Department of Health
Western Australian Hepatitis B Strategy

2019–2023
The Western Australian Hepatitis B Strategy 2019–2023 builds on the strengths and progress from our previous strategies, and is closely aligned to the Third National Hepatitis B Strategy 2018-2022. This strategy outlines a coordinated and comprehensive state-wide response to the impact of hepatitis B on target populations in Western Australia (WA).

The number of unspecified hepatitis B notifications in WA has remained relatively low over the past four years. Nevertheless, unvaccinated people from countries with a high to intermediate prevalence of hepatitis B remain at greater risk of acquiring the hepatitis B infection. Unspecified hepatitis B notifications among Aboriginal people, particularly in regional and remote WA, are also more than three-times higher compared to non-Aboriginal people, based on epidemiological data from 2017.

The WA Hepatitis B Strategy 2015-2018 set a target of achieving and maintaining vaccination rates of 95% or above in children. This target has been successfully met; with a high uptake of the hepatitis B vaccination for children by the age of 24 months. The WA Department of Health continues to fund hepatitis B vaccines for high-risk adults.

In July 2015, the process for prescribing hepatitis B medicines through the Pharmaceutical Benefits Scheme (PBS) under the Highly Specialised Drugs Program was streamlined, allowing accredited general practitioners to prescribe hepatitis B medicines in WA. There are currently 30 general practitioners accredited as hepatitis B prescribers in WA.
The goals and targets of the *WA Hepatitis B Strategy 2019–2023* have been based on those detailed in the *Third National Hepatitis B Strategy 2018-2022*. It is imperative that a consistent set of goals and targets are committed to across the nation, with local actions proposed to meet these targets, and ultimately reach the goals.

In 2016, the Australian Government endorsed the *Global Health Sector Strategy on Viral Hepatitis 2016-2025*, which proposed to globally eliminate viral hepatitis (hepatitis B and hepatitis C) as a major public health threat by the year 2030. The actions within this strategy will not only aim to achieve the goals set for WA, but also to best equip us to contribute towards the national and global elimination targets. These actions are driven by our focus on achieving significant progress towards eliminating hepatitis B as a public health threat. The personal and social impact of hepatitis B among affected target populations must also be minimised, including the elimination of the negative impact of stigma, racism, discrimination, and legal and human rights issues affecting the health of people living with hepatitis B.

As we move forward, it is crucial that we implement this strategy with inspiration from our strong collegial work with the health professionals, government departments, community and public health organisations, researchers and members of our communities affected by hepatitis B in WA. The key motivation for our work here, nevertheless, must be the optimum health and wellbeing of these communities. I look forward to seeing the positive outcomes of this strategy over the next four years.

Honourable Roger Cook MLA
Minister for Health
Western Australian Hepatitis B Strategy
2019–2023

Strategy at a glance

Goals
1. Make significant progress towards eliminating hepatitis B as a public health threat.
2. Reduce transmission of and the mortality and morbidity caused by hepatitis B.
3. Minimise the personal and social impact of hepatitis B.
4. Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on the health of people living with hepatitis B.

Targets
1. Achieve and maintain hepatitis B childhood vaccination coverage of 95% at 12 and 24 months.
2. Reduce the number of newly acquired hepatitis B infections across all age groups by 50%, with a focus on priority populations.
3. Increase the proportion of people living with chronic hepatitis B who are diagnosed to 80%.
4. Increase the proportion of people living with chronic hepatitis B receiving care to 50%.
5. Increase the proportion of people living with chronic hepatitis B who are receiving antiviral treatment to 20%.
6. Reduce hepatitis B attributable mortality by 30%.
7. Reduce the reported experience of stigma among people living with hepatitis B, and the expression of stigma, in respect to hepatitis B status.

Key actions
1. Improve hepatitis B related health literacy and access to the hepatitis B vaccination and other preventative measures among priority populations.
2. Develop partnerships to improve service coordination through sharing information and resources.
3. Increase access to routine and opportunistic testing.
4. Increase the number of people living with chronic hepatitis B on treatment and engaged in care.
5. Improve management and treatment of hepatitis B.
6. Improve the awareness, knowledge and skills of healthcare professionals in relation to management of hepatitis B.
7. Develop shared care models to better support new prescribers through linkages with experienced prescribers including the use of telehealth where required in regional and remote areas.
8. Monitor and address stigma and discrimination that impacts on the health-seeking behaviour of priority populations and their access to testing and treatment services.
9. Provide patients and consumers with information about their rights and responsibilities in relation to hepatitis B prevention, testing, treatment and care.
10. Identify research and surveillance gaps related to hepatitis B including barriers to vaccination, testing, treatment and care.

