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National Prisons Hepatitis Education Project: HepPEd

Report of findings from the National Needs Assessment and Steering Committee Process: Public Health Literacy and Hepatitis C Education in the Australian Prisons

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Kirby Institute

National Prisons Hepatitis Education Project
Version 2.0 dated September 2021

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Acknowledgements

The National Prisons Hepatitis Education Project (HepPEd) is an initiative of the National Prisons Hepatitis Network (NPHN). The Project is being undertaken by the Kirby Institute, UNSW Sydney in partnership with the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM).

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Collaborators

The Project is being conducted in collaboration with the national and state-based hepatitis and drug-user organisations, and the state and territory justice health and corrections organisations. We would like to thank members of the NPHN for facilitating connections and engagement with potential participants in each jurisdiction. We would also like to thank members of the collaborating organisations for their participation in interviews and representation on the national Steering Committees.

Participating organisations

Justice Health (ACT)
ACT Corrective Services
Top End Health Service (NT)
Northern Territory Department of Health
Northern Territory Correctional Services
Justice Health & Forensic Mental Health Network (JHFMHN - NSW)
Corrective Services NSW
South Australia Prison Health Service
Department of Correctional Services (SA)
Royal Adelaide Hospital (SA)
Queensland Health
Queensland Corrective Services
Correctional Primary Health Service (TAS)
Tasmania Prison Service
St Vincent’s Hospital Melbourne (VIC)
Justice Health (VIC)
Corrections Victoria
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Australian Injecting and Illicit Drug Users League (AIVL)
Hepatitis Australia
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Steering Committee Members

Steering Committees comprised representatives of the target audience groups and selected members of the NPHN with relevant expertise in HCV education, clinical care, epidemiological and public health research, consumerism, and advocacy.

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Funding

The Project was funded by AbbVie Pty Ltd, Gilead Sciences, Eliminate hepatitis C Australia (EC Australia), and the National Health and Medical Research Council (NHMRC).

Purpose of this document

This report details the outcomes of the Development Phase for the National Prisons Hepatitis Education Project (HepPEd; the 'Project') and describes findings from a national needs assessment and steering committee process. It brings together national-level data gathered to provide an understanding of the perceived knowledge, attitudes, and capabilities regarding hepatitis C (HCV) testing and treatment in the prison sector by the three target audience groups - healthcare providers, correctional officers and people who are incarcerated.

For the needs assessment, a review of the hepatitis service infrastructure within each Australian state and territory prison jurisdiction was undertaken, and mixed methods interviews of key stakeholders in each jurisdictions were undertaken. These interviews allowed identification of existing HCV education programs and resources (and education covering blood-borne viruses (BBVs) or communicable diseases more broadly) and perceptions of the key stakeholders regarding the effectiveness of these existing education programs and resources, as well as perspectives on the HCV-related knowledge, attitudes and capabilities of the three target audience groups in each jurisdiction. Additionally, this report collates the advice from the three national Steering Committees which were convened (one for each target audience group) to make recommendations on the resource types, key topics/themes, and delivery mode of the Education Program (the 'Program').

The first iteration of this report (version 1.0 dated 8 July 2020) was drafted to provide background and preliminary recommendations to the Steering Committees from the needs assessment - to inform the design of an evidence-based Education Program tailored to three target audience groups. This finalised Development Phase report has been extended to describe the co-design process undertaken by the key stakeholders during the consultation process with the Steering Committees leading to the design brief.

The overall goal of the Education Program is to improve HCV public health literacy (knowledge; attitudes; capabilities) in the prison sector, to facilitate enhanced HCV testing and treatment uptake, and ultimately contribute towards efforts to achieve national elimination of HCV.

Executive summary

Background	Australia is progressing well towards the World Health Organisation hepatitis C virus (HCV) elimination goals for the country. Direct acting antiviral (DAA) therapies are available to all Australians, including people in prison. Given the high HCV incidence and prevalence in the prisons, there is an ongoing need for scale-up of DAA treatment in this sector. Although the hepatitis health service infrastructure in prisons is now generally mature across the country, only a minority of those potentially eligible are being treated. Further initiatives are needed to address residual barriers to increasing treatment uptake in Australian prisons. The National Prisons Hepatitis Education Project (HepPEd) aims to deliver prison-specific HCV education to enhance the *public health literacy* (knowledge; attitudes; capabilities) of the custodial sector including healthcare providers, correctional officers, and people in prison. In the first instance, a national needs assessment was conducted to understand the health literacy needs of these specific target audience groups, and to identify barriers to the scale-up of HCV testing and treatment in the sector. The outcomes of the needs assessment informed the co-design process with national Steering Committees (one for each target audience group). The Project is being facilitated by a Project Team, made up of individuals with relevant expertise from the Kirby Institute and the Australasian Society for HIV and Hepatitis Medicine (ASHM).
Methodology A	National needs assessment: Background information regarding the demographic and educational characteristics of the healthcare and correctional staff, and the characteristics of prisons and prisoner populations were gathered from public domain sources, including academic publications, organisational websites, as well as annual organisational reports and other related documents. Information on available online and offline educational resources for HCV (or covering blood borne viruses (BBVs) or communicable diseases more broadly) in the sector, were collected to assess gaps in resources and potential for adaptation as a national resource. A description of each resource along with a copy of the resource (where available) has been collated in a *Resource Catalogue.* Mixed-methods interviews were conducted with 33 selected key stakeholders, including directors and senior managers of custodial and justice health services, and non-governmental organisations (Interview A), prison-based HCV education developers/providers (Interview B), and 7 members of the Education Program target audience groups: healthcare providers and correctional officers (Interview C). Interviews with people in prison continue to be delayed due to barriers relating to the COVID-19 pandemic. Interviews with people in prison will occur in the second half of 2021 and findings will be included in a research paper planned for publication in late 2021.

Methodology B	Stakeholder workshops: Three National Steering Committees were convened to advise the Project Team on the design concepts and delivery modes for educational resources for each stream of the Program (one for each target audience group; see Fig 1). Each Steering Committee was led by two Co-Chairs with diverse background expertise relevant to that group. The specific aims of the Steering Committees were to resolve: 1) key educational themes and messaging; 2) key topics and learning objectives; and 3) educational resource types for each target audience group. A framework was developed to guide the Committees through the design, development, and delivery stages of the Program (see Appendix B). In the period between September 2020 and February 2021, Steering Committees met for two rounds of consultation to discuss high-level concepts and resource types, themes, and topics for their element of the Program. Steering Committee Co-Chairs met an additional three times to further refine the overall direction and the specific content for each element of the Program and to ensure consistency and cohesiveness across the Program as a whole. Based on the Steering Committee discussions, the key themes and messaging, key topics and learning objectives, and planned resource types for each element of the Program were collated into a design brief, which was used to inform design agencies in an open tender process. A preferred design agency was then selected, and has been contracted to undertake the design and development of the suite of resources for the Program.
Findings A	National needs assessment: there were high levels of consensus from among those interviewed (Interviews A, B, and C) regarding the need for development of prison-specific HCV education for healthcare providers (82% of respondents), correctional officers (91%), and people in prison (91%). Clinicians actively involved with hepatitis care in the prison sector were considered by interview participants to have strong HCV health literacy across all aspects (knowledge; attitudes; capabilities). In contrast, clinicians not directly involved with hepatitis care were generally viewed by interview participants as around ‘average’ across all health literacy aspects. Non-clinicians (e.g. drug and alcohol workers) were perceived by interview participants to have the lowest health literacy, with the majority of interview participants perceiving this group to only have ‘adequate’ health literacy across all aspects. Correctional officers were generally considered to have ‘poor’ to ‘adequate’ health literacy across all aspects. Perceptions of the health literacy of people in prison were varied, ranging from ’good’ knowledge, attitudes, and capabilities to ‘poor’. These findings were consistent with the findings from interviews with members of the target audience groups.

Findings B	The Steering Committee for the Healthcare Provider elements of the Program resolved to focus on the non-hepatitis skilled healthcare workforce (i.e. clinicians and non-clinicians that are not directly involved with hepatitis care), and for this element of the Program to have an overall objective to better encourage and support this group in facilitating the engagement of people in prison with HCV testing and treatment services, and thereby to enhance testing and treatment uptake. This aligns with the health literacy concept that seeks to enhance 'capabilities'. The Steering Committee for the Correctional Officer element of the Program resolved that the focus should be on increasing support for people in prison (by officers) to attend health services for HCV testing and treatment, with a particular emphasis on shifting officer attitudes. Proposed solutions to overcome negative attitudes were centralised around the concepts of safety in the workplace (personal safety), and to leverage the recent increase in general awareness of public health (due to the COVID-19 pandemic), essentially establishing a 'call to action' for a safer work environment. This aligns with the health literacy concepts that seek to enhance each of 'knowledge', 'attitudes', and 'capabilities' among the correctional officer population. The Steering Committee for the People in Prison element of the Program resolved that the focus should be on encouraging all people in prison to actively engage, and to encourage others to engage, with HCV testing and treatment services - in order to enhance testing and treatment uptake. This aligns with each health literacy concept and seeks to particularly enhance 'attitudes', and 'capabilities' among the population of people in prison.
Conclusions	Key educational focus areas were identified for each of the target audiences. Amongst the healthcare provider group, the non-hepatitis skilled workforce is most likely to benefit from further HCV education, in particular focussing on enhancing skills and building confidence to actively promote HCV testing and treatment of people in prison. Correctional officers and people in prison would benefit from prison-specific HCV education particularly aimed at enhancing knowledge and shifting negative attitudes. It was resolved that the resources for each target audience group must account for the barriers to education delivery identified in this report. Most notably, this included lack of time for healthcare providers; the lack of mandatory health training, limited opportunities for education, and potential disinterest (i.e needing incentives) for correctional officers; and the stigma and discrimination towards people in prison living with, or at risk of, HCV. Development and delivery of a Program addressing these gaps for each target audience group will likely enhance the scale-up of HCV testing and treatment in the sector. The Project Team resolved that the Program should be developed with an intention to value-add, rather than replace, existing education being provided in the sector.

Recommendations - General	Based on the findings from the needs assessment and outcomes from the national Steering Committees, as outlined in this report, the Project Team provided the following recommendations to inform the development of resources. *Each* Program was recommended to incorporate: • consistent and clear messaging, and prison-identifiable characters; • elements of narrative, storytelling, and conversations; • short and targeted resources aligning with health literacy outcomes; • an element of face-to-face delivery – particularly peer-to-peer; • incentives for participation (e.g. accreditation, barbeques, merchandise); and adaptation of, or building upon, existing education resources (if relevant).
Target audience group-specific recommendations - *Healthcare providers*	Healthcare Providers Program theme: **'Let's talk about hep C: prevent, participate, eliminate (PPE)'** The Steering Committee recommended a shift away from traditional and lengthy face-to-face workshops (e.g. half or full-day workshops) to short, focussed messaging. The following combination of resources/modes of delivery were recommended for development (focussing on capabilities relevant to non-hepatitis clinicians): • health promotion-style clinician print resources (e.g. posters and information booklet; key take home messages/top tips on mugs/pens etc; concise step-by-step guidelines); • story-driven, interactive online modules and evaluation resources (e.g. through the clinical care cascade; order a step-by-step process; brief drag and drop knowledge assessment quiz) • audio-visual narrative and story-telling resources (e.g. a series of short, animated video clips) • small group discussion sessions, facilitated by local champions (e.g. prison-based hepatitis nurses)
Target audience group-specific recommendations - *Correctional Officers*	Correctional Officer Program theme: **'Let's talk about hep C: stop the spread, reduce the risk'** The following combination of resources/modes of delivery were recommended for development: • low literacy resources (e.g. more pictures, less text) • peer-to-peer materials (e.g. facilitator guide and resources) • small group discussion sessions, facilitated by peer champions • health promotion style print resources (e.g. information booklet with knowledge testing; key take home messages/top tips on merchandise; posters with key messages) • story-driven, interactive online modules (e.g. scenario-based 'choose your own adventure' online module); audio-visual

	narrative and story-telling resources (e.g. series of short, animated video clips)
Target audience group-specific recommendations - *People in prison*	People in Prison Program theme: **'Let's talk about hep C: test, treat, cure, prevent – it's simple'** The following combination of resources/modes of delivery have been recommended for development: • low literacy resources (e.g. more pictures, less text) • peer-to-peer materials (e.g. facilitator guide and resources) • informal one-on-one or small group discussion, led by peer-educators (e.g. speaker with lived experience and/or peer-based storytelling) • print resources (e.g. information booklet with knowledge testing; key take home messages/top tips on merchandise (e.g. beanies etc); posters with key messages; series of short comic book stories) • audio-visual narrative and storytelling resources (e.g. series of short, animated video clips)

