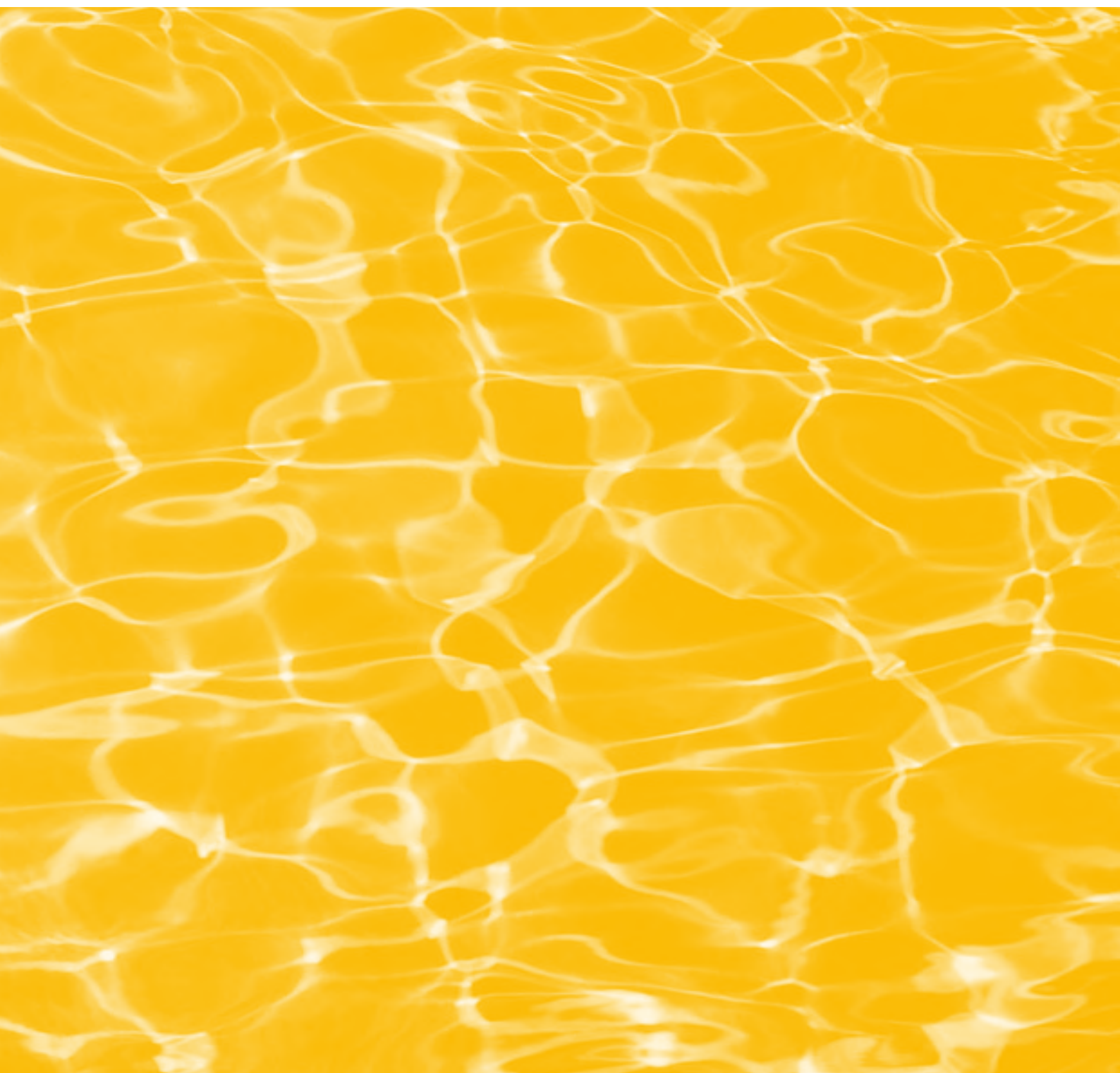


Victorian Hepatitis C Strategy 2002–2004 and Addendum 2005–2009



**Victorian Hepatitis C Strategy 2002–2004
and Addendum 2005–2009**

Published by the Rural and Regional Health and Aged Care Services Division of the Victorian Department of Human Services, Melbourne, Victoria.

Published 2006

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ISBN: 0 73116 254 4

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Disclaimer

This strategy was prepared following consultation with the Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases and its Hepatitis Subcommittee, other experts in the field, government and the wider community. The addendum was prepared following consultation with the Ministerial Advisory Committee on Blood-borne and Sexually Transmissible Infections and its Hepatitis subcommittee.

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Addendum 2005–2009

The second *Victorian Hepatitis C Strategy (2002–2004)* was a whole of government document developed to help strengthen Victoria's responses to the current and emerging challenges of the hepatitis C epidemic. It was built on the successes of the first *Victorian Hepatitis C Strategy* that was implemented in 1996. The second strategy was developed in collaboration with the former Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases with broad consultation within the health sector in rural, regional and metropolitan areas as well as the general community and people living with and affected by hepatitis C infection. The strategy guided the public health and acute care responses and was the basis of the community and service providers' partnership in relation to hepatitis C during 2002–2004.

The Ministerial Advisory Committee on Blood-borne and Sexually Transmissible Infections and its hepatitis subcommittee have advised that the priority activities identified in the second *Victorian Hepatitis C Strategy (2002–2004)* continue to be relevant and that the document does not yet need to be rewritten. However, the committee has identified a number of emerging issues that will require attention over the next two to three years. As such, the *Victorian Hepatitis C Strategy 2002–2004 and Addendum 2005–2009*, is comprised of the original text of the second *Victorian Hepatitis C Strategy (2002–2004)* with a number of additional priority issues. The committee has developed evidence-

based recommendations in the following domains, to be addressed during the term of the extended second strategy:

Key priority area 1: Prevention and control of hepatitis C transmission

- Improve access to Needle and Syringe Programs, especially out of hours access
- Improve access to hepatitis C prevention and education for youth
- Strengthen prevention and education programs in Victorian adult and juvenile correctional services.
- Expand the role of peer-education and community development approaches in relation to hepatitis C prevention and education initiatives.

Key priority area 2: Preventing discrimination and reducing stigma and isolation

- Improve education programs for general practitioners and health care workers in relation to hepatitis C and related issues to meet the service and treatment needs of all infected and affected people including people who inject drugs.

Key priority area 3: Health maintenance, care and support for people affected by hepatitis C

- Develop a best practice treatment and care model for the management of hepatitis C to increase the quality and access of service provision in Victoria.

Key priority area 4: Research and surveillance

- Develop innovative methods of identifying and delivering education and prevention messages in a timely manner to vulnerable groups with or at risk of hepatitis C.
- Identify ways to improve access to hepatitis C treatment, in particular, for marginalised groups such as injecting drug users, individuals on pharmacotherapy, people from culturally and linguistically diverse backgrounds and prisoners.
- Explore ways to reduce unsafe injecting practices, particularly focussing on the early years of injecting when injecting drug users are most vulnerable to hepatitis C infection.
- Explore the adequacy of current services and systems in meeting the hepatitis C-related needs (including prevention) of people released from adult and juvenile correctional services.
- Identify factors affecting the integration of hepatitis C issues within pharmacotherapy prescribers' practice.

Key priority area 5: Pharmaceutical treatments

- Increase the number of referrals from general practitioners to liver clinics for newly diagnosed patients especially in the Aboriginal community and from prison health service providers.
- Develop and implement education and training programs for health care workers with respect to available hepatitis C treatment and support services.

- Improve access to hepatitis C treatment services for patients in regional areas.

These new priorities will be progressed during the extended term of the second strategy in addition to the priorities identified in the original second strategy. Implementation will be progressed with the advice of the Ministerial Advisory Committee on Blood-borne and Sexually Transmissible Infections and its Hepatitis subcommittee and through the further development of the Victorian hepatitis C strategy implementation plan.

An overview of the key outcomes under the Victorian Hepatitis C Strategy (2002–2004)

The number of hepatitis C notifications to the department remained high during the term of the second strategy. In 2003, 2004 and 2005, there were 3,655, 3,029 and 3,031 hepatitis C notifications respectively. The average proportion of newly acquired infections for this period was four per cent of total notifications. In 2003, 2004 and 2005 there were 110 (3 per cent), 119 (3.9 per cent) and 167 (5.5 per cent) newly acquired infections reported to the department. Of the newly acquired infections in 2005, 55 per cent were male, 56 per cent were under the age of 25 years and the most common risk factor reported was injecting drug use (84 per cent).

There have been significant advances in pharmaceutical treatments for people infected with hepatitis C during the term of the second strategy. Treatment of chronic hepatitis C now includes a combination of pegylated interferon and ribavirin. Patients with genotypes 2 and 3 require 24 weeks treatment, with approximately 80 per cent expected to achieve a sustained virological response (SVR). Patients with genotype 1 require 48 weeks treatment and it is anticipated that 50 per cent will have a SVR. Better treatment outcomes and the removal of both the liver biopsy and the alanine aminotransferase test (ALT) from the eligibility criteria for accessing government-funded hepatitis C treatment¹, will invariably increase the demand for treatment services. Improving access to testing, education and counselling, treatment and support

for people who are affected with hepatitis C will be an important priority to be continued within the extension of the time frame of the second strategy.

The second *Victorian Hepatitis C Strategy (2002–2004)* resulted in a number of substantial cross-sectorial responses. In particular it should be acknowledged that substantial progress has been made in all areas of the strategy. Key outcomes include:

Prevention and control of hepatitis C

- Redevelopment and accreditation of the general practitioner HIV and hepatitis C education program.
- Redevelopment and accreditation of competency based pre- and post-HIV and hepatitis C test counselling training for health workers.
- Development and implementation of a hepatitis C specific general practitioner education program through the Divisions of General Practice, Victoria.
- Annual delivery of the hepatitis C specific community awareness initiative.
- Delivery of a pilot hepatitis C treatment prescribers training program for Victorian general practitioners.
- Strengthening of hepatitis C community education project particularly in rural Victoria.
- Development of the Prisoner Health Initiative.
- Implementation of the Vein Care Program for Needle and Syringe Program clients.

- Development and implementation of an electronic data collection system to monitor Needle and Syringe Programs' client demographics and usage of the service.

Culturally and linguistically diverse communities

- Implementation of the Vietnamese and Cambodian hepatitis C telephone helpline.
- Development and implementation of hepatitis C education and prevention initiative for Vietnamese–Australians at risk of hepatitis C.
- Improved accessibility of hepatitis C information by translation into community languages.
- Strengthening of hepatitis C outreach programs targeting the Cambodian, Laotian and Vietnamese communities.

Indigenous populations

- Provision of introductory NSP training to staff at Aboriginal community controlled health services and medical services.
- Provision of hepatitis C and related issues training to Aboriginal community health workers.

Young people

- Development of a web based education activity on hepatitis C for schools.
- Development and release of a Victorian Secondary School Nurses' Kit for hepatitis C education and prevention.
- Development and implementation of hepatitis C education and prevention interventions for young people experiencing homelessness.

¹ Effective 1 April 2006

Preventing discrimination and reducing stigma and isolation

- Development and piloting of an education intervention to reduce levels of discrimination experienced by people with or at risk of hepatitis C when accessing health and community services.
- Ongoing education activities for health workers throughout Victoria.

Health maintenance and care and support for people affected by hepatitis C

- Establishment of the Hepatitis C Multicultural Health & Support Service (for HIV, hepatitis C and STIs).
- Implementation of a pilot hepatitis B immunisation program in the two Victorian female prisons (Dame Phyllis Frost Centre and Tarrengower Prison).
- Expansion of the state-wide hepatitis C educator program to include hepatitis B.
- The provision of free hepatitis B vaccination to injecting drug users through needle and syringe programs and drug treatment clinics.
- Improved primary health care service delivery to injecting drug users (IDU).

