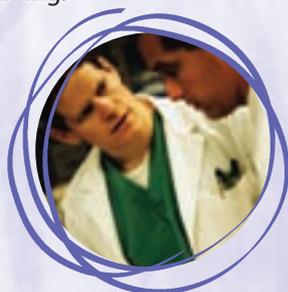




EDUCATION AND TRAINING

- Hepatitis C education is diverse and takes place in many different environments.
- There are numerous strategies and tools available to the hepatitis C educator.
- Schools, Needle and Syringe Programs, pharmacies, custodial and police settings have been identified as key targets for hepatitis C prevention, education and training.
- Community education, through peer networks, plays an important role in targeting hard to reach/isolated groups.
- Specialised services provide education and resource material to meet the cultural/ language needs of specific groups e.g. the Multicultural HIV/AIDS and Hepatitis C Service (MHAHS), Aboriginal and Torres Strait Islander services.



SUMMARY OF IMPORTANT POINTS

- While the above agencies have been selected for specific discussion in this chapter, the educational principles and strategies outlined can be employed in a wide range of settings where informal, peer settings or professional and occupational education takes place. These might include alcohol and other drug agencies, hospitals, community health centres, universities, and peak and professional bodies.

WORKFORCE DEVELOPMENT

ADULT EDUCATION PRINCIPLES

Training and other learning activities in any setting can be enhanced when education programs are interactive, informal, respectful of previous learning and enjoyable. Those with alternative views about complex and controversial aspects of harm reduction can be encouraged to share their views and present their arguments. By making links between theoretical models (e.g. harm minimisation), personal values and attitudes and work practices that reflect these, educators can highlight any discrepancies that may emerge. Often this involves lively debate, clarification of values and possible re-alignment of programs to more effectively meet the needs of participants.

It is also important to allow space for personal stories, and a skilled educator can create learning opportunities using such stories. While it is difficult to ensure confidentiality in some settings, it should be a guiding principle in the practice of education.

The information presented in training materials must include the most recent epidemiological, transmission, prevention and infection control data available, and be presented in language that is easily accessible.

A wide range of hepatitis C resource material is available via the Department of Health and Ageing website, state and territory government websites and the websites of organisations such as the Australian Injecting & Illicit Drug Users League, Hepatitis Australia, local hepatitis councils and on the Hepatitis C Information Clearinghouse website at: <http://theconsortium.nchr.arts.unsw.edu.au/Clearinghouse/search.htm>

REFLECTIVE PRACTICE

Regardless of whether the title 'educator' appears in their job description, most health care workers in the area of hepatitis C are involved in educational processes. However, many of these workers often have limited opportunities to

reflect on their educational aims and practices. Evaluation of the effectiveness of educational outcomes is all too often limited to quantitative measures, such as numbers of people seen, fits (syringes) distributed, events organised or pamphlets produced.

Reflective practice entails re-assessing activities for their underlying values and assumptions, and monitoring their effectiveness and appropriateness. This assessment can take place formally or informally, individually or with co-workers, and can incorporate a range of practices, such as:



- planning days;
- thinking in the car;
- chats over coffee;
- staff meetings;
- de-briefing sessions; and
- actively seeking new resources.

Objectives for reflective practice in the workplace can include:

- assessing how educators think and plan, what experiences they use, what ideas influence them, and how these ideas contribute to educational practice in the area of health and wellbeing;
- evaluating the impact of interactions with consumers and peers, and the uses of de-briefing; and
- managing workloads so that there is time for reflection.

Activities that may enhance collective reflection and can be built into workplace strategies include:

- regular staff meetings;
- documenting and discussing in teams;
- post-project de-briefs;

- considering the theory and principles of peer education practice, and updating this knowledge on a regular basis;
- planning to make room for critical reflection time; and
- national, state and territory workshops, where workers who provide education have the opportunity to meet with others working in the field.



EDUCATION OF HEALTH AND COMMUNITY WORKERS

In today's evolving workforce, learning and working are inextricably linked. Learning strategies which integrate individual learning needs, work-based activities, organisational structures and professional partnerships can produce more dynamic and sustainable learning outcomes. This comprehensive and responsive approach to learning has the capacity to build a skilled, knowledgeable and adaptable workforce.

There is a broad range of activities and structures that support learning, program development and workplace systems. Many of these can easily be taken for granted or not appreciated as significant opportunities where valuable learning can occur. For example, routine team meetings, unit changeovers or scheduled de-briefing sessions are common in health workplaces. These can be opportunities for information exchange and discussion about people's needs, workers' existing skills and knowledge, case management and referral options, brief intervention strategies, internal operating systems, critical incidents and new resources. Site visits to referring agencies can also be organised as a strategy to improve workers' knowledge of other local services and programs, and as a means of developing and improving partnerships with others.

The *National Hepatitis C Strategy 2005–2008* is guided by the following specific principles:

- developing partnerships and involving affected communities;
- social determinants model of ill health and equity of access to services;

- harm minimisation and harm reduction;
- involvement of people with or at risk of hepatitis C; and
- implementation underpinned by evidence.

These components also serve as useful tools to guide workforce learning activities and the development of hepatitis C-related programs. A skilled, knowledgeable and adaptable workforce embraces a broad view of how, where and when effective workplace learning can occur.

