Hepatitis C (HCV) is an increasing issue among Aboriginal Australians. Aboriginal people are overrepresented in prison and in injecting drug using (IDU) populations, both of which are high priority groups for HCV. However, recognition of the significant impact of HCV amongst this community has been slow to occur.

Hepatitis C is a major public health issue in Australia. By the end of 2008 it was estimated that 284,000 people were infected with HCV with an incidence rate of 10,000 new infections each year (NCHECR, 2009). There are substantial medical costs associated with living with HCV. In 2005 in Australia, 37% of all liver transplants stemmed from chronic HCV infection. Between 2000 and 2005, the number of liver transplants nearly tripled for those living with chronic HCV (McNalley & Latham, 2009). Between 2000 and 2005, the number of liver transplants nearly tripled for those living with chronic HCV (McNalley & Latham, 2009). The lifetime [medical] cost for a person living with HCV is estimated at $46,600, resulting in a cost of $9.2 billion to the health care system (Hepatitis C Council of NSW, 2008).

Contrary to a decreasing national trend, the rate of HCV diagnosis among the Aboriginal population is on the rise. The rate of new HCV infections in the Aboriginal population is between two and ten times higher than that in non-Indigenous populations, depending on location (McNally & Latham, 2009). While Aboriginal people only make up 2.4% of Australia’s total population, they constitute 8.3% of the Australian population living with HCV (McNally & Latham, 2009). That equates to an estimated 22,000 Aboriginal people who have HCV (DH&A, 2006). One reason that might contribute to the higher prevalence of HCV amongst the Aboriginal population is the disproportionate amount of Aboriginal people in priority populations for HCV: people who inject drugs (PWID) and people within the prison system (Hepatitis Australia, 2006).

People who inject drugs are at risk for various health problems, most notably HCV infection. Over 91% of new infections were acquired through injecting drug use (IDU) (Ministerial Advisory Committee, 2006). HCV prevalence among PWID in Australia has been estimated at around 55% (Zhou, et al., 2003). Twelve per cent of NSP survey respondents identified as Aboriginal Australian (NCHECR, 2010). This represents a proportion five times the proportion of people who identify as Aboriginal within the general population (Australian Bureau of Statistics, 2006).

Identifying as Aboriginal has also been found to be associated with early onset injecting (Abelson, et al., 2006) and commencing heroin use via injecting (Day, et al., 2005). Being of Aboriginal origin increases the likelihood of experiencing social, economic or family disadvantage (Oxfam Australia, 2007); and injecting drug use is more likely to occur among people who experience such hardships and are disadvantaged in a particular society (Fuller, et al., 2005). Aboriginal PWID may be at increased risk of contracting HCV and of other risks associated with sharing of injecting equipment. Research shows rates of sharing among Aboriginal IDU to be high and HIV knowledge to be low (Larsen, et al., 1999). Aboriginal people report sharing their injecting equipment more than other Australians (Correll, et al., 2000). Sharing of equipment among Indigenous people has been linked to cultural norms associated with sharing, especially where sharing with kin is not seen as sharing (Larson, et al., 1999). Additionally, when knowledge might be high in some places, there are still other barriers to preventing HCV such as limited access due to low income, issues with transport, and less access to appropriate services (DH&A, 2010).

Incarceration is an independent risk factor for HCV (AH&MRC Consultancy Service, 2004). The incidence of HCV within custodial settings has been reported between 40% (Hepatitis Australia, 2006) and 59% (AH&MRC Consultancy Service, 2004) in various locations. With Aboriginal people constituting 27% of the prison population, it is 14 times more probable for an Aboriginal person to be imprisoned than a non-Aboriginal Australian (Hepatitis Australia, 2006).
The disproportionate rate of incarceration might contribute to the increased risk of initiating injecting, sharing of equipment and increased exposure to HCV (Correll et al., 2000). Half of all prisoners report a history of IDU, and Aboriginal inmates specify prison as being an important point for transition to IDU (Lane, 1993). Beyond IDU, there are other forms of transmission that are also high risk for people incarcerated, such as tattooing or piercing. Inmates report commonly sharing and reusing equipment when injecting drugs, tattooing and piercing. There is an increased propensity for HCV to further spread into the larger Aboriginal community due to the combination of higher rates of Aboriginal people in prison, the higher rates of HCV in prison, and the shorter sentences Aboriginal prisoners typically carry out (Hepatitis Australia, 2006).