Priority populations
- people living with hepatitis B
- culturally and linguistically diverse people
- Aboriginal people
- children born to pregnant women living with hepatitis B
- other unvaccinated adults at higher risk of infection.
Other related strategies

- *Humanitarian Entrant Health Service – policies and information*
- *National Drug Strategy 2017–2026*
- *Third National Hepatitis B Strategy 2018–2022*
- *Western Australian Aboriginal Health and Wellbeing Framework 2015–2030*
- *Western Australian Aboriginal Sexual Health and Blood-borne Virus Strategy 2019–2023*
- *Western Australian Alcohol and Drug Interagency Strategy 2018–2022*
- *Western Australian Country Health Service Aboriginal Health Strategy 2018–2023 (to be published)*
- *Western Australian Health Aboriginal Workforce Strategy 2014–2024*
- *Western Australian Hepatitis C Strategy 2019–2023*
- *Western Australian HIV Strategy 2019–2023*
- *Western Australian Immunisation Strategy 2016–2020*
- *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*
- *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018–2025 (to be published)*
- *Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018–2025*
- *Western Australian Methamphetamine Action Plan*
- *Western Australian Sexually Transmissible Infections Strategy 2019–2023*
- *Western Australian Youth Health Policy 2018–2023*
- *World Health Organisation (WHO) Global Health Sector Strategy on Viral Hepatitis 2016–2021*
List of acronyms

Consistent list of terms across the suite of sexually transmissible infections and blood-borne virus strategies 2019–2023

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<th>Full Form</th>
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<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Services</td>
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<td>ACIR</td>
<td>Australian Childhood Immunisation Register</td>
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<td>AHCWA</td>
<td>Aboriginal Health Council of WA</td>
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<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
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<tr>
<td>AHS</td>
<td>Aboriginal Health Service</td>
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<td>AHW</td>
<td>Aboriginal health worker</td>
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<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AMR</td>
<td>antimicrobial resistant</td>
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<tr>
<td>ANSPS</td>
<td>Australian Needle and Syringe Program Survey</td>
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<td>APNA</td>
<td>Australian Primary Health Care Nurses Association</td>
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<tr>
<td>ART</td>
<td>antiretroviral treatment</td>
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<tr>
<td>ASHM</td>
<td>Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine</td>
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<tr>
<td>AOD</td>
<td>alcohol and other drug</td>
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<tr>
<td>BBV</td>
<td>blood-borne virus</td>
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<tr>
<td>BBVSS</td>
<td>Blood-borne Viruses and Sexually Transmissible Infections Standing Committee</td>
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<tr>
<td>CALD</td>
<td>culturally and linguistically diverse</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CDCD</td>
<td>Communicable Disease Control Directorate</td>
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<tr>
<td>CLAI</td>
<td>condomless anal intercourse</td>
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<tr>
<td>CSRH</td>
<td>Centre for Social Research in Health</td>
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<tr>
<td>DAA</td>
<td>direct-acting antiviral</td>
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<tr>
<td>GDHR</td>
<td>Growing and Developing Health Relationships</td>
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<tr>
<td>GIPA</td>
<td>greater involvement of PLWH</td>
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<tr>
<td>GP</td>
<td>general practitioner</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<tr>
<td>HPV</td>
<td>human papillomavirus</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>HTLV1</td>
<td>human T-cell lymphotropic virus type 1</td>
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<tr>
<td>LASH</td>
<td>WA Law and Sex Worker Health</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender and Intersex</td>
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<tr>
<td>MIPA</td>
<td>meaningful involvement of PLWH</td>
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<tr>
<td>MSM</td>
<td>men who have sex with men</td>
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<tr>
<td>NCHECR</td>
<td>National Centre in HIV Epidemiology and Clinical Research</td>
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<tr>
<td>NGO</td>
<td>non-government organisation</td>
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<tr>
<td>NHVPR</td>
<td>National Human Papillomavirus Vaccination Program Register</td>
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<tr>
<td>NiPHC</td>
<td>Nursing in Primary Health Care</td>
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<td>NSP</td>
<td>needle and syringe program</td>
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<td>NSEP</td>
<td>needle and syringe exchange program</td>
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<tr>
<td>OTP</td>
<td>opioid treatment programs</td>
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<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>PEP</td>
<td>post exposure prophylaxis</td>
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<td>PGCPs</td>
<td>Perth Gay Community Periodic Survey</td>
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<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
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<tr>
<td>PIS</td>
<td>Patient Information System</td>
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<tr>
<td>PLWH</td>
<td>people living with HIV</td>
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<td>POCT</td>
<td>point-of-care testing</td>
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<tr>
<td>PrEP</td>
<td>pre-exposure prophylaxis</td>
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<td>PWID</td>
<td>people who inject drugs</td>
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<td>RDT</td>
<td>Rapid diagnostic test</td>
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<td>RNA</td>
<td>ribonucleic acid</td>
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<td>RSE</td>
<td>relationships and sexuality education</td>
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<td>RTO</td>
<td>Registered Training Organisation</td>
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<tr>
<td>SASA</td>
<td>Structured Administration and Supply Arrangement</td>
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<tr>
<td>SHBBVP</td>
<td>Sexual Health and Blood-borne Virus Program</td>
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<tr>
<td>SiREn</td>
<td>WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network</td>
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<tr>
<td>SMS</td>
<td>short message service</td>
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<tr>
<td>STI</td>
<td>sexually transmissible infection</td>
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<tr>
<td>s100</td>
<td>section 100</td>
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<tr>
<td>TAFE</td>
<td>Technical and Further Education</td>
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<tr>
<td>TasP</td>
<td>treatment as prevention</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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Clarifications

* This strategy uses the terms ‘regional’ and ‘remote’ which applies to all non-metropolitan areas in Western Australia (WA).

