

***BUILDING RESPONSES TO  
BLOOD-BORNE VIRUS INFECTION  
AMONG KOORIS USING  
INJECTING DRUGS –  
IMPROVING THE LINK BETWEEN  
POLICY AND SERVICE DELIVERY***

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# **Victorian Aboriginal Health Service Co-operative Ltd**

The Victorian Aboriginal Health Service Co-operative Ltd (VAHS) was established in 1973 in response to the need for appropriate and accessible health care for Aboriginal people in Melbourne. The programs available at the VAHS have developed and expanded, and in 1992 the service moved to a purpose-built building in its present location at 186 Nicholson Street, Fitzroy. The VAHS is a registered co-operative controlled by a Board of Aboriginal Directors elected by the Koori community. It is a member of the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

The central philosophy of the VAHS is to provide comprehensive and holistic health care to Aboriginal people living in or visiting Melbourne. Services include: general medical care; visiting specialist services; dental care; specific programs for women and children; community-based programs such as home and community care; and family counselling services for children, adolescents and adults.

Research and health promotion have always been an important part of the work of the VAHS. Specific research projects at the VAHS have informed the development of effective health programs, most recently through two long-term studies: the Young People's Study of Health and Wellbeing, and the Injecting Drug Use Project. Findings from these projects have led to a better understanding of the health and social issues facing Koori youth and Kooris using injecting drugs respectively, and have led to the development of health care interventions targeting these groups. Several community reports and journal articles are available from the VAHS documenting these findings and interventions. Research to inform public health practice remains an important priority for the VAHS, although resources to conduct and complete this work are limited and not recurrent.

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# VicHealth Koori Health Research and Community Development Unit

## ***Discussion Paper Series***

The VicHealth Koori Health Research and Community Development Unit (VKHR&CDU) was launched in June 1999 and has been developed in partnership with the Victorian Aboriginal Community Controlled Health Organisation, the Victorian Health Promotion Foundation (which funds the Unit) and the University of Melbourne through the Centre for the Study of Health and Society where the Unit is located.

At the core of the Unit's work is a commitment to undertaking, collaborating in and supporting research that directly benefits the Koori community. The work of the Unit spans academic and applied research, community development, and medical education. The combination of these activities is a central and innovative aspect of the Unit's function, as is the identification and use of mechanisms to link research with the improvement of health care practices and policy reform. Overall, these tasks are guided by both an Advisory Committee and a Research Advisory Group.

In relation to the research program, five key areas govern the inquiry undertaken within the Unit. These comprise: historical research into Koori health policy and practice; historical and contemporary research into health research practice, ethics and capacity building; applied research on the social and cultural experience of Koori health, well-being and health care delivery; health economics research on the factors and processes that impact on the provision and use of Koori health care; and the evaluation of Koori primary health care and related health promotion programs.

The Discussion Paper Series (DPS) is directly linked to this diverse program of research and provides a forum for the Unit's work. The DPS also includes papers by researchers working outside the Unit or in collaboration with VKHR&CDU staff. Individual papers aim to summarise current work and debate on key issues in Indigenous health, discuss aspects of Indigenous health research practice and process, or review interim findings of larger research projects. It is assumed that the readership for the series is a broad one, and each paper is closely edited for clarity and accessibility. Additionally, draft papers are 'refereed' so as to ensure a high standard of content.

More information on the series, on the preparation of draft papers, and on the work of the Unit can be obtained by directly contacting the VKHR&CDU.

## **Discussion Paper Series**

**Discussion Paper No. 1:** *Ian Anderson, Harriet Young, Milica Markovic & Lenore Manderson*, 'Aboriginal Primary Health Care in Victoria: Issues for Policy and Regional Planning' (December 2000).

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**Discussion Paper No. 5:** *Daniel McAullay, Robert Griew & Ian Anderson*, 'The Ethics of Aboriginal Health Research: An Annotated Bibliography' (January 2002).

**Discussion Paper No. 6:** *Ian Anderson*, 'National Strategy in Aboriginal and Torres Strait Islander Health: A Framework for Health Gain?' (March 2002).

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# **Building Responses to Blood-Borne Virus Infection among Kooris Using Injecting Drugs – Improving the Link between Policy and Service Delivery**

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## **Summary**

Over the past ten years, concern about the impact of injecting drug use within Victorian Koori communities has increased. Many families in these communities are negatively affected by the harms associated with injecting drug use, including the harms from blood-borne virus transmission. A number of State and Commonwealth strategies have been developed to address these issues in the general community but, while they identify Koori communities as having special needs, they do not clearly articulate how specific strategic activities are to be effectively delivered in these communities.

In this discussion paper, we outline a model that we believe will enhance the abilities of Koori communities to respond more effectively to the harms associated with injecting drug use, including the transmission of blood-borne viruses resulting from the sharing of non-sterile injecting equipment. The model focuses on two issues: building the capacity of local Koori communities to respond at the primary health care level; and developing meaningful and workable linkages between these Koori community responses and the various other components of the service delivery system.

Firstly, the capacity for Koori communities to deliver health care programs around injecting drug use must be enhanced at the primary health care level. The primary health care model delivered through Aboriginal Community-Controlled Health Services and Co-ops gives individual Koori communities the flexibility to respond with a mix of services that meets the needs of the local community. These services might incorporate clinical, health promotion, assessment, referral, counselling, specialist and harm minimisation services. However, such responses require adequate financial resourcing and appropriate training for Aboriginal Health Workers and non-Aboriginal health professionals. Both the mix of services provided and the mode of provision must pay attention to the needs and attitudes of the local community to improve their levels of acceptance and success.

