Viral Hepatitis Prevention and Management

Policy Position Statement

Key messages:

Effective national responses to hepatitis B and C include meaningful involvement of priority populations, human rights, access and equality, health promotion, prevention, quality health services, harm reduction, shared responsibility, commitment to evidence-based policy and partnership.

Key policy positions:

1. Support full implementation of the Third National Hepatitis B Strategy and Fifth National Hepatitis C Strategy.
2. Adequate resourcing for implementation to achieve the full range of objectives and targets.

Audience:

Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.

Responsibility:

PHAA Health Promotion Special Interest Group

Date adopted:

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Policy position statement

PHAA affirms the following principles:

1. Effective national responses to hepatitis B and C include meaningful involvement of priority populations, human rights, access and equality, health promotion, prevention, quality health services, harm reduction, shared responsibility, commitment to evidence-based policy and partnership.[1, 2]
2. Chronic hepatitis B and hepatitis C should be recognised as public health issues.
3. Improved knowledge and awareness of viral hepatitis in the general community, health professionals and priority populations, creates a supportive environment for increased uptake of testing, prevention, treatment and care by people at risk of or living with viral hepatitis.
4. Legal, regulatory and policy barriers affect priority populations at risk of viral hepatitis, influencing their health-seeking behaviours, and should be addressed through collaboration with governments and non-government organisations to change the policy focus of drug use and addiction from a law enforcement issue to a health issue.
5. Policies for hepatitis B and C should be integrated with other public health policies, including prison health reform.

PHAA notes the following evidence:

Hepatitis B

6. Hepatitis B is a vaccine-preventable blood borne virus and sexually transmissible infection that can cause liver inflammation and liver disease.[1]
7. In Australia, an estimated 230,154 people were living with chronic hepatitis B in 2019 representing 0.90% of the total population, with an estimated 32% of those being undiagnosed, and only 22% engaged in guideline based care.[2]
8. Hepatitis B disproportionately impacts on a number of key populations, and priority groups and settings. Among the total people living with chronic Hepatitis B, about three-quarters (70%) of them were born overseas, a quarter of them (23%) were Australian-born non-Indigenous people, 7% were Aboriginal and/or Torres Strait Islander people and 3% among gay and bisexual men.[4]
9. Advanced liver disease will be developed by 20-30% of people with untreated chronic hepatitis B, which can lead to complications including liver failure, liver cancer and death. In 2019, there was an estimated 427 deaths in Australia due to complications from chronic Hepatitis B.[3]
10. Early detection and prolonged, adequate suppression of viral replication should be the practical goal for the management of chronic hepatitis B. People living with hepatitis B require lifelong management, involving 6-monthly clinical assessments (including blood and liver function tests), plus tests every 2-3

years to detect liver scarring, and liver ultrasounds where clinically indicated. Antiviral treatment (potentially lifelong) should be used to treat advancing chronic hepatitis B where clinically indicated.[5]

11. Hepatitis B can be prevented through vaccination. If there was no primary prevention, the risk of transmission should be actively reduced. Other ways to prevent hepatitis B infection include using condoms during sex, covering any open wounds or cuts with a waterproof dressing, not sharing personal items like toothbrushes and razors, only going to piercing and tattoo studios that are registered and use proper sterilisation techniques. using gloves when helping with first aid.[6]

12. Affected communities and individuals should be actively engaged and supported, with policies and laws formulated to encourage healthy behaviours. Support for multicultural communities should also be strengthened by working with community groups and leaders.

Hepatitis C

13. Hepatitis C is a blood borne virus that can cause liver inflammation and liver disease, and there is no vaccination available.[2]

14. An estimated 129,640 people were living with chronic hepatitis C at the end of 2018 in Australia, with an estimated 21% of those being undiagnosed.[4]

15. Hepatitis C disproportionately impacts and number of key populations, and priority groups and settings. The impact is disproportionate, primarily due to unsafe injecting drug use, with the most affected population comprising injecting drug users, the incarcerated and Aboriginal and Torres Strait Islander people.[4]

16. In 2016-18, Hepatitis C RNA testing among Aboriginal and Torres Strait Islander people was lower (56%) than that of non-Indigenous people (74%).[8]

17. The primary route of transmission is injecting drug use, specifically receptive needle and syringe sharing. Other routes include failure of infection control procedure during medical/dental procedures, vertical transmission from mothers to babies, unsterile piercings and tattoos, and men having sex with men. Custodial settings have heightened risk of transmission.[7]

18. Hepatitis C causes both acute and chronic infection, with acute hepatitis C being usually asymptomatic and very rarely associated with life-threatening disease. Untreated hepatitis C progresses to chronic infection in 70-80% of cases, with a 15-30% risk of cirrhosis of the liver within 20 years. People with cirrhosis are at increased risk of developing liver cancer, and in 2018 there was an estimated 460 hepatitis C related deaths in Australia.[4]

19. People with chronic hepatitis C require treatment.[3] Following Pharmaceutical Benefits Scheme listing of highly effective, tolerable direct acting antiviral (DAA) treatments in 2016, there has been a significant increase in treatment uptake. An estimated around 82 000 people receiving DAA therapy by the end of 2019 (equivalent to 44% of the estimated chronic hepatitis C population in 2016).[9]

20. Treatment of a HCV-infective prisoner is highly cost-effective and should therefore be dealt with as a priority within the prison budget.[10]

21. The risk of transmission should be actively reduced through education and appropriate prevention programs such as vaccination and diagnostic testing of high-risk population.[11] Harm reduction and demand reduction are the primary prevention strategies for people who inject drugs incorporating needle and syringe programs (NSPs) and evidence-based opioid treatment programs (OTP). Other

measures include standard infection control procedures, safety and quality regulation for blood transmission, and safe sex practice.[7]

22. Similar to Hepatitis B, affected communities and individuals should be actively engaged and supported, with policies and laws formulated to encourage healthy behaviours. Support for multicultural communities should also be strengthened by working with community groups and leaders.

Sustainable Development

23. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goal 3 – Good Health and Wellbeing.

PHAA seeks the following actions:

24. Full implementation and appropriate resourcing of the Third National Hepatitis B Strategy[1] and Fifth National Hepatitis C Strategy[7] to achieve the full range of objectives and targets.
25. Integration of hepatitis B and C policies with other public health policies including prison health reform.

PHAA resolves to:

26. Advocate for the above steps to be taken based on the principles in this position statement.

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(First adopted 2002, revised 2005, 2008, 2011, 2015, 2019)

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