* The WA health system uses ‘Aboriginal’ rather than ‘Aboriginal and Torres Strait Islander’ or ‘Indigenous’ in all forms of communication. The use of the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition of the Aboriginal people as the original inhabitants of WA. No disrespect is intended to our Torres Strait Islander colleagues and community. Where referenced documents use the term Aboriginal and Torres Strait Islander, that term is used instead.

* ‘Aboriginal Health Service’ (AHS) refers to all health and medical services targeting Aboriginal people including government-run health services and Aboriginal Community Controlled Health Services (ACCHS).

* ‘Chronic’ refers to diagnosis of infection lasting longer than six months.

* ‘Newly acquired’ refers to evidence of infection having been acquired in the 24 months prior to diagnosis.

* ‘Unspecified’ refers to infections of unknown duration.
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Why is this strategy needed?

Snapshot of hepatitis B in Western Australia

What is hepatitis B?
Hepatitis B is a disease that affects the liver and is caused by a virus that can be passed on when infected blood enters another person’s bloodstream. It is mainly spread through direct contact with infected blood and blood products, but it can also be spread through other body fluids including semen and vaginal fluids. A pregnant mother can also pass hepatitis B to her baby during birth or soon after.

Risk behaviours for the transmission of hepatitis B include sharing injecting equipment, unprotected sex, tattooing and body piercing using unsterile equipment, and sharing personal hygiene items such as razors, toothbrushes and dental floss.

How is hepatitis B prevented?
A vaccine for hepatitis B is available. Since 2000, every baby born in Australia has been eligible to receive a free vaccine at birth and further doses at 2, 4 and 6 months. The Australian Immunisation Handbook recommends vaccination for other people at risk of infection including sexual and household contact of people with chronic hepatitis B, people with human immunodeficiency virus (HIV), Aboriginal people, people who inject drugs (PWID), sex workers and men who have sex with men.¹

What health issues can it cause?
Most adults recover completely from hepatitis B and they cannot get it again. However, some people, and most babies with hepatitis B, will go on to develop a chronic infection. People with chronic hepatitis B can develop serious liver diseases including liver failure and liver cancer.

How is it managed?
There is treatment available for chronic hepatitis B that can reduce the progress of liver damage and loss of liver function. It will generally consist of oral antiviral therapy, which needs to be taken on a long-term basis. People with chronic hepatitis B should be monitored regularly by their general practitioners (GP) for signs and symptoms of liver disease.

Vaccination
In 2018, 93.88% of children in WA were fully immunised for hepatitis B at 12 months and 96.09% were fully immunised for hepatitis B at 24 months.²
New diagnoses

The number of newly acquired (evidence of the disease having been acquired in the 24 months prior to diagnosis) hepatitis B notifications in WA in 2017 (n = 20), was 30% lower than the 2012 to 2016 five-year average of 28 notifications per year, and represented 4% of total hepatitis B notifications in 2017. Approximately 71% of newly acquired hepatitis B cases reported no history of injecting drug use, while 18% reported a history of injecting drug use in the previous two years.

Prevalence

In 2016, an estimated 24,183 people in WA (0.94% of the total population) were living with chronic hepatitis B (positive for hepatitis B surface antigen HBsAg). In 2017, 37% of unspecified hepatitis B (infections of unknown duration) notifications in WA were among people who were born overseas and had acquired the infection overseas (primarily in Northeast and Southeast Asia), and 6% of unspecified hepatitis B notifications were among Aboriginal people.

Treatment and care

In 2016, an estimated 7.8% of people living with chronic hepatitis B in WA were engaged in care and 4.3% were receiving antiviral treatment.

There is limited data available on the uptake of diagnostic testing.
Progress under the last strategy

The **WA Hepatitis B Strategy 2015–2018** set a target of achieving and maintaining vaccination rates of 95% or above in children. Hepatitis B vaccination rates have improved throughout the term of the strategy, with a significant increase in hepatitis B vaccination rates among infants aged 12 months and the target achieved for infants aged 24 months. In 2017, the hepatitis B vaccination rate among infants aged 12 months was 93.88% (2010–2014 average: 90.8%) and among infants aged 24 months was 96.09% (2010–2014 average: 90.5%).

Hepatitis B testing rates initially saw a decrease by 6% from 2010 to 2014 (45.3 to 39.5 tests per 1000 population respectively). However, testing rates then saw a significant increase by 32% from 2015 to 2018 (42.5 to 56.2 tests per 1000 population respectively).