Secondly, these services must have workable linkages with other agencies providing

care, treatment and support to injecting drug users. These include both Aboriginal and non-Aboriginal agencies and services offering detoxification, rehabilitation, referral, counselling, welfare support, primary health care, substitute pharmacotherapy provision, and needle and syringe programs. While these relationships are often referred to in strategy documents and service agreements, there is rarely any attention given to the actual quality of the relationships. Effective service delivery relies on real and workable relationships. A model of service delivery for the Koori community around injecting drug use must include mechanisms to develop, build and sustain quality relationships between Aboriginal services and mainstream agencies and governments.

# **Building Responses to Blood-borne Virus Infection among Kooris Using Injecting Drugs – Improving the Link between Policy and Service Delivery**

## ***Introduction***

Injecting drug use is a significant concern for the Victorian Koori<sup>1</sup> community, with most Kooris knowing someone in their extended family who is an injecting drug user. Many families are affected by the harmful consequences of injecting drug use, including harm from infection with blood-borne viruses. The capacities of Aboriginal communities in Victoria to respond to the issues around blood-borne virus prevention and injecting drug use is limited. While current policies provide effective general frameworks for sustained action, they are yet to articulate how support can be given to Koori communities at a local level to enable them to respond to these issues.

The National Aboriginal Health Strategy recognises the important role that community-controlled primary health care services play in improving Aboriginal health outcomes in Australia. We suggest in this paper that there is also a crucial role for these community-controlled services within a broader service model in the development and implementation of strategies for Koori injecting drug users. We outline a model around building primary care capacity and improving co-ordination between various service agencies that will better enable Koori community responses to the issues around injecting drug use and blood-borne viruses.

This paper begins by considering the policy context in which service delivery to reduce drug-related harm among Koori injecting drug users operates. This includes illicit drug and blood-borne virus strategies at both the State and Commonwealth levels, as well as strategies around service delivery to the Aboriginal community in Victoria. This provides the context for discussing the components of a model for the delivery of drug and alcohol services to the Koori community. The paper then goes on to describe the problem of injecting drug use and blood-borne viruses in the Aboriginal community and the socio-cultural context of injecting drug use, including the implications of the Koori cultural environment on the interventions which can be developed by, or offered to, the community. Finally, it draws together existing knowledge about the problem, and the current approaches to it, and suggests a model that could provide an environment for appropriate resource development and community action to address the issues. In developing our ideas, we have reviewed current policy documents related to injecting drug use and blood-borne viruses, as well as the existing literature and research on these topics within Aboriginal

1 In this paper the term Aboriginal will be used to refer to Indigenous Australians, while the term Koori will be used to refer specifically to Aboriginal people in Victoria.

communities. We have further built our understanding of the issues by using data collected through the Injecting Drug Use (IDU) Research Project conducted at the Victorian Aboriginal Health Service. This project examined the socio-cultural context within which injecting drug use occurs in the Melbourne Koori community, in order to inform the development of community-based responses.

## **The current policy context**

Several factors have combined to increase public concern about illicit drug use in Australia, resulting in more intensive responses by local, State and Commonwealth governments. While the availability, cost and use of illicit drugs fluctuates from year to year, the general trend, both nationally and in Victoria, appears to have been towards a growth in demand, availability and affordability. There has been an increase in the public presence of dealing and use of illicit drugs, particularly in the so-called 'hot-spots' of Melbourne, and, until recently, a rise in the numbers of deaths from overdoses (Drug Policy Expert Committee 2000).<sup>2</sup> Fuelled by heightened media reporting, the perceived threat to community safety, including public fear of discarded used needles, has led to increased government action over illicit drug use.

Commonwealth and Victorian strategies which respond to drug-related harms, including those from blood-borne viruses, are summarised in Table 1. These strategies have a number of key principles in common, including:

- harm minimisation;
- co-ordination and integration across a variety of areas, such as health, education, housing, employment, law enforcement, and criminal justice;
- partnerships involving all levels of government, the community-based sector, local communities, business and industry, service providers, research institutions, and, in particular, individuals or communities affected by drug use or blood-borne viruses;
- social justice, including principles of access and equity;
- linkages to other related strategies;
- adherence to health promotion principles laid down in the 1986 *Ottawa Charter for Health Promotion*; and
- evidence-based practice to inform interventions.

The harm minimisation approach is specific to strategies that aim to reduce drug-related harm, and is central to the development of initiatives in this area. The approach integrates three types of responses (Ministerial Council on Drug Strategy 1998):

- *supply-reduction* strategies designed to disrupt the production and supply of illicit drugs;

2 At the time of the release of the Drug Policy Expert Committee's (DPEC) report to the Victorian government in November 2000, the trends reported above were accurate. The 'hotspots' are places where increased, street-based, drug activity have been noted over the past few years: Fitzroy / Collingwood / Richmond, St Kilda, Footscray, Springvale, and the Central Business District. The municipalities responsible for these areas have been given additional State funding under the Saving Lives and Local Drug Strategies to cope with the resulting drug-related harm ('Victorian Government Drug Initiative. An Overview' 2000). Since late in 2000, there has been a shortage of heroin in Melbourne, and prices have been higher. The use of other drugs, such as amphetamines and cocaine, has increased and there has been a decrease in the numbers of fatal and non-fatal overdoses (Fry & Miller 2002).