EDUCATION OF NEEDLE AND SYRINGE PROGRAM WORKFORCE

Of all Australian health care workers, NSP workers have contact with the largest populations of people who inject drugs. Throughout Australia there are over 3,000 NSP sites. The NSP delivers over 33 million units of injecting equipment each year to injecting drug users. Because of this front-line contact, NSP workers have a unique opportunity to play a key role in the prevention of hepatitis C transmission.

The success of NSPs in averting an epidemic of HIV among people who injected drugs has been well-documented. The prime strategy of HIV prevention for this population was to make sterile injecting equipment available. This coupled with a simple education intervention about the non-sharing of contaminated injecting equipment was sufficient to significantly reduce the number of HIV transmissions.

The availability of sterile needles and syringes through NSPs is a key component of hepatitis C prevention, and there are indications that sterile needles and syringes are being used more frequently than ever before for each injecting occasion. However the impact of NSPs on lowering hepatitis C transmission rates has not been as significant as in the prevention of HIV. This has been attributed to a range of factors including:

- the highly infectious nature of hepatitis C which means that each separate step of the injecting process and each piece of equipment used needs to be considered as a potential source for transmission of the hepatitis C virus;
- there was an existing pool of people infected before the virus was identified in 1989; and

- many infected people are not aware of their hepatitis C status, are asymptomatic for longer periods, and may unknowingly put others at risk of infection during this time.

The implication for NSP workers, when educating their clients, is the need to focus on the high infectivity of the hepatitis C virus, the complex nature of hepatitis C transmission and the need to be blood aware and to adopt harm reduction behaviours, in particular safer injecting practices.

To educate effectively, NSP workers need:

- access to referral information;
- skills and knowledge to impart personalised safer using information;
- to be supported by a structure or organisation that enables adequate time to be spent with clients;
- to have private and confidential settings where sensitive information may be discussed; and
- to have communication skills which enable effective interaction with clients from a variety of backgrounds.

Training programs for NSP workers also need to take into account existing differences between individual workers such as:

- skill levels;
- personal, educational and occupational backgrounds;
- amount of time spent delivering NSP services;
- size of NSP client population; and
- level of commitment to providing services for people who inject drugs.

In addition, there are differing levels of support for NSPs from state or local jurisdictions, and differences in the status of services, e.g. primary or secondary.

Primary NSPs are funded to provide specialist education and prevention programs to people who inject drugs, and are often stand-alone agencies. Secondary NSPs are located under the auspice of another agency, such as a community health centre or hospital, and their capacity to deliver services is

often limited to the basic provision of injecting equipment, due to competition with other health service demands.

Given these issues, NSP workers have had difficulty in accessing appropriate training and professional development relative to their divergent needs and responsibilities. However, there are accredited training programs available for NSP staff. As well, some important Commonwealth-funded initiatives continue to provide NSP workers with useful resource material, including:

- the *National Hepatitis C Resource Manual, 2nd Edition*;
- the booklet *NSPs: Needle & Syringe Programs: Your questions answered; A Review of the Evidence*. This can be ordered by free call (1800 020 103) or online at www.health.gov.au;
- the *National Needle and Syringe Program (NSP) Workers' Training Package and Manual*;
- the *National Amphetamine Training Package* which provides appropriate training for NSP and other staff within environments where contact with amphetamine users occurs; and
- an email discussion (NPSFORUM) list is hosted by the Association for Prevention and Harm Reduction Programs Australia Inc. (Anex) to facilitate discussion and information sharing on NSP-related issues. To subscribe to NPSFORUM, email npsforum@anex.org.au with the subject heading "subscribe".

The NSP worker sector is diverse with a range of peak bodies and drug user organisations fulfilling the education, support and advocacy role, such as Anex, Australian Injecting & Illicit Drug Users League, Hepatitis Australia, hepatitis councils, Australian Federation of AIDS Organisations and pharmacy peak bodies.

EDUCATION OF CUSTODIAL WORKFORCE

Custodial staff and those responsible for the management of a custodial setting, should be given every opportunity to understand the nature of the hepatitis C virus, its epidemiology, transmission and prevention; the management and treatment of the disease; and be made aware of the practical on-the-job consequences and requirements of working with a population which has a high

hepatitis C prevalence. Staff need to have access to regular updated training which provides insight into hepatitis C infection and the affected community. New staff should receive education about all aspects of hepatitis C as part of their induction and on-the-job training programs, including 'lock-down' training.

While each custodial facility will have to develop resources and delivery strategies specific to their institution, there are considerable resources in the community which can be drawn on to facilitate this. Linkages with community-based agencies and professional organisations will assist these collaborative strategies. The socio-demographics of the custodial population may influence the type of information required. Training must include, but not be limited to, infection control and harm minimisation strategies. Each institution needs to have in place appropriate infection control procedures. Staff education and training about infection control measures in relation to blood-borne viruses should be an integral part of the proper application of these procedures. Education of custodial staff will assist correctional authorities in meeting their occupational health and safety obligations to their employees, contractors and others in the workplace. Training should address personal and community attitudes and values.