In July 2015, improvements were made to the way some PBS medicines under the Highly Specialised Drugs Program can be prescribed. The process for prescribing hepatitis B medicines has been simplified, allowing GPs who have been accredited by the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), are approved by the WA health system and maintain continuing professional development in hepatitis B treatment and care to prescribe hepatitis B medicines in WA. Since the improvements, there have been 30 GPs recruited as hepatitis B prescribers in WA.

A number of community-based initiatives have been implemented to increase awareness of hepatitis B among priority populations and to continue providing education and support services for the hepatitis B affected community. Initiatives included peer-based outreach programs, vaccinations and educational workshops.

Multilingual resources were produced on testing and treatment for those at risk or affected by hepatitis B and displayed at stalls at various multicultural events. Workshops focusing on educating those living with hepatitis B about healthy eating and liver health were also run.
The Guiding Principles for this strategy reflect those in the *Third National Hepatitis B Strategy 2018–2022*, adapted for the Western Australian context.

1. **Meaningful involvement of priority populations**
   People living with or at risk of hepatitis B should be central to the public health response to hepatitis B, and along with other priority populations should have meaningful participation in the development, implementation, monitoring and evaluation of effective programs and policies.

2. **Human rights**
   People living with hepatitis B, or those at risk of hepatitis B, have the right to live without stigma and discrimination. It is vital to safeguard the human rights of priority populations so as not to face stigma and discrimination based on their actual or perceived health status, cultural background, socio-economic status, age, sex, sexual or gender orientation or identity. They have the same rights to comprehensive and appropriate information and health care as other members of the community, including the right to the confidential and sensitive handling of personal and medical information.

3. **Access and equity**
   Health and community care in WA should be accessible to all, based on need. The multiple dimensions of inequality should be addressed, whether related to gender, sexuality, disease status, drug use, occupation, socio-economic status, migration status, language, religion, culture or geographic location, including in custodial settings. Health and community services should be welcoming and should work towards increasing access for priority populations.

4. **Health promotion**
   All actions related to the prevention of hepatitis B transmission, the provision of clinical and diagnostic services, and ongoing support and care for those at risk of or living with hepatitis B should reflect the Ottawa Charter for Health Promotion.\(^5\)

5. **Prevention**
   The transmission of hepatitis B can be reduced through the appropriate combination of evidence-based biomedical, behavioural and social approaches within a supportive and enabling environment. Education and prevention programs, together with access to the means of prevention, will be vital going forward, to achieve the targets set within this strategy.
6. **Quality health services**

Supporting and coordinating a multidisciplinary workforce of motivated, trained and informed health professionals, community and peer-based workers and volunteers is essential in delivering culturally secure and high-quality services for priority populations across WA. Health service delivery should respond to new technologies and best practice in models of care for those living with or at risk of hepatitis B.

7. **Harm reduction**

Harm reduction approaches strengthen effective measures to prevent the transmission of hepatitis B and minimise the health and social burden of hepatitis B in the community. Approaches include needle and syringe programs (NSPs), alcohol and other drug (AOD) treatment programs, counselling and mental health support, and measures to address social determinants of health.

8. **Shared responsibility**

Individuals and communities are empowered when they can prevent themselves and others from acquiring hepatitis B. Government and community organisations have a shared responsibility to address education and support needs through the provision of resources and supportive environments that facilitate priority population led prevention action.

9. **Commitment to evidence-based policy and programs**

The response to hepatitis B in WA has been built on a strong evidence base, informed by high-quality research and surveillance, monitoring and evaluation. With new research findings, it will be essential to refine the evidence base in order to meet new challenges, evaluate current and new interventions, and to develop effective social policy and clinical guidelines.

10. **Partnership**

Effective and collaborative partnerships between priority populations, health services, community organisations, the clinical workforce, researchers and government are fundamental to the response to hepatitis B and to achieve the goals and targets set out in this strategy. A partnership approach is characterised by consultation, cooperative effort, clear roles and responsibilities, meaningful contributions, empowerment, respectful dialogue and appropriate resourcing and leadership in order to achieve the goals and targets within this strategy.
The goals and targets presented in this strategy are aligned with the goals and targets detailed within the *Third National Hepatitis B Strategy 2018–2022*. It is imperative that a consistent set of goals and targets are committed to across the nation, with local actions proposed to meet these targets, and ultimately reach the goals.

**Goals**

1. Make significant progress towards eliminating hepatitis B as a public health threat.
2. Reduce transmission of and mortality and morbidity caused by hepatitis B.
3. Minimise the personal and social impact of hepatitis B.
4. Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on the health of people living with hepatitis B.

