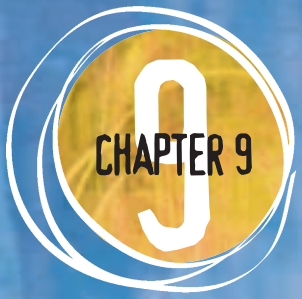



# National, State and Territory and Local Responses to Hepatitis C

- Since hepatitis C was first identified in 1989, Australia's national, state, territory and local governments have worked collaboratively with organisations and communities to address the social, economic, psychological, and health issues faced by people affected.

- These responses are multi-faceted and have resulted in numerous local, state and territory, and national initiatives, including the development of an on-going National Hepatitis C Strategy by the Australian Government.

## SUMMARY OF IMPORTANT POINTS

- Implementation of the *National Hepatitis C Strategy* is underpinned by a successful partnership approach which involves governments, affected communities, researchers, educators and health care professionals.

# THE PARTNERSHIP APPROACH

Partnership is a fundamental principle of any successful population health policy. As with Australia's response to HIV/AIDS, the medical, health care, research and scientific communities, and people affected by hepatitis C are required to collaborate toward an effective response.

It is also a well recognised basic principle that education programs for the groups affected by any health issue are most effective if designed and delivered at the community level by members of the target group themselves, in consultation with government agencies.

Elements of the partnership approach, which are still evolving and developing, can be seen in the extensive consultation, communication, advocacy and sustained collaboration that have characterised Australia's response to the hepatitis C epidemic. Some of the outcomes of the partnership approach are illustrated in the responses outlined below.

The Australian Government recognises the value of the partnership approach in providing funding for the peak hepatitis C community organisations.

# SUMMARY OF NATIONAL RESPONSES

Australia is one of the leading countries in responding to the hepatitis C epidemic.

Population health action relating to hepatitis C began in February 1990. Following identification of the virus and the development of a suitable test, screening of the blood supply was promptly introduced. As part of the continuing efforts to keep abreast of best international standards, Nucleic Acid Testing (NAT) was introduced from June 2000 to further reduce the risk of hepatitis C transmission through transfusion of fresh blood products.

In 1994, the Australian Health Ministers' Advisory Council (AHMAC) developed the *National Hepatitis C Action Plan* and in 1995, the *Nationally Coordinated*

*Hepatitis C Education and Prevention Approach* as a national public health response to hepatitis C. This was endorsed by the Australian Government, states and territories. This document set the direction for action on hepatitis C by outlining the respective roles and responsibilities of the Australian, state and territory governments as well as medical, academic and community organisations. It also acknowledged the vital role played by these groups in responding to hepatitis C.

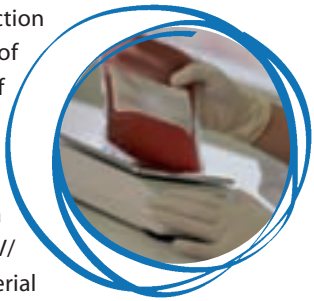
A review of the *National Hepatitis C Action Plan* and the nationally coordinated hepatitis C education and prevention approach was commissioned in 1998. The report *Hepatitis C: A Review of Australia's Response* was published in January 1999 and contained the key recommendation that Australia develop a national hepatitis C strategy to provide direction and determine priorities for action relating to hepatitis C.

The development of Australia's first *National Hepatitis C Strategy* commenced in July 1999 and was facilitated by the then Department of Health and Aged Care. In developing this population health strategy, extensive involvement and consultation with all levels of government, community organisations, medical, health care, research and scientific communities, people affected by hepatitis C and the wider Australian community occurred. This cooperative effort is known as the partnership approach and recognises that genuine cooperation and collaboration is essential if population health measures are to be successful and effective.

The need for the Australian Government to be informed by independent and expert advice on the national response to hepatitis C has been recognised for many years. The Australian National Council on AIDS and Related Diseases (ANCARD) gave hepatitis C a platform at the national advisory level. The Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) was established in late 1999, replacing ANCARD.