Research and surveillance

- Development of a hepatitis C sentinel surveillance pilot program.

Departmentally funded research

- Psychological and social factors associated with uptake and maintenance of clinical treatment for hepatitis C.
- Determination of acute phase hepatitis C virus infections.
- Hepatitis C and initiation into injecting drug use in a rural setting.

Pharmaceutical treatments

- Review of hepatology nurse consultants in Victorian liver clinics.
- Development and piloting of community based models of care for people accessing hepatitis C treatments.

Foreword

While Australia's response to the hepatitis C epidemic has featured on the political agenda at the Commonwealth and state/territory levels, the rate of transmission of hepatitis C in Australia remains unacceptably high.

Hepatitis C is a blood-borne virus affecting the liver. It is estimated that over 200,000 Australians are currently infected with this virus. The major mode of transmission is unsafe drug injecting.

The first *Victorian Hepatitis C Strategy* was developed and implemented in 1996. It set out a clear framework to address the emerging challenges of hepatitis C in Victoria. The 1996 strategy contributed to a significant increase in our understanding of hepatitis C, modes of transmission, natural history, efficacy of treatments, as well as improvements in health maintenance and support and care services for people with hepatitis C.

This second *Victorian Hepatitis C Strategy 2002–2004* builds on the successes of the first strategy and identifies new initiatives that will help strengthen Victoria's responses to the current and emerging challenges of the hepatitis C epidemic. This strategy has been developed in collaboration with the

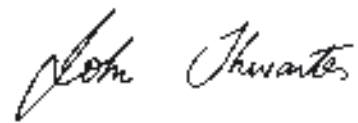
Department of Human Services and the Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases. Extensive consultations with the health sector in rural, regional and metropolitan areas, as well as the broader community, have also informed this document.

This strategy is intended as a working document. It provides direction for necessary areas of action around prevention, education, treatment, care and support, to meet the needs of people who are affected by hepatitis C. It is underpinned by a partnership approach between affected communities, government, professional, non-government and community-based organisations in Victoria. Hence, the success of this strategy relies on effective participation and cooperation between the different groups within the hepatitis C sector.

The key areas for action identified in this strategy include:

- Reducing the personal and social impact of hepatitis C infection, by enhancing health maintenance, treatment and care and support services for affected people.
- Strengthening the research and surveillance capacity across a variety of disciplines and institutions, to better inform policy and practices and to improve the treatment and services aimed at meeting the needs of those who are affected by hepatitis C.
- Strengthening existing and considering new initiatives around prevention and control of hepatitis C transmission.
- Preventing discrimination and reducing stigma and isolation of those affected with hepatitis C.

It is with great pleasure that I commend to you the *Victorian Hepatitis C Strategy 2002–2004*. I am confident that the strategy will provide the direction for necessary areas of action, by developing new initiatives and strengthening existing services, to effectively address current and emerging hepatitis C issues in Victoria.



Hon John Thwaites MP
Minister for Health
28 October 2002

Acknowledgements

The Department of Human Services wishes to thank the following persons for their time and invaluable contributions to this project:

Name	Organisation
Ms Rosa Billi	Department of Human Services
Professor Graham Brown	Victorian Infectious Diseases Service
Mr Carlo Campora	Hepatitis C Council of Victoria
Ms Helen Clarke	Department of Human Services
Dr Nick Crofts	The Macfarlane Burnet Institute for Medical Research and Public Health
Dr Paul Desmond	St Vincent's Hospital, Melbourne
Ms Debbie Heery	Upper Hume Community Health Service
Ms Judith Jones	Australian Institute for Primary Care, La Trobe University
Ms Maria Karvelas	Department of Human Services
Professor Rob Moodie	Chair, MACAHRD VicHealth
Ms Kirsty Morgan	Victorian Drug User Group (VIVAIDS)
Professor Marian Pitts	Australian Research Centre in Sex, Health and Society (ARCSHS)
Mrs Jenny Ross	Haemophilia Foundation Australia
Mr John Ryan	Association of Needle and Syringe Programs (ANEX)
Ms Deb Sansom	Deb Sansom, Creative
Dr Joe Sasaduesz	Victorian Infectious Diseases Service
Dr William Sievert	Department of Medicine, Monash Medical Centre
Dr John Stanton	Department of Human Services
Professor Steve Wesselingh	Chair, MACAHRD Hepatitis C Strategy Review and Development Subcommittee. Infectious Diseases, The Alfred
Mr Mark Young	Youth Projects Inc.

In addition, the Department of Human Services acknowledges the individuals who participated in the rural and metropolitan community consultations. Their involvement, as well as comments submitted in writing from numerous organisations, including other government departments, greatly contributed to the development of this strategy for the Victorian community.

Executive summary

The *Victorian Hepatitis C Strategy 2002–2004* provides goals and direction for necessary action in relation to prevention, education, treatment, care and support, for people affected by hepatitis C. It has been developed in collaboration with the Department of Human Services and the Hepatitis C Strategy Development Subcommittee of the Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases (MACAHRD). Further, the strategy has been informed and guided by extensive community consultation. Key priority areas identified in this document are:

1. Prevention and control of hepatitis C transmission

- To ensure reasonable access for all Victorians to needle and syringe programs (NSPs) and facilitate the integration of primary care objectives in the provision of services for people who inject drugs.
- To facilitate the development of new programs and enhance current practice in relation to the treatment and prevention of hepatitis C within correctional facilities.
- To further extend the operational reach of hepatitis C awareness campaigns.

2. Preventing discrimination and reducing stigma and isolation

- To develop a supportive legislative and political framework that recognises the needs and rights of people affected by hepatitis C and helps reduce discrimination, stigma and marginalisation.
- To ensure that health care services are accessible to, and tolerant of, the

individual needs and rights of people affected by hepatitis C.

- To provide workforce education and training for all health care workers as well as the general community, to ensure that they do not engage in practices that are discriminatory.
- To ensure that standard infection control procedures in health care and other skin penetration settings are universally implemented.

3. Health maintenance, care and support for people affected by hepatitis C

- To develop and implement best practice strategies and programs to lessen the personal and social impact of hepatitis C infection.
- To develop and facilitate a variety of partnerships, environments, services and access pathways to cater for the diverse needs of people affected by hepatitis C.
- To facilitate the development and implementation of a variety of workforce development programs for a diverse range of health service providers that standardise competencies, challenge discriminatory attitudes and values, and enhance non-discriminatory behaviours and practices in all services and contexts.

4. Research and surveillance

Clinical research

Development of a multidisciplinary research capacity that incorporates basic virology, clinical research, epidemiology and social research that will provide the basis for:

- Natural history studies of acute and chronic hepatitis C through the formation of an observational database supported by a linked serum bank
- Clinical trials of antiviral and treatment to reduce the amount of scar tissue in the liver (antifibrotic therapy), including a study of factors affecting treatment uptake, conducted through an adequately funded network of established investigators and trial coordinators.

Epidemiological research

- Systematic integration of and information sharing between surveillance, research and intervention activities.
- Development of a comprehensive, multifaceted, integrated system in Victoria to provide information about the hepatitis C epidemic. Key components of such a system should include:
 - A network of sentinel clinics.
 - Annual surveys of populations at high risk of hepatitis C transmission.
 - Surveillance for disease and other outcomes of hepatitis C.

Social research

Development of social research program should include:

- Collection of qualitative and quantitative data on living with hepatitis C, including health maintenance behaviours, symptoms, pharmaceutical and alternative treatments.
- Routine collection of qualitative and quantitative social research data to enhance the sentinel surveillance system.

- Research that identifies the cultural, social and psychological factors that impact on prevention, treatment and health maintenance for those with hepatitis C.
- Research that improves our understanding of the basis of stigma and discrimination amongst general community members and specific professional groups, such as health care workers, correctional and police officers and others.

5. Pharmaceutical treatments

To provide equal access to all Victorians requiring treatment for hepatitis C by:

- The employment of interferon nurse educators and psychiatric/psychological staff to support city and rural hepatitis treatment clinics, through appropriately trained treatment counsellors and treatment providers.
- The development of models of care for the treatment of patients with hepatitis C, in particular, for those who live in rural areas, through shared care arrangements with metropolitan clinics or stand-alone rural clinics.
- The provision of services, information and education about hepatitis C that is linguistically and culturally sensitive.

1 Introduction

Hepatitis C is a major population health challenge in Australia and in Victoria.

This strategy sets out a clear strategic framework to address the current and emerging challenges of hepatitis C in Victoria. It provides direction for necessary areas of action in the prevention, control, management, treatment, surveillance and care and support of people affected by hepatitis C.

The strategy is guided by Australia's first *National Hepatitis C Strategy 1999–2000 to 2003–2004*, which provides direction for responses to hepatitis C on a national and state level. It is underpinned by a partnership approach, involving affected communities and key stakeholders, including all levels of government, community and advocacy agencies, researchers, health professionals and pharmaceutical companies. It provides a framework for Victoria to further develop its current harm reduction approach to risk-related behaviours, in both community and clinical contexts.

This second *Victorian Hepatitis C Strategy* builds on the acknowledged successes of the first *Victorian Hepatitis C Strategy* of 1996. It has been developed in collaboration with the Department of Human Services and the Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases (MACAHRD). Extensive consultations in rural, regional and metropolitan areas of Victoria were

undertaken during the development of the strategy and the document has been informed and guided by the feedback provided at these forums.

1.1 Hepatitis C in Victoria

Hepatitis C is a blood-borne virus that affects the liver and it is estimated that 200,000² Australians are currently affected by the virus. Hepatitis C affects a wide range of people. The major continuing transmission is among people who are involved in unsafe injecting practices. People with histories of injecting drug use make up a substantial portion of people with hepatitis C in Victoria. Prior to the introduction of universal donor screening in Australian blood banks in 1990, which used a test that could detect hepatitis C, a small number of people were infected by contaminated blood or blood products. A third, sizeable group of people with hepatitis C in Victoria is made up of those whose birthplace was not Australia, and who were infected in their country of origin, probably through the use of unsterile injecting equipment in immunisation campaigns or therapeutic settings.

1.2 Hepatitis C transmission

Any activity or setting where blood is present and may be exchanged between people can pose a transmission risk. One example of an activity where blood may be present is during the process of unsafe drug injecting. Unsafe procedures can lead to the hepatitis C transmission.

In June 2000, Nucleic Acid Testing (NAT) was introduced into blood bank screening and has further reduced the risk of transmission through transfusion of blood or blood products. Standard infection control procedures have considerably reduced the risk of acquiring hepatitis C during a medical procedure in Victoria; the risk of hepatitis C transmission in this way is now considered to be minimal.

1.3 Notifications surveillance

Surveillance in Victoria is currently based on a system in which diagnosing physicians send notifications of positive hepatitis C test results to laboratories, which then notify the Department of Human Services. Hepatitis C notifications are listed in Group B under the *Victorian Health (Infectious Diseases) Regulations 2001*. These notifications are collated and published in the quarterly *Victorian Infectious Diseases Bulletin* (VIDB) and in the annual report, *Surveillance of Notifiable Infectious Diseases in Victoria 2000*. In 1999, the total number of notified cases of hepatitis C in Australia reached more than 140,000³. Between 1995 and 1999, the annual number of notifications remained stable at between 18,000 and 22,000. In Victoria, the number of notifications for 2000 and 2001 was 5,923⁴ and 5,219⁵ respectively.