Despite the high prevalence of HCV within the Aboriginal community compared to the non-Aboriginal community, there is relatively sparse research that focuses on this population. Where such research does exist, the Aboriginal community is not usually the focus, but rather is a subgroup within a larger study with a mainstream focus; or, alternatively, where the Aboriginal community is the focus, HCV is not. For example, in Victoria the Victorian Aboriginal Controlled Health Organisation (VACCHO) and the association for harm reduction and prevention programs (ANEX) are currently working in partnership to tangibly improve health outcomes for Aboriginal Victorians who inject drugs (Find and Renew Projects, 2009). However, these programs do not focus specifically on HCV, but, rather, on Aboriginal health more broadly. The available research is often limited to small groups and most is over ten years old. Therefore, there is a need for targeted research focusing specifically on Aboriginal people and HCV, IDU, and prison. This will lead to a greater understanding of injection risk practices and issues around HCV knowledge and prevention among Aboriginal people.

Perhaps one reason for a lack of specific attention to HCV within Aboriginal communities is the high rates of competing health and social factors. While treatment uptake for HCV is low across all Australians at approximately 3,500 (National HCV Strategy 2010–2013), competing co-morbidities are often cited as a barrier for Aboriginal people (McNally & Latham, 2009). Aboriginal communities have limited knowledge of HCV and available treatments (NCHECR, 2009b). They have poorer health and access to health care as well as lower socio-economic status than non-indigenous Australians. They are faced with real and perceived discrimination surrounding race, IDU, and HCV together with shame and stigma associated with HCV within the community (McNally & Latham, 2009) resulting in PWID unwillingness to use Aboriginal-specific and mainstream health services (Coupland et al., 2005).

However, it is clear that much more research focused directly on HCV within the Aboriginal community as well as within the general population is needed. Research should address educating Aboriginal people on safe injecting practices, HCV knowledge, and available treatments, as well as finding and promoting effective ways to relieve the burden of living with HCV and to prevent its transmission. Interventions need to focus on cultural competency among health care professionals working with Aboriginal people, making services more attractive and accessible to Aboriginal people, and supporting Aboriginal-specific services to deliver a range of HCV programs. Additionally, culturally appropriate models to deliver treatment need to be developed.

References


AH&MRC Consultancy Services and Mandala Consulting (2004). Increasing access to services in NSW for Aboriginal people at risk of contracting or who have blood borne infections. NSW Aboriginal Health Partnership.


Where does HCV fit into Australia’s approach to Aboriginal health?

The current national strategy that guides Australia’s response to BBVs and STIs is comprised of a suite of five strategies, which focus on specific areas of concern. While there is one strategy dedicated to HCV, in order to reflect on the role of HCV within the broader Aboriginal community, this summary will focus on the Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy. The overarching goal of this strategy is to “reduce the transmission of, and morbidity and mortality caused by, STIs and BBVs, and to minimise the personal and social impact of these infections in Aboriginal and Torres Strait Islander communities” (p.11).

In the context of other BBVs and STIs, it is evident that while HCV is a growing issue within the Aboriginal community, there is a much larger focus on other communicable diseases. For example, while there are seven objectives of this strategy, only one refers to HCV: to increase the number of Aboriginal people receiving treatment for HCV, along with HIV and hepatitis B. Of the ten areas for action put forth, there were four applicable to HCV.

How can the Aboriginal population be reached?

This study examined Aboriginal people’s experiences with IDU and related issues through semi-structured interviews. Findings suggest Aboriginal PWID are a heterogeneous population with different drug-related problems and willingness for treatment. There is a need to increase safer injection practices, BBV prevention, and regular testing for BBV. Targeting misconceptions about routes of BBV transmission and health consequences is advocated. Aboriginal participants suggested distributing such information on pamphlets included with fitpacks, and making these pamphlets and fitpacks more accessible. Despite high rates of stigma and discrimination, participants recommended the implementation of peer education. Strategies to reduce BBV transmission include having greater acknowledgment of IDU by Aboriginal leaders, thus making IDU an issue for the larger community, and improving access to sterile injection equipment.