1. Introduction

Australia is progressing well in efforts towards elimination of hepatitis C virus (HCV) infection as a public health threat by 2030 in line with the World Health Organisation goals.[1] Highly effective direct acting antiviral (DAA) therapies for HCV are available to all Australians, including those who spend time incarcerated. Given a 10-20% prevalence of chronic HCV amongst the prisoner population,[2 3] Australia has recognised the opportunity the prison setting can provide in the focussed scale-up of HCV testing and treatment.[4] The number of eligible individuals initiating HCV therapy in Australian prisons has steadily increased since the initial availability of DAAs in 2016, rising from over 2,000 in 2016 to approximately 4,000 in 2019, reflecting the fact that that at least more than a quarter of all those initiated on treatment nationally in 2019 did so from prison.[5 6] Nevertheless, a significant portion of the chronically infected population in correctional centres remains untreated. It is evident that the health service infrastructure in the prisons is now reasonably well-established in each jurisdiction, supported by GP- and nurse-led models of care with specialist support and telemedicine, as well as reasonable access to laboratory testing for fibrosis assessment or portable fibro-elastography.[7 8] However, in order to keep on track towards national elimination targets, further initiatives are needed to address barriers that remain to achieving scale-up of HCV treatment in prisons, most notably lack of awareness of HCV and its highly effective treatment, stigma against people who inject drugs (PWID) and/or have HCV infection, and the lack of a conducive environment to support individuals to engage with the HCV testing and treatment services in prisons.[5 9]

The Kirby Institute on behalf of the National Prisons Hepatitis Network (NPHN) was funded by the National Health and Medical Research Council (NHMRC) Centre for Excellence in Offender Health, Eliminate C Australia, AbbVie Pty Ltd., and Gilead Sciences to undertake the National Prisons Hepatitis Education Project. A Project team with expertise in: prison-based hepatitis service, as well as education resource development and delivery was formed with members of the Kirby Institute and the ASHM. In addition, a NHMRC Partnership Project was awarded to support a formal research evaluation of the effectiveness of the HepPed project.

The broad aim of the Project is to develop, deliver, and evaluate a prison-specific HCV Education Program targeting *health literacy* for the three key populations in the prison setting (healthcare providers; correctional officers; and people in prison). Health literacy refers to “people’s knowledge, motivation and competencies to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion.”[10 11] Importantly, improving health literacy is associated with informed health choices, reduced health risks, better navigation of the health system, improved patient safety, and fewer inequities in health.[12] When a whole-of-sector approach is taken to improve health literacy, it is considered a *public health literacy* intervention,[13] which again infers: knowledge, including awareness of the health of other populations (in this case prisoners); attitudes, which here includes adopting a positive approach towards supporting the health of other populations (in this case prisoners); and capabilities, which here refers to acquiring the skills to act in support of the health of other populations (in this case prisoners). It is anticipated that the development and delivery of the Education Program will be associated with enhanced HCV testing and treatment of prisoners.

Against this backdrop, the Education Program will cover three health literacy domains (*knowledge*, *attitudes*, and *capabilities)* tailored for three target audience groups (healthcare providers; correctional officers; and people in prison). The principles of health literacy outlined above will be applied in the Program as follows:

- *knowledge* refers to general awareness of HCV infection and disease, as well as prison-based HCV testing and treatment services. For healthcare providers, this may include a basic understanding of epidemiology (prevalence, incidence, risk groups and behaviours), testing

modalities (phlebotomy, rapid point-of-care, dried blood spot), diagnosis (HCV antibody and PCR testing), disease (symptoms, and complications such as cirrhosis and hepatocellular carcinoma), treatment (regimens, side effects, duration, efficacy), and prevention (opiate substitution treatment, treatment-as-prevention); and for correctional officers and people in prison, this may include a basic understanding of risk factors and behaviours, available testing modalities, HCV antibody and PCR testing and diagnosis of acute and chronic infection, treatment options (side effects, duration, efficacy), and harm reduction or prevention measures;
- *attitudes* refers to willingness of the individual to engage with HCV testing and treatment, and willingness of correctional officers and healthcare providers to support people in prison to participate in the HCV care cascade. In addition, *attitudes* refers to overcoming stigma against those engaging with, or supporting, HCV testing and treatment amongst people in prison, correctional officers, and health care providers; and
- *capabilities* refers to the awareness of, and ability to support, engagement with local HCV testing and treatment services, as well as the capacity to inform others about the merits of HCV testing and treatment.

In the first instance, a national needs assessment was conducted to understand the health literacy of the target audience groups for the Education Program and to identify the key barriers relating to HCV testing and treatment scale-up in the prison setting. Following the national needs assessment, a national steering committee process was undertaken to co-design the Program, including specific elements for each target audience group.

2. Methods

2.1 Methods A: needs assessment and scoping exercise

Background information regarding the demographic and educational characteristics of healthcare and correctional staff were gathered from public domain sources, including academic publications, organisational websites, as well as annual organisational reports and other related documents. In addition, data regarding the characteristics of people in prison and the prisons in which they were housed were collected.

The educational needs assessment was based on three semi-structured interview schedules utilising mixed qualitative and quantitative methods which were developed for this exercise, to interview: directors and senior managers of custodial and justice health services, and non-governmental organisations (Interview A); prison-based HCV education developers/providers (Interview B); and Education Program target audience groups: healthcare providers; correctional officers; people in prison (Interview C). For the purposes of anonymity, quotes are presented with broad organisational affiliation, rather than identification of a role within the organisation (i.e., corrections personnel rather governor).

Ethical approval for the needs assessment interviews (A-C) was obtained from the UNSW Human Research Ethics Committee (HC190435 and HC190436), with additional ethics approvals obtained as required by jurisdictions.

Participants in Interview A included male and female directors and commissioners of state government corrective service organisations and justice health hepatitis services, and CEO's and senior managers of national and state-based hepatitis and drug-user non-governmental organisations. Participants in Interview B included male and female education providers/trainers and developers of existing hepatitis education programs for the three target audience groups, and staff members involved in education delivery from state government corrections and health organisations, as well as state-based hepatitis and drug-user organisations. Participants in Interview C included male and female key informants from the healthcare provider and correctional officer target audience group, including registered nurses, medical officers, correctional officers, and senior custodial staff. Interviews with people in prison continue to be delayed due to COVID-19 pandemic-related barriers and restrictions. Interviews with this group are planned for the second half of 2021 and findings included in a research paper planned for publication in late 2021/early 2022.

Audiotaped, conversation-style telephone or video interviews were conducted to discuss topics relating to health literacy of the target audience groups, prison-based HCV testing and treatment services, and HCV education programs. Qualitative and quantitative data were collected from interview participants regarding their perceptions of healthcare providers', correctional officers', and prisoners' health literacy (knowledge of HCV and HCV services; attitudes towards HCV testing and treatment of prisoners; awareness of prison-based HCV services; and the ability to engage prisoners with these services). Information on the importance and effectiveness of existing HCV education resources and programs, barriers to delivery of education in the sector, as well as information regarding areas of need and optimal modality of education for the target audience groups were also collected. These topics were explored initially with open-ended questions, followed by a series of more structured multiple-choice questions to quantify information. Select quotes from the qualitative components are included throughout this report. The information gathered on existing education resources and programs specific to HCV (or covering BBVs or communicable diseases more broadly) available in the prisons in each state or territory was collated into a comprehensive *Resource Catalogue*, supplemented by copies of the resources (where available).

2.2 Methods B: National Steering Committees

Three National Steering Committees were convened to advise the Project Team on the design concepts for each element of the Program (see Fig 1). The specific aims of the Steering Committees were to resolve: 1) the key themes and messaging, 2) the key topics and learning objectives, and 3) the resource types, for each target audience group. Steering Committee invitations were extended to members of the target audience groups and selected members of the NPHN with relevant expertise in education, clinical care, epidemiological and public health research, consumerism and advocacy.

A framework was developed to guide the Committees through the design, development, and delivery stages of the Program (see Appendix B). This report includes findings from Components 1 - 3 as outlined in the Steering Committee Framework Document (Components 4 - 6 pertain to the 'delivery phase' and will be undertaken in the second half of 2021/early 2022).

Each Committee included multi-disciplinary and multi-jurisdictional representation and was led by two Co-Chairs. Specifically, the Healthcare Provider Program Committee comprised eight male and female members from six jurisdictions (including healthcare providers working in the prison setting), the Correctional Officer Program Committee comprised eight male and female members from seven jurisdictions (including a correctional officer), and the Prisoner Program Committee comprised ten male and female members from four jurisdictions (including members with lived experience of incarceration and experience with HCV treatment).

In August 2020, the Co-Chairs met with the Project Team for a briefing session on the objectives of the overall project and their role as Co-Chairs for their Committee, the findings and recommendations from the Needs assessment, the Steering Committee Framework, and to initiate discussion around creative resources for their Program. A follow-up briefing to introduce all Co-Chairs to each other and to consider initial thoughts on design directions for each target audience group was also undertaken to ensure cohesion across the Program as a whole. Both meetings were held via videoconference on Zoom.

Between September 2020 and February 2021, Steering Committees met with the Project Team for two rounds of consultation to discuss high-level concepts and resource types, themes, and topics for their Program. All Committee members were provided with the relevant Project briefing documents (Project Plan; Interim Report of Findings from the Needs Assessment; Steering Committee Framework Document; Resource Catalogue), prior to the first meeting. The Project Team and the Co-Chairs met one additional time during this period to further refine the direction and specific content for each target audience group, and to ensure consistency and cohesiveness across the Program as a whole. Each Committee meeting was approximately 60 - 90 minutes. Meetings were held via videoconference on Zoom, and discussions were recorded and minuted. Surveys aiming to finalise key concepts, themes, learning objectives, and topics, and consolidate outstanding discussion points, were completed by members following each meeting, and additional input was sought via email between meetings, to ensure each Committee member had ample opportunity to contribute.

Based on the Committee discussions, the key themes and messaging, key topics and learning objectives, and planned resource types for each Program were collated into a design brief, used to inform design agencies during an open tender process. A design agency has been contracted to undertake the design and development of the suite of resources for the Education Program. Once developed, the resources will be focus tested for acceptability of the 'look and feel' of the character design and storyline with members of the target audience groups. An 'Education Program Instruction Manual' that outlines the learning objectives, describes the overall program and resources, defines roles and responsibilities of those involved in the delivery of the Program, and instructions for educators on how to deliver the Program, will be developed as part of the Education Program package.

Additionally, an 'Implementation Plan' that outlines the logistics and plans for the national roll-out of the Program, the organisations involved in each jurisdiction, site selection, and timelines and milestones, will also be developed as part of the Education Program package.