*The National Hepatitis C Strategy 1999–2004* was launched in June 2000. Its two primary aims were to reduce the transmission of hepatitis C in Australia and to minimise the personal and social impacts of hepatitis C infection. The Australian Government has provided $28.3 million in funding through the Hepatitis C Education and Prevention Imitative over the last 8 years (1999–2000 to 2006–2007) to support these aims. The Australian Government will provide $17.0 million over the next four years (2007–2011).

In 2002, an independent review of the *National Hepatitis C Strategy* (*Reviews of the National HIV/AIDS and Hepatitis C Strategies and Strategic Research 2002*) was undertaken concurrently with reviews of the National HIV/AIDS Strategy and of the National Centres in HIV Research. The review acknowledged that the strategy established a good foundation for action and had contributed to an increased awareness of hepatitis. It also concluded that due to the infancy of Australia's response to hepatitis C, the strategy had not succeeded in controlling the hepatitis C epidemic.



The 2002 review also identified the need for a restructure of the Australian Government's existing HIV/AIDS and hepatitis C advisory mechanisms. The Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH) was established in late 2003 to replace ANCAHRD. The current advisory structure consists of an overarching MACASHH, supported by three expert subcommittees, including the Hepatitis C Subcommittee.

In November 2003, the Australian Government response to the *2002 Reviews of the National HIV/AIDS and Hepatitis C Strategies and Strategic Research* was released.

The second *National Hepatitis C Strategy 2005–2008,* which was released in June 2005, builds on the success of the first strategy and continues to provide a focus for recognising hepatitis C as a significant population health issue.

In 2005, the national *Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy* was developed. It recognised the need to build collaborative partnerships between the Aboriginal and Torres Islander community sector and the mainstream health sector.

The Hepatitis C Subcommittee of MACASHH has played an active role in developing national guidelines and policies including the 2007 edition of the *National Hepatitis C Testing Policy*. This and other national guidelines, policies and strategies are available at www.health.gov.au.

# NATIONAL RESEARCH INITIATIVES

Since 2002 four national research centres, initially established in the 1980s to address the HIV /AIDS epidemic, have expanded the scope of their work program to include research into hepatitis C. In line with the recommendations of the second Hepatitis C Strategy, the Australian Centre in HIV and Hepatitis Virology Research (ACH²), the National Centre in HIV Epidemiology and Clinical Research (NCHECR); the National Centre in HIV Social Research (NCHSR) and the Australian Centre in Sex, Health and Society (ARCSHS) have conducted research to establish a biomedical and social / behavioural evidence base to inform initiatives for the prevention, treatment and care of people living with hepatitis C.

While the national research centres receive core funding from the Australian Government, they work with an extensive range of collaborators, including state and territory health departments, public and private clinical units, national and international organisations, and the corporate sector including the pharmaceutical industry.

# STATE AND TERRITORY RESPONSES

State and territory governments and health authorities have responsibility for and flexibility in, program delivery. Among their particular activities are the following:

- implementing the *National Hepatitis C Strategy* at the jurisdictional level;
- establishing individual state and territory hepatitis C strategies, including treatment, care and support plans;
- establishing advisory forums with representation from all members of the partnership in their jurisdiction;
- establishing public policy and legislative frameworks consistent with the aims and objectives of the *National Hepatitis C Strategy*;

- investigating, analysing and monitoring the epidemiology of hepatitis C within their jurisdiction;
- developing, funding, delivering and evaluating a range of services, such as public hospital services (delivered on-site or as outreach services), health promotion, and care and support services provided by public and community-based organisations that reflect the prevalence and changing needs of people affected by hepatitis C;
- funding, supporting and evaluating the work of hepatitis councils and drug user organisations;
- providing workforce infrastructure and professional development and training for workers who deal with hepatitis C related issues;
- funding and evaluating Needle and Syringe Programs;
- ensuring effective intersectoral co-operation between state and territory and local government agencies;
- ensuring that resources are allocated in accordance with the priority areas, having regard to the essential components expressed in the *National Hepatitis C Strategy*; and
- measuring and reporting on the implementation of the *National Hepatitis C Strategy* within their jurisdiction.