- *demand-reduction* strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use; and
- a range of targeted *harm-reduction* strategies designed to reduce drug-related harm for individuals and communities.

While supply-reduction activities are mainly in the area of law enforcement, demand- and harm-reduction activities include:

- health education, which can have a range of aims from promoting abstinence to teaching safe injecting practices;
- early primary health care interventions;
- specialist mental health care, and treatment for chronic conditions;
- specialist detoxification and rehabilitation services;
- specific initiatives to reduce harm to users, such as needle and syringe programs, and safe-injecting facilities; and
- support from community services, such as welfare, employment and housing.

A specific issue that needs to be defined in a service model such as this is how the different components should be linked. Linkages may be informal; referral based, they may entail shared service planning or a common administrative structure. There are a range of possibilities that need to be determined. There also needs to be an understanding of the appropriate mix of these activities in specific contexts, as well as what capacity is required to implement them effectively. In addition, a better appreciation is needed of how communities (including Aboriginal communities) understand harm minimisation, and how this impacts on the mix of activities chosen.

**Table 1: Current Commonwealth and Victorian strategies to address blood-borne viruses and injecting drug use**

	<b>Commonwealth</b>	<b>Victoria</b>
HIV/AIDS and Hepatitis C	<ul style="list-style-type: none"> <li>– National HIV/AIDS Strategy 1996–97 to 1998–99</li> <li>– National Indigenous Australians’ Sexual Health Strategy 1996–97 to 1998–99</li> <li>– National Hepatitis C Strategy 1999–2000 to 2003–04</li> </ul>	<ul style="list-style-type: none"> <li>– Victorian HIV/AIDS Strategy 2002–04</li> <li>– Hepatitis C Strategy for Victoria 2002–04</li> </ul>
Injecting drug use	<ul style="list-style-type: none"> <li>– National Drug Strategy</li> <li>– National Illicit Drug Strategy</li> <li>– National Drug Strategic Framework 1998–99 to 2002–03</li> </ul>	<ul style="list-style-type: none"> <li>– Victorian Government Drug Initiative (incorporating a number of different programs and strategies)</li> </ul>

All of the above strategies clearly identify Aboriginal communities as needing particular attention and requiring additional resources. They also recognise the importance of involving Aboriginal people in developing community-appropriate strategies and initiatives. Aboriginal representatives are included on key drug and blood-borne virus advisory councils, such as the Australian National Council on Drugs (ANCD) and the Intergovernmental Committee on Drugs (IGCD),<sup>3</sup> and through national advisory groups. The National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander Peoples, for example, provides advice to other advisory committees and the IGCD to ensure that Aboriginal issues are appropriately represented in drug strategies and action plans. The strategies all encourage a linkage with the National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99 (NIASHS), which specifically addresses blood-borne viruses in the Aboriginal community. The NIASHS was developed by the Indigenous Australians Sexual Health Committee, a working party assisting the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD), the key advisory body on Australia's response to, and management of, blood-borne viruses. While the strategy's main emphasis is on the sexual transmission of HIV, some discussion and recommendations about needle and syringe programs (NSP) is also included. The NIASHS recommends promoting further debate about the provision of NSPs, evaluating how this approach can translate to Aboriginal communities, and discussing how to improve access to, and the cultural appropriateness of, NSPs in Aboriginal communities. In addition, it advocates that extensive community liaison and negotiation occur before such services are introduced into Aboriginal communities (ANCARD Working Party on Indigenous Australians' Sexual Health 1997: 8–9).

Victoria has used the national strategies as the basis for developing regional approaches to reduce drug-related harm, and harm minimisation remains a cornerstone of these State strategies. Current priorities identified by the recent Drug Policy Expert Committee (DPEC) report (2000) that have been taken up by the Victorian government are in the areas of:

- prevention through the reduction of demand, and the promotion of opportunities, settings and values that promote resilience and reduce risk;
- criminal justice and law enforcement through interventions to reduce availability and supply;
- 'getting lives back on track' through providing treatment and support;
- saving lives by reducing drug-related harms; and
- capacity building through workforce development, research and by monitoring and evaluating the drug strategy.

As a result of the recommendations of the DPEC report, funding has become available in the areas of public education and information campaigns, targeted prevention and education programs for specific cultural groups, activities to strengthen communities,

<sup>3</sup> The Australian National Council on Drugs (ANCD) provides independent strategic advice to the Prime Minister and to the Ministerial Council on Drug Strategies, while the Intergovernmental Committee on Drugs (IGCD) provides policy advice to ministers and co-ordinates, develops, implements and evaluates policies and programs of the National Drug Strategy.

additional drug treatment services, extra specific services for families, young people and post-release offenders, and law enforcement, including drug diversion programs. In addition, funding has been specifically directed to those local municipalities particularly affected by illicit drug use for ‘saving lives’ initiatives—such as overdose response teams and mobile drug safety workers—and for developing local drug strategies (‘Victorian Government Drug Initiative. An Overview’ 2000). Priorities identified by the Department of Human Services (DHS) document, *Local Drug Strategies*, are initiatives directed at prevention, strengthening communities, improving the amenity and safety of public spaces, and providing greater access to primary health care for drug users (which includes improved linkages among organisations) (DHS 2001c).