**Targets – by 2023**

1. Achieve and maintain hepatitis B childhood vaccination coverage of 95% at 12 and 24 months.
2. Reduce the number of newly acquired hepatitis B infections across all age groups by 50%, with a focus on priority populations.
3. Increase the proportion of people living with chronic hepatitis B who are diagnosed to 80%.
4. Increase the proportion of people living with chronic hepatitis B receiving care to 50%.
5. Increase the proportion of people living with chronic hepatitis B who are receiving antiviral treatment to 20%.
6. Reduce hepatitis B attributable mortality by 30%.
7. Reduce the reported experience of stigma among people living with hepatitis B, and the expression of stigma, in respect to hepatitis B status.
Australia signs on to global elimination targets

In 2016, the Australian Government endorsed the *Global Health Sector Strategy on Viral Hepatitis, 2016–2021,* which proposed targets to globally eliminate viral hepatitis (hepatitis B and hepatitis C) as a major public health threat by the year 2030.

**Global targets**

**By 2020**
- 30% reduction in new cases
- 10% reduction in the number of hepatitis-related deaths.

**By 2030**
- 90% reduction in new cases
- 65% reduction in hepatitis-related deaths.

The actions within this strategy not only aim to achieve the goals set for the state of WA, but also to best equip WA to contribute towards national and global elimination targets.
People living with hepatitis B

The prevalence of chronic hepatitis B in WA remains low with 0.94% of the total population of WA living with chronic hepatitis B in 2016. However, there are groups of people more affected by hepatitis B.

Key subpopulations of people living with hepatitis B include those who are:

- from countries with an intermediate or high prevalence of hepatitis B
- Aboriginal
- pregnant
- children
- PWID or with a history of injecting drug use
- also living with hepatitis C and/or HIV
- also living with hepatitis D
- in, or previously in, custodial settings.

People from culturally and linguistically diverse backgrounds

Unvaccinated people from culturally and linguistically diverse (CALD) backgrounds from countries with an intermediate to high prevalence of hepatitis B (primarily countries within the Asia-Pacific region) are at greater risk of acquiring hepatitis B infection.

Aboriginal people

In WA, the hepatitis B notification rate in the Aboriginal population in 2017 was more than three times higher compared to non-Aboriginal people. Aboriginal people, especially in regional and remote areas, face a lack of access to culturally secure prevention, testing and treatment services. Together with the *WA Aboriginal Sexual Health and Blood-borne Virus Strategy 2019–2023*, initiatives within this strategy will aim to engage, educate and support Aboriginal people living with or at risk of hepatitis B.
Children born to pregnant women living with hepatitis B

Babies born to mothers with hepatitis B have a more than 90% chance of developing a chronic hepatitis B infection if they are not managed at birth. Hepatitis B is vaccine preventable, and every baby born in Australia is eligible for a free vaccine. If babies born to pregnant women living with hepatitis B correctly receive the vaccine and hepatitis B immune globulin, they are more than 90% likely to be protected against a hepatitis B infection.

Other unvaccinated adults at higher risk of infection

If hepatitis B is untreated it can lead to liver scarring (cirrhosis), liver cancer or even death. However, hepatitis B is completely vaccine preventable. All adults at higher risk of a hepatitis B infection are highly encouraged to receive a hepatitis B vaccination to prevent the likelihood of a chronic hepatitis B infection.

Key sub-populations of other unvaccinated adults at higher risk of infection include those who are:

- partners or other household and intimate contacts of people living with hepatitis B
- PWID
- Gay and bisexual men, and men who have sex with men (MSM)
- sex workers
- in custodial settings
- living with HIV and/or hepatitis C.
Evidence to support the action areas

Consultation undertaken

The Sexual Health and Blood-borne Virus Program (SHBBVP) undertook consultations between August and November 2018 to inform the development of the *WA Sexual Health and Blood-borne Virus Strategies 2019–2023*. The consultations were conducted via an online survey and nine face-to-face workshops held in Perth and regional areas of WA.

Various online platforms were used to promote the consultations including social media, websites, e-newsletters and via email.

Online survey

The online survey opened on 1 August 2018 and closed on 31 October 2018. Data was collected through SurveyMonkey with a total of 103 responses received. The majority of participants (85%) identified as health professionals while community members represented 16%. Some respondents selected more than one category. Health professionals who completed the survey were from state government organisations, non-government organisations (NGOs), universities or research-based organisations, local governments, Aboriginal health organisations and private organisations. Most participants were based in metropolitan Perth (62%), followed by regional WA (24%) and remote WA (14%).

Metropolitan consultations

There were two face-to-face consultations held in Perth in early September 2018 facilitated by an external consultant, Tuna Blue. Data was collected through software that allowed for real-time responses from participants as each of the strategies were discussed. The 41 participants attending the consultations represented hospitals, health consumers, prisons, NGOs, AHSs, affected communities, education and research institutes.

Regional consultations

The regional consultations were facilitated by SHBBVP staff in all WA Country Health Service (WACHS) regions including the South West, Goldfields, Wheatbelt, Pilbara, Midwest, Great Southern and the Kimberley. Regional sexual health coordinators and NSP coordinators were contacted to assist with arranging the consultation workshops and existing networks were utilised where possible such as Aboriginal Health Planning Forum Sexual Health subcommittees. Data was collected by SHBBVP staff and categorised into each of the priority action areas as they were discussed. Over the seven regional workshops, a total of 79 participants attended with representation from state government organisations, NGOs, health networks, family support services, local government, AHSs and research institutes.
Once data collection was completed, the responses were analysed to inform the development of the *WA Sexual Health and Blood-borne Virus Strategies 2019–2023*.

