

Prehospital Care Workers and Blood-borne Viruses

The facts

The three major blood-borne viruses, hepatitis B (HBV), hepatitis C (HCV) and the human immunodeficiency virus (HIV), are members of different species but share a common mode of transmission via blood. HBV and HIV can also be transmitted via other body fluids.

HBV

Over the last five years, rates of newly acquired HBV infections have steadily declined. Adolescent vaccine coverage is likely to have played a role in this decrease. However, it is currently estimated that between 90,000 and 160,000 people are chronically infected with HBV in Australia.¹ HBV can cause long term liver problems, including cirrhosis and liver cancer.

HCV

HCV has been Australia's most commonly notified infectious disease over the past decade. By the end of 2006, it was estimated that 271,000 people in Australia had been exposed to the hepatitis C virus, of whom 202,400 were living with chronic HCV infection. The number of new HCV infections in 2006 was estimated at 12,526.² HCV can also cause long-term liver problems, including cirrhosis and liver cancer. Unlike HBV, there is no vaccine for HCV.

HIV

By 31 December 2006 26,267 diagnoses of HIV infection had occurred in Australia. The number of new HIV diagnoses in Australia increased by 31% between 2000 and 2006.³ Advances in treatment for HIV have dramatically improved the health and life expectancy of people living with HIV. There is no vaccine for HIV.

As a prehospital care worker you may have already provided care to someone with a blood-borne virus (BBV). Many people with HBV, HCV and some people with HIV are unaware that they are infected. Prehospital care workers should have an accurate understanding of BBVs and the importance of infection control practices.

Transmission

Although HBV, HCV and HIV are all BBVs, the efficiency of transmission of each virus varies enormously. Transmission depends on many factors, including infectivity of the source (e.g. high viral load in blood or body fluids), first aid administered and the nature of exposure. The modes of transmission for HBV, HCV and HIV are summarised in Table 1.



Transmission of HBV, HCV and HIV

Exposure	HBV	HCV	HIV
Sexual contact (unprotected anal and vaginal sex)	Yes	Risk of transmitting HCV via sexual contact is considered to be extremely low but may occur if there is blood to blood contact during sex. Risk is higher if person is coinfecting with HIV.	Yes
Contaminated injecting equipment	Yes	Yes	Yes
Mother-to-child transmission	Yes	Yes	Yes
Non-sterile tattooing or body piercing	Yes	Yes	Yes
Needlestick injury	Yes	Yes	Yes
Blood transfusion in Australia	No (screening introduced in early 1970s)	No (screening introduced in 1990)	No (screening introduced in 1985)
Non-sterile vaccinations and medical procedures, particularly in countries with high prevalence	Yes	Yes	Yes
Saliva (through biting that breaks the skin)	Yes	No	No

Table 1

Natural history

HBV

The outcome of HBV infection is largely determined by the age of infection. Ninety per cent of HBV infections acquired during birth (perinatal infection) or early childhood will become chronic, compared to 5% if infected as an adult. Adults newly infected with HBV have a 50% chance of becoming ill and developing jaundice, however, a 90–95% chance of ‘clearing’ the virus.

People who do not clear the virus develop chronic HBV infection. The vast majority of people with chronic HBV infection remain asymptomatic for many years, however, may transmit the virus. The body’s response to the virus results in an increased risk of developing cirrhosis, liver failure and liver cancer during their lifetime.