2 Commonwealth Department of Health and Aged Care 2000, *The prevalence and incidence of hepatitis C*, National Hepatitis C Strategy 1999–2000 to 2003–2004, p.6.

3 National Centre in HIV Epidemiology and Clinical Research, 2000, *2000 Annual Surveillance Report: HIV/AIDS, Hepatitis C and Sexual Transmissible Infections in Australia*. p.11.

4 Department of Human Services, 2001, *Victorian Infectious Diseases Bulletin* vol. 4:2 p.18.

5 Department of Human Services, 2002, *Victorian Infectious Diseases Bulletin* vol. 5:1 p.15.

Laboratory testing

Laboratory testing for hepatitis C in Victoria is delivered via a three-tiered system:

- Blood banks and the Department of Human Services approve public and private laboratories to undertake screening tests for hepatitis C antibodies. Blood banks have also recently introduced NAT as an additional safeguard to protect the blood supply. Some public and private laboratories also perform NAT when indicated or requested.
- Indeterminate or inconclusive specimens are referred to the Victorian Infectious Diseases Reference Laboratory (VIDRL), which is the State Reference Laboratory for hepatitis testing. The VIDRL provides confirmatory antibody testing and, when indicated in particular cases, qualitative diagnostic NAT.
- The VIDRL also provides pre-treatment hepatitis C genotyping (genotypes 1–6) and monitoring of hepatitis C antiviral therapy with quantitative NAT, monitoring of hepatitis C treatment success or failure and, occasionally, testing for the molecular relationship between hepatitis C strains in epidemiological investigations for the Department of Human Services.

Quality assurance monitoring of new assays such as NAT has lagged behind the diagnostic application of the assays, but the National Serological Reference Laboratory has recently introduced quality assurance panels and quality control samples to evaluate testing standards. The VIDRL has also initiated

an informal quality assurance panel for hepatitis C genotyping that has been distributed to a number of Victorian and interstate laboratories.

1.4 Responses to date

National

Following identification of the hepatitis C virus in 1989, and the prompt introduction of blood screening in 1990, Australia has responded with several key initiatives. These have included:

- Access to testing for hepatitis C funded through the Medicare Benefits Schedule since 1990.
- A joint Australian Health Ministers Advisory Committee (AHMAC) and National Health and Medical Research Council (NHMRC) taskforce on hepatitis C in 1993.
- A National Hepatitis C Action Plan in 1994.
- Incorporation of hepatitis C into the third Partnerships in Practice, *National HIV/AIDS Strategy 1996–1997 to 1998–1999*.
- A review of the population health response to hepatitis C commenced in 1998 and the resulting report, *Hepatitis C: A Review of Australia's Response*, recommended that a separate national hepatitis C strategy be developed.
- Four-year Commonwealth funding through the 1999 COAG Illicit Drug Diversion Initiative-Supporting Measures for NSPs.
- Development of the *Australian Hepatitis C Surveillance Strategy* in 1999.

- Publication of the first *National Hepatitis C Strategy* in 2000.
- Broadening the eligibility criteria under the Pharmaceutical Benefits Scheme (PBS) for combination antiviral treatment for hepatitis C in 2001.
- Australia's first enquiry into hepatitis C-related discrimination conducted by the NSW Anti-Discrimination Board, which produced the 2001 report *C Change*.
- The *National Hepatitis C Resource Manual for Health Care Workers 2001*, produced by the Commonwealth Department of Health and Aged Care (CDHA).

Victorian government

Since publication of the first *Victorian Hepatitis C Strategy* in 1996, there has been a significant increase in our understanding of hepatitis C, including transmission modes and natural history, and in the efficacy of treatments. There have also been significant improvements in the level and range of services offered to people affected by hepatitis C. Community-based responses have become more sophisticated and there is now a broad spectrum of prevention and education programs in place within Victoria. Additional four-year Commonwealth funding, through the COAG Supporting Measures for NSPs and the Hepatitis C Education and Prevention Initiative, has built on the successes of the first *Victorian Hepatitis C Strategy*. Victoria has developed and implemented the following new initiatives:

- A training needs analysis of Needle and Syringe Program (NSP) workers.

- A pharmacy survey exploring the provision and disposal of needles and syringes.
- An increase in the number of rural NSPs.
- Development of a steroid peer education project.
- Development of a project focusing on blood-borne viruses and sexually transmissible infections (STIs) for people from culturally and linguistically diverse backgrounds.
- Expansion of existing NSP services.
- Development of the Association of Needle and Syringe Programs (ANEX) as a state peak body.
- Development of Victoria's *Safe Needle Disposal Strategy 2001*.
- Development of an Infectious Diseases Prevention Program for all employees of Victoria Police.
- An enhanced surveillance strategy to identify newly acquired cases of hepatitis C.

Local government

Following the Premier's Drug Policy Expert Committee 2000, a number of local governments in Victoria have developed Strategic Drug Plans. All local governments produce a Municipal Public Health Plan that identifies local blood-borne virus prevention and education strategies, including:

- Education and training in standard infection control procedures for a broad range of occupations.
- Safe needle and syringe disposal.
- Support for community groups.

Community

Community-led responses in Victoria have played a key role in the development of appropriate and inclusive services throughout the state. The inclusion of affected communities in innovative and dynamic programs, which aim to reduce transmission and prevent discrimination and stigma, have been provided by the Hepatitis C Council of Victoria Inc., the Victorian drug user group VIVAIDS, and other education, support, advocacy and information services. Key initiatives to date have included:

- The development of an annual Hepatitis C Awareness campaign.
- The establishment of communication networks across the state.
- A diverse range of training and education programs.
- Provision of information and support services.
- Involvement in national activities.
- Community conferences.

Rural and regional

Access to, and provision of services in rural and regional areas is identified as a key area for development in this strategy. Responses to date include:

- Implementation of Regional Health Plans.
- Expansion of NSPs in regional areas.
- Provision of dedicated rural educators.
- Funding for community organisations with a focus on support and advocacy.
- Ongoing initiatives organised by the Hepatitis C Council of Victoria Inc. and the Victorian Hepatitis C Educator based at St Vincent's Hospital.

Health care services

- Victoria currently funds a dedicated Hepatitis C Educator for health care workers and this strategy acknowledges the importance of expanding and supporting this work to meet the broad needs of health care workers across the state.
- The Department of Human Services recently conducted a review of the GP Education Program for HIV/Hepatitis C Education, the recommendations of which are currently being implemented.
- At present there is no regulation under the *Victorian Health (Infectious Diseases) Regulations 2001* for the provision of pre- and post-test counselling for individuals who are tested for hepatitis C in Victoria. A review of the *Health Act 1958* (Vic) is currently proposed and the Department of Human Services is undertaking a needs assessment to determine areas for inclusion in the review.

1.5 Current and emerging challenges

Unsafe injecting practices

It is estimated that approximately 90 per cent⁶ of all new hepatitis C infections arise from unsafe injecting practice. Harm reduction measures introduced in the late 1980s, such as Needle and Syringe Programs (NSPs), have made an impact on preventing significant numbers of HIV transmissions among people who inject drugs. Such programs are also believed

⁶ ANCARD Hepatitis C Sub-committee 1998, *Hepatitis C Virus Projections Working Group: Estimates and Projections of the Hepatitis C Epidemic in Australia*, p1.

to be having an impact on the number of hepatitis C transmissions. However, the higher prevalence of hepatitis C among people who currently inject drugs and the greater infectiousness of hepatitis C pose major challenges in reducing transmission within the Victorian community⁷.

It can be difficult to access people who currently inject drugs, due to the illicit nature of the activity, because they already face high levels of stigma and discrimination and because they are not a homogenous group. For this reason, NSPs and peer-based organisations are a valuable resource for prevention education.

The provision of sterile injecting equipment remains a key component of prevention strategies. In Victoria most NSPs operate from 9.00am to 5.00pm, with mobile outreach services operating in some regions in the evenings. Outside of these hours, clients do not have access to sterile injecting equipment, thus creating a known risk context for needle sharing⁸. Strategies to improve the accessibility of sterile injecting equipment would need to be considered.

Information and targeted education activities about hepatitis C prevention to facilitate behaviour change within

networks of people who inject drugs are equally important components of a comprehensive strategy. Social research into the motivations and factors for sharing injecting equipment and other contexts of risk can contribute to more effective planning, development and implementation of targeted prevention strategies.

The potential for hepatitis C transmission via shared injecting equipment, other than needles and syringes, requires more sophisticated messages if educational strategies are to be effective. The continued development and maintenance of 'blood awareness' through social marketing strategies targeted at people who inject drugs and, in particular, long term users who are familiar with the 'clean fit every hit' message, is recommended. These experienced users are a key conduit for promoting injecting culture messages to less experienced users.

Correctional settings

Correctional settings include juvenile justice centres, adult prisons and community correctional services. The potential for transmission between people in correctional facilities is greatly increased by structural and logistical barriers, pre-existing levels of infection and high levels of risk behaviours, such as unsafe injecting and tattooing. While harm reduction strategies have been implemented in prisons in accordance with the new *Victorian Prison Drug Strategy 2002*, there is considerable scope in Victoria to improve the overall health of people in correctional settings. In relation to hepatitis C and other blood-borne virus issues, there is a further need to improve access to health, education

and harm reduction initiatives and treatments for hepatitis C for people in correctional settings.

Skin penetration practices

Under the *Health Act 1958* (Vic), skin penetration practitioners must register with their local council. However, there are some practitioners who are unregistered or are unaware of the regulations outlined in the Standards of Practice produced by the Department of Human Services. While there are initiatives currently underway, there is a great deal of scope for further work in this area, particularly in addressing the training and education needs of practitioners.

Schools

Of the 79 hepatitis C notifications in 2000 that were identified as newly acquired cases, 19 per cent were in the 15 to 19 year age group⁹. Schools have a vital role to play in hepatitis C prevention and education. While approximately only two per cent¹⁰ of young people inject drugs in Australia, unsafe injecting practices and a lack of knowledge about blood-borne viruses is a high priority area for public health educators and teachers in Victoria. There are structural barriers in accessing young people in schools but, to be effective, the prevention of hepatitis C must begin with sound prevention and blood-borne virus education programs in this setting.

7 Crofts N, Aitken C, Kaldor J 1999, *The force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not*, Med J Aust, 1 March, 170;5, p.220–221.

8 Kelaher M, and Ross M 1999 'Dominant situational determinants of needle sharing in injecting drug users' *Drugs: Education, Prevention and Policy* vol 6:3, pp. 399–407; Ross M 1994 'Explanations for sharing injecting equipment in injecting drug users and barriers to safer drug use' *Addiction* vol 89:4 (1994), pp. 473–479; Southgate E, Ireland K 1999 *Drug use and Gay Men*, NCHSR, Sydney.

9 Department of Human Services, 2000, *Surveillance of Notifiable Infectious Diseases in Victoria 2000* p.72.

10 Lindsay J, Smith A, Rosenthal D, 1997, *Secondary students, HIV/AIDS and sexual health*, Melbourne Centre for the Study of STDs, Faculty of Health Sciences, La Trobe University

This strategy also recognises that not all youth can be accessed through schools. There is a need to investigate innovative methods to communicate information to early school leavers to ensure that they have access to hepatitis C prevention and education initiatives. For example, youth culture and youth cultural events present prime opportunities to access diverse groups of young people including early school leavers. Further, the close relationship between young people and innovation in information and communication technologies should also be explored as a medium to deliver relevant and accurate information to young people online.