### Consultation findings

Through these consultations, you told us that:

- There is a need to improve community health literacy to deliver optimum health outcomes for people living with and/or at risk of acquiring hepatitis B.
- There is value in enhancing health services targeting people living with and/or at risk of acquiring hepatitis B.
- It is important to share knowledge and create partnerships between multicultural organisations, communities, researchers and primary and tertiary healthcare providers.
- The success in achieving high rates of antenatal screening and neonatal vaccination coverage must be maintained.
- It is imperative that access to hepatitis B testing and treatment increases among priority populations.
- Work must continue to improve access to harm reduction initiatives for all priority populations.
- It is important to identify barriers, gaps and opportunities to improve health outcomes for people living with and/or at risk of acquiring hepatitis B.
- There is a need to support initiatives such as:
  - nurse-led models of care for management of hepatitis B
  - utilising Aboriginal health practitioners
  - increasing the scope of Aboriginal health workers (AHW).

### Evidence to support actions

#### Prevention and education

- Interventions aimed at improving skills of individuals with low health literacy can lead to increased immunisation rates.7
- Hepatitis B related knowledge gaps were identified among people with chronic hepatitis B. Interventions should focus on improving knowledge of people with limited English ability and low levels of academic education.8
- In WA, there was a significant decline in hepatitis B prevalence among Aboriginal birthing mothers after hepatitis B vaccination programs were introduced.9
Testing and diagnosis

- Studies conducted in Chinese and Vietnamese communities in Victoria showed that improving awareness of the link between chronic hepatitis B and liver cancer would motivate people to seek hepatitis B testing. However, the perception that hepatitis B is not of significant concern in Australia compared to China and Vietnam acted as a barrier to testing, along with reliance on their GPs to keep them informed about the testing.\textsuperscript{10,11}

- Developing a broader model of contact tracing is recommended as a significant number of people with chronic hepatitis B in Australia are not engaged in regular clinical monitoring.\textsuperscript{12}

Disease management and clinical care

- A nurse-led hepatitis B clinic can bring benefits in improving access and providing good patient outcomes.\textsuperscript{13}

- Communities can be supported to reduce language barriers and changing expectations of people living with chronic hepatitis B.\textsuperscript{14}

Workforce development

- Workforce development is vital for implementation of an effective public health response to hepatitis B.\textsuperscript{14}

- Given the long-term nature of chronic hepatitis B treatment, there is support to develop a shared care model for hepatitis B treatment.\textsuperscript{14}

- An external review of the ASHM Hepatitis B s100 Prescriber Program conducted in 2018 recommended providing better support and improving access and promotion of hepatitis B prescriber courses to increase participation from non-accredited GP prescribers.\textsuperscript{15}

- GPs have poor knowledge, specifically in interpreting hepatitis B serology results, and experience systematic barriers to testing people at risk of hepatitis B.\textsuperscript{16}

Enabling environment

- In a study commissioned by SHBBVP, 58% of WA participants reported that they would behave negatively towards people living with hepatitis B, higher than the nationally reported figure of 49%.\textsuperscript{17}

- Language and culture are often major barriers to health care and health promotion participation.\textsuperscript{13}

Data collection, research and evaluation

- There is a lack of clarity regarding the nature of stigma and discrimination experienced by people living with hepatitis B and its differences to HIV and hepatitis C related stigma and discrimination.\textsuperscript{18}

- Further research is needed to enable a better understanding of the non-clinical factors that facilitate and act as barriers to hepatitis B testing, vaccination and clinical management including a better understanding of the extent and influence of stigma and discrimination across the different affected communities in Australia.\textsuperscript{18}
Action areas

The key actions for the *WA Hepatitis B Strategy 2019–2023* are condensed into six action areas to align with the *Third National Hepatitis B Strategy 2018–2022*. These action areas are not standalone categories, rather they overlap and can exist on a continuum. A successful approach towards reducing the transmission of and the morbidity, mortality and social impact of hepatitis B requires focus on all action areas.

**Prevention and education**

The following actions aim to improve hepatitis B related knowledge among the priority populations and to improve access to hepatitis B prevention initiatives, thus contributing towards achieving the goals and targets set out in this strategy.

1. Improve hepatitis B related health literacy among priority populations in relation to the:
   - risk factors and preventative factors
   - availability of hepatitis B vaccinations and testing
   - availability of treatment
   - need for regular monitoring.

2. Increase access to:
   - hepatitis B vaccination for all priority populations including free vaccination for infants, adolescents, pregnant women and unvaccinated adults at higher risk of infections
   - other preventative measures such as condoms, sterile needles and syringes, and safer sex education.