HOW IS EDUCATION BEST DELIVERED IN THE CUSTODIAL SETTING?

Correctional services differ in all states and territories and differences in the custodial system are created through institutional security classifications and hierarchies. Organisational arrangements can also differ: custodial settings are managed by state governments and in some instances, by private operators. Some correctional health services are part of general health services (as in NSW), or they may be part of corrective services (as in Queensland). Health care provision in custodial settings also differs between each state and territory. In addition, custodial staff and people in custody do not form homogeneous groups. Educational strategies must acknowledge and respond to these differences. Individual factors such as sex, age, Indigenous status, ethnicity, possible pre-conceptions about injecting drug use, literacy, ideological beliefs and previous educational opportunities must be taken into consideration by educators when planning sessions.

WHEN AND TO WHOM IS BLOOD-BORNE VIRUS EDUCATION TARGETED IN CUSTODIAL SETTINGS?

Peer educators:

- during initial peer supporter training; and
- periodically thereafter.

Peer educators in custodial settings are people respected by both staff and inmates who volunteer to help other inmates stay safe and well. They receive some training and have access to staff support and debriefing. Peer education and support does not occur in all jurisdictions, and problems can be encountered when inmates are transferred or released, and when there are changes in the staff dedicated to supporting these programs. Additional problems may also occur due to the lack of confidentiality within such settings or if the peer educators are in a position of authority, therefore placing them outside the group.

Educators working for hepatitis councils and peer-based drug user organisations are encouraged to take part in advanced training of peer educators or provide the training themselves in custodial settings. Peer educators/supporters should be encouraged to employ peer education principles (see above section) to enable them to better support their peers.

Custodial health care providers:

- during induction; and
- periodically, throughout their careers.

Regular on-site information updates can be organised from within the custodial service, or can involve an outside provider e.g. hepatitis councils.

There should be a formal mechanism in place for the distribution of current medical, nursing and public health journal articles. In addition, it is recommended that health care providers be given opportunities to attend conferences and off-site health promotion workshops with general community colleagues.

Other custodial staff and correctional administrators:

- during induction training.
- periodically throughout their careers.

Peer education is also considered useful for these groups. Officers who are able to provide training for their peers can provide an effective way to deliver training.

EDUCATION OF POLICE WORKFORCE

In all Australian states and territories, the police, in collaboration with service providers and governments, are increasingly involved in harm reduction, diversion and cautioning strategies that aim to: reduce police presence around NSPs; improve access to sterile injecting equipment for people who inject drugs; reduce the number of injecting drug users held in custody; and improve their access to drug treatments.

Police interactions with drug users are no longer solely based on law enforcement, and the police can play an important role in health promotion, including hepatitis C prevention. An understanding of the individual, structural and cultural influences that shape police attitudes and interactions with people who inject drugs is a crucial part of a comprehensive public health response to hepatitis C-related issues.

In the course of their normal duties, operational police come into physical contact with people who inject drugs and this can bring with it the potential risk of hepatitis C and other blood-borne virus transmission. While the national number of blood-borne virus transmissions via needlestick injury, blood or other body fluid contact is not known, there is a real and ongoing risk of transmission for police officers.

A 1998 research study on stigma and discrimination against People Living with HIV/AIDS (PLWHA), suggests that the more contact people have with any specific group, the less likely it is that they will harbour discriminatory attitudes towards them.

Changes in attitudes and practices do not come about overnight. A significant investment has been made in training operational police in the health and welfare issues of people who use alcohol and other drugs. This training occurs at a number of levels, involving recruit, probationary constable, sub-officer and officer levels, and includes blood-borne virus information and education about related issues.

As part of the comprehensive training process, it is beneficial for police to receive education about harm minimisation and harm reduction, and for officers to have contact with people who use drugs in order that they can understand the social and personal issues involved in drug use. One way in which this can be achieved is for police officers to hear a presentation from drug user organisations about the social and political issues that confront them.

Other constructive strategies that have been implemented in a number of jurisdictions include:

- guidelines for police operating around NSPs in some state and territories;
- the identification of individual police as community liaison officers in areas where drug dealing and injecting are common;
- the establishment of close working relations between NSP managers and police; and
- joint education programs for the police and local workers, such as NSP staff, alcohol and other drug workers, people who use drugs and local government personnel.

The national commitment to hepatitis C prevention will be substantially strengthened by ensuring that all Australian police personnel have access to hepatitis C-related education and training.

EDUCATION AND TRAINING FOR OTHER SERVICE PROVIDERS

Hepatitis C education and training is included in a number of professional programs, sometimes at the undergraduate and post-graduate levels and sometimes in professional development programs. In some Australian states and territories, hepatitis C and other blood-borne viruses (usually HIV) are the

subject of training programs specifically developed for general practitioners, counsellors, nurses, community health workers and volunteer carers. These programs are not consistent across jurisdictions. Check with your local health department for more information.

Non-Government peak organisations provide a wide range of education programs and resource material for health care professionals. These include: the Gastroenterological Society of Australia (GESA); the Australian Liver Association (ALA), the Australasian Society for HIV Medicine (ASHM), Anex, Hepatitis Australia, AVIL, the Haemophilia Foundation, the Australasian Hepatology Association and the Royal College of Nursing.