Needle and syringe programs remain an essential component of the Victorian approach. The Victorian program is managed by the Department of Human Services, and is run through a variety of settings, including community health centres, alcohol and drug agencies, shop fronts, hospitals, pharmacies, youth services, university student health services, municipal councils, Aboriginal co-operatives, and sexual health services.<sup>4</sup> Ten single-purpose, fully government-funded primary sites distribute free needles and syringes to injecting drug users, collect needles and syringes for disposal, and provide specialist education and referral services. The approximately 190 secondary outlets form the majority of NSP sites and are agencies for which NSP is not the core function. These agencies receive DHS funding for consumables, training and support, while staffing and space is provided from within the existing resources of the agency (DHS 1996). Although controversial, the Victorian NSP appears to have been successful in limiting HIV transmission among injecting drug users (Lowe & Cotton 1999: 49).

Currently, Koori drug services include: Koori Community Alcohol and Drug Workers located in Aboriginal Medical Services and Co-operatives throughout the State; the Koori Community Alcohol and Drug Resource Service, which operates ‘sobering up’ centres; Koori alcohol and drug rehabilitation services; and a number of specific programs around the State. Funding for Aboriginal drug initiatives and treatment services is administered both directly through the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and through the mechanisms of Public Health Outcome Funding Agreements (PHOFAs) to the State. As funding through PHOFAs is tied to outcomes within the context of agreed national priorities, rather than specific programs, this enables the Victorian government to use funding on local priorities and high-need populations (Commonwealth Dept of Health & Family Services, CDHFS, 1998). As part of the Victorian Government Drug Initiative, additional State funding has been made available for Koori-specific prevention and education, and for projects under the Community Strengthening Initiatives. Resources have also been made available to implement a specific recommendation of the DPEC Report calling for the development of a Koori Drug Strategy, as ‘an integrated yet identifiable component of the overall drug strategy’ (DPEC 2000: 177).

<sup>4</sup> NSPs allow for the distribution of sterile needles and syringes and the collection of used ones in order to minimise the sharing of equipment by users. Needle and syringe services are not available within correctional or youth detention settings. There continues to be resistance to their introduction, despite the commonly accepted truth that risky injecting drug use is widespread in prisons and youth detention centres.

While Commonwealth and State strategies identify Aboriginal communities as requiring particular attention when addressing blood-borne viruses and injecting drug use, they do not provide a guide to specific strategic activities related to Aboriginal communities. Aboriginal issues have been considered and articulated in these policies, but the capacity for regional planning or for local delivery structures to develop detailed policy responses to these issues is limited given the range of priority issues in Aboriginal health. Further to that there is little detail in national policy statements that could usefully guide the translation of policy discourse into action in the community. Blood-borne virus and injecting drug use strategies do not clearly explain how, or by whom, resource provision and program development should be delivered at the local level.

There have been significant developments over recent years in the policy framework within which Aboriginal health priorities are determined and health planning is operationalised. The Aboriginal Health Framework Agreements—signed between the Commonwealth government, Victorian government, Aboriginal and Torres Strait Islander Commission (ATSIC), and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO)—provide the agreed basis for regional planning in Aboriginal health including improving Koori access to services and improving Koori health outcomes, such as those associated with drug-related harm. The Victorian Advisory Council on Koori Health has developed its first regional plan and nationally negotiations are in progress in order to seek the consent of health jurisdictions to enter a second round of Aboriginal Health Framework Agreements. Current Victorian state mechanisms through which integrated service delivery to drug users could be implemented include Primary Care Partnerships and review and integration of the Koori Health Outcome Agreements and Koori Service Improvement Strategy.<sup>5</sup> These strategic frameworks could improve collaborative service linkages between Koori and mainstream services. However, they are only slowly being implemented, and there are also still gaps between local and State planning processes and implementing service relationship agreements.

### ***The context of service delivery to Kooris who use injecting drugs***

While these policies provide broad guidelines as to what service components are needed by injecting drug users, they do not specify how these components can be delivered in the Koori community context: service delivery to the Koori community has simply been inferred and adapted from mainstream service delivery models. This section of the paper will describe the service components needed by Koori communities to enable them to build responses to the issue of injecting drug use. To better understand this, we will first give a brief description of the current situation of injecting drug use and blood-borne virus infection in the Koori community, as well as the socio-cultural context of injecting drug use.

5 For further discussion of these mechanisms, refer to I. Anderson, H. Young, M. Markovic & L. Manderson, 'Aboriginal Primary Health Care in Victoria: Issues for Policy and Regional Planning', VicHealth Koori Health Research & Community Development Unit, Discussion Paper No.1, February 2001, VKHR&CDU, University of Melbourne, Melbourne; and I. Anderson, 'National Strategy in Aboriginal and Torres Strait Islander Health: A Framework for Health Gain?', VicHealth Koori Health Research & Community Development Unit, Discussion Paper No.6, March 2002, VKHR&CDU, University of Melbourne, Melbourne.

## **The need to address injecting drug use in the Koori community**

There is a clear need for service delivery models to address injecting drug use in the Melbourne Koori community. Although the exact prevalence of the illicit use of drugs in this community is unknown, the qualitative data of the VAHS study suggests that the problem is significant. Comparisons of surveys and studies of illicit drug use show that there appears to be a higher prevalence of injecting drug use among Aboriginal Australians than among non-Aboriginal Australians (Commonwealth Dept of Human Services & Health 1996; Perkins, *et al.* 1994).

