



The Hepatitis Equity Report

Champions and Challenges:
Australia's responses to viral hepatitis and HIV

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Formed in 1997, Hepatitis Australia is the peak national organisation representing the interests of Australians affected by hepatitis B and hepatitis C. Our mission is to provide leadership and advocacy on viral hepatitis and support partnerships for action to ensure the needs of Australians affected by, or at risk of viral hepatitis are met. Our members consist of the state and territory hepatitis organisations.

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Recommendations for action to end the inequity

Hepatitis Australia believes that Australia needs appropriately supported and resourced responses to all blood-borne viruses (BBVs), including hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV).

In Australia, annual deaths due to viral hepatitis are now higher than they ever were for HIV. A failure to act now will result in a rising number of avoidable deaths and increasing burden of chronic hepatitis.

Australia is considered a world leader in its response to HIV, but the national response to viral hepatitis is falling well short of this status. The evidence shows us there is an urgent need to do more to strengthen the response to viral hepatitis.

It is time to ask the hard questions about why there are such inequities in the response to BBVs in Australia and what can be done to address these.

Without an equitable commitment from governments for HBV and HCV, we will not achieve the changes needed to turn these epidemics around.

With more than 1,000 deaths each year from viral hepatitis, Australia needs its politicians to take the lead, speak up and act now to end the invisibility of viral hepatitis.

To reduce the increasing loss of life due to viral hepatitis, our recommendations to Australian Governments are:

1. Acknowledge the successful outcomes of the HIV response and act now to achieve similar outcomes for viral hepatitis in Australia;
2. Act quickly to increase treatment access to the best available medicines to reach the National Strategy targets, avert further preventable deaths from HBV and HCV and reduce the burden of disease;
3. Apply the existing evidence-based tools for prevention to the most cost-effective levels, in particular increase access to funded HBV vaccinations and needle and syringe programs by the priority populations;
4. Establish a more equitable relationship between the size of the epidemics, burden of disease and the funding allocations for HBV and HCV vis-à-vis HIV across all aspects of the response;
5. Speak up and address the invisibility of viral hepatitis, which in turn will support the affected communities to also speak out.



Executive Summary

Addressing BBVs has been an important aspect of public health in Australia for over thirty years. The Australian responses to HBV, HCV and HIV have varied significantly. Based on the *Champions and Challenges* presentation at the 9th Australasian Viral Hepatitis Conference in September 2014, this document reviews the champions and challenges of Australia's response to BBVs.

In many respects, Australia is often regarded as a world leader for its response to HIV. Other health areas frequently refer to the HIV response to demonstrate the benefits of a highly effective and well-resourced response. This includes those working in the area of viral hepatitis.

However, due in part to the differential responses to these BBVs, deaths from HIV have significantly dropped at the same time that deaths from viral hepatitis have significantly increased. In 2013, the number of deaths due to complications of chronic HBV or chronic HCV exceeded those at the peak of the HIV epidemic in 1994, and these deaths are projected to continue to rise without urgent intervention. It is imperative that Australia emulate the highly effective response implemented for HIV to prevent further unnecessary deaths from HBV and HCV. To facilitate this, we need decision makers to look at the readily available facts, side by side.

"In 2013, the number of deaths due to complications of chronic hepatitis B or C exceeded those at the peak of the HIV epidemic in 1994, and these deaths are projected to continue to rise without urgent intervention."

Historically, those working in the area of BBVs have tended to shy away from direct comparisons of data relating to the epidemiology and responses to viral hepatitis and HIV. This is largely due to the competitive nature of federal government funding arrangements. This paper provides direct comparisons between the responses to HBV, HCV and HIV and highlights stark inequities.

In considering the development of this paper it was important from the outset to reinforce the view that increasing the Australian response to viral hepatitis is vital, but should not detract from the continuing and important response to HIV.

With 1,000 deaths each year from viral hepatitis, there is an imperative for Australia to quickly improve its response to HBV and HCV. The challenges in escalating the response to viral hepatitis include:

- Providing ongoing support to the affected community to speak out and tell their stories;
- Ensuring governments speak up as loudly for viral hepatitis as they do for HIV; and
- Establishing a more equitable approach to resourcing a comprehensive and effective response for HCV and HBV vis-à-vis HIV.