It is recommended that health care workers and health educators check with their state or territory health department, hepatitis council, peer-based organisation and relevant peak or professional bodies for up-to-date information on available training programs on hepatitis C and other blood-borne viruses.



HEPATITIS C EDUCATION IN THE COMMUNITY

PEER EDUCATION

Definition of a Peer

A peer is 'one who is the equal of another in rank or merit'. There is some debate about what or who constitutes a peer in relation to people with hepatitis C. Because of people's diverse backgrounds and beliefs, it is possibly a question without a definitive answer. In practice, the important thing is that those involved in the education process regard each other as peers. Peer educators may have had direct experience of injecting drug use and an understanding of drug-using practices and cultures. In other peer-based programs, a 'peer' may be defined as an individual who has experience of living with hepatitis C. They are well-placed to give information about reducing the risk of hepatitis C transmission and other drug-related harms.

Key Principles of the Peer Education Process

Peer education is based on the principles of **community development**, and is usually facilitated from within the peer group. Peer education processes use an empowerment model of community development, and work with the culture of the group to encourage a bottom-up approach to decision making and responsibility. Ownership of the learning process belongs to the group and is self-directed, which is fundamental to bringing about sustainable change among sub-cultures and their networks.

To be a useful and legitimate educational practice, peer education should include key principles, including:

- respect for the existing knowledge, skills and experience that people have;
- enabling people to define their own issues and develop their own solutions rather than giving pre-determined messages;
- recognition of the importance of the situation and cultural context, which may be unique to each network;
- provision of accessible and appropriate information;
- support for information-sharing in the context of continually evolving networks of people;
- delegation of power and responsibility for decision-making to the group involved, rather than placing peer educators (or project managers) in a position of authority and therefore outside the group;
- educational strategies that equally value the processes of learning; self-defined skills development, capacity-building, empowerment and participation;
- strategies that incorporate a process of learning that is owned by those who are learning, including ownership of budget, reporting and other group processes; and
- recognition that for maximum effect on risk behaviours, explicit language and images are warranted for effective communication which can also be culturally relevant and require targeted distribution.

Peer education is a crucial approach in preventing hepatitis C transmission, in maintaining the health of people with hepatitis C and in enabling communities as a whole to participate in their own health care.

Currently, peer education is a popular term applied to a range of projects within peer-based drug user and other organisations. The term 'peer education' is often poorly understood and is applied inappropriately to many initiatives. If an educational activity is not underpinned by the principles listed above, it is more accurately classified as education or information provision rather than peer education.

EDUCATION TARGETING SPECIFIC COMMUNITY GROUPS

EDUCATION FOR PEOPLE WHO INJECT DRUGS

For a variety of reasons, traditional forms of education and health promotion have not been particularly effective when working with people who inject drugs. However, peer education has been shown to be an effective educational approach to increase knowledge about hepatitis C, encourage people to maintain health, and to prevent further transmission of hepatitis C. It can also effectively encourage a change in behaviour.

Peer education for people who inject drugs must be flexible and can be implemented in a number of different situations, including:

- workshops facilitated by peer educators;
- services that provide for people who use drugs, such as NSPs, where a peer educator can be based; this is known as 'opportunistic' peer education;
- conversations in the dealing, scoring and injecting environments;
- development and distribution of peer-based education resources (e.g. pamphlets, magazines); and

- formal peer education projects, usually located in an agency that has ongoing access to people who use drugs and their networks.

One example of peer education in practice is the series of Tribes projects, facilitated by the New South Wales Users & AIDS Association (NUAA). The projects aim to use relevant language, images, information and media as a peer-based educational resource for subcultures of people who inject drugs, with the primary aim of relaying information and encouraging debate about harm reduction and blood-borne virus issues. Projects have included the development of videos, pamphlets, murals and stickers.

EDUCATION IN SCHOOLS

Schools play a critical role in hepatitis C education and prevention. Informing young people about blood-borne virus issues is regarded as a primary public health responsibility. Approximately 2% of young people in schools have ever injected drugs. Hepatitis C prevalence among young people who participated in the 2002–2006 Australian NSP survey has remained relatively stable over the period 2002 to 2006. Rates for 2006 were 17% for people under 20 and 48% for the 20–24 year age group. The survey also reported that the median age of first drug injection has remained stable at 18 years between 2002 and 2006. This means that inexperienced young people are likely to be initiated into drug use by other inexperienced people who inject. *Refer to the NSP Survey Report. See References Section in Resources.*

Teachers have access to large populations of young people and are regarded by both parents and students as appropriate people to conduct hepatitis C education. Hepatitis C prevention education can be effectively taught by schools who are not afraid to tackle sensitive and contentious issues, and who work within the social realities of young people's lives (which may include testing of boundaries and risk-taking) to provide practical harm reduction messages. Additionally, blood awareness and liver health programs can be used in settings where a direct focus on specific injecting drug use issues is thought to be too sensitive.