Data collected by the National Centre in HIV Epidemiology and Clinical Research (NCHECR) examined the proportion of injecting drugs users who self-identified as Aboriginal. The study relied on surveys, conducted over a week-long period each year from 1995 to 1998, of injecting drugs users who attended needle and syringe programs in each State and Territory and who agreed to participate in the study (overall response rate of around 50 per cent). It found that 5.4 per cent of participants self-identified as Aboriginal, a proportion more than double the proportion of Aboriginal people in Australia (2.1 per cent). If it is assumed that the numbers of Aboriginal people attending NSPs and the numbers who agree to participate in the survey are low, then the proportion of Aboriginal people in the sample could be an underestimate (Correll, MacDonald & Dore 2000). Of Victorian injecting drug users in this study, around 3 per cent self-identified as Aboriginal, a proportion six times the Aboriginal population of Victoria (0.5 per cent) (Correll, MacDonald & Dore 2000: 52–3; ABS & AIHW 1999).

## **Blood-borne viruses in the Koori community**

Although there is no clear idea of the prevalence of blood-borne viruses in the Aboriginal community,<sup>6</sup> the high rates of incarceration and of injecting drug use mean that the levels could be expected to be high. Between 1992 and 1998, ‘injecting drug use’ was reported to be the exclusive exposure category for 5 per cent of the HIV cases among Aboriginal people: i.e. six of the 127 total cases (NCHECR 1999). The prevalence of hepatitis B and C are much higher. Hepatitis C antibodies were present in 56 per cent of the Aboriginal injecting drug users attending needle and syringe programs across Australia (Correll, MacDonald & Dore 2000), and in 35.5 per cent of Aboriginal prisoners in a New South Wales prison population (Butler, *et al.* 1999). These figures are comparable or lower than those for non-Aboriginal injecting drug users. Hepatitis B antibodies are, however, more common among Aboriginal injecting drug users, which is related to the endemic nature of this infection in the Aboriginal population. High levels of chronic hepatitis B infection mean that the impact of hepatitis C on the Aboriginal community can be potentially greater, with more rapid progression to advanced liver disease. In addition, a possible interrelationship between hepatitis C infection and chronic disease would greatly affect Aboriginal people, among whom chronic diseases are common.

<sup>6</sup> The actual rates of blood-borne viruses among Aboriginal people are not clear, as Aboriginal status is not comprehensively reported in the notification of diseases to the Commonwealth.

The disproportionate representation of Aboriginal people in the correctional system, where it is acknowledged that the risk of sharing injecting equipment and acquiring blood-borne viruses is high, means that exposure to blood-borne viruses could be disproportionately high among Aboriginal users of injecting drugs. A Queensland study found that injecting by Aboriginal people in prisons and detention centres was rare: eight out of the thirty users who had been to prison, with the average frequency being three times. However, when these users did inject, their injecting practices were more likely to be unsafe (Larson 1996). Incarceration does not prevent injecting drug use, and, in fact, the VAHS research found that some people were initiated to use in jail as a way of coping with their sentences and making time pass more quickly (Edwards, Frances & Lehmann 1998). High rates of blood-borne virus infection among Aboriginal prisoners translate to a higher proportion in the overall Aboriginal community.

### **The socio-cultural context of injecting drug use in the Koori community**

Injecting drug use in the Koori community occurs within a very particular socio-cultural context. To be effective, strategies must address the underlying issues of alcohol and drug abuse and keep in mind the context of a history of colonisation and dispossession, which impacts on drug abuse. As a result of this history of violence, attempted destruction of culture, removal of children, institutionalisation, and discrimination, Aboriginal people are disproportionately affected both by dislocation and social and economic inequalities. Such inequalities impact on psychosocial factors, such as low self-esteem, high self-blame, low perceived power and self-efficacy, and the loss of meaning or purpose in life. These issues have helped to shape the patterns of social and emotional health and well-being, and alcohol and drug abuse in Aboriginal communities. The strong causal connection between the two has important implications for interventions.

Injecting drug use is extremely harmful to the health and well-being of individual users and impacts considerably on their family relationships. Kooris who use injecting drugs are very much part of the family and community networks (Edwards, Frances & Lehmann 1998). However, not all drug use is located within these networks, and Kooris who use injecting drugs are obviously not isolated from the broader drug-using culture in Victoria. The interactions involved in buying, dealing and using drugs occur within and across community boundaries, and are strongly influenced both by family and community relationships and by broader market and social forces.

The closeness of family ties has a number of important implications for service choice and provision. Drug education and intervention strategies in the Koori community must involve and address the needs of the entire community, as drug use is everybody's problem. Such close family relationships often necessitate involving the entire family in drug treatment, and offering structured support around families. Close family bonds also affect Koori staff working in the drug and alcohol field. They are subject to enormous stresses as they are pressed to provide for their family and friends in an environment with inadequate health, treatment, counselling, or advocacy services for client referrals. Their strong links to the community also mean

that they are not in an easy position to manage their workload by limiting their assistance to members of the community.

Several studies have found that Aboriginal users of injecting drugs are more likely to share injecting equipment than non-Aboriginal users, and that there could be a cultural basis for this increased risk behaviour (Correll, McDonald & Dore 2000; Lane 1993). Among family and close friends, open-ended reciprocity is an important cultural value, and is the context within which the sharing of possessions occurs. People may feel under an obligation to share injecting equipment with family and close friends. They might also be more likely to share equipment with those who they perceive to be disease free because of their close relationship.