Health care workers

While research shows that the risk of hepatitis C transmission in health care settings is low, health care workers are at increased risk of occupational exposure through needlestick injuries and blood splashes. There is an ongoing need to provide health care workers with education, training and support about occupational blood-borne virus issues, to reduce the risk of transmission in these settings. There is also an urgent need for education to reduce levels of discrimination against people with hepatitis C in the health care setting, so that these people can have equitable access to care.

Workforce development

The development of a highly skilled workforce is an important component in ensuring that the outcomes of this strategy can be delivered. The Community Education Workforce and Training (CEWT) study based at

Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University investigated the HIV/hepatitis C community-based health education sector in Australia, with a view to informing policy, training and capacity strengthening initiatives.

This study found that workforce training for educators and care and support workers is usually ad hoc and reliant on individual initiative. People working in this area are often left to develop their own skills, without clear professional guidance or support.

Building the capacity of the sector to appreciate the complex environments of the hepatitis C epidemic is essential. This strategy recognises the need to enhance existing training opportunities and to develop new courses and strategies to ensure a skilled workforce able to share expertise and respond to changes in the epidemic. Learning strategies, and reflexive practice within organisations and across health services, are also important means to promote exchange of ideas and new initiatives.

Services for rural and regional Victoria

Many people in rural and regional areas of Victoria do not have the same access to services as people in metropolitan Melbourne. The personal difficulties associated with disclosure and subsequent discrimination in smaller communities can prevent people from accessing services. This strategy acknowledges the need for further development across all sectors, to ensure equitable access to services for all Victorians.

Aboriginal and Torres Strait Islander people

Access to, and provision of health care services that are culturally appropriate and responsive to the needs of Aboriginal and Torres Strait Islander people is essential for effective education, prevention and management of hepatitis C in these communities.

Primary health care services, both community-controlled and mainstream, have an important role in improving the health outcomes for Aboriginal and Torres Strait Islander people who have hepatitis C.

There are more than 20 community-controlled health services in Victoria. Strengthening the capacity of these services around hepatitis C testing practices is vital to ensure prompt diagnosis and treatment. Such specialised services also need to enhance partnerships with the broader health sector to facilitate a system of coordinated care for people who have hepatitis C. This will promote appropriate referral practices to specialist care and support, leading to better health outcomes for those who have hepatitis C.

To ensure equity in access and to meet the identified needs of Aboriginal and Torres Strait Islander people, health workers who are working in mainstream services across Victoria must be adequately trained to deal appropriately with the complexity of cultural beliefs and be sensitive to the needs of indigenous clients. This is particularly important for those working in rural and remote areas of Victoria, where there are few Aboriginal and Torres Strait Islander community-controlled health services.

The possibility of building on existing hepatitis C specific prevention and health promotion initiatives should also be explored during the lifetime of this strategy. For example, the Well Person's Health Check is a Commonwealth-supported program directed at Aboriginal and Torres Strait Islander people. These health checks include hepatitis C screening and provide opportunities for prevention education and health promotion to those at risk of, or who have, hepatitis C. Further developing these initiatives through enhanced partnerships between the Commonwealth and state governments would promote equity in access to these community-controlled services.

This strategy recognises the important role of the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) as the peak body in indigenous health in Victoria. Successful management of hepatitis C and related issues can only be achieved by involving the community in the development, planning and implementation of policy and practices around prevention, treatment, care and support.

People from culturally and linguistically diverse backgrounds

There is a lack of meaningful information available for people from culturally and linguistically diverse backgrounds about hepatitis C related issues. Sensitivity and awareness of the complex issues surrounding cultural influences, language considerations, religious traditions and traditional practices are required to re-orient and improve access to services in Victoria. People must be offered assistance in dealing with the issues of drug use in their own communities and be offered choices in service providers and interpreting services. Health information must be planned and delivered in a flexible and responsive manner.

2 Goals and principles

This strategy has been developed in accordance with the four priority areas outlined in the National Hepatitis C Strategy. These are:

- Reducing hepatitis C transmission in the community.
- Treatment of hepatitis C infection.
- Health maintenance, care and support for people affected by hepatitis C.
- Preventing discrimination and reducing stigma and isolation.

2.1 Developing partnerships and involving affected communities

This strategy recognises the need for collaborative effort across all levels of government, community organisations, medical, health, research and scientific sectors and people affected by hepatitis C. To establish and develop such partnerships, this strategy supports a continued dialogue between partners, including a commitment to consultation and joint decision making in policy and program development and resource allocation.

2.2 Access and equity

All people in Victoria have the right to access appropriate services and the design, implementation and evaluation of the initiatives outlined in this strategy must consider the contexts and capacities of affected people. The state government is committed to developing health, social and legal environments to make access and equity possible for all people, including those from rural

and regional Victoria, culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander people affected by hepatitis C and for those who may be at risk of acquiring the virus.

2.3 Harm reduction

Consistent with the *National Hepatitis C Strategy* and the *National Drug Strategic Framework*, this strategy is underpinned by a harm reduction approach. This approach is designed to reduce drug-related harm and the transmission of blood-borne viruses such as hepatitis C in Victoria. As such, this strategy supports and promotes the development of initiatives that utilise the principles of harm reduction in relation to hepatitis C.

2.4 Health promotion

Diverse health promotion activities are required to create supportive and enabling environments for Victorians affected by hepatitis C. In recognising the political, economic, social, cultural, environmental, behavioural and biological determinants of health, this strategy supports activities that involve and strengthen community action, emphasise local needs and are community-directed in their development and implementation.

2.5 Research and surveillance

Victoria recognises the imperative for local and state-based research and surveillance initiatives to further our understanding of hepatitis C and related issues. This will include collaboration

across the areas of epidemiology, basic scientific research and virology and clinical, social and behavioural research. This strategy is committed to the inclusion of affected communities in the design, execution and dissemination of such research and acknowledges the need for both investigator-led and commissioned research in the state.

2.6 Linked strategies

This strategy has been developed to improve the quality of life for people affected by hepatitis C throughout the state. Its successful implementation depends on its alignment with other national and state and territory strategies and infrastructures. Linked strategies include:

National

- *National Hepatitis C Strategy 1999–2000 to 2003–2004*
- *National HIV/AIDS Strategy 1999–2000 to 2003–2004*
- *National Mental Health Strategy*
- *National Drug Strategic Framework 1998–99 to 2002–2003*
- *National Aboriginal and Torres Strait Islander Sexual Health Strategy*
- *National Health Plan for Young Australians*
- *National Hepatitis C Testing Policy (due 2002)*
- *Healthy Horizons: A Framework for Improving the Health of Rural, Regional and Remote Australians 1999–2003.*

Victoria

- *Victorian HIV/AIDS Strategy 2002–2004*
- *Victorian Health (Infectious Diseases) Regulations 2001*
- *Victorian Prison Drug Strategy 2002*
- *Prisoner Healthcare Standards*
- *Information Privacy Act 2000*
- *Health Records Act 2001*
- *Victorian Women’s Health Plan 1999*
- *Women’s Health and Wellbeing Strategy 2001*
- *Safe Needle Disposal Strategy 2001.*

3 Key priority areas

3.1 Prevention and control of hepatitis C transmission

Prevention and control activities in Victoria utilise the key principles of the *Ottawa Charter 1986*, Harm Reduction and Community Development. Community education initiatives have focused on the provision of relevant, respectful and inclusive programs that take into account population diversity and cultural differences in their design and delivery.

There are significant and ongoing challenges in the maintenance and development of services to meet the needs of those who are at risk of acquiring hepatitis C within the state. Diverse and appropriate prevention and control approaches from all sectors are required if current transmission rates are to be further reduced.

Objectives

Key principles to guide the design and implementation of prevention and control initiatives in Victoria are consistent with the guiding principles for reducing hepatitis C transmission identified in the *National Hepatitis C Strategy*. These are:

- The principle of harm reduction has primacy in the development and implementation of interventions to reduce hepatitis C transmission.
- Transmission of hepatitis C is preventable, providing people have adequate and equitable access to information, specific education and sterile equipment.
- Each person must accept responsibility for taking action to avoid becoming infected and for preventing further transmission of the virus.

- Ensuring optimum access to prevention and education interventions for people at risk of hepatitis C infection through initiatives that take account of cultural and linguistic backgrounds, indigenous status, gender, age, standards of literacy, disability, geographical location, and economic and financial factors.
- Prevention and education initiatives need to accept and respect existing social and cultural practices within target populations and be delivered in a non-judgmental, non-discriminatory manner.
- The involvement of people affected by hepatitis C in reducing hepatitis C transmission is fundamental to prevention work.
- Health promotion activities for specific communities are best developed and delivered by those communities, through peer-based initiatives in partnership with governments, health professionals and researchers.
- The best available evidence must underpin education and prevention interventions and, where appropriate, innovative projects that do not have a clear or direct evidence base must also be considered.
- Adequate surveillance and monitoring mechanisms are essential for identifying key population groups at risk, guiding prevention interventions and evaluating outcomes.
- Materials designed to reduce transmission of hepatitis C and risk-related behaviours in specific contexts must be effective. The use of explicit images and language in education programs is warranted, if it is necessary

for effective communication and if it is culturally relevant and accurately targeted.

To address the objectives outlined above, a number of areas of work have been identified for action/development in the Victorian context.

Areas for action

Implementing the National Hepatitis C Testing Policy

In accordance with the forthcoming National Hepatitis C Testing Policy, further consideration should be given to the development of standard guidelines for all hepatitis C testing in Victoria. This initiative would involve relevant agencies in its development. Areas that have been identified for examination in such guidelines include:

- Whether routine antibody testing of pregnant women is warranted and a review of issues relating to informed consent and pre- and post-test counselling in this area.
- Informed consent.
- Access to testing, particularly in rural areas.
- Mechanisms to improve issues relating to confidentiality and privacy.
- Consistency and accuracy in pre- and post-test counselling.

Developing NSPs

Needle and Syringe Programs provide services for large numbers of people who inject drugs and who may have, or be at risk of acquiring, hepatitis C. The importance of NSPs goes beyond their capacity to provide sterile injecting equipment; they provide opportunities

to access otherwise difficult-to-reach populations. These programs have frequent and ongoing interactions with users and are often the only non-judgemental and friendly environments for many people who inject drugs. For this reason, and given the diverse nature of the injecting drug user population, NSPs are a valuable resource for targeted prevention education and community development initiatives among local networks of people who inject drugs.

Education and marketing of harm reduction concepts and of NSPs to the wider community are crucial. Program development and re-orientation in this area will ensure that NSPs continue to work towards reducing rates of hepatitis C transmission within the Victorian community. Existing NSP initiatives, including the provision of education, the development of better-targeted service models, and workforce training, should be strengthened and the feasibility of new initiatives should be explored during the life of this strategy. Such initiatives may include:

- Increasing the number of NSPs in rural and outer suburban areas.
- Providing all NSP staff with ongoing professional development and support.
- Reviewing the appropriateness of NSP services in regional and rural areas that have an increased flux of people during particular times of the year (for example, fruit picking and ski season).
- Reviewing relevant legislation to ensure the inclusion of NSPs as an essential public health service.
- Linking primary health care facilities with NSPs.

- Reviewing approaches to address the lack of ‘after hours’ access to sterile injecting equipment and appropriate disposal facilities.
- Reviewing the types of injecting equipment available at NSPs.
- Reviewing the mechanisms for data collection at NSPs, and mechanisms for the evaluation, analysis and dissemination of this data.
- Funding and support for identified educational interventions for NSP clients.

Enhancing drug treatment services

Drug treatment services play an important role in providing specific drug interventions, as well as support and care to people who inject drugs.