The resource, *Hepatitis C + Body Art – Educators’ kit for secondary schools* (Hepatitis C Council of Victoria) notes that “While most young people have a reasonable grasp of HIV transmission and prevention, relatively few have even a basic understanding of the different hepatitis viruses. There is limited information on hepatitis available in the school environment for students. There is also a lack of consensus on how best to educate young people about hepatitis.” According to the 2002 Secondary School Students and Sexual Health Survey, a significant minority of young people are uncertain as to whether they have been vaccinated against hepatitis A and B, which is consistent with the finding of poor knowledge about hepatitis generally. About a quarter of all students mistakenly believed they had been vaccinated against hepatitis C.

Curriculum guidelines vary around Australia and the amount of education teenagers receive about hepatitis C differs between jurisdictions. In 1999, *Talking Sexual Health: National Framework for Education about STIs, HIV/AIDS and Blood-borne Viruses in Secondary Schools* was developed as a curriculum package, aimed at prevention of HIV/AIDS and other STIs, for use in high schools. The package is utilised in many jurisdictions and has informed the development of other school-based sexual health programs and materials.

The National Centre in HIV Social Research publication “*Hepatitis and Health*” (2001) considered the development of a framework and appropriate teaching/learning materials for the inclusion of hepatitis education within high school programs. This report concludes that education about hepatitis C needs to be addressed in the context of drug education and a blood-borne infections model, rather than within a sexually transmissible infections model.

As approved school curricula differ between jurisdictions and between public and private schools within the same jurisdictions, there is no nationally consistent educational program. For example, NSW has required a 25-hour course in personal development and health education over Years 11–12 with an emphasis on drug and HIV/AIDS education issues. However, within this course each school may select content which best suits the needs of their students. The NSW resource *Hepatitis – Promoting Understanding Through Education* provides staff development material and teaching and learning activities about hepatitis A, B and C for use within secondary Personal Development, Health and Physical Education programs.

Hepatitis C information is not being routinely communicated in school programs for a number of reasons including:

- Teachers have many competing priorities for their time and a wide range of topics from which they can choose to cover as part of the personal development curriculum. In an environment of crowded curricula and timetables and lack of preparation teachers may choose to tackle issues other than hepatitis C.
- Teachers may not be specifically trained or have the capacity or be given the authority to educate students on risks related to hepatitis C and address any contentious issues this topic may generate. They may not feel comfortable in responding to questions which may arise in relation to injecting drug use (which is possible even if the program does not mention the risks of injecting drugs).
- Education about hepatitis C may not be considered to be relevant to the school's needs and teachers may lack the support of the school administration or parents' and citizens' group.
- School drug education is often broad-based, covering both licit and illicit drugs. Although the topics of blood awareness and hepatitis C are relevant to its harm minimisation framework, they are not specifically included in the *National School Drug Education Strategy, 1999*.
- Historically, hepatitis C and blood-borne viruses (such as hepatitis B that can be sexually transmissible), have been added onto the HIV/AIDS and STIs agenda. This has occurred for both political and educational purposes, but not necessarily with equal weighting.

There are several major lessons from HIV prevention education in schools that are relevant to hepatitis C prevention education, including:

- explaining and promoting the harm reduction framework;
- helping students develop an understanding of community values and opinions, and the effect of these on their own efforts to construct a personal ethic; and
- acknowledging that behaviours, including risk behaviours, are shaped by students' individual and personal values and beliefs.

Hepatitis C education in schools needs to be placed in the broader context of personal health choices which examines the process of making lifestyle decisions and putting them into practice. This framework considers the personal health decisions that students make about their lives relating to nutrition, hygiene, consumerism, drug use, the environment and disease prevention.

A whole-school approach has been shown to be most effective in bringing about behaviour change in areas of health and wellbeing. In relation to hepatitis C prevention, this involves the development and implementation of policies relating to:

- the confidentiality and prevention of discrimination for anyone living with a disease;
- teaching students how to be blood aware; and
- adopting standard infection control procedures in all situations where blood is present.

It is also important to consider broader education opportunities for young people who are not attending or have completed school.

EDUCATION IN CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES

People born in countries of high hepatitis C prevalence now living in Australia may have been infected in their country of birth through unsterile medical, dental or vaccination programs and other health care and traditional practices involving blood-to-blood contact. Unsafe injecting practices among injecting drug users from CALD communities account for some cases of hepatitis C transmission, with several studies finding very high levels of hepatitis C among CALD injecting drug users, particularly people from South East Asian backgrounds.

Furthermore, people born in high prevalence countries often acquire hepatitis C at a young age and may not be aware of their hepatitis C status until later in life, which may result in late presentation to health services and possibly higher risk of developing serious liver disease such as cirrhosis and/or hepatocellular carcinoma.

Considerations when working with CALD communities

Educators involved in providing hepatitis C training and support to people from CALD communities and/or workers involved with CALD communities need to be aware of the challenges and unique experiences of their audience. Developing and maintaining partnerships with CALD organisations will assist educators to gain an understanding of the needs of communities and provide access to culturally appropriate services, referral points and resources.

The benefits of interpreters

It is important that educators promote the use of interpreters, especially when people are receiving detailed health information or new diagnoses. A national telephone interpreting service can be used where health care interpreters are not available. Individuals can use the Translating and Interpreting Service by calling 131 450 from anywhere in Australia for the cost of a local call. Private medical practitioners can access telephone interpreting with their patients at no cost by calling 1300 131 450.