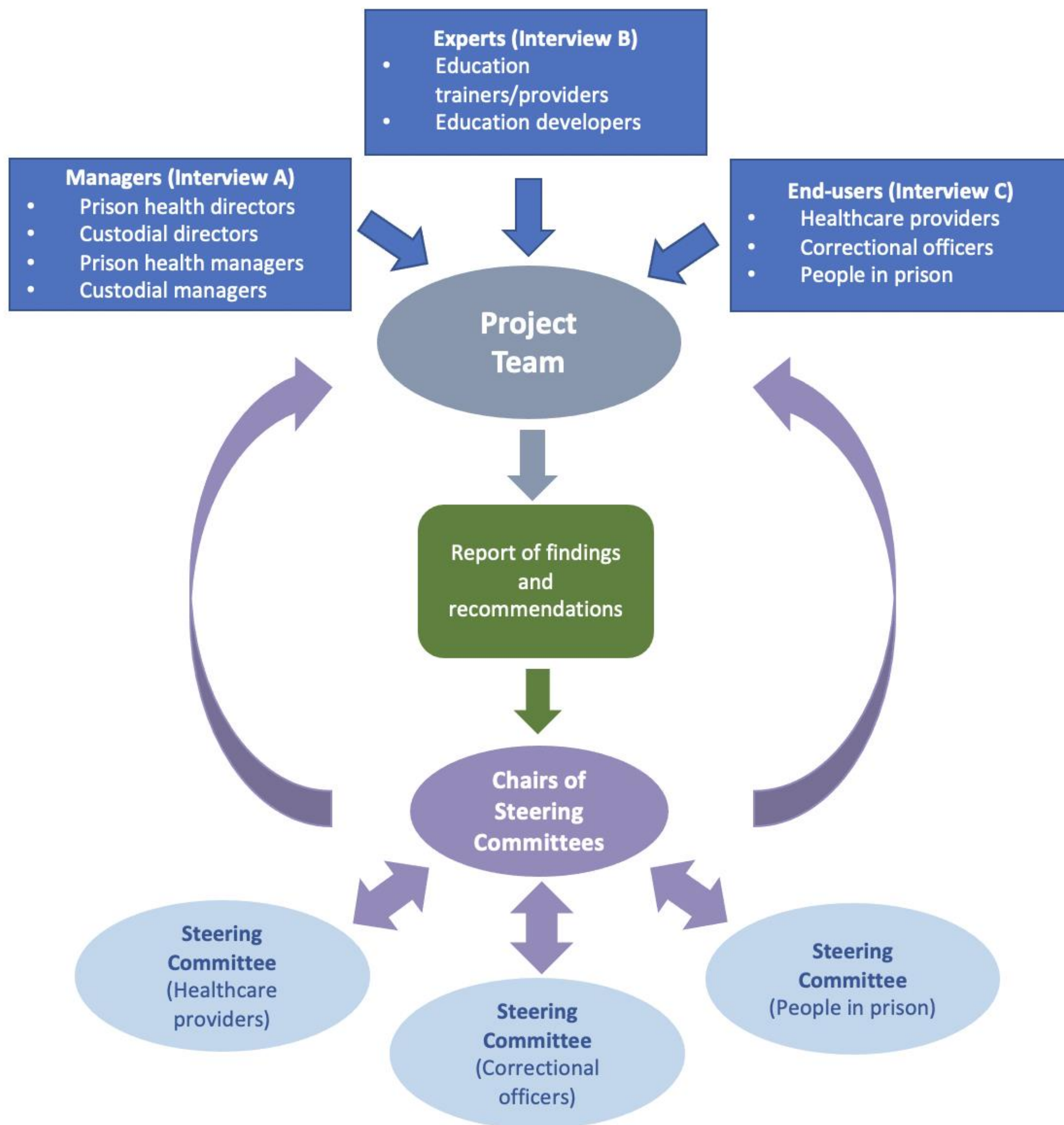

Figure 1. Steering Committee consultation process

3. Results

3.1 Results A: Background information

3.1.1 Target audience group characteristics

Health care providers in the custodial sector across the country include: nurses (primary care, mental health, drug and alcohol), doctors (general practitioners, psychiatrists, drug and alcohol physicians), dentists, psychologists, other allied health practitioners (physiotherapists, occupational therapists) and Aboriginal Health Workers. These health care providers were found to generally be required to complete a mandatory training program, which typically included a section on infection control and blood borne virus risks, but no specific information regarding HCV testing or treatment.

Correctional personnel across the country include senior administrators (including governors, managers of security) and officers. Correctional personnel are responsible for the custody, care, supervision, welfare, and rehabilitation of people in correctional centres. For initial eligibility, state and territory employers generally require potential officers to have: Year 10 education; adequate standards in literacy and numeracy tests, a psychological evaluation and a medical assessment; and completion of a National Police Check. The 9-to-12-week initial training program in each state or territory generally covers correctional rules and procedures, legislation, weapons handling, social issues, and human relations. For existing correctional officers, further optional training is available in some jurisdictions to acquire knowledge and skills in areas such as Aboriginal cultural awareness, management of at-risk people in prison, and security awareness. In NSW for instance, a one-hour communicable diseases training program is available that covers “HIV/AIDS, reducing the spread of communicable infections, standard and additional precautions, needlestick injuries, confidentiality and blood spills”.

Prisoners: in June 2019, there were 43,028 individuals accommodated in Australian adult correctional facilities, including 14,210 who were unsentenced (28%).[14] Males accounted for 92% of all people in prison (39,586 prisoners) and females the remaining 8% (3,494 prisoners). People of Aboriginal and Torres Strait Islander descent accounted for over a quarter (28% or 12,048 prisoners) of the total prisoner population. The 2018 Health of Australia’s Prisoners report found that 17% of people entering prison had either no education or had completed Year 8 or less, 17% had completed Year 9, and 29% had Year 10 education only.[15] The 2016 National Prison Entrants Blood Borne Virus Survey revealed that: 38% of people entering into prison were aware of the new DAA treatments for HCV, however only 16% or fewer were confident that DAA treatment *did not*: involve injections, take up to a year, or have limited side effects.[3]

3.1.2 Prison characteristics

In 2019, there were 111 correctional centres in Australia.[16] A state by state review of the characteristics of the prisons and the target audience populations for this education Project is outlined below:

- In the ACT,[14] there was one prison – the Alexander Maconochie Centre, with the territory being 2,358 square kilometres in size. The prison housed approximately 474 individuals at any one time. People who were incarcerated included: 40% remandees; 94% males; with 22% being of Aboriginal and Torres Strait Islander descent. The custodial service is public sector and provided by ACT Corrective Services, with a workforce of approximately 404 FTE.[17] Health services are provided by the territory-wide Justice Health Service.
- In NSW,[14] there were 40 prisons spread across 800,000 square kilometres, housing approximately 13,458 individuals at any one time. People who were incarcerated included: 34% remandees; 93% males; with 23% being of Aboriginal or Torres Strait Islander descent. The state custodial service was predominantly public sector with approximately 4,000 frontline employees. There were also two privately run prisons, Junee and Parklea, run by GEP Group. Health services were provided by the state-wide, public sector Justice Health & Forensic Mental Network (JH&FMN) (under the NSW Ministry of Health) in all but the same two prisons (Junee and Parklea), with a JH&FMN clinical workforce (doctors, nurses, allied health practitioners) of approximately 800 fulltime equivalents (FTE).
- In the NT ,[14] there were two prisons located across 1.421 million square kilometres housing approximately 1,731 individuals at any one time. People who were incarcerated included: 30% remandees; 94% male; with 83% being of Aboriginal and Torres Strait Islander descent. The custodial services were public sector, provided by NT Correctional Services (NTCS) across both prisons. Health services were provided in prison by the regional service delivery arms of the Department of Health.
- In QLD,[14] there were 14 prisons spread across 1.853 million square kilometres, housing approximately 8,771 individuals at any one time. This included two privately owned prisons, Arthur Gorrie Correctional Centre (AGCC) and Southern Queensland Correctional Centre. People who were incarcerated included: 31% remandees; 90% males; with 33% being of ATSI descent. The custodial service was predominantly public sector and provided by Queensland Corrective Services. Health services were operated independently for each prison as they were the responsibility of the local Hospital and Health Services under a state departmnet, excluding privately operated prisons.
- In SA,[14] there were 9 prisons located across 984,000 square kilometres, housing approximately 2,862 individuals at any one time. People who were incarcerated included: 38% remandees; 93% males; with 24% being of Aboriginal and Torres Strait Islander descent. The custodial service was public sector and provided by Department for Correctional Services (DCS). As part of the Central Adelaide Local Health Network (CALHN), the South Australia Prison Health Service collaborated with DCS to provide primary health services for all prisons across the state.
- In TAS,[14] there were five prisons located across 68,400 square kilometres, housing approximately 693 individuals at any one time, with the great majority being located in the Risdon prison complex near Hobart. People who were incarcerated included: 33% remandees; 92% male; with 20% being of Aboriginal and Torres Strait Islander descent. The custodial service was public sector; provided by the Tasmanian Prison Service, with a workforce of approximately 469 FTE.[18] The health service was provided state-wide by the Correctional Health Service.
- In VIC,[14] there were 11 publicly owned prisons, three privately operated prisons, and one transition centre located across 237,000 square kilometres, housing approximately 8,101 individuals at any one time. People who were incarcerated included: 37% remandees; 93%

males; with 10% being of Aboriginal or Torres Strait Islander decent descent. The custodial service was largely public sector; managed by Corrections Victoria with a workforce of approximately 989 FTE, with the exception of Ravenhall which is operated by the GEP Group.[19] The health service was provided by Justice Health (under the auspices of Corrections Victoria) for all prisons in Victoria, including those that are privately operated.

- In WA,[14] there were 15 prisons located across 2.646 million square kilometres, housing approximately 6,943 individuals at any one time. People who were incarcerated included 28% remandees; 90% males; with 39% being of Aboriginal and Torres Strait Islander descent. The custodial services and health services were both public sector; provided by the Department of Justice.

3.1.3 Needs assessment interviews

a. Interviews A, B, and C

Interviews were conducted between October 2019 and February 2020 (Interviews A & B) and during October 2020 (Interview C). There were 33 selected key informants from each Australian state and territory who participated in Interviews A & B: ACT (3); NSW (3); NT (4); QLD (6); SA (4); TAS (3); VIC (5); WA (5); and 7 members of the target audience groups from two Australian states and territories who participated in Interview C: ACT (1) and TAS (6). The quantitative data gathered in the interviews are illustrated in the Figures (see below); selected quotes from the qualitative dataset are also included (see below).

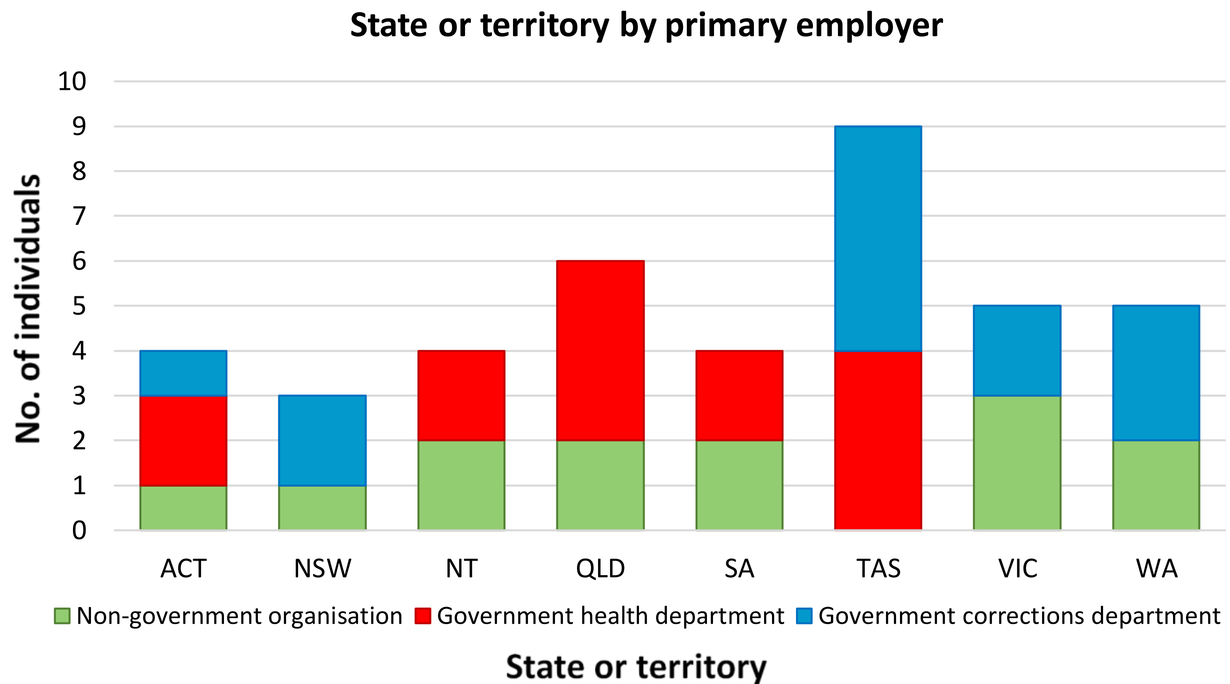

Figure 2. No. of interview participants by primary employer and state/territory

b. Existing resources

A total of 53 education resources and programs specific to HCV (and an additional 59 resources covering BBVs or communicable diseases more broadly) were identified by interview participants as being in current or recent use, and potentially available for wider use in the Australian prison setting. A description of each resource along with a copy of the resource (where available) has been collated in the *Resource Catalogue*. The resource types span print, face-to-face, online, and audio-visual formats; and the frequency of the education programs range from weekly sessions within a short course program to annual sessions, as well as one-off and *ad-hoc* sessions. Participation in the programs were found to predominantly occur on an opt-in or voluntary basis, and as such the reach was generally limited for all target audience groups. Both the resource types and the frequency of sessions varied significantly across jurisdictions. More than half of the resources were designed for the prison setting (versus simply being adopted, unmodified from community resources). It was generally noted that many of the resources appeared to require literacy skills beyond the average level of the target audience, in particular those intended for correctional officers and people in prison. Further, the resource designs rarely included characters recognisable as being from within the prison setting.

