Human Papilloma Vaccine Schedule for Western Australia

The National Human Papilloma Virus (HPV) Vaccination Catch-up Program is a joint initiative between the Australian and Western Australian (WA) Governments under the National Immunisation Program. Vaccine is funded by the Commonwealth Government.

The Schedule
There are 2 components to the HPV catch-up program.
1. The school-based immunisation program will target girls aged between 12 and 18 years in 2007 and 2008. The program will commence in May 2007, with the vaccine offered through WA schools to girls in Years 10, 11 and 12. In 2008, the HPV vaccine will be offered to girls in Years 7, 8, 9 and 10. The HPV school immunisation schedule may vary in regional WA.
2. The GP and other immunisation providers program will target 18 to 26 year old women, and girls aged 12 to 18 years who did not receive any or all HPV vaccine doses through the school program. This program will run from July 2007 to June 2009. The HPV catch-up program will cease at the end of June 2009, and partially immunised females will not be eligible to receive further doses of funded HPV vaccine after this date.

At the completion of the HPV catch-up program, there will be an ongoing school-based immunisation program offered to females aged between 12 and 13 years of age.

(See the schedule overleaf).

The Vaccine
The Human Papilloma Virus (HPV) vaccine is GARDASIL®. It is administered intramuscularly, usually in the upper arm, as a series of 3 injections over a period of 4 to 6 months. The optimal recommended schedule is 0, 2 and 6 months.

If a shorter vaccination schedule is necessary, the accelerated HPV schedule based on minimum intervals is 0, 1 and 4 months. This schedule will be required for the 2007 school based program to enable 3 doses to be offered to girls during the school year. This schedule may also be required to ensure that the full 3 dose course of HPV vaccine is provided prior to cessation of the catch up program at the end of June 2009.

The vaccine has been shown to be effective if all 3 doses are given within 12 months. However, if doses cannot be completed within this time, it is not recommended to restart the course. Missed doses should be given as soon as is practicable.

GARDASIL® can be administered concomitantly in different injection sites with the routine vaccines listed on the National Immunisation Program.

This vaccine is not licensed for use in women older than 26 years of age.

Under the National HPV Vaccination Program the HPV vaccine is not funded for males.

National HPV Vaccination Register
A National HPV Vaccination Program Register is being developed by the Australian Government to collect data about the program. Personal information collected will be used to evaluate the impact of the HPV Vaccination Program on cervical cancer rates and to issue reminders if the course is incomplete. If your patient’s details are not included on the Register it will not be possible to contact her about missed doses.

Information will not be sought about your patient’s sexual history. Your patients can decline to have their details included on the HPV Register.

Data collection is a requirement for girls aged 12 to 18 years who may have received doses in the school-based program. Data collection is not a requirement for vaccinating females aged 18 to 26 years, however, the Register will accept data for females in this age group if they consent to have their details included.

This National Vaccination HPV Register is still in the early stages of development by the Australian Government. Information regarding this will be provided prior to the individual immunisation provider component of the program commencing in July 2007.

Information
- The Australian Government has produced separate fact sheets for parents and women, and an information sheet for health professionals, available at the Immunise Australia Program website at www.immunise.health.gov.au.
- The National Centre for Immunisation Research and Surveillance (NCIRS) have also produced a detailed information sheet for providers available at www.ncirs.usyd.edu.au.

Information about the National Cervical Screening Program is available on the Cancer Screening website at www.cancerscreening.gov.au.

**WA HPV Catch-up Immunisation Program Schedule May 2007 to June 2009**

Administer the recommended 3 dose Commonwealth funded HPV Vaccine as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Target Group</th>
<th>School Year or Age Group</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Female school students</td>
<td>Years 10, 11 and 12</td>
<td>School-based program; Start 2nd Term – May 2007</td>
</tr>
<tr>
<td></td>
<td>Adult females</td>
<td>18 to 26 year olds; 12 to 18 year olds that did not receive HPV vaccine at school</td>
<td>Opportunistic immunisation; GPs and immunisation providers from July 2007</td>
</tr>
<tr>
<td>2008</td>
<td>Female school students</td>
<td>Years 7, 8, 9 and 10</td>
<td>School-based program</td>
</tr>
<tr>
<td></td>
<td>Adult females</td>
<td>18 to 26 year olds; 12 to 18 year olds that did not receive HPV vaccine at school</td>
<td>Opportunistic immunisation until end of June 2009</td>
</tr>
<tr>
<td>2009</td>
<td>Females</td>
<td>Aged 12 to 26 that have not received HPV vaccine</td>
<td>Opportunistic immunisation until end of June 2009</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>Aged 12 to 13 year olds</td>
<td>Ongoing school-based program</td>
</tr>
</tbody>
</table>

**Updated National HIV Testing Policy (continued from page 3)**

- Health care workers have a professional obligation to know their HIV status if they are performing exposure-prone procedures (EPPs).
- Health care workers who have a confirmed positive HIV antibody test must not perform EPPs.
- Testing, and if appropriate, post-exposure prophylaxis, should be offered to health care workers following occupational exposure to blood or body substances, for example through a needlestick injury.

Influenza Vaccine 2007

The 2 influenza vaccines now available through the Commonwealth Government funded program are:
- CSL – Fluvax®
- Sanofi Pasteur – VAXIGRIP®

The 2007 Australian influenza vaccine strains are:
- A (H1N1): A/New Caledonia/20/99 (H1N1) - like strain
- A (H3N2): A/Wisconsin/67/2005 (H3N2) - like strain
- B: B/Malaysia/2506/2004 - like strain.