Culturally-appropriate and language specific hepatitis C information

Educational resources need to be produced in community languages and plain English and need to be focus tested with members of the relevant community to assess the cultural appropriateness of the resource. Even if individuals speak English, they may feel more literate and comfortable reading or hearing information in their first language.

Educators need to identify resources that are produced in community languages and have been developed “in-language” in contrast to resources that are directly translated from an English format that was aimed at the Anglo-Celtic population of injecting drug users. Educators need to be aware of resources that have been developed in-language and promote them. For more information see the Hepatitis Australia Educators Website at www.hepedu.org.au. Resource material in a range of languages is available via state and territory government websites and from the Multicultural HIV/AIDS and Hepatitis C Service website at www.multiculturalhivhepc.net.au .

EDUCATION IN ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES WHERE PEOPLE ENGAGE IN RISK BEHAVIOURS

Hepatitis C in Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are particularly vulnerable to hepatitis C due to lack of access to needle and syringe programs (NSPs) and over representation in the correctional system. Many Aboriginal people have limited access to NSPs because there are fewer NSPs in rural areas where many Aboriginal people live and the costs associated with travelling and buying equipment from pharmacies and other locations is prohibitive. Lack of access to NSPs has a significant impact on hepatitis C prevention efforts in Aboriginal communities. Imprisonment has been identified as an independent risk factor for hepatitis C transmission. Aboriginal and Torres Strait Islander people are 10 times more likely to be incarcerated than non-Aboriginal Australians and constitute 27% of the total prison population.

Considerations when working with Aboriginal and Torres Strait Islander people

Hepatitis C education programs need to be offered in partnership with Aboriginal and Torres Strait Islander health services and communities to create working environments that encourage Aboriginal and Torres Strait Islander people to contribute to educational programs and policies and facilitate control over the development and implementation of the projects. Aboriginal communities are not heterogeneous. Therefore, partnerships with Aboriginal and Torres Strait Islander organisations will assist in providing hepatitis C educators with guidance and support to address the cultural, community-specific and educational considerations when working with Aboriginal and Torres Strait Islander people.

The Aboriginal and Torres Strait Islander community's approach toward illicit drug use

Aboriginal and Torres Strait Islander people who inject drugs may experience disapproval and social marginalisation within their own communities, which may lead to reluctance to access preventive services such as NSPs. Access to

NSPs is limited in Aboriginal communities. Improving access to NSPs is a priority of the *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005–2008* because access to harm reduction measures will greatly impact on hepatitis C transmission. For more information, see the Hepatitis Australia Educators Website at: www.hepedu.org.au or go to www.healthinfolnet.ecu.edu.au/.

EDUCATION IN CUSTODIAL SETTINGS

Preventing the transmission of hepatitis C among people in custodial settings continues to be one of the most urgent public health issues for correctional administrators, custodial staff, prison inmates, health care providers and for politicians. Education of inmates about the prevention and management of hepatitis C, including treatment, is a fundamental, necessary and effective preventive intervention.

In general terms, Australia adheres to the principle that people in custody are entitled to the same standard of health care as citizens in the general community. Not all members of the community share this view. Some consider that people in custody are less deserving of equivalent standards of health care, while others have difficulty with the concept of health promotion and its implementation in the custodial setting.

In order to constructively address the challenges posed in custodial settings by hepatitis C, it should be noted that:

- individuals are incarcerated as punishment, not for additional punishment. People in custodial settings are entitled to health care of a standard equivalent to that of the community as a whole; and
- because the average length of a prison sentence in Australia is approximately 3 months, many prisoners return to the wider community after short periods of time. Consequently, health gains within custodial centres translate into health gains for the wider community. Similarly, adverse health outcomes in custody become health problems for the wider community.

Until the health issues of people in custody who were also living with HIV began to have an impact on occupational cultures and health care provision, little

research had been conducted into the health needs of this group. Research now shows us that three main themes are emerging in this area:

- the health status of people living in custody is generally lower than that of the wider community;
- there are high rates of physical and mental health disorders among the custodial population; and
- social and economic disadvantage is identified as the major cause of ill health for people in custody.

Ill health among this population has been observed in the areas of mental health, substance use and communicable diseases. Examples of co-infection (e.g. with hepatitis B or HIV) and infection with hepatitis C together with other health conditions (e.g. mental health problems) have also been observed.

HEPATITIS C PREVENTION IN CUSTODIAL SETTINGS

An effective program of hepatitis C prevention education in custodial settings may include:

- pre-course assessment and analysis of training and education needs;
- natural history of hepatitis C;
- modes of transmission especially in the prison setting;
- strategies to reduce/minimise harm that can be practically applied within the prison setting;
- recommendations for cleaning equipment used in injecting, tattooing and piercing;
- international, national and state custody hepatitis C epidemiology (i.e. prevalence and incidence rates);
- information on transmission myths and realities;
- current information on standard precautions;
- blood and body fluids protocols;

- post-occupational blood-borne virus exposure risk assessment;
- a comprehensive testing policy;
- a comprehensive policy on the provision of pharmacotherapies;
- correctional policies regarding ethical behaviour, including non-discriminatory practice and confidentiality;
- information on differential sanctions in regard to the possession of different categories of drugs (as an example: cannabis is detected in urine for much longer than heroin. The absence of differential sanctions may inadvertently encourage a switch from smoking cannabis to injecting heroin, with an increase in overall harm);
- hepatitis A and B vaccinations;
- hepatitis C treatment, care and support options;
- acknowledging and challenging the institutionalised attitudes that stigmatise inmates, and can also marginalise empathetic staff;
- a permanent record of training undertaken;
- information on opportunities for health monitoring and treatment, including post-release; and
- post-training evaluation of risk prevention competencies, potential behavioural change and subjective feedback.