Studies of Aboriginal injecting drug users, including the VAHS IDU Research Project, have found that Kooris using injecting drugs want a range of specialist drug services, and that these services need to be available to them when they ask for help. Once the moment when people seek this help has passed, it could be a while before it comes again. On the one hand, some Kooris using injecting drugs favour being able to attend Koori-specific drug services where they feel that their issues and needs can be better understood. Many Kooris feel that mainstream services do not welcome them and are not able to meet their specific cultural needs, such as enabling contact with family or accommodating dependants (Edwards, Frances & Lehmann 1998; Larson 1996). On the other hand, some Koori injecting drug users feel ashamed about going to Koori-specific services where they will be recognised by their family and friends. Their main concerns are the shame, breaches of confidentiality and discrimination from the community. They would prefer to access mainstream services, but are often hindered by the perception that these are not Koori-friendly.

### **The range of community opinions around injecting drug use**

There is clearly a range of opinions and attitudes within the Koori community about the development and delivery of drug programs. The introduction of needle and syringe programs, for example, has been met with resistance in some communities. While there are community members who support NSPs, others are concerned that such programs condone injecting drug use, send the wrong message to children and teenagers, and increase the numbers of 'undesirables' in the community setting where the NSP is operating. These attitudes are understandable when one considers the enormous impact of injecting drug use on families. Many people, simply fed up with the constant worry and harassment they endure from drug-using family members, access community meeting spaces, such as health services, as a way to escape this. Even among those who support the concept of needle and syringe programs, the idea of having one located within a community space is problematic (Edwards, Frances & Lehmann 1998).

Any planned strategy in the Koori community, therefore, needs to take into account this diversity of views if an effective harm-minimisation program, which does not alienate sections of the Koori community, is to be delivered. Placing some members of the community off-side by implementing controversial harm-minimisation programs will most likely result in the overall failure of the program as their support is

withdrawn. Even people who use injecting drugs are not unified in their attitudes and behaviours, as they all have different reasons for taking drugs, live under a variety of circumstances, and have varying levels of support from family and friends. Different strategies are going to work for different people and this must be taken into account when planning prevention programs.

The VAHS IDU research has found that there needs to be a range of interventions across the spectrum of harm minimisation to accommodate the differing opinions in the community about injecting drug use, as well as flexibility in their implementation. These interventions should not only address the needs of the individual, but also those of the family and the entire community (Edwards, Frances & Lehmann 1998). Interventions should be aimed at three broad areas: promoting drug-free lifestyles and encouraging people not to start injecting; protecting the health of those who inject, their families and the community; and providing support and choices to people who inject and want to stop. More specifically, this would lead to activities such as:

- a health information and promotion campaign across all areas of the community;
- expanding the range of existing drug services, including prescribing methadone, and developing counselling and support services specifically for injecting drug users and their families;
- developing Koori-specific detoxification and rehabilitation facilities; and
- setting up a (mobile) needle syringe program.

Many of these services can be made available through the primary health care setting, while others are already offered through specialist drug and alcohol services. The need for a range of programs has been consistently found in studies of Aboriginal communities, including the VAHS research.

### ***Delivery of services to Kooris using injecting drugs***

To address the need for a range of services and programs, an effective model of service delivery to the Koori community must include both Koori and mainstream services. Ideally these have the following service components:

- Koori-specific services
  - primary health care services,
  - specialist drug and alcohol services,
  - community services; and
- mainstream services
  - local GPs and pharmacists,
  - drug and alcohol detoxification and rehabilitation services,
  - needle and syringe programs,
  - community services.

The mix of service components, their responsibilities and their interactions will vary according to local community needs. The key issues for policy development are determining which services should deliver each program component and how these components might best be linked. This is particularly problematic if services are delivered within different structures, for example, State/Commonwealth, Koori/mainstream. The specific contexts and needs of each community should determine which program components are to be delivered and how this will be done; a degree of flexibility in policy is required to enable this. Each of these service components is described in greater detail below.

### **Koori-specific primary health care services**

Koori-specific primary health care services include Aboriginal Medical Services (AMSs) and Aboriginal Co-operatives (Co-ops). These are based on a model that enables local communities to participate actively in the development and delivery of services. There is widespread government recognition that community-controlled primary health care services are essential to the process of improving the health outcomes of Aboriginal Australians as laid down in the Commonwealth's National Aboriginal Health Strategy. The Aboriginal community-controlled primary health care model provides a structure for community leadership and a framework for self-determination, as the community is able to design, manage and control its own health care. This is successful as long as this autonomy is recognised and respected by government bureaucracy and funding bodies. An important component of Koori community-controlled primary health care services is the training and employment of Kooris as health workers. A service designed according to these principles covers a wide range of health care activities and is better able to respond to the particular needs of the local community. It is a model that is effective in addressing and improving the overall health and well-being of the community. Services include medical and dental care, specialist services, allied health care services, special programs for women, children and men, social and emotional health services, health promotion activities, specialised programs according to community needs, and services for the elderly and the disabled. While Aboriginal Medical Services have the resources to provide most of these services under one roof, Co-ops focus on health education and promotion activities and on providing primary health care through Aboriginal Health Workers and linkages with local doctors. AMSs and Co-ops may deliver the following specific services for injecting drug users and their families.

