Drugs that can be injected include: heroin; amphetamines; cocaine; prescription opioids; benzodiazepines; and performance and image-enhancing drugs (steroids).

Drug-Related Harm
Any adverse social, physical, psychological, legal or other consequence of drug use that is experienced by a person using drugs or by people living with or otherwise affected by the actions of a person using drugs.

Drug User Organisations
Peer based organisations representing the needs and interests of people who use drugs illicitly.

Equipment Provision
The provision of injecting equipment to IDUs including any equipment required to inject drugs; condoms; and water-based lubricant. This provision is guided by differing legislation and policy across jurisdictions.

Harm Minimisation
One of the features of the National Drug Strategy is harm minimisation. It aims to improve health, social and economic outcomes for both the community and the individual

and encompasses a wide range of approaches in dealing with drug related harm, including supply reduction, demand reduction and harm reduction strategies. A comprehensive harm minimisation approach must account for the interaction of the individual, the community, and the drug.

The National Drug Strategy focuses on both licit and illicit drugs.

Harm minimisation includes preventing anticipated harm and reducing actual harm.

Harm Reduction Strategies
Strategies designed to reduce the impacts of drug-related harm on individuals and communities. Harm reduction does not condone illegal risk behaviours such as injecting drug use, rather, it acknowledges that these behaviours occur and therefore, there is a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause.

Health Promotion
Australia's approach to health promotion is based on the 1986 Ottawa Charter on Health Promotion (WHO 1986). The Ottawa Charter defines health promotion as the process of enabling people to increase control over and improve their health. It includes equity in disease prevention, education, social mobilisation and advocacy to provide appropriate and accurate information to enable individuals to make healthy choices.

Hepatitis
Inflammation of the liver caused by viruses, alcohol, drugs and other toxins or, less commonly, by a breakdown in a person's immune system. There are five viruses that specifically cause hepatitis, labelled: hepatitis A, B, C, D and E. Each may produce similar symptoms with the main difference between them being the mode of transmission and the effects on a person's health. Hepatitis viruses that develop into a chronic infection may, over time, cause fibrosis (liver cells are damaged and destroyed and scar tissue takes their place).

Hepatitis B
A viral infection caused by the HBV, which can cause damage to the liver and may be transmitted through blood-to-blood contact and unprotected sexual contact.

Hepatitis C

A viral infection caused by the HCV which belongs to the flavivirus family of ribonucleic acid (RNA) viruses. Discovered in 1988 HCV is spread through blood-to-blood contact. The slow progression of the disease means that people are often unaware of being infected until symptoms present many years later.

Human Immuno-Deficiency Virus (HIV) / Acquired Immuno-Deficiency Syndrome (AIDS)
HIV is a human retrovirus that leads to AIDS. AIDS is a syndrome defined by the development of serious opportunistic infections, neoplasms or other life threatening manifestations resulting from progressive HIV-induced immuno-suppression.

Infection with HIV occurs when the virus present in the bodily fluids of an infected person is transmitted to another person by blood-to-blood contact. Bodily fluids include blood, semen, vaginal fluid, pre-ejaculate or breast milk. The major routes of transmission are unprotected anal or vaginal sex, sharing needles and syringes when injecting drugs, and from mother to baby during pregnancy, at birth or through breast-feeding.

Illicit Drug
A drug whose production, sale, possession or use is prohibited by law.

Illicit Drug Reporting System (IDRS)
The IDRS monitors the price, purity, availability and patterns of use of heroin, methamphetamine, cocaine and cannabis in illicit drug markets in Australia. The IDRS involves the collection and analysis of three sources of data: interviews with regular IDUs, semi-structured interviews with experts working with drug users, such as treatment, law enforcement and NSP workers; and existing databases on drug-related issues, such as customs, overdose and seizure data, as well as National Household Surveys of Drug Use. The national IDRS has been conducted annually since 2000.

Incidence
The number of new cases of a disease in a defined population within a defined period.