The majority of resources available were designed for people in prison (49 HCV-specific resources; 24 resources covering BBVs or infectious diseases more broadly) and included posters, postcards, and pamphlets, face-to-face workshop programs with group discussions, videos and magazines, playing cards, and workbooks and notebooks. All jurisdictions provided people in prison with access to a variety or combination of these resource types. In NSW, people in prison receive a ‘Prisoner Info Pack’ on reception that includes a combination of community and prison-specific resources on HCV testing, treatment, and support services (Hepatitis NSW; also available upon request through the Hepatitis NSW hotline). However, whilst comprehensive, the resources in this pack are quite text heavy, and include graphs and diagrams that appear likely to exceed the health literacy level of the prisoner population.

Hepatitis QLD has developed a series of short videos and a matching set of playing cards, with the theme ‘Easy to get. Easy to test. Easy to treat’. These videos are no more than 60 seconds in length and include simple, targeted and clear messaging, and a light-hearted design. People in prison in WA are also able to access a video as part of the ‘Health in Prison and Health Outta Prison (HIP-HOP)’ program. In contrast to the Hepatitis QLD videos, this video is close to 4 minutes in length and provides detailed information on testing, treatment, and liver disease. The video was designed for Aboriginal people in the community setting, and as such does not contain prison-specific information or characters (Hepatitis WA). In SA, education is occasionally provided through playing games, including card games, aimed at determining risk factors, true or false statements, and trivia, with an element of incentivisation through providing prizes for winners.

There were no resources identified that were specific to HCV for correctional officers, however 22 resources covering BBVs or communicable diseases more broadly were identified. These resources included PowerPoint presentations, face-to-face training sessions, and booklets, worksheets, and fact sheets. HCV education for correctional officers was generally found to be provided at induction as part of a broader blood-borne virus or communicable diseases topic. Correctional officers were unlikely to receive further education throughout their employment. Additionally, the majority of the resources were found to be text heavy and include graphs and figures likely to be beyond the health literacy of the correctional officer population.

"I don't think the information in their initial training has been updated…there's been so many changes around hep C. What I've heard from correctional staff when I see them is that they received different information about hep C back when they were trained." – Education provider on correctional officer education.

In SA, education for correctional officers is provided by Hepatitis SA, primarily as part of induction. Additional training is occasionally provided on an *ad-hoc* basis by Hepatitis SA staff members each time they go into prison, if opportunity permits. The *ad-hoc* education ranges in length and scope depending on time available and generally involves presentations with a particular focus on HCV testing and treatment, and the importance of supporting prisoners to engage with the prison-based health services. This education is perceived to be quite effective at influencing correctional officer knowledge and attitudes, with room for improvement in influencing capabilities.

Several jurisdictions reported utilising the nationally available 'Correctional Officers and Blood-Borne Viruses' booklet to supplement jurisdiction-specific correctional officer training. The booklet is designed to provide correctional officers with essential information about BBVs, how the viruses are spread, and how to protect against infection (ASHM). The resource contains large sections of small text with use of clinical terminology and detailed information presented in tables, likely to be beyond the health literacy of the correctional officer population.

There were four resources specific to HCV for healthcare providers identified (and an additional 10 resources covering BBVs or communicable diseases more broadly). Education for healthcare providers in general was considered to be thorough. However, the resources were typically not designed specifically for the prison setting, the format of the resources were generally that of traditional style presentations which were lengthy and detailed, and were not part of mandatory training - leading to low rates of engagement. Education for this group was predominately designed to train or upskill healthcare providers directly working in the hepatitis space, rather than for the general healthcare provider population, and was occasionally provided via videoconference. In QLD, a PowerPoint presentation detailing the nurse's role in the clinical pathway from diagnosis to cure is available and provided during the nurse induction training session. Several jurisdictions reported utilising the ASHM face-to-face or webinar courses on BBVs and sexually transmitted infections (STIs) for healthcare providers, which are available several times per year. These courses are designed for the general community setting, rather than the prison setting. Additionally, healthcare providers working in HCV care in some jurisdictions were reported to attend viral hepatitis or BBV forums or conferences (both prison- and community-focussed) annually.

c. Effectiveness of existing resources

Interview A and B participants were asked to provide opinions on whether the existing education effectively influenced the knowledge, attitudes, and capabilities of the target audience group. Responses varied both within and across jurisdictions for all target audience groups. For example, education for healthcare providers in the NT was overall considered particularly effective, whereas in VIC and WA the education was deemed to provide only limited effectiveness. For the correctional officer group, there was variability in perceived effectiveness of the education both across and within jurisdictions. There was no jurisdiction that clearly perceived correctional officer education to be particularly effective. For the prisoner population, most jurisdictions considered existing resources to be effective at influencing the health literacy of people in prison, except NSW where the impact was considered to be limited. Several jurisdictions reported the desire for evaluation measures.

d. Importance of prison-specific education

There were high levels of consensus from essentially all those interviewed in Interviews A & B regarding the need for development of prison-specific HCV education for healthcare providers (82%), correctional officers (91%), and people in prison (91%). Members of the target audience groups interviewed in Interview C were also in consensus about the importance of, and need for, HCV education for the prison sector.

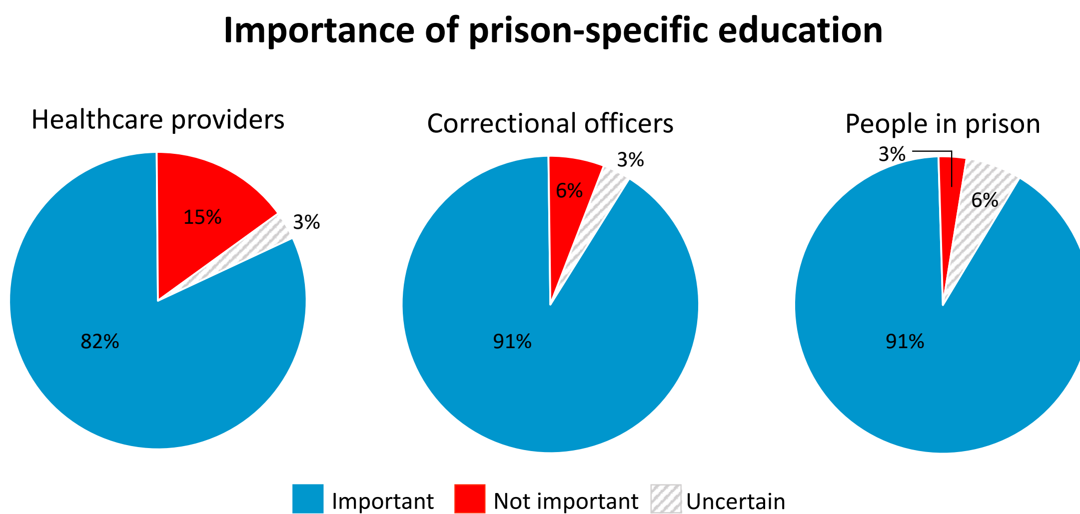

Figure 3. Perceived importance of prison-specific education by target audience

e. Perceived health literacy of target audience groups (Interviews A & B)

Healthcare providers in general were perceived to have 'average' to 'good' knowledge, attitudes, and capabilities. However, when taking a more focussed look into specific sub-groups of healthcare providers, such as clinicians involved with hepatitis services (hepatitis nurses), clinicians not generally involved with hepatitis services (general practitioners; general nurses; psychiatrists etc), and non-clinicians (drug & alcohol counsellors; Aboriginal Health Workers, etc), there was noticeable variance across the groups. A table detailing the collated results of the quantitative interview dataset is provided in Appendix A: Perceived health literacy for each target audience group.

Clinicians involved with hepatitis care were considered to have strong HCV health literacy across all aspects (see Fig. 4; Appendix A). More specifically, 89% of participants considered the knowledge of HCV and HCV services, attitudes towards testing and treatment of people in prison, awareness of prison-based HCV services, and ability to engage people in prison with these services, to be in the 'good' to 'very good' range.

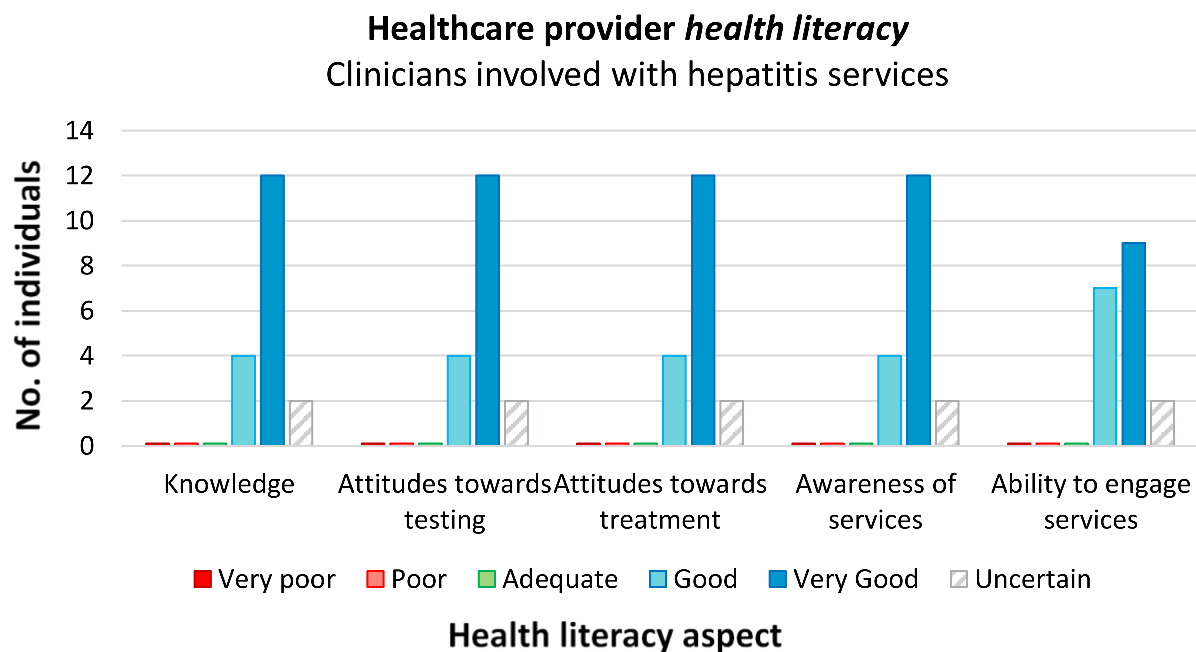

Figure 4. Perceived health literacy of healthcare providers (clinicians involved with hepatitis services)

In contrast, clinicians not directly involved with hepatitis care were generally considered as around 'average' across all health literacy aspects (see Fig. 5; Appendix A). Cross-jurisdiction variance was also evident. For example, knowledge and attitudes towards testing and treatment were most frequently in the 'good' range for this population, however two respondents considered this group to have poor knowledge and attitudes. Interestingly, there was also evidence of within-state variance, with one VIC participant considering this group to be in the good range, whereas another considered the group to be in the poor range.

"People that do work in the hepatitis C space are well across it, but there are other healthcare staff that probably don't have as great a knowledge" – Education developer/provider on health literacy of healthcare providers.

Non-clinicians were perceived to have the lowest health literacy, with the majority perceiving this group to only have 'adequate' skills across all aspects (see Fig. 6; Appendix A).