Collaboration with existing services in the community, particularly those provided by peer-based organisations, will allow the translation of community strategies into custodial settings and tailoring of programs for high-priority groups such as the Aboriginal and Torres Strait Islanders or CALD populations. Cooperative development of education programs and resources between custodial staff and peer educators maximises their success.

INJECTING DRUG USE, CORRECTIONAL SETTINGS AND HEPATITIS C

There is no national surveillance system for hepatitis C in correctional facilities. However a number of studies have shown that the prevalence rate is many times higher than hepatitis C prevalence in the general community which is estimated at approximately 1%.

Thousands of people who inject illicit drugs are incarcerated each year. Many inmates are drug dependent, regardless of whether they were incarcerated for drug-related crimes or not. *The National Prison Entrants' Blood Borne Virus Survey: National Report 2005* found that 59% of prison entrants screened had a history of injecting drugs and that the hepatitis C prevalence for entrants with a history of injecting drug use was 54% among men and 83% among women. Similar rates of hepatitis C antibody prevalence were found between Aboriginal and Torres Strait Islander (37%) and non-Aboriginal (34%) respondents. Thirty six percent (36%) of all prison entrants reported they had never previously been tested for hepatitis C antibody (17% among injecting drug users). These figures highlight both the increased prevalence and therefore risk of transmission within these settings and the importance of providing inmates with comprehensive blood-borne virus education and the means for preventing further transmission of hepatitis C.

There is an overrepresentation of Aboriginal and Torres Strait Islander people in custodial settings (including in juvenile detention settings). On a per capita basis Aboriginal and Torres Strait Islander Australians have an incarceration rate which is 10 times higher than non-Aboriginal Australians. This has raised questions about the most effective way to educate this 'captive' audience.

People in custody need information about hepatitis C transmission, treatment and management so that they can assess risk and make informed decisions about protection, testing and counselling. However, public health practitioners working in correctional settings suggest that while education is essential, it is not in itself sufficient to prevent the further transmission of hepatitis C.

People in custody need access to the same harm reduction strategies that are available to the wider community. In the custodial setting this means having reliable access to:

- methadone maintenance programs or other pharmacotherapies;
- bleach; and
- current, appropriate information.

Injecting drug use in custody occurs less frequently than in the general community, but given that injecting equipment is currently banned within and consequently scarce in all Australian custodial settings, needles, syringes and other equipment are shared more often than in the general community. To avoid detection and punishment, injecting is usually performed in secret and in haste, and because of pervasive surveillance, there is little incentive or opportunity to clean the equipment. The equipment used for injecting and tattooing is often improvised. Given these circumstances, the overall risks associated with injecting drug use are greater in correctional centres than in the wider community.

An important part of prison culture is not to 'dog' on another inmate, i.e. report them to the authorities. This may limit the willingness of people to call for assistance from staff when their peers suffer an accidental drug overdose. For these reasons people in custody often inject alone, and this increases the chance of accidental overdose.

RISK BEHAVIOURS FOR HEPATITIS C TRANSMISSION IN CUSTODIAL SETTINGS

With the higher prevalence of hepatitis C and the higher incidence of violent behaviour in custodial settings, the following risk behaviours, some of which are features of prison culture, have been identified:

- sharing and re-using injecting equipment including needles and syringes;
- tattooing, body piercing and other skin penetration practices without appropriate infection control;
- accidental needlestick injuries;
- injury and self harm, fighting and assaults (including sexual assaults);

- sporting activities and injuries;
- barbering without appropriate infection control; and
- sharing of personal grooming implements such as razors and toothbrushes.

WHEN AND TO WHOM IS BLOOD-BORNE VIRUS EDUCATION TARGETED IN CUSTODIAL SETTINGS?

The provision of health education is a fundamental strategy in the prevention of transmission of blood-borne diseases. In custodial settings, education is targeted to the following groups:

People in custody:

- generally at reception/remand centres;
- on admission to a new correctional institution; and
- when progressing through the correctional system..

TESTING POLICIES IN CUSTODIAL SETTINGS

Voluntary testing for hepatitis C is available for inmates in all states, apart from the Northern Territory where testing is mandatory on entry, in accordance with the *National Hepatitis C Testing Policy* which provides the framework for testing for hepatitis C in Australia, including within correctional services. See *Chapter 4: Hepatitis C Testing* and the Educators Website at Hepatitis Australia: www.hepedu.org.au.