HCV

HCV affects different people in different ways. The vast majority of people with HCV are asymptomatic during the initial (acute) phase of infection. However, for those who are symptomatic, common symptoms include fatigue, nausea, headaches, depression, upper abdominal pain and intolerance to fatty foods and alcohol. During the acute phase, levels of the virus in the blood rise dramatically until the body’s immune response starts producing antibodies. Although the immune response tries to clear the virus, 70–80% of people infected will develop a long-term (chronic) infection and may transmit the virus to others.⁴ Only a small proportion of people with chronic HCV will develop serious long-term liver problems such as cirrhosis, liver failure and liver cancer.⁵

HIV

HIV attacks the immune system and breaks down the body’s ability to fight disease and infection. Shortly after infection with HIV, most people experience flu-like symptoms, which may include fever, sore throat, and rash. Following this, people may be relatively asymptomatic for five to ten years, however, will then be at much higher risk of developing opportunistic infections and malignancies.⁶ If left untreated, HIV will lead to Acquired Immune Deficiency Syndrome (AIDS). AIDS develops when the immune system is no longer able to effectively fight disease and infection.

Treatment

HBV

The management of acute HBV is symptomatic care. Since most patients recover, antiviral therapy is not usually recommended. For treatment of chronic HBV, however, pegylated interferon, lamivudine and entecavir are all approved for use as initial antiviral therapy. Treatment is only commenced when there are indications of liver damage. The aims of treatment are to achieve prolonged suppression of HBV replication and to arrest (or reverse) the progression of liver damage, with the ultimate goal to prevent cirrhosis, hepatocellular carcinoma and liver failure. Combination therapy has proved highly beneficial in reducing drug resistance in HIV and it is likely that a similar scenario will emerge in HBV treatment. Therapy of chronic HBV is advancing at a rapid rate and treatment paradigms are constantly changing.¹

HCV

Antiviral treatment with pegylated interferon and ribavirin has considerably improved the rates of successful therapy for HCV over the last few years. This combination treatment can now achieve successful viral clearance in 50–60% of those treated and in some cases, depending on factors such as genotype and HCV viral load, this success rate may rise to over 80%.⁷ Other factors, such as age when infection occurred, alcohol use and the degree of liver fibrosis (which develops over decades), may also affect the response rate to therapy. These factors are considered on an individual basis during consultation with the prescribing doctor, and the decision to commence therapy is made by the patient and doctor taking into account the clinical, personal and lifestyle issues of the patient.^{8,9}

HIV

HIV can be managed through combination therapy with antiretroviral drugs. This involves using a number of different medications to suppress viral replication, consequently minimising the damage to the immune system and the progression to AIDS. The time for treatment commencement is a decision made by the patient in consultation with their monitoring doctor. Antiretroviral drugs have been very successful at reducing morbidity and mortality due to HIV infection. The quality of life and life-expectancy for people living with HIV have both increased dramatically due to advances in drug therapy.

Discrimination

HBV, HCV and HIV are highly stigmatised conditions and many people living with these viruses experience discrimination. In health care settings, non-standard infection control procedures, restriction of access to treatment (such as being placed last in the clinic or surgery queue) and breaches of confidentiality are all aspects of discrimination. Clear policies and practices that protect people's privacy and confidentiality and ensure the implementation of standard infection control are currently in place in all state and territory health departments, and are important elements in tackling discrimination in the health care setting. Education is also vital, enabling people to understand how HBV, HCV and HIV are transmitted and how to reduce the risk of transmission.¹⁰ It should be noted that the Australian Government and most states and territories prohibit discrimination against someone with a blood-borne viral infection. There are also statutory privacy protections regarding people's health status. HBV, HCV and HIV are all notifiable diseases, but the notification process maintains confidentiality (refer to contacts on pages 7 and 8 for more information).

Accurate non-judgemental language, combined with a concern for the patient's welfare, helps to build trust with a patient. Therefore, terms such as: addict, addiction, drug addict, drug abuse, drug abuser and intravenous should

be avoided. Instead, use the terms: drug use rather than drug abuse; reused equipment rather than shared equipment; new equipment rather than clean equipment; and injecting rather than intravenous. Injecting equipment covers more than just needles, and includes swabs, filters, water, tourniquets and syringes. When discussing drug use with the patient, it is best to ask about the presence of drug dependence or withdrawal symptoms, rather than addiction. Clarifying the meaning of any colloquial terms, or terms that you do not understand, facilitates more effective communication with patients.