#### ***Aboriginal Medical Services***

- primary medical care
  - general health care,
  - specific care and treatment relating to injecting drug use and blood-borne viruses, including: methadone prescription (and possibly dispensing), prescription of other drugs to relieve withdrawal symptoms, home-based detox services, vein care, and testing and pre- and post-test counselling;
- community-specific health promotion and prevention activities

- strategies targeting people across the community—young people, parents, workers and managements of organisations, and community leaders—are crucial to help dispel misinformation about injecting drug use and blood-borne viruses,
- messages that can address various community needs: encouraging drug-free lifestyles, limiting harm from using injecting drugs (including BBV infection), and assisting those who wish to stop using;
- social and emotional health and well-being services
  - counselling and social support services, and welfare support services to deal with the underlying issues of using drugs,
  - greater understanding of specific concerns of Koori users related to grief, loss and stolen generation issues,
  - locating social and emotional health and well-being services alongside medical services, so drug and alcohol workers can assist in dealing with issues of dual diagnosis;
- referral and co-ordination of clients
  - diversity of services enables the health service to service the client more comprehensively and to co-ordinate their care,
  - State and Commonwealth governments fund Koori community alcohol and drug worker positions, placed at AMSs and Co-ops throughout the State, who provide assessment, support and referral services for clients,
  - essential referral linkages with both Aboriginal and mainstream specialist agencies in the drug and alcohol field improve treatment options; and
- needle and syringe program—could be a secondary site depending on local community attitudes.

### ***Aboriginal Co-operatives***

- primary medical care
  - general health care,
  - could have some capacity to offer more specific care and treatment relating to injecting drug use and blood-borne viruses,
  - less capacity to offer these services as they are often reliant on relationships with local GPs;
- community-specific health promotion and prevention activities (as above);
- Koori community alcohol and drug workers provide assessment, support and referral services;
- linkages with local GPs and mainstream community counselling and social support services; and
- needle and syringe program—can be a secondary site depending on local community attitudes.

## **Koori-specific drug and alcohol services**

Primary health care services must rely on specialist drug and alcohol services for support in the management of more complex clients. Currently, Ngwala Willumbong is the only specialist Aboriginal drug and alcohol agency in Victoria. It manages two residential recovery services in metropolitan Melbourne, one for men (Galliamble) and one for women (Winja Ulupna), an alcohol recovery centre in Shepparton, and the Koori Community Alcohol and Drug Resource Centre. There are several State Koori drug and alcohol positions located at Ngwala Willumbong. The services of this organisation include assessment, social and emotional support, rehabilitation, and referral to mainstream agencies.

## **Koori-specific community services**

A number of Koori services can provide for the specific welfare and support needs of Kooris using injecting drugs. These include organisations such as the Aboriginal Legal Service, Aboriginal Child Care Agency and various Aboriginal hostels.

## **Mainstream local GPs and pharmacists**

This includes general practitioners in private practices and mainstream community health centres, and those working in outpatient and emergency departments in hospitals. They may provide:

- primary medical care
  - general health care,
  - specific care and treatment relating to injecting drug use and blood-borne viruses—methadone prescription, other prescriptions and home-based detoxification;
- methadone dispensing and clean needle provision; and
- tertiary care related to emergency or serious health problems (e.g. overdose).

## **Mainstream drug and alcohol detoxification and rehabilitation services**

These services may provide any of the following functions:

- assessment;
- withdrawal programs—residential or home-based;
- rehabilitation, including counselling and therapy, and support and self-help activities;
- management of particularly complex clients;
- substitute pharmacotherapy provision;
- research;
- needle and syringe programs—primary or secondary; and
- education and information services.

## **Mainstream needle and syringe programs**

primary services—single-purpose programs, although they may offer a number of other additional related services, often in conjunction with other local agencies; and secondary services—run through a variety of service settings to complement existing service activities.

## **Mainstream community services**

These agencies include those offering services such as short-term accommodation, housing assistance, meals, clothing, advocacy, and legal aid and financial assistance.

## ***Building responses for Koori communities***

While there has been considerable activity at the advisory level to develop policy responses to injecting drug use in Aboriginal communities, there has been little capacity built for planning responses at the regional level and for co-ordinating action across delivery structures. Central to building responses for Kooris who use injecting drugs is building the capacity of Koori communities to undertake these responses and improving the co-ordination of a mixture of services—primary and specialist, Koori and mainstream.

## **Building capacity**

Community-controlled primary health care services are, clearly, extremely important in the overall injecting drug use response within Koori communities. The flexibility afforded by a primary health care service enables a community to incorporate services and health promotion activities around injecting drug use into their primary health care activities in a manner that is acceptable to that community. Responses can be shaped and developed to address the particular concerns and biases of each community, at a pace that matches the changing attitudes and needs at each location. The development of responses at the local level allows community concerns and interests to be accommodated by acknowledging and responding to the diversity of opinions in the community. The community is then able to work together to develop creative options for the provision of services to Koori injecting drug users and their families, while respecting the concerns of other members of the community. Primary health care services in a community-controlled setting allow this kind of individual response to be developed and, thus, are crucial to the implementation of effective strategic responses to injecting drug use in Koori communities.

To provide an effective balance of services appropriate for their communities, community-controlled primary health care services must be properly resourced, both financially and with a well-trained workforce. AMSs and Aboriginal Co-ops need to build a greater capacity to respond to the issues on their own terms. Communities should be adequately resourced to provide education and information to all their members about the issues and to consult with the community in the development of appropriate program responses. They should also receive sufficient funding to put

their chosen programs into action and to evaluate their effectiveness. The capacity of primary health care services to plan responses and to integrate service delivery with mainstream services must also be developed, as discussed further below. Such resourcing should be provided at the community level as each community will respond according to their own needs.