In addition to drug treatment, clients presenting at these services may have many other needs, such as medical, psychological and social. These needs may be further complicated by the fact that clients are likely to have or be at risk of hepatitis C. As such, it is important that the capacity of drug treatment services is strengthened to facilitate appropriate client management particularly around hepatitis C prevention and management. In this context, enhanced links with mainstream service providers are vital to ensure that clients have access to a variety of interventions such as harm reduction programs, prompt diagnosis and appropriate referral to hepatitis C-specific treatment and support services.

Addressing needs in correctional settings

Currently there are four health providers delivering health services in prisons across Victoria and no

central coordination to collect data for surveillance purposes. Hepatitis C positive cases represent over 40 per cent¹¹ (and in some studies over 60 per cent) of all receptions in the correctional population in NSW. The NSW study has been replicated for Victorian correctional settings, but no data is yet available. This strategy acknowledges the need to support prison health providers to monitor and develop an integrated surveillance system that will provide valuable accurate data for prevalence, incident cases and transmission rates. This issue has also been considered as a component of the active surveillance system outlined in Section 2.5.

The policy across Victorian correctional settings is for voluntary testing on reception or at any time during incarceration. Section 29 of the *Corrections Act 1986* provides for mandatory testing. All ‘at risk’ offenders are encouraged to be tested. A feasibility study into the issue of informed consent and whether a systemic approach to routine testing at different intervals of incarceration should be considered during the life of this strategy.

Another initiative that has been identified for consideration is the development of diversion schemes for drug offenders, which would further reduce the number of drug-related incarcerations. Increased access to drug treatment services during and after prison, access to hepatitis C treatment during incarceration and the further development of hepatitis C training and education initiatives in

11 Awofeso N, Harper SE, Levy MH, 2000, *Prevalence of exposure to hepatitis C virus among prison inmates 1999*, MJA vol. 172, p.94.

correctional settings would also improve the health outcomes of this group.

Improving skin penetration practices

The development of appropriate blood-borne virus training and education is necessary for practitioners and for those enforcing the Victorian Standards of Practice. In line with this, the Hepatitis C Council of Victoria Inc. is currently developing a Health Audit that includes a checklist for standard inspections by Environmental Health Officers. Other initiatives that have been identified include:

- A review of the *Health Act 1958* (Vic) with consideration of strategies to improve the link between registration and standards of practice in the field.
- An update of the current Victorian Standards of Practice to reflect national Standard Infection Control Procedures.
- The promotion of effective infection control practices in all non-health care settings where skin penetration practices take place: tattoo parlours, body piercing establishments, beauty and hair salons and chemists practising body piercing.
- The development of training in Standard Infection Control Procedures for skin penetration, body art and beauty therapy professionals.

Reviewing police activity in street-based drug markets

In recent years, there has been a cultural shift toward street-based drug markets in Victoria that has contributed to an increase in unsafe injecting practices. Police enforcement of section 75 of the *Drugs, Poisons and Controlled Substances Act 1981* makes it an offence to use a

drug of dependence. Further, possession of needles and syringes has been used as evidence of drug use¹².

Reports indicate that one reason why street users inject unsafely is fear of arrest under section 75¹². In addition, it has been shown that street-based drug users are likely to dispose of needles and syringes as quickly as possible after injecting and, in some cases, unsafely, because if intercepted by police while carrying a needle or syringe, they could be searched, questioned and possibly charged with use of a drug of dependence. Further, there is concern about the level of unsafe disposal of needles and syringes in the community because of the potential risk of needlestick injuries.

There have been calls for review or repeal of section 75 from advocacy groups and support for this from the Drug Policy Expert Committee¹² on public health grounds in order to facilitate safer injecting practices and appropriate disposal of injection equipment. However, the government did not support this recommendation: 'A number of police and court programs are underway as part of the COAG Drug Diversion Program and until these have been evaluated this matter will not be further considered'¹³. To inform future decisions in relation to this issue, this strategy supports the timely evaluation of these diversion programs to ensure an appropriate assessment of the merits of reviewing section 75.

¹² Victorian Drug Policy Expert Committee, 2000 *Drugs: Meeting the Challenge. Stage Two Report* pp 156–158.

¹³ Victorian Government, 2000, Response to the Second Stage Report of the Drug Policy Expert Committee, State Government, Victoria.

Developing blood-borne virus education in schools

This strategy supports the incorporation of blood-borne virus education into primary and secondary school curricula. Existing initiatives that have been identified as key opportunities for the development of hepatitis C prevention and education include:

- The *Framework for Student Support Services in Victorian Government Schools*, which outlines primary prevention and early and post-intervention initiatives for student welfare. These initiatives are designed for implementation on a whole-school basis.
- The *Curriculum and Standards Framework (CSFII)* is the basis for curriculum planning in Victorian schools for years Preparatory to year 10. Health and Physical Education is one of the key learning areas in the framework and covers studies relating to health, safety, human development and human relations.
- The continued implementation and promotion of the Commonwealth's *Talking Sexual Health* project.
- Existing peer-based education initiatives.
- 'Opportunistic' education provided by youth or community workers.
- Targeted resources about hepatitis C for use in schools.
- Ongoing professional development and support for teaching and non-teaching school staff.

Implementing a general population awareness campaign

Engaging the Victorian media in meaningful dialogue about issues relating to hepatitis C has proved difficult. A cross-sector strategic approach to engage the media in raising the profile of issues relating to hepatitis C should be developed during the life of this strategy. This initiative should be informed by:

- Affected Victorian communities.
- National and Victorian media expertise.
- The Australian Media Guide to Hepatitis C.
- The experiences of other states that have developed similar campaigns.
- The current work of agencies involved in the annual Victorian Hepatitis C Awareness Week.

Improving test discussion and pre- and post-test counselling protocols

It is important that there be consistent testing information and pre- and post-test counselling for hepatitis C testing across all sectors involved in hepatitis C prevention and education, in accordance with the National Hepatitis C Testing Policy. The Department of Human Services currently supports a number of programs that aim to promote and improve practices for clients at the time of hepatitis C testing. These programs include the Pre- and Post- Test Counsellors Training Course for health workers and the Victorian GP HIV and Hepatitis C Education Program.

Evaluating educational processes

Education programs must be supported by sound evaluation practices.

To continue quality improvement processes, the appropriate bodies must systematically review strategies and resources to ensure the satisfactory attainment of goals, targets and outcomes. This will include evaluation of input, process and outcome data, and should include qualitative as well as quantitative evaluation.

Key goals

- 1 To ensure reasonable access for all Victorians to NSPs and facilitate the integration of primary care objectives in the provision of services for people who inject drugs.
- 2 To facilitate the development of new programs and enhance current practices for initiating pharmacotherapy treatment while in prison, access to education and harm minimisation interventions and instigate the regulation of body art practices within correctional facilities.
- 3 To further extend the operational reach of hepatitis C awareness campaigns.

3.2 Preventing discrimination and reducing stigma and isolation

Under the Victorian *Equal Opportunity Act 1995*, discrimination on the basis of infection, assumed infection, infection in the future, or association with a person who is or is assumed to have hepatitis C, is unlawful. This strategy acknowledges that some people with hepatitis C and people who may be at risk of acquiring hepatitis C through unsafe injecting practices are often treated less favourably in certain circumstances. Mechanisms to address this must involve all Victorians and should be developed across all sectors.

All people affected by hepatitis C should have the same access to services as the general population. This strategy acknowledges that people with hepatitis C come from diverse backgrounds and that factors such as culture and language, gender, age, standards of literacy, socio-economic status, disability and geographic location impact on an individual's health status, requirements and ability to access services.

Discrimination, or the potential for it and fear of discrimination based on past experience, is often reported by people with hepatitis C and can occur in all areas of life. Discrimination against people with hepatitis C often results from irrational fears about transmission and an assumed association with current or past injecting drug use.

During the lifetime of this strategy, all efforts will be made to eliminate hepatitis C discrimination.

Objectives

The objectives of this strategy are consistent with those outlined in the *National Hepatitis C Strategy*. These are:

- To prevent discrimination and to reduce the stigma and isolation experienced by people affected by hepatitis C.
- To promote the rights and enhance the ability of people affected by hepatitis C to participate in society and to remove barriers to the exercising of those rights.

Areas for action

Improving access to services

The association of hepatitis C with injecting drug use has been reported as the single most common cause of discrimination, stigma and isolation experienced by people affected by hepatitis C. People who inject drugs are not a homogenous group and, as such, all endeavours to prevent discrimination must be based on a respectful and inclusive approach that encompasses the principles of harm reduction, peer education and community development. The work of drug user organisations must be continually supported and the feasibility of expanding such services to meet changing needs will be considered during the life of this strategy.

Disclosure and discrimination can limit an individual's capacity to participate in the community and potentially limit their employment opportunities, access to goods and services and health care. This strategy acknowledges that discrimination can come from within cultural groups or communities and that the resulting stigma and isolation must be addressed by all sections of the Victorian

community. This entails the involvement of affected people in appropriate initiatives. Such initiatives may include:

- Further development of support and advocacy groups in rural and regional areas.
- Promotion and inclusion of primary health care.
- Appropriate information and education for people who do not identify with a current or past history of injecting drug use.
- Targeted information and education for people with cognitive disabilities and for people with limited literacy abilities.
- Establishing a supportive political framework across all levels of government.
- A supportive and responsive legislative framework to reduce discriminatory incidents.
- Equitable access to services for people in correctional settings.
- Increased access to both complementary and pharmaceutical treatments for people with hepatitis C and co-infection with other blood-borne viruses.
- Expansion of the range and type of services currently provided by NSPs.

Enabling the workforce

Health maintenance, care and support services for people affected by hepatitis C should be provided in a non-discriminatory and inclusive manner. This can only be achieved through continued workforce development whereby individuals, groups and organisations are equipped with information about blood-borne virus issues and have the

capacity to translate this information into best practice. Initiatives that should be considered and/or developed include:

- Acknowledging individual and organisational development needs, and supporting organisational structures and professional partnerships to meet those needs.
- Providing professionals with ongoing learning opportunities, such as in-house training, seminars, conference and workshops.
- Incorporating hepatitis C information into appropriate university courses.
- Supporting and resourcing the work of non-government organisations to develop appropriate programs.

Given the broad range of occupations, contexts, capacities and skills of those involved in working with affected people, there is no single model for the provision of such training and education, and program delivery must be flexible and multifaceted. All initiatives should aim to improve the level of understanding and awareness about hepatitis C. The following occupations/groups have been identified for targeted prevention and education initiatives to help alleviate hepatitis C related discrimination in Victoria. This list is in no way exhaustive, and includes:

- Hepatitis C educators.
- Carers of people with hepatitis C.
- Police.
- Teachers.
- School nurses.
- Health care workers including those involved in skin penetration, body art and beauty practices, drug and alcohol and NSP workers, dental and pharmacy

staff and those who work with people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander communities.

- Medical practitioners including GPs, midwives, surgeons, gastroenterologists and gynaecologists.
- Environmental health officers.
- Correctional staff.
- Interpreters.
- Natural and complementary therapists.

Reducing discrimination in health care services

A recent national study found that 46 per cent¹⁴ of discriminatory incidents reported by participants with hepatitis C occurred in health care settings. To improve the level of awareness and understanding of hepatitis C among those working in health care settings, workplace training has been identified as an important method of disseminating relevant information and effecting attitudinal change about hepatitis C at a time and place that is suitable.