Prevention, infection control and standard precautions

Standard precautions are recommended for the care and treatment of all patients, regardless of their perceived or confirmed infectious status, and in the handling of:

- Blood (including dried blood)
- All other body fluids, secretions and excretions (excluding sweat), regardless of whether they contain visible blood
- Non-intact skin
- Mucous membranes

All blood and body fluids of all patients should be considered potentially infectious. Effective infection control for communicable diseases lies in the application of standard precautions when caring for all patients. These include aseptic technique, hand washing, use of appropriate personal protective equipment including gloves and eye protection, as well as appropriate reprocessing of instruments and equipment.¹¹

Gloves and masks: Prehospital care workers should always wear single use gloves (that meet the AS/NZS 4011) appropriate to the task when it is likely that their hands will be contaminated with blood or body fluid or come into contact with mucous membranes. Hands should be washed before and after using gloves as the gloves may have defects or become damaged through use. Protective eyewear or face shields should always be worn where there is the potential for splashing, splattering or spraying of blood or other body substances.

Hand hygiene: Where practical, hands should be washed with soap pH friendly to skin before significant contact with any patient (which may include physical examination, emptying a catheter, undertaking venepuncture or delivery of an injection).¹² Hands should also be washed after activities likely to cause contamination, including handling equipment or instruments soiled with blood or other body substances, direct contact with body secretions or excretions, and toileting. Paper towels or single use cloth towels must be used to dry hands. If water is not available,

an alcohol based hand rub, gel or foam may be used.¹² It should be noted that in following standard precautions, it is never necessary to isolate a patient on the basis of presumed or known viral hepatitis or HIV-positive status. People with viral hepatitis or HIV are not required to disclose their status for infection-control purposes, or may not be aware of their BBV status. Where a person's status is known, there is no need for this to be disclosed to other health care workers to facilitate infection control. Infection control procedures are established and should be applied irrespective of knowledge of a person's serostatus to prevent possible exposure.

Handling and disposal of sharps: Sharps represent the major cause of accidents involving potential exposure to BBVs and must be handled with care at all times. An approved sharps container should be located as close as possible to the site of use to ensure safe disposal. Any object with the potential to cause a sharps injury, including, for example, glass ampoules and IV-giving set spikes, should be disposed of in such a container. Sharp instruments should not be passed by hand between health care workers. Where possible, use alternatives such as needleless IV systems, blunt needles for drawing up sterile solutions from ampoules and retractable needle and syringe systems. To prevent injury in the mobile environment, needles should not be resheathed but disposed of in a sharps container. They should not be broken or bent by hand, removed from disposable syringes or otherwise manipulated by hand.¹³



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Needlestick injury

The risk of HBV transmission through a needlestick injury from a person with HBV is between 6% and 30% (significantly higher than the risk of HCV and HIV transmission from a known positive source).¹⁴ The risk of HCV transmission through a needlestick injury from people who are both HCV antibody-positive and PCR-positive (meaning that the virus has been detected using a polymerase chain reaction test) is between 3% and 10%.¹⁴ The risk depends on the viral load of the source patient, the first aid administered and the instrument involved, for example a hollow bore needle. The risk of HIV transmission through a needlestick injury from a person with HIV is about 0.3%.¹⁴ In the event of a needlestick or other blood accident, the source (if known) should be approached regarding consent for HBV, HCV or HIV antibody testing.¹⁵

All prehospital care workers should have access to infection control guidelines that advise about the management of an occupational injury, including clear written instructions on the appropriate action to take in the event of a needlestick injury and other blood or body substance exposure. Prehospital care workers are encouraged to report occupational exposures immediately and all testing procedures and follow-up treatment should be fully documented. Confidentiality should be maintained.