Information/education
The provision of information and education to IDUs in written, verbal and pictorial forms in a range of languages on a range of topics. Delivery may be passive, with service users having access to visual displays or literature, or active, through engagement by a worker in a brief intervention or in response to an individual service user request. It can also include information provided to the broader community about the purpose and practices of the Program.

Injecting Drug Use
The administration of licit or illicit drugs to the body via a needle and syringe including intra-muscular, subcutaneous or intravenous injection.

Injecting-Related Injury And Disease (IRID)
A range of vascular, soft tissue and other injuries and infections, including blood-borne viral infection and overdose, experienced by people who inject drugs. Arising from exposure to bacterial, viral, fungal and parasitic pathogens IRID includes: prominent scarring or bruising; vein collapse; swelling of hands or feet; cellulitis; abscesses or skin infections; fungal eye infection; thrombosis; septicaemia; septic arthritis; amputation and endocarditis. Risk factors for IRID include the re-use of injecting equipment and inadequate filtering.

National Drug Strategy
An endorsed policy supported by Australian Government and the State and Territory Governments. The National Drug Strategy promotes partnerships between health, law-enforcement and education agencies, drug users, people affected by drug-related harm, community-based organisations and industry to reduce drug-related harm in Australia. The partnerships approach is the basis of the three key principles of the Australian harm minimisation framework composed of:

- Demand reduction;
- Supply reduction; and
- Harm reduction.

National Drug Strategy Household Survey
One of the data-collections used to monitor trends and progress under the National Drug Strategy. Conducted by the AIHW , on behalf of DoHA, the survey has been conducted nationally in 1985, 1988, 1991, 1993, 1995, 1998, 2001, 2004 and 2007. This survey provides data on behaviour, knowledge and attitudes relating to drug use among people aged 14 years and over.

Needle And Syringe Program (NSP)
A public health harm reduction initiative formally established in Australia in 1987 within the harm minimisation framework of the National Drug Strategy to prevent the transmission of HIV among IDUs and subsequently, to the broader community. NSP

services are provided through a range of models and modalities including fixed site, outreach, and syringe vending machines.

Needle And Syringe Program Workforce
Any staff member of a primary, secondary or pharmacy NSP outlet**.**

Outreach
An outreach service is delivered by workers outside fixed-site service locations. It may be delivered via a vehicle or on foot and may attend at set locations at scheduled times, or respond to requests to attend at locations identified by service users or seek out those in need of support.

Overdose
The use of a drug, or combination of drugs, in an amount resulting in acute adverse physical or mental effects. Overdose may produce transient or lasting effects and can sometimes be fatal.

Peer education
Members providing education and information to other members of the same group in both formal and informal ways. This model of education is based on social learning and health behaviour theories and is designed to impart information, skills and knowledge to others (peers). Peer education also recognises the influence that peer pressure and the behaviours of a peer group have on the decisions an individual makes.

Pharmacy NSP
Community pharmacy NSPs provide services which range from the provision of injecting equipment sold as retail items to pharmacy based incentive schemes implemented in conjunction with state and territory health departments. Harm reduction efforts are varied with some pharmacies providing equipment and disposal facilities, referral services and established contact with health professionals while others provide injecting equipment only.

Population Group
Refers to a group of people defined by geographical location, gender, age, risk factor, culture, possession of a common condition characteristic or disease.

Prevention
Within the context of the National Drug Strategy, prevention refers to measures that prevent or delay the onset of drug use as well as measures that protect against risk and prevent and reduce the harms associated with drug supply and use.

Primary Health Care
The provision of health care and allied health services in the community. Primary health care aims to reduce the likelihood of serious illness and reduce the need for hospital and specialist medical services. Primary health care management includes prevention, early intervention and ongoing management of health care issues.

Primary NSP
An outlet specifically funded to employ staff to deliver NSP services including education, referral and support as well as injecting equipment. Primary NSP outlets typically operate in areas with high levels of injecting drug use. They may be co-located with other health services, operate as stand-alone facilities, or deliver services through outreach.

Referral
The referral of an individual to another health or welfare service. Referral may occur through providing information in writing or verbally about the other service or through a staff member initiating contact with the other service on the service user's behalf. Referral to other NSPs, such as primary sites, is included in this definition.