In Victoria, current programs that target medical, nursing and allied health, environmental and administrative staff are in place and this strategy recognises the increasing demand for such programs. The Department of Human Services is currently reviewing and restructuring existing education initiatives to ensure that the training needs of this group are met.

For example, the department has completed a review of Victoria's GP HIV and Hepatitis C Education Program, one of the key recommendations of which is the introduction of a new tiered training program, to be implemented in due course. This strategy identifies the need for the further development of education initiatives.

Standard infection control procedures ensure that all blood is treated as infectious, thereby eliminating speculation about an individual's infectious status. Practice in this area has been identified for improvement and a review of current guidelines is currently being undertaken by the Department of Human Services.

Legislation

On a national level, the *Disability Discrimination Act 1992* prohibits discrimination on the basis of disability or impairment. Currently in Victoria, the *Equal Opportunity Act 1995* covers hepatitis C-related discrimination, and discrimination in the health setting can be reported to the Health Services Commissioner, who administers the *Health Services (Conciliation and Review) Act 1987*, which acts as an alternative to the adversarial system.

However, access to legal services can be costly and time consuming and many people are unaware of or do not have the capacity to exercise their rights. During the life of this strategy, a commitment must be made by all relevant agencies to improve access to legal services for

people with hepatitis C. This may entail education and advocacy programs to enable people with hepatitis C and those at risk of acquiring hepatitis C to have better access to existing complaints mechanisms and targeted programs in the health setting, thus reducing the incidence of discrimination.

Key goals

- 1 To develop a supportive legislative and political framework that recognises the needs and rights of people affected by hepatitis C and to help reduce discrimination, stigma and marginalisation.
- 2 To ensure that health care services are accessible to, and tolerant of, the individual needs and rights of people affected by hepatitis C.
- 3 To provide workforce education and training for health care workers as well as the general community, to ensure that they do not engage in practices that are discriminatory.
- 4 To ensure that standard infection control procedures in health care and other skin penetration settings are universally implemented.

¹⁴ Crofts N, Louie R, Loff B, 1997, 'The next plague: Stigmatization and discrimination related to hepatitis C virus infection in Australia', *Health and Human Rights* Vol 2: 2, pp 87–97.

3.3 Health maintenance, care and support for people affected by hepatitis C

The World Health Organization defines health as ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity’¹⁵. In recent years, Australia has separated health maintenance, care and support issues for people affected by hepatitis C, from pharmaceutical treatment. This is in recognition of the fact that only a limited number of people with hepatitis C have access to or choose pharmaceutical treatment. This strategy acknowledges that the health and wellbeing of people with hepatitis C in Victoria does not necessarily come within the scope of hepatitis C clinical services. A range of factors like nutrition, dental care, housing, symptoms associated with infection, alcohol consumption, co-infection with HIV and other blood-borne viruses and anxiety caused by living with a chronic illness, all impact on an individual’s sense of health and wellbeing. As such, this strategy also recognises that the primary sources of care and support for people with hepatitis C are often their personal networks, and people from these networks, such as family, friends and colleagues, are included in

the scope of support and care needs outlined below.

Victoria has developed a multifaceted approach to the challenges of maintenance, care and support, which has included empowering affected communities and delivering services that acknowledge the diverse nature of those affected.

Objectives

The objectives of this strategy are consistent with those outlined in the *National Hepatitis C Strategy*. These are:

- To reduce the personal and social impact of hepatitis C infection.
- To increase the knowledge and skills of people affected by hepatitis C, to help them maintain their health and quality of life.
- To ensure equitable access to health maintenance, care and support services for all people affected by hepatitis C.

In order to achieve these objectives, Victoria is committed to the continued provision of services in the context of non-partisan political support and efforts will be required to secure and maintain this support during the lifetime of this strategy.

All education and maintenance messages will be based on the best scientific and social research evidence, and should be delivered in an appropriate environment. Existing infrastructures should be strengthened and all models of case management must contribute to

improved service delivery, be individually and collectively responsive to clients’ needs and result in improved health outcomes and greater wellbeing for people affected by hepatitis C.

Areas for action

The following areas have been identified for their significance and/or need for development.

Incorporating best available evidence

A commitment should be made by all relevant agencies to gather, review and incorporate appropriate statistics, evidence-based information and research data to support campaigns and programs. This will involve the development of best practice models in program planning. Models should also be developed to ensure the inclusion of relevant natural and complementary medicine research.

Strengthening the work of natural and complementary therapists

Natural and complementary therapies are widely used by people with hepatitis C in Victoria. There is a need to explore workforce development opportunities for those involved in this area and further scientific and social research into combining natural and complementary therapies with pharmaceutical treatments.

Building on peer education activities

Peer support and education needs to target groups with specific needs. It is important to build on existing peer programs, such as those provided by VIVAIDS. Through their design and

¹⁵ World Health Organization 2001, *Definition of Health*. In Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19 22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. Available at: <http://www.who.int/aboutwho/en/definition.html>. Accessed 26 February 2002.

delivery, it is also important that such programs continually acknowledge the diverse nature of people who inject drugs. The implementation of community-based initiatives that have responsibility for statewide policy implementation and coordination of peer education must also be encouraged throughout the life of this strategy. The development of these partnerships will depend on collaboration between relevant agencies and representative bodies.

Strengthening services for people who inject drugs

Services and environments should be created and/or developed to cater for the support, health and continuing care needs of people who inject drugs. Developing the capacity of NSPs and user organisations for this purpose is vital. The Department of Human Services will continue to fund NSP related initiatives and will explore new approaches to further develop the capacity of NSPs and drug user organisations to meet the health and support needs of people who inject drugs. Optimum service delivery models will include a mix of community outreach and in-house programs. Such services are able to identify groups and individuals and facilitate and support their contact with primary health carers.

Developing services for regional and rural areas

This strategy acknowledges that disclosure, discrimination and access to health and support services are key issues in rural and regional areas. Care and support needs differ from region to region and all care and support initiatives must be delivered in an appropriate environment, using the experiences of

existing rural organisations and rural workers assigned to metropolitan services. This strategy advocates the continued financial support and consideration for the expansion of such services in rural areas, and supports all relevant state peak bodies in maintaining and developing links with rural and regional communities.

Improving access to services in correctional settings

Development in this area requires a multifaceted approach. Constructive and innovative policy statements and positions are needed to challenge current attitudes in correctional settings. In recognition of this, the Office of the Correctional Services Commissioner in Victoria will introduce the new *Victorian Prison Drug Strategy 2002* into prisons across Victoria from 26 March 2002. This strategy aims to improve ways to keep drugs out of prisons and reduce prisoner drug use by building on the successes of the existing strategy. It also aims to prevent or minimise the health problems and other harms caused by drugs, in particular the significant problems of viral transmission, in-prison and post-release overdose and drug-related re-offending. The new strategy aims to create a healthier, safer environment for everyone living and working in the prison system, as well as assist prisoners to establish healthier, drug-free lifestyles.

As such, the new strategy will focus on developing responsive harm reduction initiatives. These initiatives are integral to the new *Victorian Prison Drug Strategy 2002* and have been developed with the guidance of leading correctional and public health experts including the

Department of Human Services, The Burnet Institute, Turning Point Alcohol and Drug Centre, VIVAIDS and the Victorian Institute of Forensic Medicine.

Key projects that have been implemented under the new prison strategy include a study to identify the prevalence of hepatitis C in prisons, a prisoner health status survey, audits of drug-related harms and continued education and awareness programs underpinned by the principles of harm reduction.

This *Hepatitis C Strategy* supports the *Victorian Prison Drug Strategy 2002* with consideration of the following issues:

- A review of current diversion strategies, harm reduction initiatives and education programs .
- Free vaccination against hepatitis A and hepatitis B for staff and people in correctional settings.
- Options for testing and treatment including information about informed consent, pre- and post-test counselling, ongoing support and discrimination.
- Provision of health maintenance regimes, including diet, exercise and counselling.
- Introduction of regulated tattooing and skin penetration practices.

Vaccinations

There is a need to explore the feasibility of funding every hepatitis clinic, key correctional settings and other identified agencies to provide hepatitis A and hepatitis B vaccinations to people with hepatitis C. The Department of Human Services is reviewing current practices in this area and has implemented a pilot program that provides free hepatitis B

vaccines to NSPs that access doctors and/or accredited immunisation nurses and GPs. Clients undergoing methadone or bupremorphine treatment who access these NSPs are offered free hepatitis B vaccinations. It is anticipated that this pilot study will provide the basis for a new vaccination initiative that will include greater coverage across relevant services to ensure equity of access to those who are most at risk and to those who have hepatitis C. In addition, the feasibility of the inclusion of hepatitis A vaccinations in this new vaccination program will also be investigated.

Key goals

- 1 To develop and implement best practice strategies and programs to lessen the personal and social impact of hepatitis C infection.
- 2 To develop and facilitate a variety of partnerships, environments, services and access pathways to cater for the diverse needs of people affected by hepatitis C.
- 3 To facilitate the development and implementation of a variety of workforce development programs for diverse health service providers that standardise competencies, challenge discriminatory attitudes and values, and enhance non-discriminatory behaviours and practices in all services and contexts.

3.4 Research and surveillance

Victorian researchers have produced innovative and rigorous contributions to national and international knowledge on hepatitis C. These research initiatives extend over a number of disciplines and institutions incorporating basic scientific research, social, behavioural, epidemiological, virological and clinical research. Such a multidisciplinary research approach is crucial in providing an evidence base that informs policy, program design and development, as well as approaches to treatments and services aimed at meeting the needs of those affected by hepatitis C. Research into the medical and non-medical needs of people affected by hepatitis C will continue to be fundamental to the success of this strategy. It is recognised that the expertise and cooperation of those affected by the virus and community-based agencies is essential in successful research.

Clinical research

Clinical research is fundamental to the development of a successful response to the hepatitis C pandemic. The importance of clinical research arises from its capacity to translate the findings of basic virological and biochemical research into improved health outcomes for those infected with the virus. Clinical research encompasses a broad range from natural history studies to clinical trials of antiviral therapy. Natural history studies are crucial in defining those host and viral factors that affect viral clearance—why some people become chronically infected with hepatitis C virus and why others resolve or clear the virus

after acute infection. For those people who do become chronically infected, natural history studies can define those subgroups that are more likely to progress to advanced liver disease and those who will progress very slowly. This information is crucial in counselling patients regarding their future risk and in devising methods to target antiviral therapy to those at greatest risk. Clinical trials of antiviral therapy in many countries and in many patient populations have defined the current standard of treatment for patients with chronic hepatitis C infection and will be crucial in proving the safety and efficacy of any future antiviral therapies.

Epidemiological surveillance

Epidemiological surveillance of hepatitis C is a core component of the Victorian public health system and of the Victorian response to the epidemic. To develop a continuing understanding of the size, nature and characteristics of the hepatitis C epidemic and its impact in Victoria, a comprehensive surveillance system should be based on, and provide information from, a range of perspectives. This will enable those working in the field to identify important needs and can be used in conjunction with social research and targeted prevention and education campaigns to address the many challenges involved in reducing transmission and providing services for those affected.

Hepatitis C surveillance in Victoria is predominantly based on the analysis of passive diagnosis notifications from the laboratory or diagnosing doctor. Passive surveillance only provides numerator data (numbers and characteristics of cases diagnosed), without denominators

(numbers, characteristics of people tested or at risk). Data produced in this way can provide a potential source of information on some phenomena, such as outbreaks or unusual modes of transmission, but only where they are constantly monitored, analysed and followed up. While this is one important aspect of surveillance, it does not provide all the necessary information. For example, calculation of incidence rates, essential for monitoring trends, is difficult without these data.

