Expanded Blood Borne Virus (BBV) Testing in Harm Reduction Settings

Read P [1, 2], Lockwood J [1], Doab A [1], McNaughton T [3], Buckley R [1], Silins E [1, 4], Brown T [5], Jauncey M [4], Harrod ME [3], Gilliver R [1].

1 - Kirketon Road Centre, Sydney. 2 - Kirby Institute, UNSW Sydney. 3 - New South Wales Users and AIDS Association Sydney.

4 - Uniting Medically Supervised Injecting Centre, Sydney. 5 - HIV and Related Programs Unit, SESLHD, Sydney.

Background:

People who inject drugs are a priority in the National and NSW HIV strategies. Many people are reluctant to attend mainstream clinical services, yet frequently attend low threshold harm reduction settings such as peer-based drug user organisations or safer injecting facilities. This study describes the clinical outcomes of a partnership between the Kirketon Road Centre (KRC), the NSW Users and AIDS Association peer-based needle and syringe program (NUAA) in Surry Hills, and the Uniting Medically Supervised Injecting Centre (MSIC) in Kings Cross Sydney. The aim of the partnership was to extend blood borne virus testing, but also to offer primary health care at a convenient and trusted location to these clients.

Methods:

Medical and nursing staff attended NUAA and MSIC 3-5 times/week to provide primary health care with a focus on BBV testing and treatment. Crucial to this activity was the client support and engagement provided by peer workers at NUAA, and health care workers at MSIC. After 8 months operation, data were extracted from the KRC clinical database relating to demographics, testing patterns and diagnostic codes.

Results:

Between November 2018 and June 2019, **646** consultations occurred among **259** clients (**161** at NUAA; **98** at MSIC). All clients had a history of injecting drugs. Overall, one in four (**26%**) had never previously attended KRC, which was higher at the NUAA location (**36%**) vs MSIC (**10%**). **19%** reported being men who have sex with men, and **21%** reported a history of sex work. BBV screens (**n=200**) detected **27** (**14%**) hepatitis RNA positive clients, **20** of whom had commenced treatment, including **8** who had received medications via NUAA or MSIC. Hepatitis B vaccination was initiated by **25** clients. There were no new HIV diagnoses, and **4** clients with a previous HIV diagnosis were linked back into care.

Other activity at these services included naloxone distribution (**n=44**), drug and alcohol assessments (**n=74**), wound dressings (**n=29**), and mental health care (**n=44**).

Conclusions:

Expanding clinical services through partnership and collaboration with community-based low threshold harm reduction services attended and trusted by people who inject drugs has identified a population of clients not previously known, or well connected to mainstream clinical services. The health and social needs of these clients are complex, and consultations rarely focus solely on BBV risk as clients of both services had multiple unmet needs and priorities.

These diverse range of issues are important to address when considering public health elimination goals for both HIV transmission and hepatitis C, and crucial in ensuring those most disenfranchised are able to gain from the personal benefits of engaging in care. This program will be evaluated more fully and results disseminated at the end of its 2 year funding period.

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