3. Develop partnerships to improve service coordination through the sharing of information and resources among:
   - CALD communities and organisations
   - service providers already engaging with priority populations
   - research institutes working in the viral hepatitis area.
Testing and diagnosis

It is estimated that in Australia nearly 38% of people living with hepatitis B are undiagnosed, making regular testing essential for early diagnosis to allow for better access to treatment, ongoing care and better health outcomes for the priority populations.3

The following actions aim to decrease the number of undiagnosed cases among people in WA living with hepatitis B.

1. Increase access to routine and opportunistic testing by:
   - increasing awareness among healthcare workers and priority populations of the need for targeted testing of those at risk of hepatitis B infection
   - increasing testing options available in primary health and community-based settings such as through outreach initiatives while maintaining appropriate standards of care
   - conducting contact tracing for people who have tested positive for the hepatitis B surface antigen.

2. Employ evidence and peer-based approaches that promote testing among priority populations.

Disease management and clinical care

These actions aim to increase the number of people living with hepatitis B who are on treatment and engaged in care. To effectively achieve this, the following actions are recommended.

1. Increase the number of people living with chronic hepatitis B on treatment and engaged in care by:
   - informing priority populations about the need to monitor and manage their hepatitis B infection and the treatment options available
   - increasing the number of accredited hepatitis B prescribers
   - monitoring the number of health services providing hepatitis B care and treatment to priority populations.

2. Improve the management and treatment of hepatitis B by:
   - identifying opportunities to improve patient management systems
   - improving access to and coordination of hepatitis B services by strengthening links between service providers already engaging with the priority populations including the use of telehealth where required in regional and remote areas
   - enhancing GP management of patients with hepatitis B including developing pathways for GP to GP and GP to specialist referrals
   - continuing to explore and share experiences of innovative models of care for hepatitis B prevention and management, particularly models for rural and remote areas such as nurse-led models and models utilising Aboriginal health practitioners
   - ensuring the provision of culturally secure services to priority populations.
Workforce development

The following actions aim to develop a healthcare workforce that is highly skilled and adequately trained in the treatment and management of hepatitis B. To effectively achieve this, the following actions are recommended.

1. Improve awareness, knowledge and skills of the healthcare workforce in relation to early detection, monitoring and treatment of hepatitis B by increasing:
   - the number of professional development opportunities available to the healthcare workforce including in regional and remote areas
   - access to training opportunities through the use of digital and online platforms such as videoconferencing, webinars and recorded presentations in addition to face-to-face training
   - the awareness of available educational resources to assist in the management of hepatitis B.

2. Increase hepatitis B treatment prescriber course access, promotion and participation of non-accredited GPs working with priority populations, including those in regional and remote areas.

3. Develop shared care models to better support new prescribers through linkages with experienced prescribers including the use of telehealth where required in regional and remote areas.

Enabling environment

People living with hepatitis B are likely to experience discrimination and stigma. This can have a significant impact on their health outcomes and may prevent them from seeking support. To effectively address stigma and discrimination, the following actions are recommended.

1. Provide patients and consumers with information about their rights and responsibilities in relation to hepatitis B prevention, testing, treatment and care.

2. Monitor stigma and discrimination in the community that impacts on health-seeking behaviour of priority populations and their access to testing and treatment services.

3. Review and address institutional, regulatory and system policies that create barriers to equality of prevention (including access to vaccination), testing, treatment, care and support for priority populations, including people living with hepatitis B.
Data collection, research and evaluation

There are a number of gaps in the research and surveillance related to hepatitis B. To fully understand the burden of disease caused by hepatitis B in WA, the following actions are recommended.

1. Identify opportunities to improve the timeliness, completeness and consistency of data collections.

2. Explore the prevalence and nature of stigma and discrimination experienced by people living with hepatitis B in WA.

3. Identify gaps in knowledge among healthcare workforce and priority populations relating to hepatitis B prevention, testing, treatment and care.

4. Identify and address barriers in accessing hepatitis B vaccination, testing, treatment and care among priority population groups, including people from countries with an intermediate or high prevalence of hepatitis B.
The monitoring and evaluation framework includes indicators and details data sources to monitor progress against the targets previously mentioned.