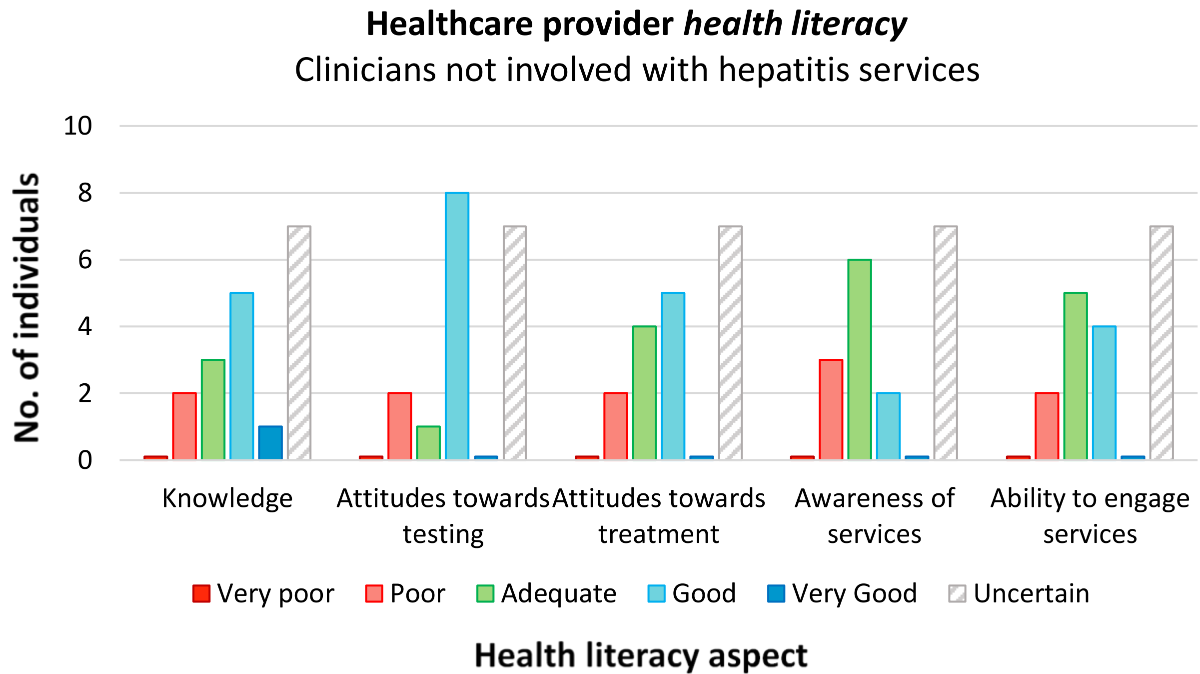

Figure 5. Perceived health literacy of healthcare providers (clinicians not involved with hepatitis services)

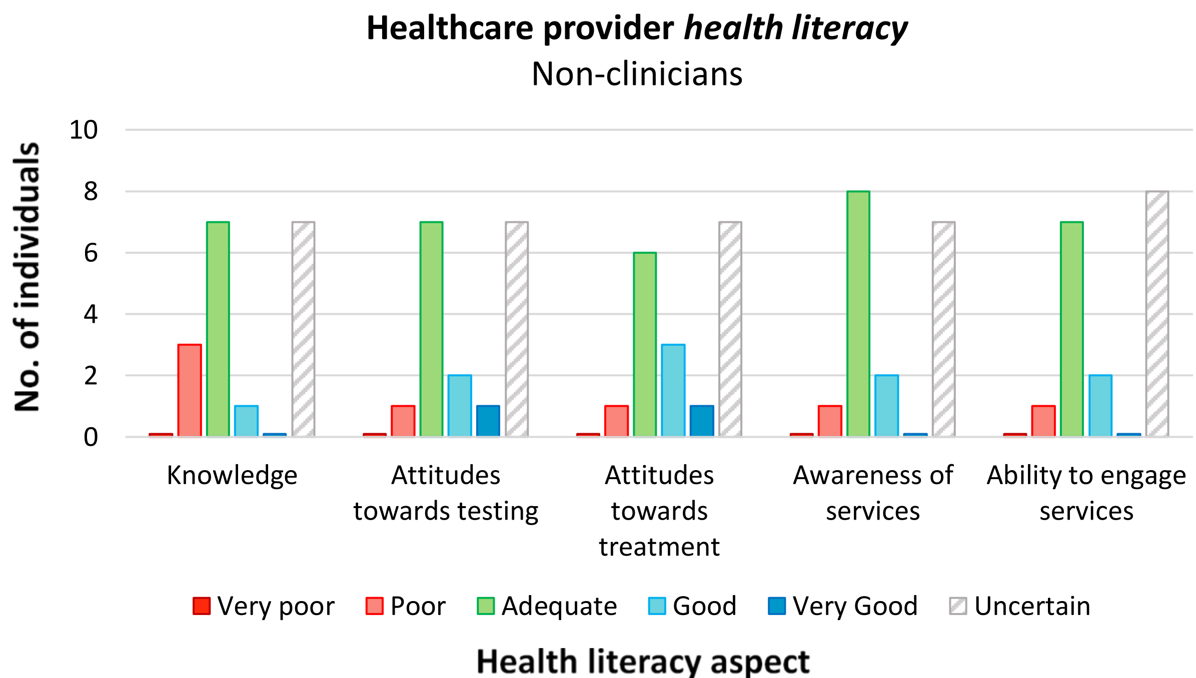

Figure 6. Perceived health literacy of healthcare providers (non-clinicians)

Correctional officers were generally considered to have 'poor' to 'adequate' health literacy across all aspects (see Fig. 7; Appendix A). Over 55% of respondents considered the knowledge and capabilities of this group to be 'poor' or 'very poor'. Attitudes towards testing and treatment of people in prison were considered below average, with the majority (~70%) in the 'poor' to 'adequate' range. Perceptions between the two interview groups (A & B) differed slightly. High level administrators were more generous with their scores for this group, more frequently providing adequate scores, compared with the on-the-ground educators and program developers who provided scores more in the poor range across all health literacy aspects.

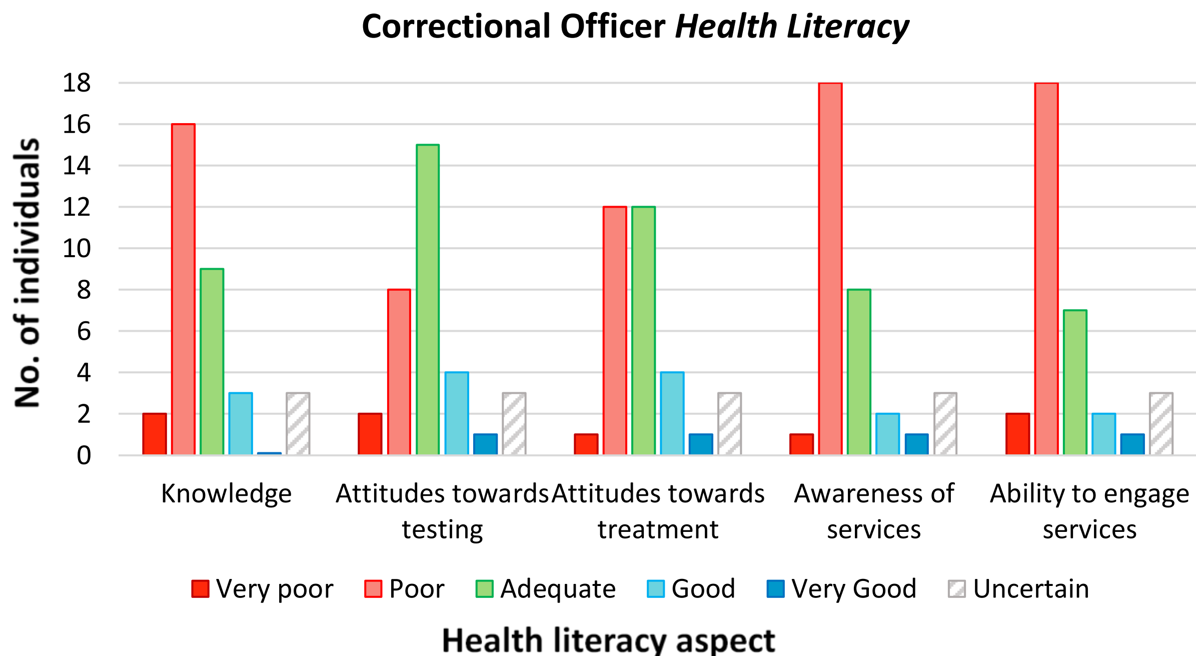

Figure 7. Perceived health literacy of correctional officers

Perceptions of the health literacy of people in prison were the most varied amongst the target audience groups (see Fig. 8; Appendix A). Interestingly, knowledge and attitudes towards testing and treatment were considered predominantly in the 'good' range (38%). Whilst awareness of services was considered to be around adequate (42% in the 'poor' to 'average' range; 33% in the 'good' range), the capability to engage those services was considered quite strong (52% in the 'good' to 'very good' range).

"One of the most informed cohorts we would see are people with a current or previous history of injecting drugs and a proportion of those people have a contact with justice…prisoners might be the most informed group you're looking at" – Executive director, non-governmental organisation, perceptions of health literacy among people in prison.

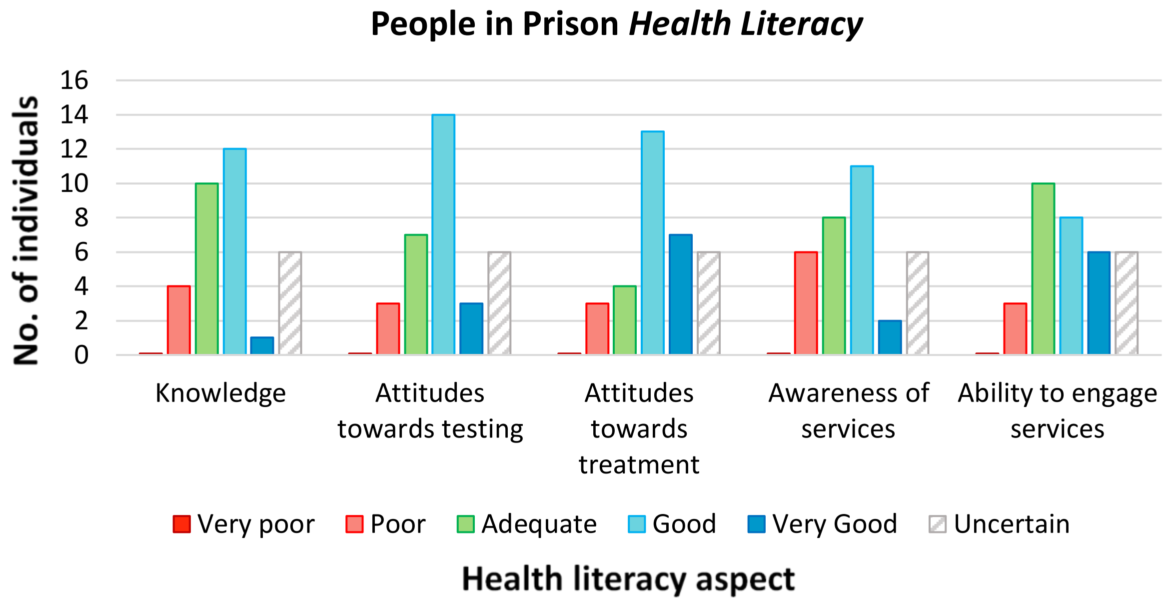

Figure 8. Perceived health literacy of people in prison

f. Perceived and reported health literacy of target audience groups (Interview C)

Healthcare providers

Knowledge: There were varied levels of HCV knowledge amongst the small number of healthcare providers interviewed (n=3). They were generally aware that HCV is common in the prison setting, although they considered the prevalence to be around 30% or higher (though this figure could pertain to pre-DAA era data of prison entrants). The healthcare providers interviewed were also generally aware of the primary transmission route (via sharing injecting equipment) and clinical aspects (positive RNA PCR test indicates current infection; high cure rate; reinfection possible). However, this group were less confident in their knowledge about DAA treatment more generally, the limited potential for side effects during treatment, and possibility of re-treatment. Healthcare providers interviewed raised the issue of a lack of needle exchange programs in prisons leading to high risk for HCV exposure for people in prison, and that education about prevention methods would be beneficial. The healthcare providers interviewed considered the broader healthcare provider group, specifically new staff and those not involved with hepatitis care, to have only moderate to good knowledge around HCV in the prisons, and that there was room for improvement in regard to HCV knowledge.

"It would be good to have more education on introduction to hep C [for new staff], to help with fully understanding [HCV] and be able to participate in the conversation." – Prison health personnel.

"We probably don't think about [HCV] enough for testing…we're probably a bit afraid of our ignorance, and because it doesn't make someone feel particularly unwell, it's easy to sideline it." – Prison health personnel.

