1. Plain language summary

Hepatitis C is a viral infection affecting approximately 1% of women of childbearing years. Hepatitis C is most commonly acquired following intravenous drug use, but is also more common in some immigrant groups and in some cases has been acquired medically. In 2016, effective treatments for Hepatitis C with cure rates of over 95% became readily available. For this reason, pre pregnancy screening of women for Hepatitis C should be considered so that treatment can be initiated and Hepatitis C cured prior to pted03.99057(ted07.00632(i)-i)-4

Recommendation 5	Grade and reference
As for all blood borne infections, it is recommended to bath the baby to remove any maternal body secretions and blood prior to IM injections e.g. vitamin K.	**Consensus-based**

2. Epidemiology

Worldwide, 71 million people are estimated to be living with Hepatitis C infection. [1]The incidence of Hepatitis C Virus (HCV) carriage in women of childbearing age is estimated to be 1-2 per cent, but may be as high as 80 per cent in high risk behaviour groups such as injecting drug users and blood product dependent patients. While the incidence of Hepatitis C is falling, the prevalence is increasing, with the major at-risk groups being; older patients (more commonly immigrants or who have acquired Hepatitis C medically), and younger patients (mostly due to intravenous drug use). While Hepatitis C does not have the same chronic disease burden as other viral infections in pregnancy such as HIV and Hepatitis B, 15-30% of untreated patients with Hepatitis C will develop cirrhosis within 20 years, and 27% of these subsequently develop hepatocellular carcinoma within 10 years. Hepatitis C is now the commonest cause for liver transplantation. Although there is not universal support for Hepatitis C screening in pregnancy[2], RANZCOG considers all women should be screened so that risk stratification (ie HCV RNA status) can be assessed and measures taken to reduce the risk to the woman, her baby and those caring for her. In addition, effective treatment is now available and should be offered postpartum to minimise risks to the woman and Mother-to-child transmission (MTCT) in future pregnancies.

3. Perinatal Transmission of Hepatitis C

Maternal HCV poses a small risk of vertical transmission of HCV to the newborn (approximately 5%), although the risk of vertical transmission is largely confined to those patients with maternal viraemia and/ or HIV co-infection.[3, 4] Only rarely has perinatal transmission been reported from HCV-RNA negative mothers. Children that contract HCV at birth are usually asymptomatic, but at risk of long-term liver disease.

Among women requiring an invasive procedure such as amniocentesis -2.997999(r)-10.9961(c)-2.98067(h)-3(

Recommendation 2	Grade and reference
It is recommended that individuals who are HCV positive have a PCR test for HCV RNA, as the risk of perinatal transmission is dependent on the presence of HCV RNA. Liver function tests should be performed at the time of checking HCV RNA status. As HIV co-infection increases the risk of transmission, HIV status should be ascertained if not already performed.	A

4. Intrapartum care

While transmission may be antenatal, peripartum infection appears to be most common with most neonates taking several weeks to become HCV RNA positive. Fetal scalp electrode placement has been associated with increased transmission rates and should be avoided[3], where possible.

Caesarean section is not recommended as a means of reducing perinatal transmission of Hepatitis C.

5. Postpartum care

As per all blood borne viral precautions, the baby should be bathed to remove any maternal body secretions and blood prior to IM injections e.g. vitamin K.

11. Patient information

A range of RANZCOG patient information pamphlets can be ordered via:

https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair and Board Member
Dr Gillian Gibson	Deputy Chair, Gynaecology
Dr Scott White	Deputy Chair, Obstetrics and Subspecialties Representative

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in June 1998 and was most recently reviewed in March 2020. The Women's Health Committee carried out the following steps in reviewing this statement:

Structured clinical questions were developed and agreed upon.

An updated literature search to answer the clinical questions was undertaken.

At the March 2020 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part ii).

ii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations