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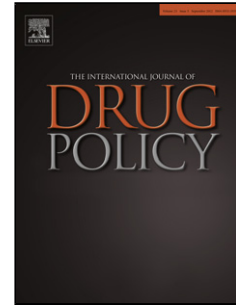
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Access to needle and syringe programs by people who inject image and performance enhancing drugs

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We appreciate van Beek and Chronister's concerns regarding the funding of harm reduction interventions in an environment of diminishing resources (1), however we disagree with their conclusion and support the international guidelines for equitable and non-discriminatory NSP provision for all people who inject drugs. van Beek and Chronister outline the response of the Kirketon Road Centre (KRC), an established primary health care facility in Sydney, New South Wales (NSW), to a potential "public policy dilemma" resulting from an increase in the injection of drugs with the primary purpose of enhancing image and/or performance in Australia (1). Using data from surveys of 102 men injecting image and performance enhancing drugs (IPEDs) attending the KRC Needle and Syringe Program (NSP), they assessed the risk of blood-borne viral (BBV) infections in this group to be lower than among people who inject drugs primarily for their psychoactive effects. The KRC subsequently implemented a policy decision to limit the availability of injecting equipment from their NSP to people who inject IPEDs. The authors also encouraged other NSP services to undertake local assessments.

"Cost and capacity" were identified as the main rationale for initiating this restrictive policy. IPED injectors comprised a minority of KRC NSP attendees (6%), but were receiving 15% of the injecting equipment distributed. A number of factors likely contribute to this disparity. Firstly, over two-fifths (44%) of the KRC IPEDs population sampled reported collecting equipment for others. Secondly, IPEDs users typically procure injecting equipment at the beginning of cycle of multiple drugs requiring both intramuscular and subcutaneous administration; potentially creating an impression that unreasonably large quantities of injecting equipment are procured. Thirdly, in Australia steroid injecting equipment (detached syringe plus injection and drawing up

needle) cost less per unit than the combined 1ml needle and syringe; thus 15% of injecting equipment does not necessarily equate to 15% of expenditure. In Queensland, where a similar increase in people who inject IPEDs was observed over the last 5 years (2) and NSP access is unrestricted, the state-wide expenditure on injecting equipment for IPED injectors attending NSPs in the 2013/14 financial year was approximately AUD\$50,000 (R Kemp 2015, pers. comm., 26 October). Assuming similar expenditure on IPED injecting equipment in NSW, this represents <1% of the annual NSW NSP budget (3) and is relatively inexpensive compared to the cost of treating BBV infections (4). Nevertheless, given the 25% reduction in NSP spending nationally between 2002-03 (AUD\$36.8M) and 2009-10 (AUD\$28.75M) (5), we agree with van Beek and Chronister that Australian NSP budgets are currently stretched and resources provision for NSPs is an issue in other countries.

The primary aim of the NSP is to prevent BBV transmission by providing sterile injecting equipment and information on safer injection practices. The results of the KRC study indicate that receptive sharing of needles and syringes is low among IPED injectors sampled, indicating that they have been successful in minimising injection-related risk in this population. This success should be applauded. Of concern is the high proportion of gay and bisexual men in the KRC study (42%), including four who self-reported that they were living with HIV infection. Although none of the KRC respondents self-reported hepatitis C virus (HCV) infection, only one third reported diagnostic screening for HCV in the previous year. Previous Australian research identified HCV antibody prevalence of 10% among people who inject steroids (6), significantly higher than observed in the general community (7). Sero-prevalence of BBVs among IPED injectors in Australia is likely to be comparable to that in United Kingdom (UK), with an estimated 1% living with HIV infection, 8% exposed to hepatitis

B and 5% to HCV (8), despite relatively short histories of injection. In the UK, the National Institute for Health and Care Excellence (NICE) guidelines specifically recommend NSP provision to people who inject IPEDs (9). In Australia, the Fourth National Hepatitis C Strategy 2014-2017 acknowledges that the drug of choice is changing among people who inject drugs (PWID), and states that the injection of methamphetamines and performance and image-enhancing drugs is creating new groups at risk of hepatitis C, and thus new target groups (10).

WHO/UNAIDS/UNODC Technical Guide for national HIV prevention, treatment and care, advocates universal access among PWID and recommend that services (including NSP) should be equitable, non-discriminatory (without exclusion criteria) and that supply should be determined by need and not limited by cost or other considerations (11). This Technical Guide also states that service access should not be restricted by sociodemographic or other criteria, including age, gender, sexual behaviour, employment status or substance use status.

As in the UK (12), a high proportion of people who inject IPEDs attending Australian NSPs obtain injecting equipment for others, sometimes for many people. This suggests that, rather than limit NSP service delivery, greater efforts are required to engage with IPEDs injectors who are not currently engaged with harm reduction services and may be at greater risk. Harms associated with injection of PIEDs extend beyond the transmission of BBVs through injection. In a previous Australian study, 41% of men who injected steroids reported an injection-related health problem in the previous month and 6% reported ever experiencing an injection site abscess (13). A recent UK study also identified high prevalence of injection site infections and injuries in this population, with over a third reporting redness, swelling or tenderness in the previous year and 6-8% ever experiencing an abscess or open wound (14). As in the

KRC study, Larance and colleagues (2008) also documented low prevalence of receptive needle and syringe sharing (5%), however injection from a shared vial or bladder was much more common (29%). Further, high levels of both current psychoactive drug use (8, 15) and transitions between IPEDs and psychoactive drug have been documented (16). Finally, a screening process to identify 'need' of specific groups of people who inject drugs, in which those injecting IPEDs are deemed to be at negligible risk of BBV transmission, may result in increased complacency and have a negative impact on risk behaviour with consequent increases in BBV transmission.

Australian NSPs have historically been guided by the principles of equity and non-discrimination in keeping with the universal access advocated in the WHO/UNAIDS/UNODC Technical Guide. The provision of NSP access to people who inject IPEDs in Australia and elsewhere should be not a public policy dilemma, as all forms of injecting drug use have the potential to increase the risk of transmission of BBVs and cause other harms.

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