In general, if an injury or incident occurs where blood or body substances come into contact with non-intact skin or membranes, the following action should be taken:¹⁶

- Wash exposed membrane or injury with soap and water (an antiseptic could also be used on the skin)
- If eyes have been exposed, thoroughly rinse the eyes with tap water or saline while open
- If mouth has been exposed, thoroughly rinse the mouth with water and spit out
- Seek medical advice immediately for assessment of the nature of the exposure, the risk of transmission of blood-borne viruses and the need for HIV or HBV post-exposure prophylaxis (PEP)
- If the exposure is significant and the source patient is known, his or her consent for HIV antibody, HCV antibody and HBsAg testing should be sought

For more information, contact the NSW Needlestick Injury Hotline on 1800 804 823. The Hotline is a free 24-hour service for health care and emergency services workers who require assistance following a needlestick injury or other occupational exposure.

Blood spills

Blood and body substance spills should be dealt with immediately or, in circumstances where procedures or urgent transport are under way, be attended to as soon as it is safe to do so. Standard precautions apply where there is any risk of contact with blood or body substance.

In the event of a blood spill, use gloves and carefully wipe up any blood with a paper towel, then wash the area with water and detergent. For larger spills, the use of granular formulations that contain the spilled material may be beneficial and also minimise the generation of aerosols. Where there is the possibility of blood or body substance remaining on a surface where cleaning is difficult (for example between tiles), a disinfectant may be used after the surface has been cleaned with detergent and water. It is considered unnecessary to use sodium hypochlorite (bleach) for managing spills. Suggested contents for a spills kit are outlined in Section 18 of *Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting 2004*.¹⁷ Dispose of bloodstained paper towel or other dressing as clinical waste.

Prehospital care workers

with HBV, HCV or HIV

All health care workers who perform exposure-prone procedures have an ongoing responsibility to know their HBV, HCV and HIV status, and should not perform exposure-prone procedures if there is evidence of current/active HBV, HCV or HIV infection, as there is a risk of transmission of infection.

An exposure-prone procedure is any in which there is a potentially high risk of BBV transmission from a health care worker to a patient during a medical procedure, such as any procedure with sharp hand-held instruments beneath the mucous membrane, or any procedure dealing with sharp pathology or bone spicules in a confined space or where visibility is poor. Exposure-prone procedures do not include non-invasive examinations or procedures, intact skin palpation, injections or venepuncture.¹⁷

For more information regarding the rights and responsibilities of health care workers with HBV, HCV or HIV, contact your state or territory's health department, your local Hepatitis C Council or AIDS Council, or your state or territory's Anti-Discrimination Board or Equal Opportunity Commission (see contacts on page 7).

Immunisation and post exposure prophylaxis

Immunisation is available for HBV and is recommended for all health care workers at risk of exposure to blood or body fluids.¹⁸ There are no vaccines for the prevention of HCV or HIV. However, there is evidence that a four week course of antiretroviral drugs (known as post-exposure prophylaxis or PEP), commenced as soon as possible within 72 hours of high risk exposure to HIV, can reduce the risk of HIV infection. PEP also exists for non-immune individuals with a HBV exposure, who should have HBV immunoglobulin administered as soon as possible within 72 hours of exposure. In addition, HBV vaccination should be injected at a separate site and a full course completed if there is uncertainty regarding their history of HBV vaccination. In the event that exposure to HIV or HBV occurs in a non-occupational setting, post-exposure prophylaxis (NPEP) is also available.

For more information on PEP and NPEP, including guidelines, refer to the ASHM website at www.ashm.org.au/pep-guidelines/ and the National code of practice for the control of work-related exposure to hepatitis and HIV (blood-borne) viruses.¹⁹

A brief overview of HBV, HCV and HIV

Virus type	Vaccination	Treatment	PEP
HBV	Yes	Antiviral therapy	Yes
HCV	No	Antiviral therapy	No
HIV	No	Antiretroviral therapy	Yes

Glossary of Terms

Antibody test – an initial screening blood test that looks for antibodies to the virus and not for the virus itself.