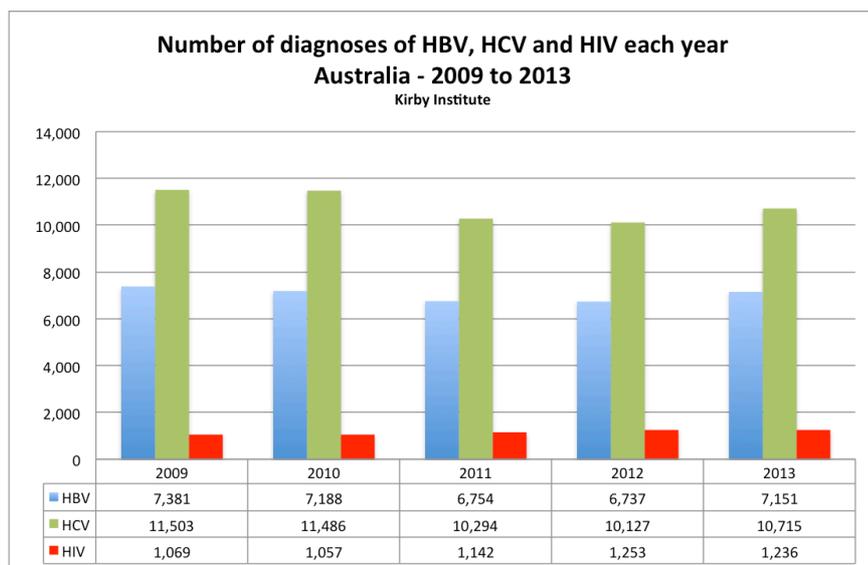
Governments must act immediately to address the current inequities and elevate the response to viral hepatitis in Australia.

There are some significant opportunities to improve Australia's response to viral hepatitis but it will take serious investment combined with a willingness of Ministers and health bureaucrats to take action to reduce the current invisibility of viral hepatitis.

The Stark Reality (statistically speaking)

The epidemiology clearly demonstrates that Australia needs to do more in responding to viral hepatitis. When looking back on *Annual Surveillance Reports* since 2009, this has been evident for a number of years. While the number of HIV diagnoses has increased in recent years, the numbers of HBV and HCV diagnoses have continued to be far too high every year. In 2013, for every one person diagnosed with HIV there were more than eight diagnosed with HCV and almost six with HBV¹.

Throughout the graphs and tables contained in this report, HIV is represented by the colour red, HCV by green and HBV by blue.

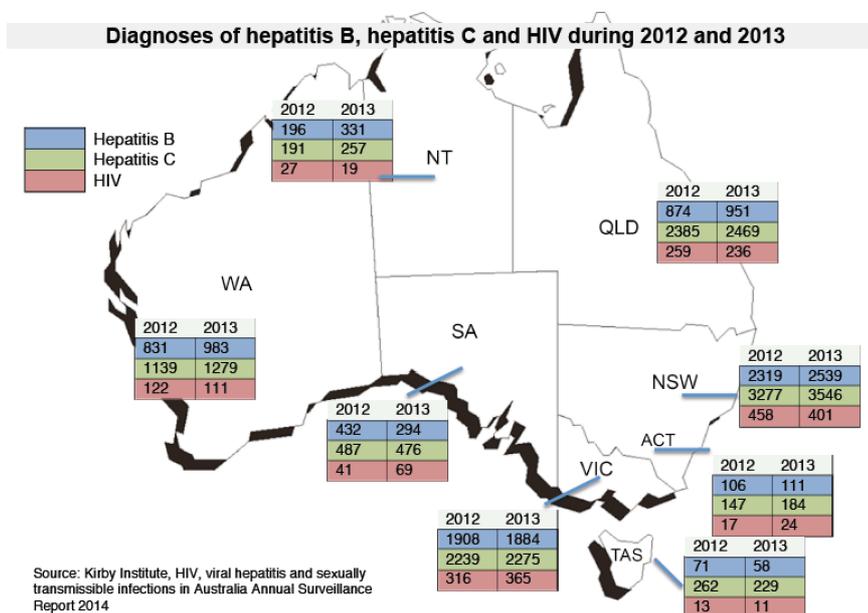


At a national level, in 2013, the diagnoses of BBVs were as follows:

- HCV – 10,715 (56% of the total)
- HBV – 7,171 (37% of the total)
- HIV – 1,236 (7% to the total)

A similar pattern of diagnoses is seen among Aboriginal and Torres Strait Islander peoples. Of those people reported to be from an Aboriginal and Torres Strait Islander background and diagnosed with a BBV in 2013, there were:

- HCV - 796 (77% of the total)
- HBV - 206 (20% of the total)
- HIV - 26 (3% of the total)².