<table>
<thead>
<tr>
<th>Targets by the end of 2023</th>
<th>Indicators</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Achieve and maintain hepatitis B childhood vaccination coverage of 95% at 12 and 24 months</td>
<td>Coverage of hepatitis B vaccination at 12 months and 24 months</td>
<td>Australian Childhood Immunisation Register (ACIR) and Rates Calculator</td>
</tr>
<tr>
<td></td>
<td>Numerator: Number of children in the relevant cohort who have dose 3 by 12 and 24 months recorded on the ACIR</td>
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<td></td>
<td>Denominator: Number of children turning 12 and 24 months in the measurement year on the ACIR</td>
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<tr>
<td>2. Reduce the number of newly acquired hepatitis B infections across all age groups by 50%, with a focus on priority populations</td>
<td>Annual rate of newly acquired hepatitis B notifications</td>
<td>WA Notifiable Infectious Diseases Database (WANIDD) and Rates Calculator</td>
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<tr>
<td></td>
<td>Numerator: Number of newly acquired hepatitis B notifications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population, Aboriginal and non-Aboriginal, all ages</td>
<td></td>
</tr>
<tr>
<td>3. Increase the proportion of people living with chronic hepatitis B who are diagnosed to 80%</td>
<td>Estimated annual proportion of people living with chronic hepatitis B who have been diagnosed</td>
<td>Indicator to be developed</td>
</tr>
<tr>
<td></td>
<td>Annual rate of unspecified hepatitis B notifications</td>
<td>WANIDD and Rates Calculator</td>
</tr>
<tr>
<td></td>
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<td>4. Increase the total proportion of people living with chronic hepatitis B receiving care to 50%</td>
<td>Proportion of people living with chronic hepatitis B who received monitoring for chronic hepatitis B</td>
<td>Data linkage study</td>
</tr>
<tr>
<td></td>
<td>Numerator: Number of people who received monitoring for chronic hepatitis B</td>
<td></td>
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<tr>
<td></td>
<td>Denominator: Modelled estimate of the number of people living with chronic hepatitis B</td>
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<tr>
<td>5. Increase the proportion of people living with chronic hepatitis B who are receiving antiviral treatment to 20%</td>
<td>Proportion of people with living chronic hepatitis B dispensed drugs for hepatitis B infection</td>
<td>PBS treatment data</td>
</tr>
<tr>
<td></td>
<td>Numerator: Number of people dispensed drugs for chronic hepatitis B infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Denominator: Modelled estimate of the number of people living with chronic hepatitis B</td>
<td></td>
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<tr>
<td>6. Reduce hepatitis B attributable mortality by 30%</td>
<td>Estimated number of deaths attributable to chronic hepatitis B</td>
<td>Data linkage study</td>
</tr>
<tr>
<td>7. Reduce the reported experience of stigma among people living with hepatitis B, and the expression of stigma, in respect to hepatitis B status</td>
<td>Proportion of people living with chronic hepatitis B who report experiencing stigma and discrimination in respect to hepatitis B status</td>
<td>Centre for Social Research in Health, University of New South Wales (UNSW)</td>
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<tr>
<td></td>
<td>Proportion of the general public who report feelings of stigma and discrimination towards people living with chronic hepatitis B</td>
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<td></td>
<td>Proportion of health professionals who report feelings of stigma and discrimination towards people living with chronic hepatitis B</td>
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Governance

The WA Department of Health is committed to a partnership approach between priority populations, government, community-based organisations, health service providers, researchers and policymakers to guide the public health response to sexually transmissible infections (STIs) and blood-borne viruses (BBVs).

The Department established the WA Sexual Health and Blood-borne Viruses Advisory Committee (WA SHaBBVAC) in accordance with the Public Health Act 2016 (WA) to provide a forum for a multi-agency partnership in the prevention and control of BBVs and STIs. Its purpose is to advise the Chief Health Officer on the development of state policies and programs relating to STIs and BBVs. The Advisory Committee members and other partners work closely with the Department in a joint approach towards the development, implementation and evaluation of the Department’s strategies and implementation plans for HIV, hepatitis B, hepatitis C and STIs, with special consideration for the impact of STIs and BBVs on Aboriginal communities, taking into account matters such as prevention, education, treatment, care, surveillance, research, legal and policy issues, monitoring and evaluation.

The Advisory Committee membership includes agencies that represent the interests of priority populations or are at the forefront of service delivery. Members include health consumers and representatives from the WA Primary Health Alliance, Health Consumers’ Council, WA AIDS Council, Peer Based Harm Reduction WA, Sexual Health Quarters, Magenta, HepatitisWA, East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, WA Country Health Service, Mental Health Commission, WA Network of Alcohol and Drug Agencies, Youth Affairs Council WA, Aboriginal Health Council of WA, WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network (SiREN) – Curtin University, Aboriginal Health Directorate (Department of Health), Department of Justice, Australian Department of Health and SECCA. Secretariat services are provided by SHBBVP.
Monitoring and reporting

The Communicable Disease Control Directorate (CDCD) within the Department is responsible for the collation, analysis and reporting on STI and BBV notifications. Consistent with the role of system manager, the CDCD will publish ongoing quarterly and annual epidemiology reports on STI and BBV notifications, testing data and test positivity data. The STI and BBV Quarterly Forum, convened by the Department, will present up-to-date STI and BBV epidemiology reports to the service sector. CDCD will also publish a mid-term and a final report on the progress towards achieving the strategy’s targets, including performance indicators relating to the cascades of care, behavioural surveillance, and stigma and discrimination as described in the monitoring and evaluation framework detailed within this strategy.

The Department will provide an activity report on the implementation of the strategy to the Advisory Committee at each meeting to monitor progress towards achieving the targets and to monitor emerging issues.

The Department is also required to report to the Blood-borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS) on the implementation of the public health response in WA and progress towards meeting the national targets set out in the suite of national STI and BBV strategies.
References