Secondary NSP
An outlet located within an agency that is not specifically funded to employ staff to deliver NSP services. NSP provision may be only one among a range of health care services provided by the agency. Secondary NSP staff deliver NSP services alongside other duties, such as reception, nursing or counselling.

Sexually Transmissible Infection (STI)
An infection – such as HIV, gonorrhoea, syphilis or chlamydia – that can be transmitted through sexual contact.

Steroids
A group of naturally occurring or synthetic hormones that may affect chemical processes in the body, rate of growth, and other physiological functions. Steroids are mainly injected to enhance muscle growth and development.

Surveillance
Continuing scrutiny of all aspects of occurrence and spread of a disease. The main purpose is to detect changes in trends or distribution in order to initiate investigative or health control measures.

Syringe Vending Machine (SVM)
A machine that dispenses needles, syringes and other injecting equipment usually in exchange for a fee. Also known as Needle Dispensing Machines (NDMs).

BIBLIOGRAPHY

Anex (2008). *Towards a National NSP Strategic Framework: Discussion Paper*, Anex, Melbourne.

Australian Federation of Aids Organisation Inc. (2008). Briefing paper, Hepatitis B.

Australian Injecting and Illicit Drug Users' League (2006). *Peer Education Among Illicit Drug Users*, Australian Injecting and Illicit Drug Users' League, Canberra.

Australian Institute of Health and Welfare (2008). *2007 National Drug Strategy Household Survey: First results.* Drug Statistics Series No. 20 Cat. No. PHE 98, AIHW, Canberra.

Australian National Council on Drugs (2002). *NSPs: position paper,* ANCD, Canberra.

Black, E., Roxburgh, A., Degenhardt, L., Bruno, R., Campbell, G., de Graff, B., Fetherston, J., Kinner, S., Moon, C., Quinn, B., Richardson, M., Sindicich, N. and White, N. (2008). *Australian Drug Trends 2007: Findings from the IDRS*, National Drug and Alcohol Research Centre, Sydney.

Bluthenthal, R., Ridgeway, G., Schell, T. L., Andersen, R., Flynn, N.M. and Kral, A.H. (2007a). "Examination of the association between syringe exchange program (SEP) dispensation policy and SEP service user-level syringe coverage among injection drug users" in *Addiction,* v. 102, no. 4, April 2007: 638 – 646.

Bluthenthal, R., Anderson, R., Flynn, N.M. and Kral, A.H. (2007b). "Higher syringe coverage is associated with lower odds of HIV risk and does not increase unsafe syringe disposal among syringe exchange program service users" in *Drug and Alcohol Dependence*, v. 89, no. 2, July 2007: 214 – 222.

Commonwealth of Australia (2004). *The National Drug Strategy: Australia's Integrated Framework 2004-2009,* Commonwealth of Australia, Canberra.

Commonwealth of Australia (2010a). *The Sixth National HIV Strategy 2010 – 2013*, Commonwealth of Australia, Canberra.

Commonwealth of Australia (2010b). *The Third National Hepatitis C Strategy 2010-2013*, Commonwealth of Australia, Canberra.

Commonwealth of Australia (2010c). *The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2009-2013*. Commonwealth of Australia, Canberra.

Commonwealth of Australia (2010d). *The National Hepatitis B Strategy 2010-2013*, Commonwealth of Australia, Canberra.

Commonwealth of Australia (2008). http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/igcd-lp, Commonwealth of Australia: Canberra, (viewed November 2008).

Consumer Focus Collaboration (2001). *The evidence supporting consumer participation in health*, National Resource Centre for Consumer Participation in Health, Melbourne.

Cook, C. and Kanaef, N. (2008). *Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics*, International Harm Reduction Association, London.

Council of Australian Governments (2008a). *Council of Australian Governments Meeting, Canberra, 29 November 2008,* Australian Government. Available at: http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/docs/communique_20081129.rtf, (viewed 31 March 2009).