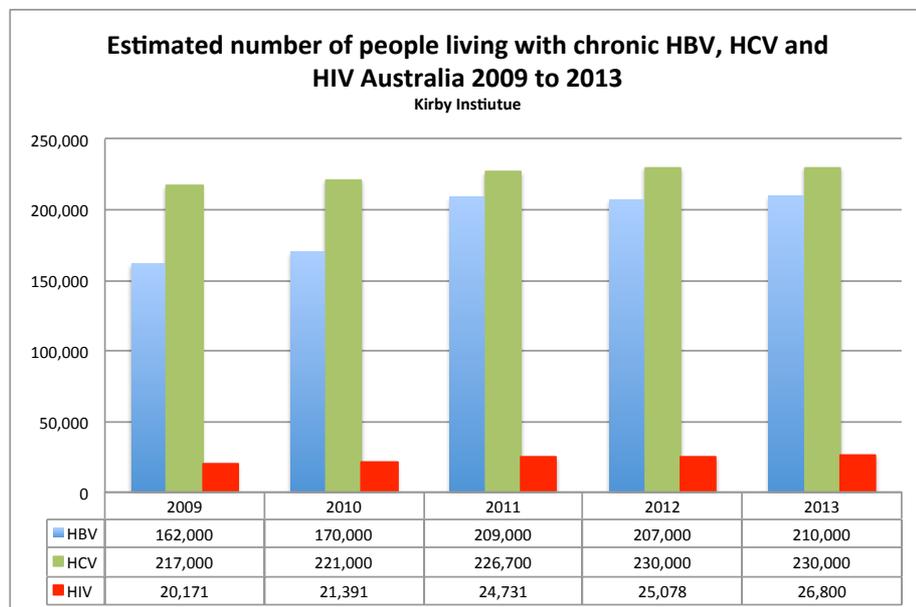
Providing a perspective for each State and Territory in Australia is important to inform governments and services at the jurisdictional level. Again the map (left) shows a similar pattern of diagnoses of HBV, HCV and HIV for each of the States and Territories in Australia during 2012 and 2013.

Diagnoses were highest for HCV and lowest for HIV in each jurisdiction apart from NT where HBV diagnoses were highest. HIV diagnoses ranged between 3% and 8% of the total for all BBVs in every jurisdiction. This reinforces the relevance of this report for State and Territory governments.

The number of people estimated to be living with chronic infection provides a good indicator of future disease burden for each of the BBVs in Australia and potential long-term impact on the health system.

Looking at the surveillance data (below) of people living with BBVs in Australia in 2013, the largest proportions are living with viral hepatitis:

- 230,000 (49%) with chronic HCV,
- 210,000 (45%) with chronic HBV and;
- 26,800 (6%) with HIV³.

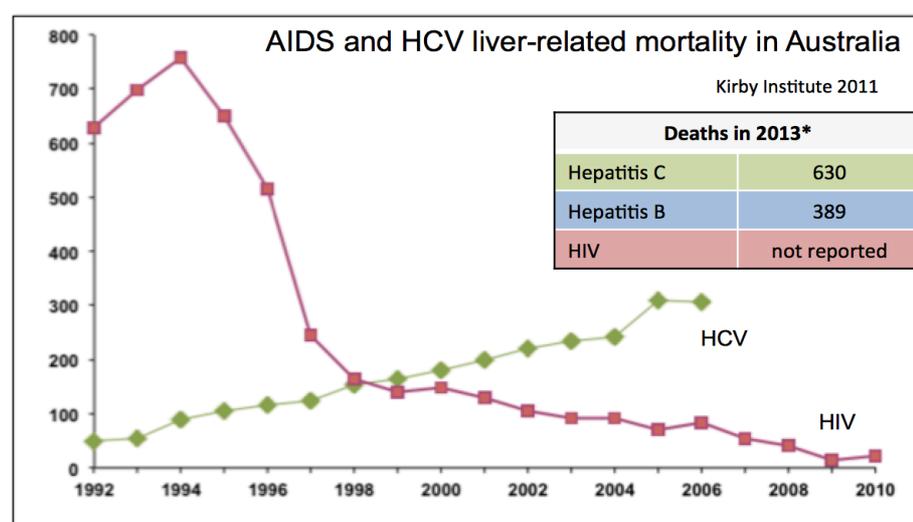


The estimated number of people living with chronic HCV and moderate to severe liver disease has more than doubled over the past ten years.¹

Nearly three-quarters of people living with HCV and more than one-third of people with HBV are aged 40 years or over⁴ and have a heightened risk of progressing to serious liver disease and life-threatening complications. Among those with HCV, without enhanced interventions, there will be a 180% increase in the number of people with cirrhosis by 2030.⁴

Blood-borne Viruses and Mortality

We know mortality related to viral hepatitis is on the increase, whereas for HIV it has declined. The following graph, originally developed by the Kirby Institute, shows deaths due to HIV peaked in 1994 and then rapidly declined with the introduction of highly active antiretroviral treatment (HAART). Since 1999, some seven years ahead of the USA, there have been more HCV-related deaths each year in Australia than HIV-related deaths.



Estimated deaths for HCV were not developed between 2006 and 2012, however, in 2013, the Kirby Institute estimated there were 630 liver-related deaths as a result of hepatitis C infection and 389 deaths due to HBV infection¹. Combined, this totals 1,019 deaths in 2013, considerably higher than the 1994 peak in HIV deaths.

As outlined in the recent Liver Danger Zone Report³, without significant changes in treatment rates for HCV, Australia faces a 230%

increase in liver-related deaths due to HCV alone by 2030. Other sources have reported that deaths from primary liver cancer in Australia are rising faster than for any other type of cancer. The major drivers of this rise are undiagnosed and/or untreated HBV and HCV^{5 6}.