Cirrhosis – extensive and permanent scarring of the liver. Cirrhosis interferes with the normal functioning of the liver.

Combination therapy – the use of two or more types of antiviral and antiretroviral drugs in combination to achieve optimum results.

Exposure-prone procedure – any situation where there is a potentially high risk of blood-borne virus transmission from a health care worker to a patient during a medical or dental procedure. Any submucosal invasion with sharp hand-held instruments, or procedure dealing with sharp pathology/bone spicules, usually in a confined space or where visibility is poor.

Fibrosis – formation of scar tissue on the surface of the liver to replace normal tissue lost through injury or infection.

Non occupational post-exposure prophylaxis (NPEP) – PEP (see below) given to a person following an exposure outside of an occupational setting, e.g. sexual exposure, sexual assault or reuse of injecting equipment.

Polymerase chain reaction (PCR) – a laboratory technique that amplifies the genetic material of a virus to a level that can be detected. The presence or absence of the virus can then be determined.

Post-exposure prophylaxis (PEP) – drugs and/or vaccination given as soon as possible within 72 hours of exposure to HIV or HBV as an attempt to prevent infection.

Prehospital care worker – the term used in this document to refer to the whole spectrum of ambulance and other health care workers involved in prehospital care, including, for example, ambulance officers, paramedics, first aid officers, and patient transport officers.

Window period – the period immediately after a person is infected with an agent, during which the infection is not detectable by laboratory tests, although the person may be infectious.

References

- 1 Matthews G, Robotin M (eds). B Positive: all you wanted to know about hepatitis B - a guide for primary care providers. Sydney: Australasian Society for HIV Medicine and Cancer Council of NSW, (at press).
- 2 Hep C Projections Working Group October 2006.
- 3 National Centre in HIV Epidemiology and Clinical Research. HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2007. Sydney: National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, 2007.
- 4 Crofts, Dore, Locarnini (eds). Hepatitis C: An Australian Perspective. Melbourne: IP Communications, 2001.
- 5 Lin R, Barker J and Batey R. Chronic Hepatitis C, Hepatitis C: A Management Guide for General Practitioners, Aus Fam Phys 1999;28:28.
- 6 Bradford D, Hoy J, Matthews G (eds). HIV, viral hepatitis and STIs: a guide for primary care. Sydney: Australasian Society for HIV Medicine, (at press).
- 7 Hadziyannis SJ, Sette H, Morgan TR, et al for the PEGASYS International Study Group. Peginterferon-alfa 2a and ribavirin combination therapy in chronic hepatitis C. A randomized study of treatment duration and ribavirin dose. Annals of Internal Medicine, 2004;140: 346-355.
- 8 Crofts, Dore, Locarnini (eds). Hepatitis C: An Australian Perspective. Melbourne: IP Communications, 2001.
- 9 Sievert W, Korevaar D. Antiviral therapy for chronic hepatitis C, Hepatitis C: A Management Guide for General Practitioners, Aust Fam Phys 1999;28:40-45.
- 10 Anti-Discrimination Board of New South Wales. C-Change: Report of the enquiry into hepatitis C related discrimination. Sydney, Anti-Discrimination Board of NSW, 2001.
- 11 Communication with Tasmanian Ambulance Service, Clinical Practice and Education Unit, 3 May 2002.
- 12 NSW Health, Policy Directive 2007_036, Infection Control Policy. 23 May 2007. Accessed on 31 Aug 2007 at http://www.health.nsw.gov.au/policies/pd/2007/PD2007_036.html
- 13 Queensland Ambulance Service. Clinical Practice Manual, Infection Control Procedures. Brisbane: Queensland Ambulance Service, 2001.
- 14 Commonwealth of Australia 2004 Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting. Endorsed by the Communicable Diseases Network Australia, The National Public Health Partnership and the Australian Health Ministers' Advisory Council. Accessed on 14 January 2008 at <http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm>, Section 23, pp.3-4.
- 15 Ibid, Section 23, p.1.
- 16 Commonwealth of Australia 2004, op.cit., section 18.2.
- 17 Commonwealth of Australia 2004, op.cit., section 24.
- 18 Commonwealth of Australia 2004, op. cit., Section 23.
- 19 National Occupational Health and Safety Commission 2003. National code of practice for the control of work-related exposure to hepatitis and HIV (blood-borne) viruses. Commonwealth of Australia. Accessed on 14 January 2008 at <http://www.ascc.gov.au/ascc/aboutus/publications/NationalStandards/ListofNationalCodesofPractice.htm>