Social research

Social research contributes to understandings of the social and cultural contexts of illness and disease. While risk behaviours are often monitored in epidemiological research, social research moves beyond individualised understandings of risks, illness and prevention. Social research draws its methods from disciplines such as anthropology, psychology, sociology and cultural studies. These methods include ethnography, surveys, studies of material culture, and a range of qualitative data collection techniques. Social research must identify the cultural and structural contexts underlying transmission of the virus, uptake and barriers to therapeutic treatments, health maintenance and support activities and discrimination and stigma.

Objectives

To strengthen the research capacity across a variety of disciplines and institutions to better inform policy and practices and to improve the treatment and services aimed at meeting the needs of those who are affected by hepatitis C:

- Research must continue to focus on the priority areas identified in this strategy (epidemiological surveillance, prevention of transmission, prevention of discrimination, health maintenance and care, pharmaceutical treatments).
- Community-focused agencies must continue to be involved in the design and conduct of investigator-led and commissioned research.
- Research needs to be responsive to new and emerging issues in the field.
- Continued development of Victoria's research capacity is essential.
- Commitment to the dissemination of research results to other researchers, service planners/providers and affected communities is essential.
- Involving community-focused agencies in the design and delivery of investigator-led and commissioned research.
- Strengthening clinical and virological research programs to improve the health outcomes of those infected with the virus.

Implementing an active surveillance system

The existing passive notification systems may be enhanced using systematic integration of prevalence, incidence and disease outcome data in conjunction with behavioural surveillance data and research, which focuses on transmission risks in key populations. Such a system would routinely produce necessary and useful data for:

Areas for action

Developing research activities

There is a need for national, state and local research initiatives and an integrated cross-sector approach between biomedical and social research is supported by this strategy. Research initiatives should be directed by the priorities outlined in this strategy and areas that have been identified for development include:

- Strengthening the work of HIV and sexual health research centres to respond to and incorporate hepatitis C.
- Including and providing adequate funding for agencies who have an understanding of, and are responsive to, the diverse needs of people affected by hepatitis C.
- Monitoring trends in infection and disease.
- Improving our understanding and knowledge of risk-taking behaviour and the factors that may place people at risk.
- Identifying phenomena requiring further investigation, such as outbreaks or seemingly unusual modes of transmission (such as nosocomial).
- Strengthening social research programs.
- Strengthening clinical and virological research programs.
- Targeting prevention, education and treatment interventions.
- Evaluating the impact of interventions.
- Estimating future infection, burden of disease and requirements for services and treatments.

To achieve a more active surveillance system, the feasibility of developing a system with the following characteristics will be explored during the life of this strategy:

- Reorientation of current reporting methods similar to those used for HIV surveillance. This would entail diagnosing doctors reporting notifications directly to the Department of Human Services through a coded system that does not identify individuals.
- Multiple perspectives requiring multiple systems monitoring different populations using different methods.
- Mechanisms for monitoring and controlling data quality.
- Timeliness of reporting of processed information derived from surveillance data enhanced with other information (such as research findings).
- Feedback to all those in need of such information, especially those responsible for, or involved in, preventive interventions or provision of services including care and treatment.
- Continual analysis and monitoring.

The following activities have been identified as components of a comprehensive and active surveillance system:

- Special surveys (benchmark and repeated) in NSPs, prisons, remand centres and juvenile justice centres and telephone surveys of the general population.

- Enrolling selected clinics from both rural and metropolitan areas in a Sentinel Clinic program, to enable the continuous monitoring of testing rates and infection among populations selected for their significance.
- A range of research, collection and analysis methods to develop surveillance of hepatitis C-related disease.

Identifying incident hepatitis C infections

This provides a clearer picture of where the current epidemic is, allows for investigation of transmission modes and supports contact tracing (tracing people who may have been exposed to hepatitis C through risk behaviours involving people who are already infected with the virus) and outbreak investigation.

Integrating surveillance, research and intervention activities

This strategy supports the systematic integration of, and information sharing between, surveillance, research and intervention activities. Through charting trends in the number and rates of hepatitis C infections and potentially the characteristics of affected individuals, surveillance highlights the need for additional research and provides key information for future research initiatives. A comprehensive system will also assist the hepatitis C workforce in the development of education and intervention programs.

Social research activities

Social research must identify the cultural and structural contexts underlying transmission of the virus, uptake and barriers to therapeutic treatments, health maintenance and support activities and discrimination and stigma. This will provide the basis for planning and implementing effective interventions aimed at both preventing transmission and improving the experience of those living with hepatitis C. Social research would include:

- Qualitative and quantitative monitoring of client health maintenance and support at specialist and primary health care facilities dealing with those at risk of, and those with, hepatitis C.
- Routine collection of qualitative and quantitative social research data should occur at sites selected for the sentinel surveillance program, to ensure comprehensive monitoring and surveillance.
- Investigation of the contribution of inequality and socioeconomic factors to hepatitis C transmission risk and access to treatment and care.
- Investigation of the physical, geographic and cultural context of injecting.
- Investigation of the gender and cultural aspects of illness experience and health maintenance activities.
- Exploration of modes of delivering hepatitis C education.
- Exploration of workforce practices in relation to needlestick injuries.
- Examination of the basis of public attitudes towards people with hepatitis C, including role of the media.

Key goals

Clinical research

Development of a multidisciplinary research capacity that incorporates basic virology, clinical research, epidemiology and social research that will provide the basis for:

- 1 Natural history studies of acute and chronic hepatitis C through the formation of an observational database supported by a linked serum bank
- 2 Clinical trials of antiviral and treatment to reduce the amount of scar tissue in the liver (antifibrotic therapy), including a study of factors affecting treatment uptake, conducted through an adequately funded network of established investigators and trial coordinators.

Epidemiological research

- 1 Systematic integration of and information sharing between surveillance, research and intervention activities.
- 2 Development of a comprehensive, multifaceted, integrated system in Victoria to provide information about the hepatitis C epidemic. Key components of such a system should include:
 - A network of sentinel clinics.
 - Annual surveys of populations at high risk of hepatitis C transmission.
 - Surveillance for disease and other outcomes of hepatitis C.

Social research

Development of social research program should include:

- 1 Collection of qualitative and quantitative data on living with hepatitis C, including health maintenance behaviours, symptoms, pharmaceutical and alternative treatment.
- 2 Routine collection of qualitative and quantitative social research data, to enhance the sentinel surveillance system.
- 3 Research that identifies the cultural, social and psychological factors that impact on prevention, treatment and health maintenance for those with hepatitis C.
- 4 Research that improves our understanding of the basis of stigma and discrimination amongst general community members, and specific professional groups such as health care workers, correctional and police officers and others.

3.5 Pharmaceutical treatments

Pharmaceutical treatments for hepatitis C include interferon and a combination of interferon and ribavirin. The advent of combination therapy has greatly improved clinical treatment outcomes for people with hepatitis C. We expect that with further developments in this area, treatments will improve. ‘Therapeutic benefit’ is defined as a histological improvement and clearance of viraemia. Multiple studies have demonstrated that such sustained responses translate into long term remissions, with potential reversal of fibrosis as well as a reduction in the incidence of liver cancer (hepatocellular carcinoma). People with genotypes 2 and 3 can achieve response rates of approximately 65 per cent¹⁶, although people with genotype 1 show lower response rates of around 30 per cent¹⁷. Pegylated interferon, taken once rather than three times a week, is an advance in therapy that has been trialled in Victoria. Early results from combination pegylated interferon and ribavirin trials

16 McHutchinson JG, Gordon SC, Schiff ER, Shiffman ML, Lee WM, Rustgi VK, Goodman ZD, Ling M-H, Cort S, Albrecht JK, 1998, ‘Interferon alfa-2b alone or in combination with ribavirin as initial treatment for chronic hepatitis C’, *N.Eng. J. Med* vol. 339, pp.1485–1492.

17 Poynard T, Marcellin P, Lee S S, Niederau C, Minuk G S, Ideo G, Bain V, Heathcote J, Zeuzem S, Trepo C, Albrecht J, 1998, ‘Randomised trial of interferon alpha-2b plus ribavirin for 48 weeks or for 24 weeks versus interferon alpha-2b plus placebo for 48 weeks for treatment of chronic infection with hepatitis C virus’, International Hepatitis Interventional Therapy Group (IHIT), *Lancet* vol. 352, pp. 1426–32.

indicate sustained response rates exceeding 50 per cent¹⁸.

There is expected to be an increase in the number of people requiring therapy for hepatitis C in Victoria in the future. This burden of disease will pose many challenges for tertiary public hospitals. During this strategy, consideration must be given to more effective systems of management to meet the needs of people who access treatment for hepatitis C, and the possibility of a new model of care must be further researched and developed.

Objectives

The overall aim of antiviral therapy is to stop viral replication, eliminate the hepatitis C virus and subsequently prevent the development of cirrhosis, liver failure and liver cancer. This clinical work must be framed in the overall context of a person's health and wellbeing. In the clinical setting, there is a need for less toxic and more effective therapies and treatment strategies to be developed and, in the overall context of treatment, there must be acknowledgement of the non-medical needs of people and their support networks before, during and after treatment.

Victorians who require clinical treatment for chronic hepatitis C must be assured of equitable access, and should be

identified, assessed and treated using an appropriate model of care. In order to achieve this, there is an urgent need for GPs in all areas of Victoria be recruited and trained.

Areas for action

The development of a new model of care for all people undergoing treatment for hepatitis C is supported by this strategy. This will include due consideration of *A Model of Care for the Management of Hepatitis C Infection in Adults*, currently being developed by ANCAHRD. Issues for further consideration and possible inclusion are:

Improving access for people who inject drugs

While people who inject drugs are not automatically excluded from accessing treatment, it is not widely prescribed. There is currently an active debate as to the merits of therapy for this diverse group due to challenges relating to lower response rates and higher toxicity. Given that all Australians have the right to access health services, further investigation of this issue is necessary to identify feasible and satisfactory strategies to meet the treatment needs of people who inject drugs.

Servicing the needs of people from culturally and linguistically diverse backgrounds

Due to varying host immune responses and viral factors such as genotype, the natural history of hepatitis C can differ in people from diverse cultural backgrounds. For these reasons, treatment responses may also vary. To improve access to pharmaceutical treatment for people from diverse

cultural backgrounds, policy makers, health service providers and community organisations should make a concerted and consistent effort to understand how culture and beliefs influence an individual's perception of hepatitis C, and the perceptions of their family or larger cultural groups. All sectors are responsible for providing culturally appropriate information about why and how treatment works and how to access it. In order to achieve this, there is a need to improve the body of current knowledge about hepatitis C for health service providers who are from, or who work with people from, these cultural groups. This may involve using resources other than written information, such as interpreters or other forms of information provision.

Improving access for people in correctional settings

An appropriate model that utilises current social and clinical research should be considered for people in correctional settings who are suited and willing to undergo antiviral therapy.

Addressing the needs of people in rural and regional areas

The issue of resource allocation to areas with high rates of infection must be reviewed. Rural and regional areas have significant issues with hepatitis C-related disclosure and discrimination, which should not be overlooked. Most liver clinics are located in public hospitals in metropolitan Melbourne and can be difficult for people from rural and regional areas to access. The establishment of discretely placed regional clinics and/or shared care with Melbourne tertiary centres is of the utmost importance and should be addressed in the early stages of the life of this strategy.