Attitudes: Healthcare providers were mostly considered by interview participants to be supportive or very supportive of HCV testing and treatment for people in prison. However, there was some variability in the attitudes reported. Healthcare providers not involved with hepatitis care, new staff, and occasionally long-service staff, were considered to potentially be less supportive or willing to promote engagement in services than those that work in hepatitis portfolios. Reasons noted were that additional work is required, often clear pathways and protocols are not available, and patients may continue to engage in risky behaviour regardless of receiving HCV care. Healthcare providers were also considered to mostly be supportive of people in prison being re-treated for HCV, however, attitudes reported were again varied, with frustration around re-infection and strain on resources being cited as potential facilitators of less supportive attitudes. Some healthcare providers were reportedly more likely to be supportive with user-benefit type scenarios (i.e. if patient stays 'clean', then supportive), but less supportive if reinfection occurs due to 'irresponsibility' of the patient.

"Healthcare provider attitudes could potentially be changed by more encouragement from nurses who are directly involved [with HCV care] and who are focussed on the process of wanting to make change." – Prison health personnel.

Capabilities: The healthcare providers interviewed were generally aware of how the hepatitis services operate in their jurisdiction and were fairly confident in their ability to refer patients to the prison hepatitis service, in particular, when they knew who specifically to refer to. However, this group had varied levels of confidence around other skills relating to HCV. Whilst some were fairly confident in their ability to educate other healthcare staff about HCV or participate in the care of patients being treated for HCV, one healthcare provider was not at all confident in educating their colleagues or participating in patient care, largely due to the absence of an HCV protocol or clear step-by-step guidelines. Additionally, the healthcare providers interviewed considered the healthcare provider group that are not directly involved in hepatitis care to have only moderate capabilities surrounding facilitation and engagement of people in prison with hepatitis services.

Correctional officers

__Knowledge:__ Levels of HCV knowledge amongst the small number of correctional officers interviewed were varied (n=4). They were generally aware that HCV is common in the prison setting, however, a majority of interview participants considered the prevalence to be around 30% or higher (though this figure could pertain to pre-DAA era data of prison entrants). Similarly, the correctional officers interviewed were generally aware of the primary transmission route (via sharing injecting equipment), with one correctional officer considering sharing tattooing equipment as the most common transmission route. Amongst this group, body fluid contact was also discussed as a route of transmission. Whilst the correctional officers interviewed were generally aware that treatment for HCV exists, the majority were not aware that there were new treatments available (DAAs) and still considered the treatment to be very difficult (i.e., interferon-based therapy). Members of this group were also less confident in their knowledge of test results, side effects, and possibility of re-treatment, although they were generally aware of the potential for re-infection. However, the perception amongst interview participants was that the correctional officer group more broadly generally had low knowledge of HCV, HCV testing, and treatment. Correctional officers interviewed also raised the issue of needle exchange programs in prisons, however whilst some were notionally supportive, the operational challenges with implementing such programs in practice were highlighted. One correctional officer indicated a need to change behaviours rather than just reduce the risk by addressing the underlying issues surrounding drug use (rather than by providing access to clean needles).

"There's a divide between corrections and health in updated knowledge about treatments, which makes things difficult." – Corrections personnel.

__Attitudes:__ Interview participants had varied perceptions of how supportive correctional officers were of HCV testing and treatment for people in prison. They perceived the majority of the correctional officer group to have poor attitudes and low willingness to facilitate engagement with HCV testing and treatment services, citing reasons such as underlying stigma and discrimination, low perception of risk-benefit, perceptions that health issues are the responsibility of health staff, a general lack of awareness of HCV and available services, perceived high costs associated with testing and treatment (and re-treatment), and competing priorities and staffing/resourcing constraints. However, some correctional officers were reportedly perceived to consider HCV as an important health matter to address, identified the broad officer group as being at high risk of exposure, and were thought to be willing to facilitate engagement with health services. Senior correctional staff and correctional managers who are more exposed to health conversations and have experience with health-related strategic issues, or experienced officers who have strong rapport with people in prison, were considered to potentially have more supportive attitudes and may potentially act as advocates for enhanced access to HCV testing and treatment. Similar to the healthcare provider group, some interview participants considered correctional officers to be supportive of treatment and re-treatment, in particular if patients make an effort to 'stay clean'.

"[HCV] is not something that is talked about and is not in general discussion….some officers think 'that's a health issue and it has nothing to do with us'…that them and us stuff…the healthcare staff say it's a health issue and that's got nothing to do with you. There needs to be more communication between uniform and health in relation to what this means for you." – Corrections personnel.

__Capabilities:__ There was generally low to moderate awareness of HCV testing and treatment services amongst the correctional officers interviewed. Whilst they were generally aware that a service does exist and were accessible via health request forms, some reported not knowing anything about how the service operates and others referred to a need to ask health staff about the services. Correctional officers interviewed also had mixed levels of confidence surrounding HCV, with participants reporting

both high and low confidence in their ability to talk with people in prison and other staff members about HCV or HCV services.

"Need to make the value [of education] more explicit to [correctional officers]…for them not to catch hepatitis, for them to know what to look for, for them to know what the support services are." – Corrections personnel.

People in prison

Perceived knowledge and attitudes: The perceived knowledge and attitudes of people in prison were mixed. Interview participants considered people in prison to generally be supportive of other people in prison being tested and treated for HCV, in particular if associated with a particular group or clique (e.g. gang or injecting circle). People in prison were also perceived to be aware of the accessibility of treatment, however, this was also stated as a source of concern, with interview participants noting potential for this group to continue engagement in risky behaviour due to the ease of accessing treatment (and re-treatment). It was also thought that there was still a lack of knowledge of the exposure risks and the long-term effects of HCV amongst the group more broadly, and that there was still a general unwillingness to talk openly about BBVs. Stigma and discrimination were also considered to still be of concern amongst people in prison, with interview participants considering some of this group to be hesitant to find out about or disclose their HCV status (due to embarrassment or shame), either to their peers or to staff, in particular in the case of re-infection.

“Hep C is losing its stigma in the world.” – Corrections personnel.

g. Barriers and solutions to delivering education in the prison setting

Interview participants were asked to identify potential barriers at the organisation- and individual-level and provide potential solutions to delivering an HCV education program in prisons for each target audience group.

Healthcare providers

The major barriers for healthcare providers were perceived as lack of time for the target audience members, and resources for the developers and providers (due to budgetary restrictions) to complete or deliver education in the sector, coupled with managing competing priorities. Proposed solutions for the healthcare provider group were provision of additional staff to deliver the education so as to not burden already demanding workloads, as well as provision of education resources that are short, targeted, and flexible in nature, that can be completed at any time. Resources centred around narrative and storytelling, such as from the perspective of people in prison, were considered to be appealing and to promote optimal engagement of the healthcare provider group in education.

"To overcome the issue of time and competing priorities it would be great to provide some short, sharp information, quick easy tools, handouts etc" – Education developer/provider on healthcare provider and correctional officer resource development.

Correctional officers

The main barriers to delivering education for correctional officers were perceived as low rates of interest and motivation due to prioritisation of security over health, and time constraints to complete tasks outside their regular custodial role, such as further education. Taking correctional officers offline to complete education was widely considered a major barrier due to the financial burden of replacing that officer on site. It was highlighted that any education must be relevant and relatable for engagement of this group, such as a focus on officer safety in terms of identification and management of incidents involving blood, rather than a focus on the disease itself; and timing and length of the education must be flexible to account for operational issues such as lockdowns. Education that addresses and encourages open dialogue, both amongst staff members and between staff and people in prison, was proposed as a useful tool to normalise conversations about HCV in the prison setting and promote a change in attitudes. Additionally, incorporation of narrative and storytelling into education was considered to provide credibility to information and hence provide better potential for engagement from correctional officers in education and facilitate better retention of information. The high rates of staff turnover were also considered a major barrier to ensuring all officers receive training and remain informed. However, gaining time in the training agenda was considered difficult, as the agenda was reported to generally be highly structured with limited time for additional training outside the regular day-to-day operations and security matters. Access to computers for training was generally considered limited. A major shift in correctional officer culture was regarded as necessary to break down misinformation and stigma around injecting drug use, HCV, and people in prison coming forward for treatment, and for this group to take a holistic approach to the care of people in prison. In addition to endorsement and support from directors of corrective services for prioritising HCV testing, treatment, and in particular education, incentivisation was also considered a likely facilitator to high rates of engagement from correctional officers. Further to this, education programs mandated by correctional authorities were perceived to have the potential to garner more interest than non-mandated courses.

"It's really critical to know how to open up conversations about hep C." – Corrections personnel.

"It's not our role to judge. It's our role to support positive decision making." – Corrections personnel.

"Their focus is much more on the security and so we're moving towards a changing of culture amongst correctional officers where they are more involved with inmates' lives and concerns, but at the moment, that shift in culture is a bit of a barrier"- Government corrections department administrator on barriers to delivering education to correctional officers.

"We need to make HCV relevant to correctional officers, otherwise they're not going to buy-in and they're not going to have any motivation to assist us eradicating it" – Justice Health medical director on correctional officer resource development.

People in prison

Several barriers to delivering education were discussed for people in prison. Stigma and discrimination around HCV and its perceived association with injecting drug use coupled with misinformation around the side effects of HCV treatment were considered the most significant barriers to engaging this population in both testing and treatment as well as HCV-related education. As such, education focussing on myth busting was proposed as a solution. High reliance on corrective services to access people in prison was also perceived as a major barrier to engaging people in prison in education (as well as other healthcare services). Accessing people in prison in a group setting was regarded as difficult due to differing security classifications and requirements. High rates of movements and short stays within the sector, as well as frequency of unexpected events such as lockdowns, were also regarded as major barriers. Engagement with the hard-to-reach population, such as those who may not attend the health clinic were also considered barriers to educating the population of people in prison as a whole. It was suggested that the involvement of peer educators could assist with overcoming this barrier, in particular through the use of narrative and storytelling from the perspective of those with lived experience. It was highlighted that education resources must be flexible, adaptable, and accessible to account for the unpredictability of the prison setting, and easy, fun, and relatable to make the education appealing.

"There's a lot of misinformation about old hepatitis C treatments and also peoples' perceived risk too" – Executive director non-governmental organisation on barriers to delivering education to people in prison.

"You know, there's lockdowns, there's drills, there's staff shortage, there's no free training room sometimes. We have certain prisoners that we can't mix together from…different bikey groups or…protection prisoners that can't be with mainstream. So, there's all of those kinds of issues as well as just…when you're planning to account for the practical aspects that can often get in the way" – Education provider/trainer on barriers to delivering education to people in prison.

"Needs to be more open dialogue about BBVs between officers and prisoners." – Prison health personnel.

h. Mode of delivery for education resources

An element of face-to-face interaction, with opportunity to ask questions, was cited as important for all target audiences, combined with online modules (for healthcare providers), or group discussions, peer-to-peer education, and videos (for correctional officers and people in prison; see Fig. 9). It should be noted that the range of options in the structured responses to this topic was limited to more traditional modes of delivery, such as those represented in Fig. 9, and did not include options for more innovative modes of delivery such as podcasts, interactive activities, scenarios or story-driven modules, infographics, and step-by-step guidelines. The qualitative feedback highlighted the importance of ensuring that the planned program was both feasible in the prison context for each target audience group (given custodial constraints, time pressures etc), and also likely to successfully engage each target audience group. Interview participants also highlighted the potential benefits of refresher sessions (e.g. 6 monthly; annually; ad-hoc) to ensure retention of information, as well as engaging local education providers (i.e. those who are already providing education in the sector) in the delivery of the program, to utilise their existing relationships to gain jurisdictional support at both the system and individual level.