Contacts

Hepatitis C Councils and AIDS Councils can be contacted for further resources and support information:

Australia

Hepatitis Australia

Tel: 61 2 6232 4257
Fax: 61 2 6232 4318
Email: achinfo@hepatitisaustralia.com
Web: www.hepatitisaustralia.com

Australian Federation of AIDS Organisations

Tel: 61 2 9557 9399
Fax: 61 2 9557 9867
Web: www.afaoo.org.au

ACT Hep C Council

Tel: 61 2 6253 9999
Fax: 61 2 6257 1611
Email: info@acthepc.org
Web: www.acthepc.org

AIDS Action Council of the ACT

Tel: 61 2 6257 2855
Fax: 61 2 6257 4838
Web: aidsaction.org.au

The Hepatitis C Council of NSW

Tel: 61 2 9332 1853
1800 803 990 (NSW country)
Fax: 61 2 9332 1730
Email: hccnsw@hepatitisc.org.au
Web: www.hepatitisc.org.au

AIDS Council of NSW

Tel: 61 2 9206 2000
Fax: 61 2 9206 2069
Email: acon@acon.org.au
Web: www.acon.org.au

Hepatitis C Council of QLD

Tel: 61 7 3229 3767
1800 648 491 (Qld country)
Fax: 61 7 3236 0610
Email: reception@hepqld.asn.au
Web: www.hepatitisc.asn.au

Queensland AIDS Council

Tel: 61 7 3017 1777
Fax: 61 7 3844 4206
Email: info@quac.org.au
Web: www.quac.org.au

Hepatitis C Council South Australia

Tel: 61 8 8362 8443
1800 821 133 (SA country)
Fax: 61 8 8362 8559
Email: admin@hepccouncilsa.asn.au
Web: www.hepccouncilsa.asn.au

AIDS Council of South Australia

Tel: 61 8 8334 1611
Fax: 61 8 8363 1046
Email: information@acsa.org.au
Web: www.acsa.org.au

Tasmanian Council on AIDS Hepatitis and Related Diseases

Tel: 61 3 6234 1242
1800 005 900 (Tas country)
Email: mail@tascard.org.au
Web: www.tascahrd.org.au

Hepatitis C Council of Victoria

Tel: 61 3 9380 4644
1800 703 003 (Vic country)
Fax: 61 3 9380 4688
Web: www.hepcvic.org.au

Victorian AIDS Council

Tel: 61 3 9285 5382
Fax: 61 3 9285 5220
Email: info@glhv.org.au
Web: www.glhv.org.au

NT AIDS and Hepatitis Council

Tel: 61 8 8941 1711
Fax: 61 8 8941 2590
Email: info@ntahc.org.au
Web: www.ntahc.org.au

Hepatitis Council of WA

Tel: 61 8 9328 8216
1800 800 070 (WA country)
Email: info@hepatitiswa.com.au
Web: www.hepatitiswa.com.au

Western Australian AIDS Council

Tel: 61 8 9482 0000
Fax: 61 8 9482 0001
Email: waac@waaid.com
Web: www.waaid.com

New Zealand

The Hepatitis Foundation

Tel: 64 7 307 1259
Freecall: 0800 332 010 (in NZ)
Fax: 64 7 307 1266
Email: hepteam@hepfoundation.org.nz
Web: www.hepfoundation.org.nz