Elements of a Champion Response

Australia has been, and continues to be a global HIV champion. The strong government leadership and investment in an effective response to HIV combined with an effective partnership with the affected communities is often considered the benchmark for an optimal public health response. This has included:

- High levels of community engagement;
- Comparatively high visibility;
- Bipartisan political support;
- Effective government investment in policy, services, clinical and social research; and
- A willingness of governments to talk about HIV as a public health issue.

A number of key elements were important in reinforcing Australia's response to HIV. Initiatives undertaken at the global level also served to reinforce activities undertaken within Australia.

Comparing the key elements of a champion response.			
In Australia	HIV	Hep C	Hep B
First dedicated National Strategy	1989	1999	2010
High profile public education campaign (Fed. Govt.)	1987 / 1993	none	none
Funding of national peak community organisation	1987 (AFAO)	1997 (Hepatitis Aust.)	#
High profile national fundraising efforts.	1987	none	none
National peer organisation for people living with HIV.	1990 (NAPWHA)	**	none
Globally			
Global observance of a 'Day' (World AIDS Day / World Hepatitis Day)	1988 (WAD)	2010 (WHD)	2010 (WHD)
Internationally recognised symbol. (e.g. Red Ribbon)	1991	none	none
Global Fund Support	Since 2002	none	none
Highly effective and well-tolerated treatments	Yes – 1996 50% access [^]	Yes - from 2014 1% access [^]	Yes 3-5% access [^]
<small># Hepatitis Australia is the national peak community organisation representing the interests of Australians affected by HBV and HCV, however dedicated government support is not provided for HBV. ** AIVL is the national peak community organisation representing people who use, or have used illicit drugs. ^ Proportion accessing treatment during 2012.</small>			

When reflecting on the timeline^{7,8,9} of the responses and as you can see in the table above, the response to HCV and HBV has been much slower and many gaps continue to be evident.

There was a gap of ten years between the *First National HIV Strategy* and the *First National Hepatitis C Strategy* and it was then another eleven years before the *First National Hepatitis B Strategy* was established.

There have been two federal government-led public advertising campaigns for HIV; initially the Grim Reaper advertisements in 1987 and then an anti-discrimination campaign in 1993. There has not been any federal government-led, or supported, public mass media advertising campaigns for either HBV or HCV.

The Australian Federation of AIDS Organisations (AFAO) was established with federal government support in 1987. The national peak body supported state and territory based AIDS Councils, enabling a stronger coordinated community response early in the HIV epidemic. Federal government support to establish

Hepatitis Australia (solely for hepatitis C work) did not eventuate until ten years later. Following the launch of the *First National Hepatitis B Strategy* in 2010, no additional government support was forthcoming to assist community organisations to implement this Strategy.

Australian and international fundraising efforts play an important role in the profile of HIV. Celebrities quickly got behind the effort participating in global awareness and fundraising events. The engagement of high profile personalities extended to the AIDS Trust of Australia, established in 1987 to raise funds and complement existing government investment in the Australian response to HIV. This combined with the global observance of World AIDS Day (WAD) from 1988, and the creation of the iconic Red Ribbon as the universal symbol, ensured that HIV became one of the most recognised diseases in a generation.

Viral hepatitis is just starting to get serious traction on the global stage, but is yet to see such high levels of engagement from the entertainment industry. Following significant advocacy from the World Hepatitis Alliance, the World Health Organisation formally endorsed World Hepatitis Day in 2010, some 20 years after the hepatitis C virus was identified and a test developed. Locally, Hepatitis Australia has been coordinating Hepatitis Awareness Weeks / World Hepatitis Days since 2005.

Despite similar global statistics to HIV and the recent adoption of resolutions¹⁰ presented at the World Health Assembly, we are yet to see a Global Fund to fight viral hepatitis.

The invisibility of viral hepatitis and ongoing stark inequities compared to HIV are hampering the Australian response to HBV and HCV. This is despite:

- A significantly greater number of people living with chronic viral hepatitis;
- High overall disease burden and an increasing number of lives being lost due to viral hepatitis; and
- The relevant data being readily available to decision makers.

Australia is failing to emulate a champion response for viral hepatitis. Government support is lagging behind that provided to HIV.

RECOMMENDATION 1: Governments must acknowledge the successful outcomes of the HIV response and act now to achieve similar outcomes for viral hepatitis in Australia.

National Policy (the National Strategies)

Australia's policy response to BBVs and sexually transmitted infections (STIs) is captured in a suite of five National Strategies; Minister Dutton released the latest versions on 7th of July 2014. These include the *2nd National Hepatitis B Strategy*¹¹, *4th National Hepatitis C Strategy*¹², *3rd National Sexually Transmissible Infections Strategy*¹³, the *7th National HIV Strategy*¹⁴ and the *4th National Aboriginal and Torres Strait Islander National BBV and STI Strategy*¹⁵.