18 Manns MP, McHutchinson JG, Gordon SC, Rustgi VK, Shiffman M, Reindollar R, Goodman ZD, Koury K, Ling M-H, Albrecht JK, 2001, 'Peginterferon alfa-2b plus ribavirin compared with interferon alfa-2b plus ribavirin for initial treatment of chronic hepatitis C: a randomised trial', *International Hepatitis Interventional Therapy Group (IHIT), Lancet* vol. 358(9286), pp. 958–65.

Providing care and support

A major complication of current pharmaceutical treatments is the psychological side effects. Depression, in varying degrees, is one of the most common side effects that can occur at any stage during and, in some cases, after treatment. Currently, this is managed on a case-by-case basis, but there is an urgent need to improve access to counselling and psychiatric support both for people undergoing treatment and their carers. Initiatives that have been identified to address this situation include:

- Liver clinics introducing support structures for the non-medical needs of people on treatment and their carers, including satisfactory and professional counselling before, during and after treatment.
- Providing a dedicated psychiatrist for every hepatitis service.
- Providing a Treatments Officer in a non-medical institution to address the cross-over between medical and non-medical needs of people on treatment.
- Research on the use of anti-depressants as a prophylaxis in clinical trials.
- Using natural and complementary therapies during treatment.

Supporting services for people with HIV co-infection

Recent successes in HIV therapy have uncovered other health problems for surviving HIV-infected individuals. Hepatitis C has become an especially significant problem due to the following issues, which characterise hepatitis C when it exists as a co-infection with HIV:

- Hepatitis C related liver disease progresses faster due to the immunosuppression associated with a reduced CD4 count.
- Efficiency of transmission, both sexual and perinatal, is increased and probably contributes significantly to incident cases.
- Tests for hepatitis C are less sensitive in the coinfecting population.
- Immune reconstitution hepatitis flares associated with the introduction of HIV therapy.
- Additional liver toxicity associated with antiretroviral therapies.
- Reduced efficacy of therapy in advanced immunodeficiency.
- The potential for drugs such as ribavirin to inactivate certain HIV drugs and potentially decrease antiretroviral efficacy.
- Therapy has largely been neglected, despite data suggesting its efficacy in HIV-hepatitis C co-infected people, due to apathy about the outcome of HIV's natural history. This is despite its recent dramatic successes in the highly active anti-retroviral therapy (HAART) era. Furthermore, unlike the non-HIV setting, large studies of hepatitis C therapy, in particular studies of combination interferon and ribavirin, are lacking.

Initiatives that have been identified to address this situation include:

- Educational campaigns to the HIV community regarding the health care implications of coinfection.

- The establishment of a funded and dedicated co-infection clinic, preferably located at The Alfred hospital, to provide the highly specialised care this group of patients needs.
- Active screening for hepatitis C infection in all HIV-infected individuals using PCR as well as serology.
- Promoting the availability of therapy to the HIV population.
- Funding for active research into this patient group, with specific emphasis on issues such as clinical trials of antivirals and the role of chronic low-grade liver function abnormalities.

Developing shared care

The clinical community should consider implementing a system of shared management between GPs and specialists. Using this model, GPs with a particular interest in hepatitis C would be able to prescribe under section 100, as is currently the case for HIV medications. There is an urgent need throughout Victoria to recruit and train GPs to work in the area of hepatitis C and this will entail recruitment, resourcing and ongoing training and education.

Developing the role of nurse practitioners

In other sensitive health areas such as sexually transmissible infections, a model exists where nurse practitioners work in conjunction with physicians. It is likely that the number of GPs willing to take part in 'shared care' arrangements will be insufficient to meet demand, and this alternative model should be investigated by those working in the field of hepatitis C treatment.

Ongoing assessment

In order to implement identified changes, ongoing assessment programs must be developed to evaluate the outcome of specific goals such as treatment access, education for people affected and health service providers and the success of counselling.

Reviewing guidelines

Pharmaceutical treatment is targeted, whereby people with more responsive infections can be treated with tailored regimens. These criteria have been incorporated in the new section 100 guidelines. This results in significant cost savings and avoids many cases of toxicity. The possibility of a regular review of therapeutic guidelines as established policy in Victoria and nationally should be investigated and, if necessary, this policy should be revised to reflect and incorporate state-of-the-art care.

Government review

Given that this area is rapidly changing, the Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases or its successor should investigate the possibility of conducting an annual review of treatments for hepatitis C. The review should be informed by the 'Areas for action' identified above.

Key goals

To provide equal access to all Victorians requiring treatment for hepatitis C by:

- 1 The employment of interferon nurse educators and psychiatric/psychological staff to support city and rural hepatitis treatment clinics, through appropriately trained treatment counsellors and treatment providers.
- 2 The development of models of care for the treatment of rural patients with hepatitis C through shared care arrangements with metropolitan clinics or stand-alone rural clinics.
- 3 The provision of services, information and education about hepatitis C which is linguistically and culturally sensitive.

4 Coordination, roles and responsibilities

Coordinating and managing the response to hepatitis C in Victoria depends on the continuing partnership approach across all sectors, including rural health services, research, medical and scientific and health care professionals, community-based or non-government organisations and government departments such as the Department of Justice. Clear definition of roles and responsibilities is required for effective implementation of this strategy.

4.1 Commonwealth Government

The Commonwealth has a leadership role, and the Department of Health and Aged Care is the principal Commonwealth agency responsible for promoting best practice and coordinating the national response to hepatitis C. The department's responsibilities include:

- Facilitating national policy formulation and coordinating hepatitis C-related policies of other Commonwealth and state and territory government agencies, in conjunction with the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD), the Intergovernmental Committee on AIDS, Hepatitis C and Related Diseases (IGCAHRD), national community-based organisations, and other members of the partnership.
- National leadership and coordination in health promotion, including the provision of public information.
- Administering funding to state and territory governments and national community-based organisations.
- Developing and promoting national standards for best practice in hepatitis

C health promotion, treatment, care and support.

- Monitoring the implementation of and evaluating the *National Hepatitis C Strategy 1999–2000 to 2003–2004*.
- Commissioning research, health promotion and policy initiatives that are best carried out on a national basis.
- Involvement in international cooperative initiatives
- Providing secretariat and policy-support functions for national committees.

4.2 State Government

The hepatitis C prevention, education and surveillance program is mostly coordinated through the Public Health Group, Rural and Regional Health and Aged Care Division of the Department of Human Services. The department will have primary responsibility to oversee the implementation of this strategy.

Responsibilities of the Department of Human Services include:

- Ensuring that resources are allocated in accordance with the guiding principles outlined in the strategy.
- Measuring and reporting to government on the implementation of the strategy.
- Coordination, facilitation and monitoring of state hepatitis C activities.
- Supporting MACAHRD, the advisory forum to the Minister for Health, with representation from appropriate members of the partnership and affected communities.
- Coordinating or facilitating the development of public policy and legislative frameworks that are

consistent with aims of the *National Hepatitis C Strategy*.

- Investigating, analysing and monitoring the epidemiology of hepatitis C.
- Ensuring the appropriate development, delivery and evaluation of services to reflect the prevalence and changing needs of populations at risk.
- Monitoring and facilitating appropriate workforce infrastructure and development for people working with hepatitis C-related issues.
- Facilitating effective inter-sectorial cooperation between national, state and local government agencies.

4.3 Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases (MACAHRD)

MACAHRD will assist the Department of Human Services to monitor the implementation of the strategy. Its current responsibilities are:

- To provide expert advice to the Minister for Health on all aspects of HIV/AIDS, hepatitis C, other blood-borne viruses, and sexually transmissible infections.
- To oversee the development and review of a Victorian HIV/AIDS Strategy and the *Victorian Hepatitis C Strategy*.
- To provide advice in the context of relevant national strategies, such as the *National HIV/AIDS Strategy* and the *National Hepatitis C Strategy*.
- To provide advice on significant areas for policy and program development in relation to prevention, health promotion, treatment and care, research, and training.

- To monitor scientific developments relevant to the control and treatment of HIV/AIDS, hepatitis C and related diseases, to help ensure that Victoria retains its excellent record in these areas.
- To consider and respond to specific requests for advice from the Minister.

4.4 Non-government organisations

Non-government organisations play a key role in the Victorian response to hepatitis C. These organisations bring particular expertise, knowledge and high-level service delivery to the community. They have particular responsibility in the following areas:

- Advocacy in decision making and policy formation for affected communities.
- Developing, implementing and evaluating policies and programs.
- Participating in and developing peer education programs and other health promotion activities.
- Providing counselling and support services for people affected by hepatitis C.
- Delivery of primary health care and health promotion programs to indigenous communities and people from culturally and linguistically diverse backgrounds.

5 Monitoring and evaluation

This strategy is intended as a working document. Monitoring and evaluation are recognised as valuable tools, ensuring that the initiatives outlined continue to be appropriate and relevant to the needs of people affected by hepatitis C across the state. Monitoring and evaluation also ensures that the goals outlined in this strategy are met in a timely fashion, observing principles that prevent any detriment to people affected by hepatitis C. Monitoring and evaluation are essential components in assessing the efficacy of this strategy.

The objectives of monitoring and evaluation are consistent with those outlined in the *National Hepatitis C Strategy*. These are:

- To contribute to improved health outcomes, by measuring the strategy's performance with reference to its stated priority areas and objectives.
- To provide a mechanism for securing the accountability of all levels of government and other sectors.
- To provide a means of communicating to the wider community the successes of the strategy and challenges that await response.
- To ensure that the strategy's priority areas and objectives are informed by the best available social and epidemiological evidence.

- To meet the program managers' and policy makers' need for timely, accurate information about program performance, especially in the context of state planning and program management.

The processes identified to ensure the full implementation and monitoring and evaluation of this strategy are:

- To identify key organisations/bodies and their responsibility in regard to the priority areas outlined.
- To determine each organisation's level of involvement, with specified actions.
- Where needed, to develop further plans for action.
- To identify responsible funding bodies and ensure that funding commitments are met.

State Government mechanisms to be employed under this strategy include:

- Establishment of a Hepatitis C Sub-Committee of MACAHRD to oversee the monitoring and evaluation of the strategy.
- Regular reports on the implementation and progress of the strategy prepared by MACAHRD for the Minister for Health.
- Standard performance indicators for program funding developed by the Department of Human Services, in conjunction with relevant agencies.

- Key performance indicators developed by the Department of Human Services, that can be incorporated into a report to be presented to MACAHRD on a regular basis.
- Department of Human Services resources allocated to enable collection of performance indicator data.
- Publication of the State Government's performance against agreed indicators.
- A review of this strategy to be undertaken by MACAHRD or its successor. Findings will inform the development of the next strategy.

Acronyms

AHMAC	Australian Health Ministers Advisory Committee
ANCAHRD	Australian National Council on AIDS, Hepatitis C and Related Diseases
AIDS	Acquired immunodeficiency syndrome
ANEX	Association of Needle and Syringe Programs
ARCSHS	Australian Research Centre in Sex, Health and Society
CDHA	Commonwealth Department of Health and Aged Care
CEWT	Community Education Workforce and Training
COAG	Council of Australian Governments
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human immunodeficiency virus
IGCAHRD	Intergovernmental Committee on AIDS, Hepatitis C and Related Diseases
MACAHRD	Ministerial Advisory Committee on AIDS, Hepatitis C and Related Diseases
NAT	Nucleic Acid Testing
NHMRC	National Health and Medical Research Council
NSP	Needle and syringe programs
PCR	Polymerase chain reaction
PBS	Pharmaceutical Benefits Scheme
STI	Sexually transmissible infection(s)
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VIDB	Victorian Infectious Diseases Bulletin
VIDRL	Victorian Infectious Diseases Reference Laboratory
VIVAIDS	Victorian Drug User Group