In recognising the need for a well co-coordinated response to hepatitis C by both the Australian Government and the states and territories, the Intergovernmental Committee on HIV/AIDS and Related Diseases (IGCAHRD) was established in 1987. Following a restructuring of the AHMAC subcommittees in 2006, IGCAHRD was disbanded and replaced by the Blood Borne Virus and Sexually Transmissible Infections Subcommittee (BBVSS), as a key advisory body to the Australian Health Ministers' Advisory Council through the Australian Population Health Development Principal Committee.

## NEEDLE AND SYRINGE PROGRAMS

The *National Hepatitis C Strategy* recognises the important contribution to hepatitis C prevention made by Needle and Syringe Programs, which were originally implemented under successive national HIV/AIDS strategies. The *2005 Economic Evaluation of Hepatitis C in Australia* (Applied Economics 2005) concluded that these programs, together with other hepatitis C education and prevention programs produced significant returns on investment in terms of cost-effectiveness, offering significant health gains, financial savings and other benefits. Support for this prevention mechanism has continued under the current *National Hepatitis C Strategy*.

Needle and Syringe Programs (NSPs) are a key public health measure established to reduce the transmission of blood-borne viruses, particularly HIV and hepatitis C, among people who inject drugs. Known by alternative titles in different parts of Australia (Clean Needle Programs in South Australia, and Needle and Syringe Programs in WA), NSPs are perhaps the most straightforward example of public health programs operating on the principles of harm reduction.

The *National Drug Strategy 2004–2009* provides an integrated framework for addressing drug issues in the Australian Community. Drug-reduction strategies such as NSPs, which reduce the impact of drug-related harm on individuals and communities, are recognised as a priority area.

The NSW Health Department's *Needle and Syringe Policy and Procedures Manual,* in describing the underlying rationale of NSPs, reflects the national position on hepatitis C prevention imperatives. It acknowledges that:

- many people will continue to inject drugs, for varying periods of time, despite drug education and treatment programs;
- all people must be provided with the knowledge and skills necessary to make informed decisions about high risk behaviours; and
- the community as a whole faces a greater threat from the social and economic consequences of infections such as hepatitis C and HIV than it does from the adverse effects of drug use itself.

The first NSP was piloted in Darlinghurst, Sydney in 1986, following concerns about the rising prevalence of HIV among people injecting drugs. In 1987, NSPs

were integrated into NSW government policy. Other states and territories soon established their own NSPs, and currently there are over 3,000 NSPs in Australia.

Several types of NSPs operate across Australia, with distinct differences. Broadly, these are classified as:

- **Primary** – fixed, stand-alone agencies that specifically provide specialist services to people who inject drugs, including the provision of sterile equipment and appropriate disposal facilities, referral and sometimes primary medical care.
- **Secondary** – outlets offering sterile equipment and appropriate disposal as one part of a range of health and community services. Examples of secondary outlets include those at community health centres and hospital-based accident and emergency departments.

NSPs operate from different service models including fixed-site outlets, and mobile/outreach facilities. NSPs are also provided through some community pharmacies.

Dispensing machines in some states dispense 'packs' which contain several 1ml syringes (for a small fee). These machines are re-stocked by NSP workers and they assist in broadening the reach of NSPs in ensuring 24-hour access to preventative equipment for blood-borne viruses. *See Chapter 8: Education and Training* for more details on training and education issues for the NSP workforce.

## LOCAL GOVERNMENT RESPONSES

The provision of services at the local government level has become increasingly important in meeting the needs of people affected by hepatitis C. Local government involves a wide range of agencies and services that can contribute to the health and wellbeing of people. It is well-placed to respond promptly and effectively to particular local needs. Furthermore, it is responsible for urban planning and development, which affects the location and operation of health promotion initiatives such as Needle and Syringe Programs, local health services and waste collection, including needles and syringes. Local governments are in a good position to become key partners in promoting population health

initiatives, and their policies should reflect the principles and priorities of the current *National Hepatitis C Strategy*.

# COMMUNITY SECTOR RESPONSES

Central to the partnership approach is the involvement of individuals and communities in program and policy development. To date, this has been principally through community-based organisations supported by Australian Government and state government funds, and includes hepatitis councils, drug user organisations, state and territory haemophilia groups and Needle and Syringe Programs.