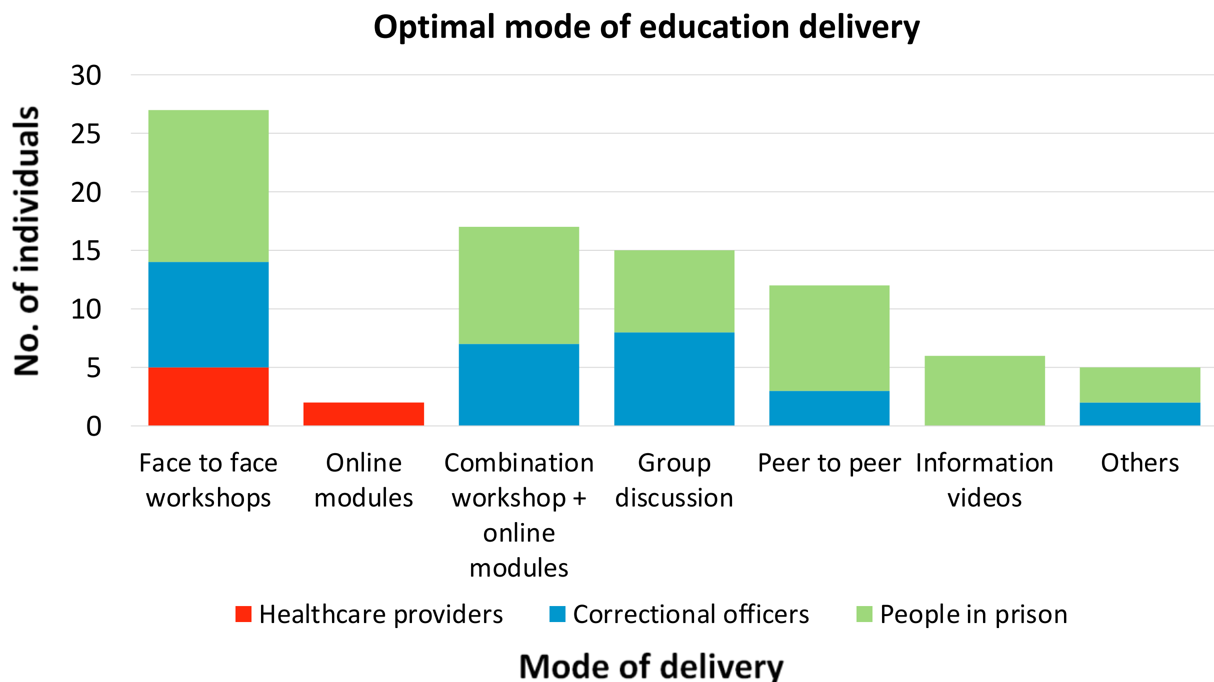

Figure 9. Optimal mode of education delivery by target audience

3.2 Results B

3.2.1 National Steering Committees

Healthcare Providers

The Co-Chairs led discussion around the concepts for the Healthcare Provider element of the Program. As a first priority, the Committee resolved that the focus should be on the non-hepatitis-skilled healthcare workforce (i.e. those clinicians and non-clinicians that are not directly involved with hepatitis care), and for the program to have an overall objective to better encourage and engage this group in facilitating engagement of people in prison with hepatitis testing and treatment services. This aligns with the health literacy concept that seeks to enhance 'capabilities'. The key topics to be addressed in this Program were resolved as: 1) what is HCV; 2) simplicity of testing; 3) simplicity of treatment; 4) equipping people in prison with knowledge to share with peers; 5) prevention and harm reduction; 6) hepatitis services; 7) national strategy and elimination targets; and 8) health and wellbeing outcomes. The Committee suggested establishing associated focus areas for learning that aim to improve awareness of: 1) facilitating referrals for HCV testing, to improve testing uptake; 2) effective and curative treatment, to enhance treatment uptake; 3) available prevention and harm reduction measures; and 4) well-being associated with overcoming stigma and discrimination. The messaging around storytelling, narrative, and conversations that came out of the interviews resonated with the Committee, and thus the theme for the Healthcare Provider element of the Program was resolved as: **Let's talk about hep C: prevent, participate, eliminate (PPE).**

"We need to get all nurses on the same side about the importance of testing and encourage everyone to test." – Prison health personnel.

Correctional Officers

The Co-Chairs led discussion around the concepts for the Correctional Officer element of the Program. The Committee resolved the focus for this target audience to be on increasing facilitation of and support for people in prison (by officers) to attend health services for hepatitis testing and treatment, with a particular emphasis on shifting attitudes. Proposed solutions to overcome negative attitudes were centralised around the concepts of safety in the workplace (personal safety), and to leverage the recent increase in general awareness of public health (due to the COVID-19 pandemic), essentially establishing a 'call to action' for a safer environment. This aligns with each health literacy concept, seeking to enhance the 'knowledge', 'attitudes', and 'capabilities' among the broad correctional officer population. The key topics to be addressed in this Program were resolved as: 1) what is HCV; 2) safer environment; 3) testing and treatment services; and 4) stigma and discrimination. The Committee suggested establishing associated focus areas for learning that aim to improve awareness of: 1) the importance of testing and treatment in creating a safer environment; 2) benefits of facilitating referrals for HCV testing; 3) benefits of effective and curative treatment; and 4) reducing stigma and discrimination. The messaging around storytelling, narrative, and conversations that came out of interviews also resonated with this Committee and, coupled with the focus on a call to action for a safer environment, the Committee resolved the theme for the Correctional Officer element of the Program as: **Let's talk about hep C: stop the spread, reduce the risk.**

"…framing messages in terms of safety will be key – if there is lower prevalence of HCV among prisoners then it also creates for a safer environment for [correctional officers]." – Correctional Officer Steering Committee member.

People in Prison Program

The Co-Chairs led discussion around the concepts for the People in Prison element of the Program. The Committee resolved that the focus for this audience group should be on encouraging all those incarcerated to actively engage, and encourage others to engage, with HCV testing and treatment services. This aligns with each health literacy concept, seeking to enhance the 'knowledge', 'attitudes', and 'capabilities' among the population in prison. The key topics to be addressed in this Program are: 1) what is HCV; 2) prevention and harm reduction; 3) simplicity of testing; 4) simplicity of treatment; and 5) mental health and personal well-being. The Committee suggested establishing associated focus areas for learning that aim to improve awareness of: 1) simple testing to increase testing uptake; 2) easy and effective treatment to increase treatment uptake; 3) available prevention and harm reduction measures; and 4) advantages of testing and treating everyone in improving well-being across the prison as a whole. The messaging around storytelling, narrative, and conversations that came out of interviews resonated with this Committee as well, and coupled with a focus on the simplicity of testing and treatment, the Committee resolved the theme for the People in Prison element of the Program as: **Let's talk about hep C: test, treat, cure, prevent – it's simple.**

Taking into consideration the findings from the needs assessment interviews, the barriers and solutions proposed above, and the outcomes from the National Steering Committee process, each Committee resolved to develop a suite of multi-modal and low literacy resources for the Program that address 'knowledge', 'attitudes', and 'capabilities' in a variety of ways and with a particular emphasis on narrative, storytelling, and conversations. The Committee highlighted a need for the characters, storyline, and design style to be consistent across the Program as a whole.

The following resource modalities were recommended for development:

- Series of short, animated video clips (2-3 videos; story and narrative) – *each target audience group*
- Information booklet with knowledge testing (true/false knowledge check) – *each target audience group*
- Key take home messages/top tips on merchandise (e.g. beanies, mugs, pens etc) – *each target audience group*
- Posters with key messages – *each target audience group*
- Series of short comic books (2-3 stories) – *People in Prison group only*
- Informal individual or small group discussion, led by prisoner peer-educators – *People in Prison group only*
- Step-by-step guidelines – *Healthcare Provider group only*
- Drag and drop/order a step-by-step process online module – *Healthcare Provider group only*
- Small group discussion sessions, facilitated by peer champions – *Healthcare Provider and Correctional Officer groups*
- Scenario-based choose your own adventure online module - *Correctional Officer group only*
- Peer-education program including a facilitator guide and resources for upskilling peer-educators and peer-champions – *Correctional Officer and People in Prison groups only*

4. Conclusion

Whilst some worthwhile education resources have been identified and described in this report, there was a notable lack of a coherent program in any jurisdiction that provides comprehensive and targeted HCV education to any one group or to the prison sector as a whole.

Amongst the healthcare provider group, the non-hepatitis skilled workforce was considered most likely to benefit from further HCV education, in particular focussing on enhancing skills and building confidence to support HCV screening and testing of people in prison (*capabilities*). Correctional officers were considered likely to benefit from prison-specific HCV education across all health literacy aspects. In particular, education for this group should account for the barriers identified in this report, most notably addressing misinformation and stigma, time constraints, and incentivisation. Whilst it was perceived that some people in prison had good health literacy, there was scope for improvement and people in prison in general would benefit from education across health literacy domains. As such, a Program for each target audience group, addressing these health literacy aspects, will be developed.

This report and associated *Resources Catalogue* identify and describe some of the existing HCV (and BBV/communicable diseases more broadly) resources for the target audience groups. These resources were considered for potential adaptation or further development by the Steering Committees during the development process. The Program will be developed with an intention to value-add, rather than replace, existing education being provided in the sector.

Development and delivery of an Education Program addressing these gaps for each target audience group will likely enhance the support for scale-up of HCV testing and treatment in the Australian prison sector.

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Appendix A: Perceived health literacy scores for each target audience group

Health literacy aspect	Audience	Very poor	Poor	Adequate	Good	Very good	Uncertain
Knowledge	*Clinicians involved with hepatitis services*	0% (0)	0% (0)	0% (0)	22% (4)	67% (12)	11% (2)
	Clinicians not involved with hepatitis services	0% (0)	11% (2)	17% (3)	28% (5)	5% (1)	39% (7)
	Non-clinicians	0% (0)	17% (3)	39% (7)	5% (1)	0% (0)	39% (7)
	*Correctional officers**	6% (2)	49% (16)	27% (9)	9% (3)	0% (0)	9% (3)
	*People in prison**	0% (0)	12% (4)	30% (10)	37% (12)	3% (1)	18% (6)
Attitudes towards testing	*Clinicians involved with hepatitis services*	0% (0)	0% (0)	0% (0)	22% (4)	67% (12)	11% (2)
	Clinicians not involved with hepatitis services	0% (0)	11% (2)	6% (1)	44% (8)	0% (0)	39% (7)
	Non-clinicians	0% (0)	5% (1)	39% (7)	12% (2)	5% (1)	39% (7)
	*Correctional officers**	6% (2)	24% (8)	46% (15)	12% (4)	3% (1)	9% (3)
	*People in prison**	0% (0)	9% (3)	21% (7)	43% (14)	9% (3)	18% (6)
Attitudes towards treatment	*Clinicians involved with hepatitis services*	0% (0)	0% (0)	0% (0)	22% (4)	67% (12)	11%
	Clinicians not involved with hepatitis services	0% (0)	11% (2)	22% (4)	28% (5)	0% (0)	39% (7)
	Non-clinicians	0% (0)	5% (1)	34% (6)	17% (3)	5% (1)	39% (7)
	*Correctional officers**	4% (1)	36% (12)	36% (12)	12% (4)	3% (1)	9% (3)
	*People in prison**	0% (0)	9% (3)	12% (4)	40% (13)	21% (7)	18% (6)
Awareness of services	*Clinicians involved with hepatitis services*	0% (0)	0% (0)	0% (0)	22% (4)	67% (12)	11% (2)
	Clinicians not involved with hepatitis services	0% (0)	17% (3)	33% (6)	11% (2)	0% (0)	39% (7)
	Non-clinicians	0% (0)	5% (1)	44% (8)	11% (2)	0% (0)	39% (7)
	*Correctional officers**	3% (1)	55% (18)	24% (8)	6% (2)	3% (1)	9% (3)
	*People in prison**	0% (0)	18% (6)	24% (8)	33% (11)	6% (2)	18% (6)
Ability to engage serves	*Clinicians involved with hepatitis services*	0% (0)	0% (0)	0% (0)	39% (7)	50% (9)	11% (2)
	Clinicians not involved with hepatitis services	0% (0)	11% (2)	28% (5)	22% (4)	0% (0)	39% (7)
	Non-clinicians	0% (0)	5% (1)	39% (7)	11% (2)	0% (0)	44% (8)
	*Correctional officers**	6% (2)	55% (18)	21% (7)	6% (2)	3% (1)	9% (3)
	*People in prison**	0% (0)	9% (3)	30% (10)	24% (8)	18% (6)	18% (6)

* For correctional officers and people in prison, data were pooled from Interviews A & B (n=33). Data for healthcare providers were taken from Interview B only (n=18).

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Appendix B: Steering Committee Framework

Framework for the Steering Committees on design, development and delivery of the National Prisons Hepatitis Education Project

About the National Prisons Hepatitis Education Project

The National Prisons Hepatitis Network (NPHN) in partnership with the Kirby Institute UNSW Sydney, the Australasian Society for HIV, viral hepatitis, and sexual health medicine (ASHM), Eliminate Hepatitis C Australia (EC Australia), and the national hepatitis and drug-user organisations are conducting the National Prisons Hepatitis Education Project. The broad goal of the Project is to develop and deliver education programs to key stakeholders in the prison setting (healthcare providers; correctional officers; prisoners) to overcome key barriers to enhanced hepatitis C (HCV) testing and treatment uptake in Australian prisons. The Project is centered around the rationale that improved *HCV public health literacy* of these key stakeholders will be associated with enhanced HCV testing and treatment of prisoners. *HCV health literacy* in this context refers to *knowledge* and awareness of HCV and its treatment, *attitudes* towards and willingness to engage with HCV testing and treatment in prison, and *capabilities* and competencies in accessing and supporting access to prison-based HCV testing and treatment services for prisoners. These public health literacy concepts will form the basis for the design, development, and delivery of three education programs, targeting: healthcare providers working in the prison setting; correctional officers; and prisoners.