THE ROLE OF PHARMACIES IN THE PREVENTION AND MANAGEMENT OF HEPATITIS C

Pharmacists and their staff are some of the most frequently contacted of all Australia's community health workers and have an appreciable impact on health care in Australia. Each man, woman and child visits a community pharmacy on average fourteen times each year in metropolitan, rural and remote, hospital and Aboriginal and Torres Strait Islander community settings. That is over 280 million occasions each year in which pharmacists are able to provide opportunistic professional advice. (Unpublished Guild Digest Data 2003).

The pharmacy profession has experienced major changes in the past 50 years. The advent of modern pharmaceuticals and pre-packaged products has seen pharmacists come out from the dispensary to the service counter where they have greater contact with their customers. They provide information, advice and counselling, which is often supported by take-home printed materials.

Pharmacies have the opportunity to play a key role in the prevention and management of hepatitis C by providing the following:

- specific illicit drug-related services such as Needle and Syringe Programs and pharmacotherapy programs;
- sale of needles, syringes and other safer injecting equipment;
- information and advice on general physical and mental health;
- information on hepatitis C transmission, including injecting drug use;
- referrals to treatment and counselling;
- information to families and friends of people who inject drugs; and
- medication management and review.

PHARMACIES AND INJECTING DRUG USE

Pharmacists and their staff are often the first point of contact for people who use drugs and can play a key role in providing education about reducing harm. They are in a unique position to provide and implement preventive health and medication management services to this client group.

Since the introduction of Needle and Syringe Programs in 1985, some pharmacies have played an important role in these programs with the provision of methadone, information, advice and referral. Many pharmacies also act as retail outlets for injecting equipment, and some offer disposal services for used injecting equipment. However, there are pharmacists who, in the absence of sufficient resources and training, remain reluctant to participate in preventive initiatives such as the provision of needles and syringes. There remains considerable scope to improve pharmacy services through developing more effective relationships between pharmacy staff and people who inject drugs, and local NSPs.

In 2002, the Australian Government Department of Health and Ageing commissioned a joint project between the Pharmaceutical Society of Australia (PSA) and the Pharmacy Guild of Australia (PGA) to develop and implement a series of nationally consistent education and training programs. The programs are designed for pharmacists and their staff who come into contact with people who inject drugs and illicit drug issues. They provide:

- education, training and support to pharmacists and their staff in relation to illicit drug issues and Needle and Syringe Programs;
- appropriate resources on injecting drug use for pharmacy staff to distribute to their customers, including Pharmacy Self Care Cards on Drug Overdose, Methadone and Safer Injecting Practices;
- improved access to counselling, referral and treatment options for people who inject drugs;
- training information from advocacy organisations as a way of breaking down the barriers and reducing discrimination; and
- a mechanism to reduce the risk of transmission of hepatitis C through injecting drug use.



COMMONLY ASKED QUESTIONS



I AM AN NSP WORKER, AND I AM WORRIED ABOUT CONTRACTING HEPATITIS C. WHAT CAN I DO?



You should not come into personal contact with any used items of injecting equipment. Your NSP will have protocols and guidelines detailing how to handle used needles and syringes and items of injecting equipment. You need to be very familiar with these, and with the infection control guidelines appropriate for your workplace. Talk with other staff that are more experienced and less anxious. More information on drug-related issues can be obtained from organisations such as Anex, peer-based drug user organisations or the hepatitis council in your state or territory.



WHAT TRAINING TAKES PLACE FOR PEOPLE IN CUSTODY AROUND BLOOD-BORNE VIRUS ISSUES?



This varies greatly in each state and territory. Check with your hepatitis council or drug user organisation, some of whom employ educators dedicated to correctional service programs, and with the health department and corrections office for details of current programs and initiatives.



I'M INVOLVED IN PROVIDING HEPATITIS C EDUCATION WITH PEOPLE WHO USE DRUGS. DOES THIS MAKE ME A PEER?



Some people believe a peer is a person who shares a detailed understanding of the culture of a group, while others believe that personal experience is the only true credential for being a peer. In practice, however, the important thing is that you are regarded as a peer, and are trusted by the people with whom you work as an educator.

Q I AM A RELATIVELY NEW WORKER IN AN OUTER URBAN SECONDARY NSP, AND I'M INTERESTED IN STRENGTHENING THE PROGRAM'S LINKS WITH THE COMMUNITY. WHAT ARE THE POSSIBILITIES?

A Community development principles may be useful to guide your thinking. First talk with your program manager and fellow workers, and with Anex and together decide how best to make contact with key people in the local community, such as your auspicing agency, the local government Environmental Health Officer, youth leaders, a drug user organisation advocate, pharmacists, GPs and a police representative. You might form a group that meets to discuss NSP-related issues that involve the whole community. Such groups can become self-directed and creative in their ideas for strengthening community links.

Q IF NSPS MAKE NEEDLES AND SYRINGES AVAILABLE FREE TO ANYONE WHO COMES IN, SURELY THEY ENCOURAGE INJECTING DRUG USE?

A Injecting drug use is a part of our society, and is not the consequence of free needles and syringes, any more than readily obtainable beer glasses encourage the consumption of alcohol. NSPs are public health initiatives which aim to reduce the transmission of blood-borne viruses and drug-related harms for people who inject drugs and for the wider community.