What's past is prologue

In the year 2000, the XIII International AIDS Conference was held in Durban, South Africa. The Conference Report published in the *MJA*[1] spoke of the disappointment in the results of a failed prevention trial, optimism for the next generation of vaccines, and findings from a pilot study of five patients who with potent therapy had achieved undetectable viral levels presented by Dr Anthony Fauci. During his closing address, Nelson Mandela[2] focused the attention of the audience to the situation that was unfolding in Africa, and the need for action:

> The challenge is to move from rhetoric to action, and action at an unprecedented intensity and scale. There is a need for us to focus on what we know works.

He spoke of the need for "… bold initiatives to prevent new infections among young people," and urged international collaboration.

> A constant theme in all our messages has been that in this inter-dependent and globalised world, we have indeed again become the keepers of our brother and sister. That cannot be more graphically the case than in the common fight against HIV/AIDS … Let us combine our efforts to ensure a future for our children. The challenge is no less.

Meanwhile in Australia, local efforts to prevent HIV and other bloodborne diseases were facing the threat posed by the heroin epidemic. After the widely publicised suspension of an inner-city needle and syringe outreach service in Sydney in early 1999, the NSW Parliament quickly passed legislation that would lead to the opening of Australia's first legal supervised injecting centre in 2001. Jump forward to 2025 and the Uniting Sydney Medically Supervised Injecting Centre is still operational and has had substantial successes over time,[3] although this model has not been widely reproduced. In contrast, needle and syringe programs are widely implemented in Australia and form a key component of our National Strategies for preventing and treating bloodborne viral infections, of which hepatitis C virus is now a key focus.[4] Despite their success, needle and syringe programs are not available to people in prisons in Australia.

In this issue of the *MJA*, Houdroge and colleagues[5] present modelling that supports the health and cost benefits of a proposed nationwide prison needle and syringe program, with about 900 new hepatitis C virus infections being prevented over the first five years of implementation and cost benefits of $2.60 per $1 invested in the program. In the accompanying editorial, Thompson and Levy[6] write that it is "time to re-think the role of prison needle and syringe programs", and that "development and implementation of a prison-based needle and syringe program in Australia would be an important advance for harm reduction in correctional facilities".

Both Houdroge and colleagues and Thompson and Levy highlight the strong human rights justification for providing prison needle and syringe programs. The United Nations Standard Minimum Rules for the Treatment of Prisoners[7] — also known as the Nelson Mandela Rules, in honour of Nelson Mandela who spent 27 years in prison and who advocated for fair and humane treatment of all — establish, among other minimum standards, that imprisoned people should have access to the same standards of health care that are available in the community.

As such, moving towards a prison-based needle and syringe program will not only be important for meeting the goal of eliminating hepatitis C as a public health threat by 2030, but also would be in keeping with the legacy of Mandela:

> It is said that no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones.[7]

In another research paper in this issue of the *MJA*, Bonney and colleagues[8] find a relatively high rate of incidental findings in an international low-dose computed tomography lung screening study. With the National Lung Cancer Screening Program beginning in July, the way in which incidental findings are reported will likely affect the net benefits and harms of the program.

Towns and colleagues[9] discuss the necessity for medical education to ensure that people in the lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) community can always obtain culturally safe health care. They specifically focus on how to ensure that international medical graduates, particularly those who are originally from a country in which same sex conduct is criminalised, receive appropriate education to enable them to practice in a culturally safe manner that meets the health care needs of members of the LGBTQI+ community.

Finally, a rare and uniquely Australian case of platypus envenomation.[10] Platypus are one of only a handful of venomous mammals, with the males having a venomous spur on their hind legs. Moyer de Miguel and colleagues note that the envenomation results in severe pain that may be refractory, with a high risk of deep tissue infection. The three case reports in the literature thus far, including this one, have resulted from handling platypus. Like most of our Australian native animals, it is probably prudent to look but not touch. ■

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doi: 10.5694/mja2.52659

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