Council of Australian Governments (2008b). *National Healthcare Agreement,* Australian Government. Available at: http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/IGA_FFR_ScheduleF_National_Healthcare_Agreement.rtf (viewed 1 April 2009).

Crofts, N., Aitken, C. and Kaldor, J. (1999). "The force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not.", in *Medical Journal of Australia* 1999, 170: 220 – 221.

Dolan, K., MacDonald, M., Silins, E. and Topp, L. (2005). *NSP: A review of the evidence*, Commonwealth Government Department of Health and Ageing, Canberra.

Fowler, D., Spina, A. and Dolan, K. (2006). *NSW NSP Strategic Planning Report* (publisher details unavailable)

Gidding, H., Warlow, M., MacIntyre, C., Bakehouse, J., Gilbert, G., Quinn, H. and McIntyre, P. *The impact of a new universal infant and school based adolescent hepatitis B vaccination program in Australia*. Vaccine 2007

Gowing, L., Proudfoot, H., Henry-Edwards, S. and Teesson, M. (2001). *Evidence Supporting Treatment: the effectiveness of interventions for illicit drug use*, Australian National Council on Drugs, Canberra.

Hagan, H., Thiede, H., Weiss, N.S., Hopkins, S.G., Duchin, J.S. and Alexander, E. R. (2001). "Sharing of drug preparation equipment as a risk factor for hepatitis C" in *American Journal of Public Health* 2001; 91(1): 42 – 46.

Health Outcomes International, National Centre for HIV Epidemiology and Clinical Research and Drummond, M. (2002). *Return on Investment in NSPs in Australia Report,* Commonwealth Department of Health and Ageing, Canberra.

Hepatitis Victoria (2008). *Impact: Information about hepatitis C*, Hepatitis Victoria, Melbourne.

Iversen, J., Deakin, R., and Maher, L. (2008). *Australian NSP Survey: Prevalence of HIV, HCV and injecting and sexual behaviour among injecting drug users at NSPs, National Data Report, 2003-2007*, National Centre in HIV Epidemiology and Clinical Research, Sydney.

Körner H, Treloar C. (2004). 'Needle and syringe programmes in the local media: 'needle anger' versus 'effective education in the community'. *International Journal of Drug Policy.* 15, 46-55.

Maher, L., Jalaludin, B., Chant, K., Jaysuria, R., Sladden, T., Kaldor, J. and Sargent, P. (2006). "Incidence and risk factors for hepatitis C seroconversion in injecting drug users in Australia", *Addiction*, 101, 1499 – 1508.

Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (2006). *Hepatitis C Virus Projections Working Group: Estimates and Projections of the Hepatitis C Virus Epidemic in Australia 2006.* Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis, Hepatitis C Sub-Committee, Canberra.

Moore, T.J. (2005). . Monograph No. 01: What is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia. *DPMP Monograph Series.* Turning Point Alcohol and Drug Centre, Fitzroy.

National Centre in HIV Epidemiology and Clinical Research (2009). *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia 2009.* The University of New South Wales, Sydney.

Parliamentary Joint Committee on the Australian Crime Commission (2007). *Inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs (AOSD) in Australia,* Commonwealth of Australia, Canberra.

Strike, C., Leonard, L., Millson, M., Anstice, S., Berkeley, N., and Medd, E. (2006). *Ontario Needle Exchange Programs: Best Practice Recommendations,* Ontario Needle Exchange Coordinating Committee, Toronto.

Thorpe, L.E., Bailey, S.L., DeZheng, H., Monterroso, E. and Ouellet, L. (2001). "Injection-related risk behaviours in young urban and suburban injection drug users in Chicago 1997-1999" in *Journal of Acquired Immune Deficiency Syndromes,* 2001; 27(1): 71 – 78.

Treloar C, Cao W. (2005). 'Access to harm reduction services and 'hidden' injectors: barriers to NSP use in a high drug use area of Sydney, New South Wales' *International Journal of Drug Policy,* 16: 308–15.

Treloar, C. and Fraser, S. (2007). "Public opinion on NSPs: avoiding assumptions for policy and practice", *Drug and Alcohol Review*, 26:4.