For the first time these strategies include measurable targets. There are targets to reduce the incidence of BBVs, and in the case of HIV, sustain the virtual elimination in some populations. Targets to increase the number of people receiving treatment have also been introduced.

Treatment for BBVs

The introduction of highly active anti-retroviral treatment (HAART) in 1996 brought about a rapid decline in HIV mortality and was the watershed moment for the HIV epidemic in Australia. Very effective treatments for HBV are already available in Australia but only one-fifth of those who would benefit from them currently receive treatment. As for HCV, we are currently in the midst of one of the most significant and rapid transformations in the treatment of any disease for decades, yet treatment rates are only 1% per annum. The urgency in facilitating treatment access and uptake for HBV and HCV has never been greater as the number of avoidable deaths per annum is climbing.

If Australia achieves the treatment targets outlined in the National Strategies, the number of people accessing treatment would increase significantly, as shown in the following table.

Increasing access to treatment for BBVs				
BBV	Est. proportion on treatment as at 2012	Target by 2017	Est. on treatment in 2012	Target by 2017
HIV	50%	90%	12,850	23,130 cumulative
HBV	5%	15%	10,350	31,050 cumulative
HCV	1%	5%*	2,300	11,500 p.a.

* Based on the National Strategy target of 50% increase each year

HBV, like HIV, is an infection that requires lifelong management and treatment. There is no cure. This means the number of people being treated will grow over time, although not all people with HBV will require treatment. It has been suggested that a target of 25% for HBV treatment would be optimal.

Unlike HBV and HIV, treatment for HCV is for a fixed period and, for most people, will result in a cure. If Australia acts now to ramp up treatment access and combines this with a strong focus on prevention, the proportion of the population living with chronic HCV will start to shrink each year, representing the turning point in the epidemic of HCV.

RECOMMENDATION 2: Governments must act quickly to increase treatment access to the best available medicines to reach the National Strategy targets, avert further preventable deaths from hepatitis B and hepatitis C and reduce the burden of disease.

Preventing BBVs

HBV is preventable through the use of a low cost and highly effective vaccine¹⁶. Increasing vaccination is a target in the *Second National Hepatitis B Strategy* but there are inconsistent eligibility criteria for access to free HBV vaccinations across Australia. Making HBV vaccination free to all the nationally designated priority populations for HBV would be a cost effective measure, reduce confusion and minimise stigma and discrimination.

In Australia, since the introduction of universal screening of blood products for HCV (1990), unsterile injecting and the sharing of injecting equipment is the primary cause of HCV transmission. Needle and syringe programs (NSPs) have proven to be highly effective and cost saving¹⁷ and investing more in NSPs would increase these savings, including in custodial settings. Increasing the accessibility of sterile injecting equipment is a target of the National Strategies. However, there have been substantial delays experienced in the roll out of the additional funding first announced in 2013.

RECOMMENDATION 3: Governments must apply the existing evidence-based tools for prevention to their most cost-effective level, in particular access to funded hepatitis B vaccinations and needle and syringe programs by the priority populations.

National Community-based Organisations (CBOs)

A key strength of Australia’s response to BBVs is that the Australian Government funds peak community-based organisations. This began with the response to HIV. However, the question must be asked whether the funding allocations across current community-based BBV organisations in 2014 are appropriate for the size and significance of the epidemics. The lack of dedicated funding support from 2010 to implement the *First National Hepatitis B Strategy* was a particular problem and remains unresolved to date.

The Australian Government’s Communicable Disease Prevention and Service Improvements Grants Fund currently resources a range of community-based organisations for BBV and STI work. In addition, the Australasian Society for HIV Medicine (ASHM) and the National Serology Reference Laboratory (NRL) also receive funding from this Federal Fund.

BBV	Federally Funded National Community-based Organisations ¹⁸
HIV	<ul style="list-style-type: none"> • Australian Federation of AIDS Organisations (AFAO) • National Association of People with HIV, Australia (NAPWHA) • Scarlet Alliance • Youth Empowerment Against HIV (YEAH)
HCV	<ul style="list-style-type: none"> • Hepatitis Australia • Australian Injecting & Illicit Drug Users League (AIVL)
HBV	<ul style="list-style-type: none"> • No additional funds allocated to CBOs