Scope of Aboriginal HCV education and prevention

This study aimed to ascertain the extent and scope of how Aboriginal Community Controlled Health Services provide hepatitis C education and prevention. The most common activities reported include the distribution of information and education within one-on-one service settings, the distribution of printed information and resources, and the provision of HCV testing. While three-quarters of respondents were highly concerned with HCV within the Aboriginal community, 43 per cent identified HCV as a low- to non-priority for their organisation. Sixty per cent reported no HCV-specific training, and 75% suggested the need for such training among staff. Most reported not having any dedicated funding for HCV specific programs. Consequently, staff reported incorporating HCV education and prevention within other health provisions.

Hepatitis Australia, National Aboriginal Community Controlled Health Organisation, Aldo Spina Consultancy Services (2009), Mapping and scoping of hepatitis C education and prevention activities in Aboriginal and Torres Strait Islander communities: survey of Aboriginal community controlled health services. Canberra: Hepatitis Australia.
Is HCV treatment the best option?

The authors note barriers to HCV treatment for Aboriginal people consistent with previous research. However, rather than attempting to overcome these seemingly insurmountable challenges associated with HCV treatment, the authors suggest promoting general health outcomes instead. HCV should not be separated from other health issues, because improving general health practices directly relates to liver function. Promoting ways to live well with the virus might have a greater impact than focusing on increasing treatment uptake.

Findings suggest there are ways to improve level of care and support in HCV treatment. Two main barriers are a lack of HCV knowledge by Aboriginal people and health care workers, and a lack of communication due to shame and stigma. These can be improved by more accessible education and increased communication in the health care setting and general community. Another suggestion is to treat people in groups so they are not confronted with treatment alone, but in a shared and collective way. The authors note diversity within the Aboriginal community, suggesting there is not one perfect model for managing health care of all Aboriginal people.


IDU, prison, and HCV among Aboriginal people

Aboriginal people are overrepresented in prisons and as PWID. The current study aggregated data from three cross-sectional studies comparing Aboriginal and non-Aboriginal PWID. With 15–19% of each sample comprised of Aboriginal people, findings support the overrepresentation of Aboriginal people as PWID. Among the Aboriginal population, there were also more female then male PWID. Findings suggest Aboriginal people have higher rates of lifetime incarceration, and choose heroin as their drug of choice more so than non-Aboriginal people. Aboriginal females reported more history of incarceration and longer periods elapsing between HCV tests than their non-Aboriginal counterparts. The higher rates of Aboriginal PWID and in custodial settings place them at an increase risk to HCV exposure.


HCV status of Aboriginal Australians: global context

This international study highlights the importance of understanding HCV prevalence in the Aboriginal population in the context of global HCV transmission rates. Such an approach strengthens knowledge related to HCV aetiology and prevention strategies, particularly as literature in this area is very limited; this review found only four articles where HCV was studied specifically in relation to race/ethnicity.

Findings suggest minority groups of PWID across the world are at higher risk of HCV then their Anglo counterparts. The largest disparity in HCV status, however, was found between the Aboriginal people of Australia and Canada and the non-Aboriginal, with Aboriginal people consistently having higher rates of HCV seroconversion.

The importance of interpreting BBV transmission through structural level factors, as opposed to individualistic frameworks, is emphasised, as they are associated with higher rates of IDU and BBV infections. Structural level factors include unequal racial, social, economic, and gender positions. For example, in Australia, HCV incidence in ethnic minorities was associated with increased social isolation and limited BBV knowledge.


Action points

- HCV is a growing burden for Aboriginal communities.
- There is a dearth of current research and literature which focuses specifically on Aboriginal communities and hepatitis C.
- There needs to be more research focused on Aboriginal peoples’ knowledge of and experience with HCV, the needs of the Aboriginal community in relation to HCV as well as the most appropriate strategies to reach this community.
- It is clear that HCV awareness and knowledge and access to appropriate services need to be drastically increased within the Aboriginal community.
- The production of Aboriginal specific health promotion and HCV materials is essential in developing effective tools to promote harm reduction, living well with hepatitis C and treatment options available within this community.
- Greater acknowledgement of the importance of being open about injecting related issues as well as other transmission routes of HCV, amongst Aboriginal communities, including leaders and Elders, is very important in increasing awareness and acceptance of hepatitis C within this community.
- Both HCV specific and general health promotion strategies need to be more fully developed for Aboriginals. The impact of both these strategies on HCV for Aboriginals needs to be better understood.
- It is crucial to increase the Aboriginal peoples’ access to HCV services (such as testing, care and support) and treatment.