Treloar C, Körner H. (2005). 'NSPs and the media: a case study of balanced and accurate reporting?' [letter] *Australian and New Zealand Journal of Public Health,* 29, 489-490.

United National General Assembly (2001). *Declaration of Commitment on HIV/AIDS*, agreed at the United Nations General Assembly Special Session on HIV/AIDS 25-27 June 2001, United Nations, New York.

Wodak, A. and Cooney, A. (2004). *Evidence for action technical papers: Effectiveness of sterile Needle and Syringe Programming in reducing HIV/AIDS among injecting drug users,* World Health Organization, Geneva.

World Health Organization (1986). Ottawa Charter for Health Promotion, First International Conference on Health Promotion Ottawa 17-21 November, 1986, WHO, Ottawa.

World Health Organization (2004). Evidence for action on HIV/AIDS and injecting drug use: Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission, World Health Organization, Geneva.

World Health Organization (2006). *Constitution of the World Health Organization*, World Health Organization, Geneva.

World Health Organization and Joint United Nations Programme on HIV/AIDS (2007). *Guide to Starting and Managing NSPs*, World Health Organization, Geneva.

APPENDIX A

Development of the Framework

In February 2006 the Anex National NSP Policy and Practice Forum, comprising State and Territory Health Department NSP policy managers and practitioners from each jurisdiction, agreed to the need for a national strategic framework. The Framework would be a means to establish the legitimacy of NSPs and facilitate improved coordination and collaboration at a national level.

In May 2006, the Pharmacy Guild of Australia hosted the first COAG Multilateral Pharmacy Workshop. National and State Health Department and Guild representatives discussed harm reduction initiatives and strategies particularly in relation to NSP service delivery. The development of a National NSP Strategic Framework, which would facilitate national consistency in NSP delivery through Community Pharmacies, was strongly supported by all stakeholders.

It was subsequently agreed between the Commonwealth and jurisdictions that Victoria's Department of Human Services would develop a proposal to manage a National NSP Strategic Framework Project, funded by the Department of Health and Ageing (DoHA), as a project of national significance. The proposal provided to DoHA and approved by the Australian National Council on Drugs (ANCD) outlined the development of a National NSP Strategic Framework that would:

- Represent the formalisation of an existing system of NSP service delivery across the nation;
- Accommodate legislative and programmatic requirements relating to NSP delivery in each State and Territory;
- Address the concerns and expectations of key stakeholders, as confirmed through consultative processes, including those of the Pharmacy Guild, police and peak NSP, HIV, HCV and IDU bodies in each jurisdiction; and
- Be consistent with and support existing jurisdictional NSP policies and guidelines and existing national and jurisdictional drug, HIV, HCV, STI, mental health and indigenous strategies as well as police operating manuals.

The project was overseen by the then Department of Human Services Victoria and undertaken by Anex in association with Professor Steve Allsop (National Drug Research Institute), Professor Lisa Maher (National Centre in HIV Epidemiology and Clinical Research) and Professor Robert Power (Burnet Institute).

A Project Steering Group guided the conduct of this project and its deliverables. The Project Steering Group included representatives from the DoHA, the Pharmacy Guild of Australia, the ANCD, the AIVL, Anex and the Northern Territory, Queensland, New South Wales and Victorian Governments. The Framework has also received contributions from members of the COAG NSP Multilateral Working Group.

This Framework has been informed by a number of research and consultation activities. These activities were:

- A Literature Review;
- A Discussion Paper which was released for comment;
- Consultations with stakeholders;
- Development of a Draft Framework released for comment;
- Feedback received on the Draft; and
- Re-drafting of the Framework.

The literature review included a review of the existing legislation, policy and practice guidelines on NSPs at both national and jurisdictional levels. This review contributed to the development of the Discussion Paper, which identified policy and practice issues that could be included in the Framework.

Consultations on the discussion paper were undertaken via workshops in each jurisdiction with key stakeholders of the Program and a request for written submissions. The Draft Framework was then developed and distributed for comment. Framework has been developed based upon received feedback.