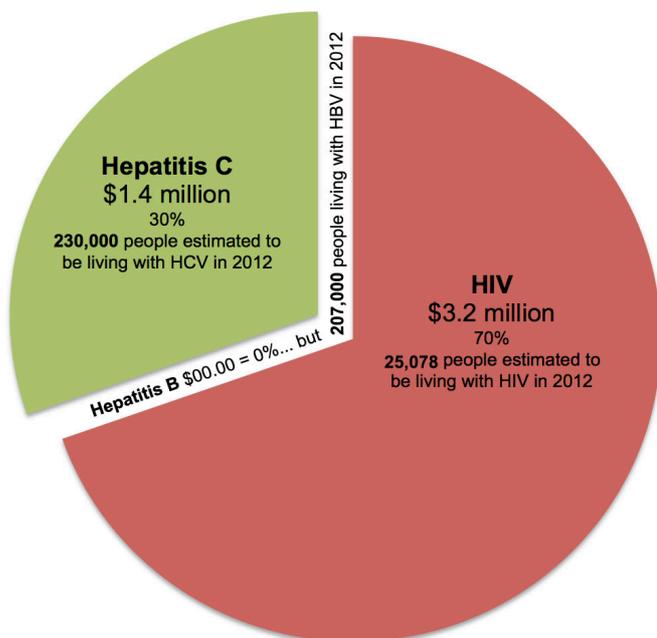
Following the release of the *First National Hepatitis B Strategy* there was no new funding allocated. However, the Australian Government expected community-based organisations to undertake HBV work to implement the Strategy. This work had to be absorbed into funding previously allocated solely for HCV work. This has been partially achieved through incorporation of some HBV work into existing programs; however the development of enhanced, specific and targeted HBV programs, which would be the optimal response, requires additional resources.

Despite each of the National Strategies including Aboriginal and Torres Strait Islander peoples as a priority population, and the existence of a separate Aboriginal and Torres Strait Islander National Strategy, there is no national peak organisation currently funded to effectively represent Australia’s Indigenous communities in relation to BBVs.

Information on the level of funding provided to each national organisation through government grants is not easily accessible. The Annual Reports from four organisations^{19, 20, 21, 22} were reviewed to establish the estimated funding provided to each of these organisations for domestic programs in 2012. Two HIV organisations (AFAO and NAPWHA) and two organisations working in viral hepatitis (Hepatitis Australia and AIVL) were chosen as the most comparable peak bodies.

**Domestic Government Grants to Australia's
National Peak Community Organisations 2012**

Surveillance data sourced from Kirby Institute. Financial data estimated from organisational Annual Reports
Organisations included: Hepatitis Australia, AIVL, AFAO & NAPWA



This pie chart (left) shows the value of domestic grant funding provided to CBOs; the proportion of the total grants; and the number of people estimated to be living with each BBV in 2012.

The government grant funding provided to the two main HIV organisations in 2012 for domestic programs is more than double that provided to the two main organisations working on viral hepatitis. It should be noted that this data is an approximation only, for one year, but it clearly demonstrates the resourcing provided to community peaks in 2012 bore no relationship to the size of the epidemics at that time.

The table below compares the proportional government funding allocations to the national peak bodies with the annual diagnoses and the number of people living with these BBVs and reveals a stark inverse relationship between the epidemiology and funding allocations.

Relationship between funding allocations, annual diagnoses and no. of people living with each BBV			
BBV	Proportion of annual diagnoses (2012)	Proportion of prevalence cases (2012)	Proportion of funding allocated to four national peak bodies (2012)
HIV	7% (1,253)	5% (25,078)	70% (\$3.2million)
HBV	37% (6,702)	45% (207,000)	0% (\$0)
HCV	56% (10,112)	50% (230,000)	30% (\$1.4million)

RECOMMENDATION 4: Governments must establish a more equitable relationship between the size of the epidemics, burden of disease and the funding allocations for hepatitis B and hepatitis C vis-à-vis HIV across all aspects of the response.

Federal Government Role in the Visibility of BBVs

The media statements released by governments play a key role in the public visibility of BBVs. The headlines (right) from Australian Government media releases relate to announcements between August 2013 and September 2014. The word 'hepatitis' has not appeared anywhere in these headlines – it is in effect invisible.

This is despite opportunities for the government to highlight viral hepatitis. In May 2014, The Australian Government supported a Resolution⁸ put to the World Health Assembly to elevate the profile of, and response to, viral hepatitis to a similar level as that for HIV, malaria and tuberculosis. Following the Resolution being passed at the World Health Assembly, no federal government media statement was issued.

On World Hepatitis Day, 28 July 2014, Hepatitis Australia, along with other leading health organisations released the 'Liver Danger Zone' report card⁴ for viral hepatitis in Australia. The report highlighted alarming projections for liver disease if Australia does not elevate its response to viral hepatitis. A copy of the report was provided to all current Australian politicians. Again, the federal government failed to issue any media release in support of World Hepatitis Day, despite having done so for HIV and other public health concerns.

The lack of public comment or support specifically naming HBV or HCV reinforces the invisibility of viral hepatitis. The emphasis of federal government BBV statements is clearly focused on HIV, which reinforces public misconceptions that HIV is a much more significant public health issue in Australia than HBV or HCV.

“Government Steps Up Fight Against Sexually Transmissible Infections and Blood Borne Viruses.”

Media release headline Tanya Plibersek Federal Health Minister (12 Aug '13)

“World Aids Day” “..... a reminder that continued vigilance was needed to prevent the spread of HIV infections.”