New Zealand AIDS Foundation

Tel: 64 9 303 3124
Fax: 64 9 309 3149
Email: contact@nzaf.org.au
Web: www.nzaf.org.nz

The following organisations can provide information and assistance regarding viral hepatitis, HIV and related issues:

Australasian Society for HIV Medicine

Tel: 61 2 8204 0700
Fax: 61 2 9212 2382
Email: ashm@ashm.org.au
Web: www.ashm.org.au

Australian Injecting and Illicit Drug Users League (AIVL)

Tel: 61 2 6279 1600
Fax: 61 2 6279 1610
Email: info@aivl.org.au
Web: www.aivl.org.au

Australian Drug Foundation

Tel: 61 3 9278 8100
Infoline: 1300 858 584
Email: adf@adf.org.au
Web: www.adf.org.au

Gastroenterological Society of Australia (GESA)

Tel: 61 2 9256 5454
Email: gesa@gesa.org.au
Web: www.gesa.org.au

HIV-Hepatitis-STI Education and Resource Centre

Tel: 03 9076 6993
Email: erc@alfred.org.au
Web: www.hivhepsti.info

Most states and territories provide information about their infection control guidelines and policies through their websites:

ACT Department of Health and Community Care

www.health.act.gov.au/publications

NSW Health Infection Control Policy

www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_036.pdf

Department of Health and Community Services - Northern Territory

www.nt.gov.au/health/

Queensland Health

www.health.qld.gov.au/infectioncontrol/

South Australian Department of Human Services

<http://www.health.sa.gov.au/Default.aspx?tabid=47>

Department of Health and Human Services Tasmania
www.dhhs.tas.gov.au/publichealth/communicablediseases/

**Victorian Department of Human Services,
Public Health Division**
Guidelines for the Control of Infectious Diseases
www.health.vic.gov.au/ideas

Health Department of Western Australia
www.health.wa.gov.au

**Information regarding discrimination can be
obtained from the following offices:**

**Human Rights & Equal Opportunity Commission -
Commonwealth**
Tel: 61 2 9284 9600

Anti-Discrimination Board of NSW
Tel: 61 2 9268 5544

Anti-Discrimination Commission - NT
Tel: 61 8 8999 1444

Anti-Discrimination Commission - QLD
Tel: 61 7 3247 0900

Equal Opportunity Commission - SA
Tel: 61 8 8207 1977

Anti-Discrimination Commission - TAS
Tel: 61 3 6224 4905

Equal Opportunity Commission - VIC
Tel: 61 3 9281 7100

Equal Opportunity Commission - WA
Tel: 61 8 9216 3900

Other ASHM resources, including the hepatitis C-related publications below, are available from the ASHM website: www.ashm.org.au/publications

Journal Supplements

- *General Practitioners and Hepatitis C*
- *Nurses and Hepatitis C*
- *Dental Health and Hepatitis C*

Fact sheet

- *Hepatitis C in Brief – a patient fact sheet*
- *HIV Positive – patient fact sheet*

Monographs

- *HIV/Viral Hepatitis and STIs: a guide for primary care (at press)*
- *HIV and hepatitis C: policy, discrimination, legal and ethical issues*
- *B Positive: all you wanted to know about hepatitis B – a guide for primary care providers (at press)*
- *Coinfection: HIV & Viral Hepatitis – a guide for clinical management*

Distance-learning kit

- *'Talking Together': Contemporary issues in Aboriginal and Torres Strait Islander health: HIV, hepatitis and sexual health*

Manual

- *Australasian Contact Tracing Manual, Edition 3 2006*

For additional copies of this resource contact:
Australasian Society for HIV Medicine Inc (ASHM)
LMB 5057 Darlinghurst NSW 1300
Tel: 61 2 8204 0700
Fax: 61 2 9212 2382
Email: resources@ashm.org.au
ABN 48 264 545 457

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