The Project is governed by a Project Team. Advice on the design, development, and delivery will be led by Steering Committees headed by Co-Chairs.

	Who	Purpose
Project Team	Key members from the Kirby Institute and ASHM	To provide high level oversight of the design, development, and delivery of the education programs
Co-Chairs of Steering Committees	Two selected members of the NPHN for each Steering Committee	To lead the Steering Committees to advise on design and development of education programs. Will work closely with the Project Team and report outcomes from each component. Link between Project Team and Steering Committee.
Steering Committees	Selected members of the NPHN with expertise in education, clinical aspects, prison systems and/or the target audience groups	To engage in expert consultation led by the Co-Chairs to advise on design and development of education programs.

Purpose of this document

This document describes a framework that has been developed to guide the design, development, and delivery of an effective education program for each target audience group for the National Prisons Hepatitis Education Project. The document is intended for use by the Project Team, Co-Chairs, and members of the Steering Committees.

Component 1: Conduct the learning analysis and gather resources

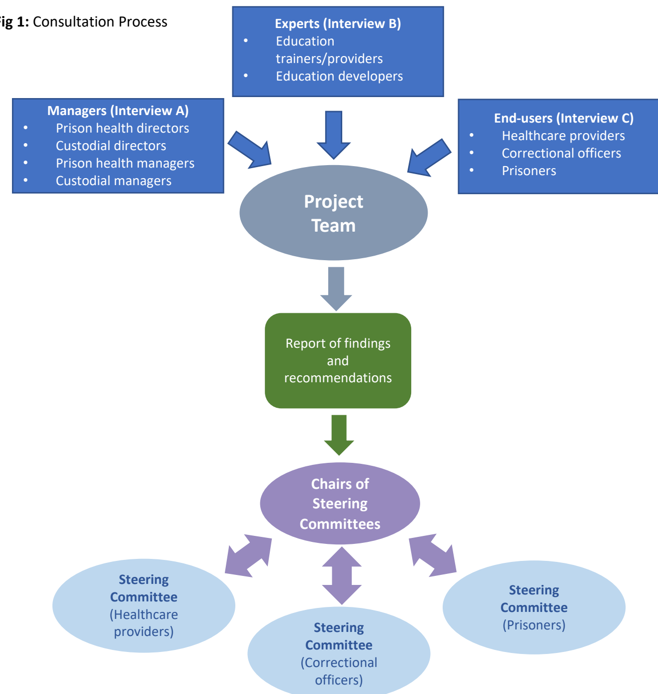
Strategy:

1. Complete a learning analysis (referred to in this project as the *Scoping and needs assessment*) aimed at understanding the knowledge, attitudes, competency gaps and current structural challenges in prison-based hepatitis treatment by interviewing all key stakeholders including: Managers (high-level administrators), Experts (education developers/providers) and End-users (education target audience groups; Figure 1) using semi-structured interviews);
2. Gather all available online, print and/or audio-visual resources nationally that can potentially be used as is, modified or further developed, or as a template for new resource development;
3. Interpret what needs to be learned (knowledge), what attitudes might need to be changed (attitudes), and what skills and behaviours need to be practiced (capabilities) amongst each target audience;
4. Understand how long each educational resource should ideally be (in pages, or minutes, or equivalent) and how they may be best delivered based on results of the *Scoping and needs assessment* interviews (quantitative and qualitative data);
5. Develop a report of the findings from the *Scoping and needs assessment* and provide recommendations for learning objectives, resource characteristics, mode of delivery, and topics for education programs to guide Steering Committee consultations.

Tasks and timeline:

1. The consultation process with Managers (Interview A) and Experts (Interview B) is completed, and consultation with End-users (Interview C) is underway (click here to access Sharepoint folder for interview schedules).
2. Report of findings and recommendations will be sent to the Co-Chairs and Steering Committee members by **end May 2020.**
3. Spreadsheet catalogue of all available resources nationally will be made available to the Co-Chairs and Steering Committee members by **end May 2020** via the Sharepoint folder (click here to access Sharepoint folder).
4. First meetings with Co-Chairs for a briefing and to discuss Component 2 to happen **in June 2020.**

Fig 1: Consultation Process



Component 2: Develop learning objectives, content, type(s) of resource, and mode(s) of delivery

Strategy:

1. Use the report of findings, recommendations, and existing resources catalogue to engage in expert consultation led by Co-Chairs to:
   a. write education program learning objectives based on recommendations of what needs to be learned (knowledge), what attitudes might need to be changed (attitudes), and what skills and behaviours need to be practiced (capabilities);
   b. list content/topics to be covered in the resource(s) based on what was identified in the learning analysis;
   c. identify any existing resources from the catalogue that can be used as is, modified or further developed, or as a template for new resources;
   d. list suitable type of resource(s) and mode(s) of delivery;
2. Organise the content into thematic modules (knowledge; attitudes; capabilities) and mind-map the high-level design to finalise the program structure.

Tasks and timelines

1. Steering Committee consultation will occur **in July – September 2020.**
2. Documents for consultations can be found via the Sharepoint folder (click here to access Sharepoint folder).
3. Co-Chairs will provide feedback to the Project Team on finalised learning objectives, what content/topics the educational material should be included, what types of resources/modes of delivery should be developed, and how the programs should be structured by **end September 2020.**
4. Co-Chairs and Project Team will review thematic modules and mind-maps to ensure the program for each target audience addresses the broader objective of public health literacy.

Component 3: Create and author content. Resolve who will develop the resources.

Strategy:

1. Use storyboard(s) to define the structure, navigation, interaction, narration and/or visuals needed for each resource of the program;
2. Review the storyboard(s);
3. Provide storyboard(s) to the developer to create each element of the content.
4. Pilot material(s) on End Users (if feasible).
5. Discuss and resolve who should develop the resources (e.g. outsource to education developer through tender process; commission organisations to further develop existing resources; combination etc).

Tasks and timelines

1. Project Team in consultation with Co-Chairs will develop the storyboard(s) by **end October 2020**.
2. Project Team in consultation with Co-Chairs will resolve who should be involved in designing and developing content by **end October 2020.**
3. Steering Committee members and key stakeholders (e.g. End-users) will review and provide feedback on the storyboard(s) by **end October 2020.**
4. Provide storyboard(s) to the Developer to create each piece of the content in consultation with the Project Team by **end October 2020**.
5. Steering Committee members and Project Team will review and provide feedback on the draft materials that have been developed between **November and December 2020**.
6. Concurrently, pilot material(s) on End Users for feedback (content overload; spatial ability; acceptability; feasibility) by between **November and December 2020** (if feasible).
7. Developer will incorporate all feedback and finalise content for programs by **end December 2020**.

Steps	1. Determine content	2. Organise content	3. Review content	4. Determine developers	5. Storyboard content	6. Review Storyboard content	7. Develop content	8. Review and test content	9. Finalise content
Actions	Identify learning objectives, key topics, and format	Organise content into thematic modules and mind-map high-level design	Review mind-maps to ensure each program addresses broader health literacy objective	Identify who will develop the content	Use storyboard to define content, structure, and narrative for each resource	Review storyboard and incorporate feedback	Develop the program resources	Review program and pilot on End-users	Revise content and format based on feedback
Stakeholders	Steering Committee	Steering Committee	Chairs; Project Team	Chairs; Project Team	Chairs; Project Team	Steering Committee; Chairs; Project Team	Developer; Project Team	Steering Committee; End-users; Chairs; Project Team	Developer; Project Team; Chairs

Table 1. Tasks for overall program design and development

Component 4: Resolve who will deliver the program, site selection, and implementation plan

Strategy:

1. Resolve who should deliver the program (e.g. utilise local staff; utilise education providers from existing programs; contract new external education provider etc).
2. Select suitable prison sites for participation in the education program based on: feasibility and accessibility; location (all jurisdictions); prison characteristics (prisoners, staff, health service); prison type and classification (e.g. men's and women's; security classification, rural or urban, etc).
3. Use the report of findings and expertise of the Steering Committees to develop a plan for how to implement the program at each site.

Tasks:

1. Who will deliver the program, sites, implementation plan will be selected by the Project Team in consultation with the Steering Committees and the NPHN Executive Committee.

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Steps	1. Determine providers and sites	2. Determine delivery plan	3. Market programs	4. Implement delivery of programs	5. Evaluate programs	6. Evaluate outcomes
Actions	Identify suitable sites for delivering programs	Identify how the programs will be delivered at sites and who will deliver the programs	Advertise programs through managers and highlight benefits	Deliver programs to target audiences at selected sites	Evaluate the feasibility and acceptability of programs	Evaluate the health literacy outcomes
Stakeholders	Project Team; Steering Committee; NPHN Executive Committee	Project Team; Chairs	Project Team; Steering Committee	Education providers; Project Team	Project Team	Project Team

Table 2. Tasks for program delivery

Component 5: Market the program

Strategy:

1. Resolve the marketing and incentives plan (e.g. accreditation; barbeques; advertisements; launch video)

Task:

1. Project Team and Co-Chairs should consider the marketing and incentives plan as intrinsic to the development of the program and will resolve during Component 3 (above)

Component 6: Evaluation of program

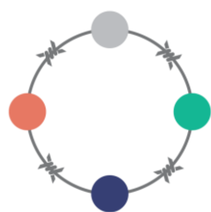
Strategy:

1. Resolve the plan for program evaluation (feasibility and acceptability) and outcome evaluation (health literacy: knowledge; attitudes; capabilities)

Steering Committee Framework Appendix A: Meeting Schedule

Anticipated meeting schedule for Project Team, Co-Chairs, and Steering Committee members. This schedule is intended as a guideline only and is subject to change as the project progresses through each Component. Additionally, it is expected that members will engage in email communication as required between meetings.

Who	Type	Purpose	When and how long
Component 2			
Project Team & Co-Chairs	Initial briefing	Briefing for Co-Chairs on the objectives of the overall project, report of findings and recommendations, the Steering Committee framework, and initiate discussion around creative resources for the target audience group.	1 x 1.5 hr meeting per Committee in July 2020.
Project Team & Co-Chairs	Follow-up briefing	Introduce all Co-Chairs. Opportunity for Co-Chairs to present initial plans for direction of resource development. Engage in further discussion around creative resources.	1 x 1.5 hr combined meeting in August 2020.
Co-Chairs and Steering Committees	Consultation	Introductions and briefing. Identify learning objectives, key topics, and format/modality.	1 x 1.5 hr meeting per Committee in September 2020
Co-Chairs and Steering Committees	Consultation	Organise content into thematic modules and mind-map the high-level design to finalise program structure.	1 x 1.5 hr meeting per Committee in September – October 2020
Project Team & Co-Chairs	Review and feedback	Review and finalise learning objectives, key topics, format/modality, and program structure (mind-maps), ensuring alignment with broader health literacy objectives.	1 x 2 hr combined meeting in October 2020.
Component 3			
Project Team & Co-Chairs	Consultation	Develop storyboard to define content, structure, and narrative of each resource	1 x 2 hr combined meeting in October 2020.
Project Team, Co-Chairs, and Steering Committees	Review and feedback	Review and provide feedback on materials	1 x 2 hr combined meeting in November - December 2020.
Project Team & Developer	Consultation	Develop, review, and finalise materials	3 x 2 hr meetings in October - December 2020.
Component 4			
Project Team & Co-Chairs	Consultation	Resolve education provider, site selection, and implementation plan	1 x 2 hr combined meeting in October – November 2020.
Project Team, Co-Chairs, and Steering Committees	Presentation	Showcase finalised materials and present implementation plan	1 x 2 hr combined meeting in TBC.
Components 5 & 6			
TBA	TBA	TBA	TBA



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About the National Prisons Hepatitis Network (NPHN)

The NPHN is dedicated to enhancing development of health service infrastructure for HCV testing and treatment in the custodial sector nationally. The NPHN connects key stakeholders from the corrections and justice health, health policy, academia, and consumer sectors in each Australian jurisdiction. Through innovative research and initiatives, the NPHN aims to contribute to Australia's goal to eliminate HCV as a public health threat by 2030 through coordinating a *national* approach to prison-based elimination.

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