Appropriate program responses require the development of the clinical capacity of primary health care services to manage Koori injecting drug users and those diagnosed with blood-borne viruses. Workforces in Koori health services and co-operatives must be provided with information and training on:

- blood-borne virus prevention, screening (including pre- and post-test counselling) and management; and
- information on the management of drug clients, including
  - training and registration in methadone buprenorphine prescription,
  - up-to-date information on the use of other prescription drugs in the treatment of clients using injecting drugs, and how to manage the prescription of these drugs to clients,
  - information on some of the particular medical issues for people using injecting drugs, such as nutrition, infection and care during pregnancy.

Database and recall systems are also crucial in managing more effectively the care of clients who are or have been using injecting drugs, and/or those with blood-borne viruses who may need continuing care. Additionally, in order to design, implement and evaluate programs, organisations need the capacity to gather data on injecting drug use and blood-borne viruses. There has, to date, been little evaluation of harm-minimisation and drug-treatment programs developed by, and implemented in, Aboriginal communities.

Improving community capacities to respond to these issues relies on the development of policies and strategies around injecting drug use and blood-borne viruses that facilitate appropriate responses. Koori involvement in the development of these policies should be promoted. Greater control of programs, strategies and policies can be achieved through increased representation by Kooris on working parties and review committees, for instance, in the development of hepatitis C strategies and the national and State drug strategies. However, for Aboriginal communities to have this input capacity must be developed through the provision of resources and training in policy development.

The development of interventions in a community-controlled context is often a long and drawn-out process of negotiating through a wide range of differing opinions. There must be a recognition by policy makers and government bureaucrats that 'harm minimisation' is an ideology that does not necessarily sit comfortably with a community whose attitudes to drug use are shaped by direct experience with its effects on their lives. Resistance to, or rejection of, particular harm-minimisation interventions should be seen as part of an overall process of community development rather than as a failure of the project. Attitudinal change cannot occur overnight; it

needs to be constantly chipped away at over a period of time. While there might not be a tangible activity outcome to a project, the very process of bringing issues onto the agenda can, in the long-term, lead to attitudinal change and community action. The need for this process must be understood and recognised by government bureaucracies, funding bodies, and mainstream drug and alcohol agencies.

## **Co-ordinating service components**

While the role of community-controlled primary health care services is central to an overall response to injecting drug use in the Koori community, there are certain limitations to the services that can be provided at this level. Close and well-constructed links with Aboriginal and mainstream specialist drug and alcohol services, local pharmacists, NSPs, and welfare services are imperative to enable Kooris using injecting drugs to choose from a range of services. Strong links between Koori and mainstream organisations must continue to be built and maintained. Support for the principle of community control should not be an excuse for mainstream services to give up their responsibilities of providing for the Koori community.

An example of an area in obvious need of improved linkage is between Koori services, and prisons and detention centres. There are currently few integrated education, information and support programs in prisons and detention centres that are run by Kooris and specifically address Koori needs, and few programs that provide meaningful support for people who are leaving prison. Injecting drug users in the Koori community are already alienated from services that provide health, social and welfare support, and will need additional support in transition after leaving prison. To target these people effectively, it is important not only to enhance and promote social and support services at AMSs, but also to build relationships with prisons and youth detention centres.

Building strong links between Koori and mainstream organisations is the central idea behind strategies such as the Health Outcome Agreements. However, the capacity to develop these agreements is currently limited on both sides and must be built upon further. On the one hand, Aboriginal community-controlled health services generally lack the resources, time and skills to develop and implement these agreements, and this has hampered their ability to enter into and sustain such collaborations. On the other hand, the abilities of mainstream agencies to implement these agreements and meet the needs of Koori injecting drug users may require additional training of staff and managers in:

- cross-cultural issues;
- knowledge of the specific patterns of morbidity among Kooris and how this may affect treatment; and
- service delivery in the context of disadvantage.

So, while it is necessary to expand and improve Koori-specific services for injecting drug users, it is also crucial to build the capacity for improving links between mainstream and Koori services. It cannot be assumed that partnerships between organisations as specified in agreements are automatically of a sufficient quality to actually work in practice. These partnerships must continue to be built and

maintained and must receive adequate resources and support to do this. A model of service delivery to the Koori community around injecting drug use must, therefore, improve the capacity of Koori communities to develop localised primary care responses, and include mechanisms for developing, building and sustaining relationships among components of the service delivery system. How exactly this can be done is the next question that needs to be considered.

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## **Abbreviations**

AMS	Aboriginal Medical Services
ANCD	Australian National Council on Drugs
ANCAHRD	Australian National Council on AIDS, Hepatitis C and Related Diseases
ANCARD	Australian National Council on AIDS and Related Diseases
ATSIC	Aboriginal and Torres Strait Islander Commission
CDHFS	Commonwealth Department of Health and Family Services
Co-op	Aboriginal Co-operative
DHS	Department of Human Services (Victoria)
DPEC	Drug Policy Expert Committee
IDU	Injecting Drug Use
IGCD	Intergovernmental Committee on Drugs
NAHS	National Aboriginal Health Strategy
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NIASHS	National Indigenous Australians' Sexual Health Strategy
NSP	Needle and Syringe Program(s)
OATSIHS	Office of Aboriginal and Torres Strait Islander Health
PHOFAs	Public Health Outcome Funding Agreements
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAHS	Victorian Aboriginal Health Service Co-operative Ltd
VKHR&CDU	VicHealth Koori Health Research & Community Development Unit