## HEPATITIS COUNCILS

The first councils were formed in the early 1990s, evolving primarily from hepatitis C support groups. The councils were organised in response to the confusion and ignorance associated with diagnosis, the absence of reliable information, and the misunderstanding and discrimination encountered by many affected people. The development of support through the provision of information, telephone 'buddy' systems, meetings and public information seminars stimulated local communities to form incorporated associations.

**Hepatitis Australia** is the lead national agency for people with hepatitis C and other viral hepatitis. Hepatitis Australia is a strong and effective voice for the people it represents.

The state-based hepatitis councils define their principal tasks as the provision of:

- information;
- referral to appropriate agencies and expertise;
- education, training and development services;
- peer-based support services to people affected by hepatitis C; and
- community representation at all levels of policy development and decision-making relating to hepatitis C issues.

All hepatitis councils have recognised the importance of partnerships and of establishing infrastructure to meet local needs. Good examples of such community involvement and empowerment are seen in management committees, project co-ordination and provision of services to people with hepatitis C. These endeavours often involve people who use drugs, health professionals, counsellors and researchers, government representatives and people with hepatitis C, who work together for the benefit of affected people.

## DRUG USER ORGANISATIONS

The illicit nature of injecting drug use has meant that traditional public health promotion approaches are not always appropriate or effective. Consequently, peer-based drug user organisations have been funded to involve affected people in harm reduction initiatives that include:

- design, delivery and development of education, support and training programs;
- information provision;
- participation in the development of health policy and programs; and
- referral to appropriate agencies.

**The Australian Injecting and Illicit Drug Users League** (**AIVL**) is the national peak organisation representing the state and territory drug user organisations and issues of national significance for people who use or have used illicit drugs. AIVL is a peer organisation. AIVL member organisations have had interrupted histories and, in some jurisdictions, operate as semi-autonomous programs within other organisations. These factors and local conditions have resulted in variations between state and territory organisations in terms of their size, the range of services provided, organisational style, and their capacity to participate in the partnership approach to prevent blood-borne virus transmission. However, all of these organisations are characterised by their focus on facilitating involvement of people who inject and use drugs to manage their own health and that of their peers.

## OTHER ORGANISATIONS

**The Multicultural HIV/AIDS and Hepatitis C Service** undertakes and supports initiatives to address hepatitis C in CALD communities. It also works to build the capacity of agencies to address hepatitis C amongst people from CALD backgrounds.

**National and State Haemophilia Foundations** were formed to represent and address the needs of people with haemophilia, including complications in their treatment arising from blood-borne viruses. Since 1990, these groups have worked towards responding to the additional health needs of people with bleeding disorders who have hepatitis C.

**The Australasian Society for HIV Medicine** is a key partner in the Australian response to HIV, hepatitis and related diseases. The Society conducts a broad education program in HIV and viral hepatitis for medical practitioners, health care providers and allied health workers, and manages a program of continuing medical education in HIV and viral hepatitis.

# DIRECTIONS FOR THE FUTURE

A mid-term stock-take of the four National Strategies, including the *National Hepatitis C Strategy 2005–2008* was held on 27 March 2007. The meeting was attended by approximately 80 people and included representatives from community based, clinical and research organisations and relevant committees.

The key priorities which were identified by participants as requiring progress in the hepatitis C sector in the next 18 months were:

- continuing to progress hepatitis C as a public health issue in the corrections sector;
- pursuing the need to extend access to clean injecting equipment, including access after hours;

- documenting and disseminating flexible models for hepatitis C treatment; and
- creating an enabling environment for a hepatitis C education and prevention campaign, underpinned by relevant social research.

Whilst these are not the only actions that will need to be taken forward as a result of the stock-take, their identification as 'key priorities' signifies agreement amongst Forum participants that these actions should be pursued with renewed focus and drive during the next period.

Another key piece of work which will commence during 2008 is the evaluation of the *National Hepatitis C Strategy 2005–2008* and the development of the next National Strategy. In order to appropriately reflect the partnership approach, it is expected that there will be extensive stakeholder consultation in developing the next National Strategy.