Influenza vaccine funded by the Commonwealth Government is available from the CSL distribution centre. Orders will be processed within a 2 day turn-around cycle. Only call CSL if you do not receive your order within this timeframe. This product will be labelled “government-funded program”.

Free influenza vaccine is available each year for:
- Non-Indigenous adults 65 years of age or older,
- Indigenous adults 50 years of age or older,
- Indigenous adults 15 to 49 years of age with a predisposing medical condition.

Influenza is also recommended but unfunded for the following groups:
- People less than 65 years of age with chronic medical conditions that predispose them to complications of influenza. These vaccines must be prescribed and are subsidised through the Pharmaceutical Benefits Scheme (PBS).
- High risk children (≥ 6 months of age) with chronic cardiac conditions, chronic suppurative lung disease and chronic illnesses requiring regular hospitalisation and intervention. Caregivers and household contacts of high risk children should also be vaccinated against influenza each year. Two doses of influenza vaccine, at least one month apart, are recommended for children aged less than 9 years of age who are receiving influenza vaccine for the first time. For further information and recommended doses refer to The Australian Immunisation Handbook 8th Edition (2003), p170. These vaccines must be prescribed, and are subsidised through the PBS.
- Health care providers and staff of nursing homes and long-term care facilities. This should be funded by their employer.

Updated National HIV Testing Policy

The updated National HIV Testing Policy 2006 provides valuable information for health care professionals involved in HIV testing, and has been revised in accordance with the changing epidemiology, technology and social context of the HIV epidemic in Australia. The Guiding Principles for HIV testing highlighted in the policy state that:
- Confidential voluntary testing with informed consent is fundamental to Australia’s HIV/AIDS response
- Testing is of the highest possible standard
- Testing is of benefit to the person being tested
- Testing is accessible to all at risk of HIV infection
- Testing is critical to understanding the epidemiology of HIV infection in the community;
- Testing is critical to interruption of transmission.

The policy includes sections on:
- indications for HIV testing
- pre- and post-test discussions (previously referred to as pre- and post-test counselling)
- surveillance and research
- Aboriginal and Torres Strait Islander people
- post-exposure prophylaxis
- quality assurance and HIV testing
- short incubation (rapid) tests for HIV and home-based (self) testing in Australia
- funding for HIV testing
- Human T-Cell Lymphotropic Virus (HTLV) testing. The rationale for this inclusion is that HTLV is a retrovirus similar to HIV that is also blood-borne.

Antenatal Testing

For the first time this policy also includes an offer of routine antenatal testing to all women; and an outline of the ethical responsibilities of health care workers performing exposure prone procedures. Key points are provided below:
- HIV testing should be routinely offered to all women antenatally.
- Antenatal testing must only be performed with the informed consent of the woman. Routine HIV testing without consent is not supported.
- All women contemplating pregnancy or seeking antenatal care should be made aware of the benefits of diagnosis of HIV infection and management, and of prevention strategies available for both the mother and the infant.
- Women should receive information (in written and other formats) outlining the tests that will be offered antenatally. The testing procedure should be explained to each woman by a team member involved in her antenatal care. Health care workers in antenatal settings should be

(continued on page 2)
HIV Notification in Western Australia

Figure 1. Number of notifications for HIV in persons infections, WA residents, 2002 to 2006.

There has been an increase in HIV notifications over the last 2 years, with 51, 64 and 70 cases notified in 2004, 2005 and 2006 respectively. Other Australian states have observed similar increases in HIV notifications.

Of the 70 HIV cases reported in 2006, there were 51 males and 19 females. The 70 cases comprised 64 non-Aboriginal cases (crude rate 3.5 cases/100,000 population) and 6 Aboriginal cases (crude rate 9.1 cases/100,000).

The number of Aboriginal cases notified per year has remained stable (4 year average is 6 cases/year). In 2006, there were 6 Aboriginal cases (4 females and 2 males). Of the 4 females, 3 reported heterosexual exposure and 1 intravenous drug use (IDU) exposure. Of the 2 male Aboriginal cases, 1 case reported heterosexual exposure and the other reported sex with another male (MSM). These proportions of exposures among Aboriginal cases are consistent with the previous 4 years when 73%, 15%, and 12% of 26 cases reported heterosexual, IDU and MSM exposure respectively.

There has been an increase in HIV notifications among the non-Aboriginal population (see Figure 1). Compared to Aboriginal cases, MSM exposure is a major exposure reported in the non-Aboriginal population, although the main increase in numbers and proportion of notifications has been in the heterosexual exposure group.

Of the 64 non-Aboriginal cases for 2006, there were 16 female cases and 48 males cases. These cases included 37% (n=22) with MSM exposure and 56% (n=38) with heterosexual exposure. This is in contrast to the 2002 to 2005 period, when 53% of cases reported MSM exposure and 36% reported heterosexual exposure. There were also 3 non-Aboriginal cases reporting an MSM/IDU exposure in 2006, and 1 unknown exposure. Of the non-Aboriginal heterosexual cases, 14 (21% of total) were female and 22 (34% of total) were male. The MSM exposure group (24 cases) in 2006 reported mainly acquiring their infection in Australia (75%), consistent with previous years. Of the male heterosexual cases, 60% reported acquiring their infection overseas and many had travelled to SE Asia (41%), again consistent with previous years. Of the 14 cases of female heterosexual exposure, 50% acquired their infection in Australia and 36% were “migrants with pre-existing illness”.

These changes provide further challenges in developing HIV prevention strategies, especially as the male heterosexuals are also acquiring their infections overseas.

Patients should be offered HIV testing routinely if they have reported an at-risk exposure such as a heterosexual exposure overseas (particularly in South-East Asian countries) or had unprotected sex between males.