Headline and quote - Federal Health Minister Peter Dutton (1 Dec '13)

“Australia's commitment to fight HIV/AIDS, Tuberculosis and Malaria”

Media release headline - Hon Julie Bishop MP, Minister for Foreign Affairs (3 Dec '13)

“New Strategies on Blood Borne and Sexually Transmissible Diseases”

Media release headline – Federal Health Minister (7 July '14)

“New Access to HIV Tests and Treatments”

Media release headline – Federal Health Minister (7 July '14)

“Health Ministers sign on to end HIV transmissions by 2020”

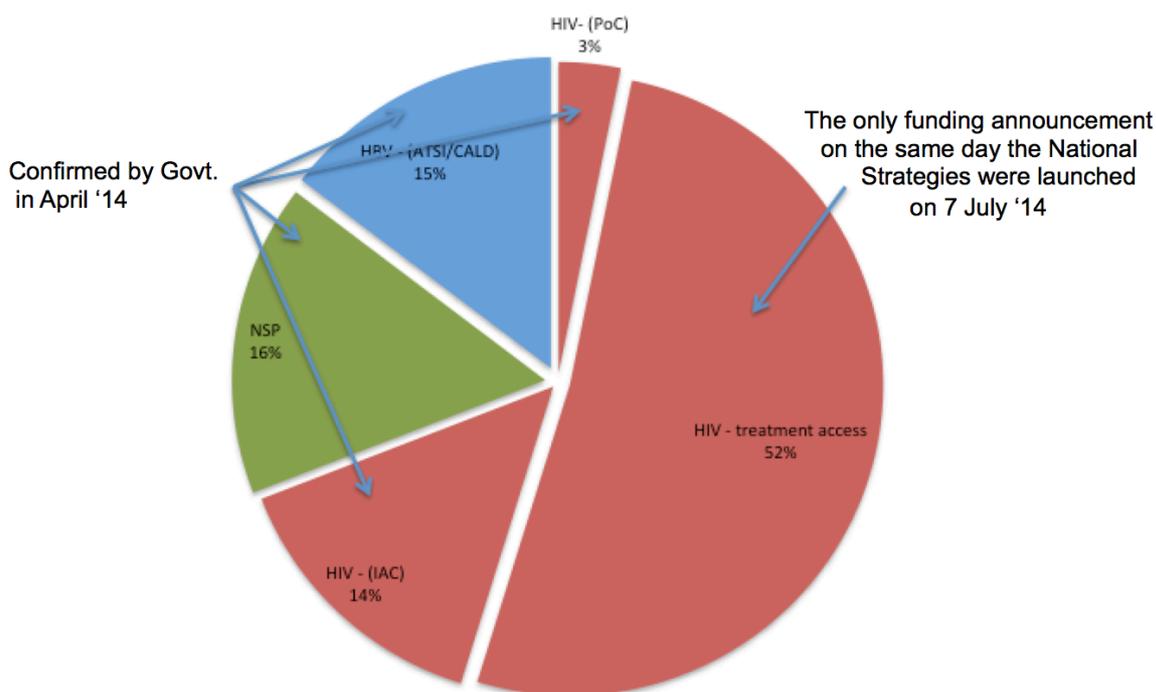
COAG Health Council 20 July '14

RECOMMENDATION 5: Governments must speak up and address the invisibility of viral hepatitis, which in turn will support the affected communities to also speak out.

If we look at the federal BBV funding announcements in recent times, totalling 31.4 million over four years for the domestic response to BBVs, we can again see a very stark favouring of HIV over HBV and HCV.

Event	Government Media Releases/Funding Announcements
Election campaign, August 2013	Labor announces that new funding over four years is in the Budget. The announcement included the following: <ul style="list-style-type: none"> - \$4.8m - HIV (AIDS 2014 Conference.) - 1.3m - HIV (point of care testing) - \$5.6m - HBV (testing and treatment) - \$5.6m - NSPs (regional and remote).
World AIDS Day (1 December 2013)	<ul style="list-style-type: none"> • Media release to mark the event • Reinstatement of \$200m to global fund
New funding, (previously announced by Labor) is confirmed (April 2014)	<ul style="list-style-type: none"> • Media release confirmed funding over four years of: <ul style="list-style-type: none"> - \$5.5m – HIV (\$4.1 AIDS 2014 Conf. + \$1m point of care testing) - \$4.6m – HBV (testing & treatment) - \$5.1m – NSPs (regional and remote).
World Health Assembly (May 2014) Australia supports hepatitis resolutions.	-- SILENCE -- No media release or public comment
Launch of National Strategies (7 July 2014)	<ul style="list-style-type: none"> • Media release: National strategies • Media release - new funding over four years of: <ul style="list-style-type: none"> - \$16.2m for access to HIV medicines.
International AIDS Conference (July 2014)	AIDS 2014 Legacy Statement (signed by all Australian Health Ministers)
World Hepatitis Day/Liver Danger Zone Report Launch (28 July 2014)	-- SILENCE -- No media release or public comment

Federal Government funding announcements - April to July 2014



Originally announced by the former government, 48% (as shown in the pie chart) of the total new funding announcements made in 2014 (\$15.2m over 4 years) was confirmed following the Commission of Audit Report. This was a good outcome and incorporated the first dedicated HBV funding (\$4.6m for testing and treatment) since the launch of the *First National Hepatitis B Strategy* in 2010.

The allocation of the remaining 52% of the funds (\$16.2m) was announced on the same day as the launch of the suite of National Strategies; this entire amount was allocated to improving the accessibility of HIV treatment. There were no funding announcements related to any of the other National Strategies.

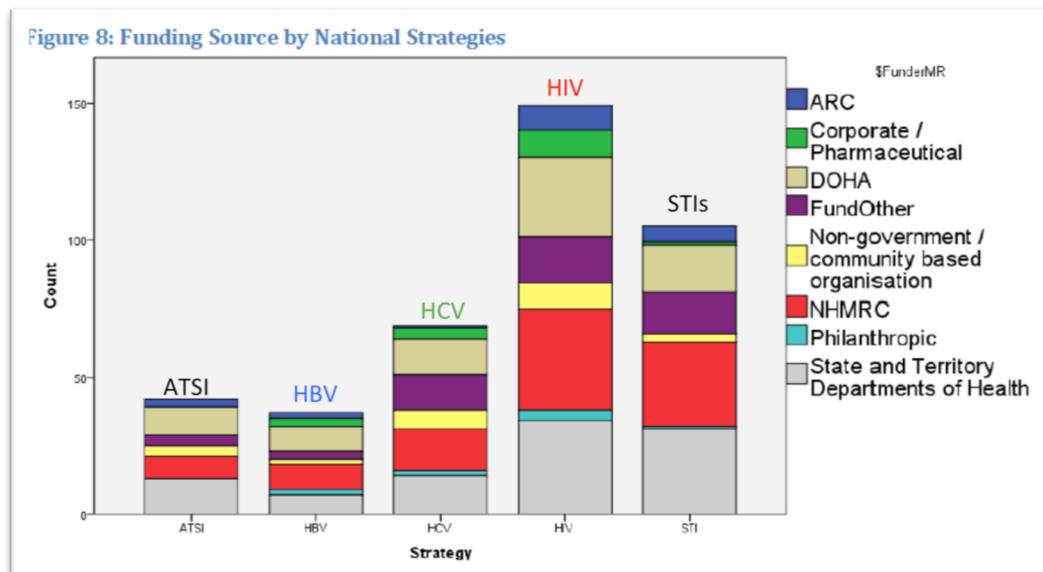
The later funding is to support community prescribing and dispensing of HIV medicines. This initiative could have easily been expanded to include improved access for HBV treatment as the medicines are very similar and in one case exactly the same.

In addition, such significant systemic change should consider the rapid developments in HCV treatment and accommodate the future transition of HCV treatment to primary care.

It should be noted that the vast majority of these new funds, apart from the allocation for the International AIDS Conference 2014, have not been rolled out by the Federal Government to date.

Focus on Research

Research is vital to inform the responses to BBVs. This graph (below) from the *National BBV and STI Research Audit Report*²³ provides a visual representation of the allocation of research funding. Again, there is an inverse relationship between the size of the epidemics and the focus of research across the BBVs. There are twice as many projects funded for HIV than for HCV and more than three times the number of HIV projects than HBV projects. It should also be noted some research projects align with more than one of the National Strategies. HIV and STIs' research (the second largest focus for research) is often linked, for example to health promotion and prevention strategies, for both HIV and STIs have similar elements across priority groups.



Source: Australian Research Centre in Sex, Health and Society, *National BBV and STI Research Audit Report*, 2013

Conclusions

The information presented in this paper clearly demonstrates there are inequities in Australia's response to BBVs. There is a clear need to urgently elevate the response to viral hepatitis and reduce the number of people contracting HBV and HCV and to prevent an increasing number of lives being lost through enhanced access to treatment.

The Australian Government and all State and Territory Governments have committed to the suite of National Strategies addressing BBVs and STIs. To ensure an equitable approach, all these governments need to rapidly increase their focus on, and commitment to, the response to viral hepatitis. As was the case in the response to HIV, the involvement of the affected communities and governments working effectively with community sector organisations is vital.

Without an elevated response for HBV and HCV, Australia cannot expect to meet the targets included in the National Strategies. In line with those targets, an elevated response must equally address increasing prevention strategies and improving treatment accessibility and uptake to urgently and effectively address the growing burden of viral hepatitis in Australia.

Hepatitis Australia is ideally placed to work with, and assist the Federal Government to progress the recommendations for action to end the inequity contained in this report.



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