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

The number of newly acquired hepatitis C notifications in WA in 2017 was lower than the 2012 to 2016 five-year average, which is encouraging. Nevertheless, the newly acquired hepatitis C notification rate remained 28 times higher among Aboriginal people compared to non-Aboriginal people. Significant work needs to be done to increase testing and to address the risk factors associated with hepatitis C.

New and highly effective direct-acting antiviral (DAA) treatments became available on the Pharmaceutical Benefits Scheme in March 2016 under both section 100 (Highly Specialised Drugs) and section 85 (General Schedule), which has greatly increased access to hepatitis C treatment. In WA between March 2016 and March 2018, an estimated 22% (4560 people) of those living with chronic hepatitis C initiated treatment, with 30% of the prescriptions for DAA treatment written by general practitioners, one of the highest proportions across Australian jurisdictions.

The WA Department of Health released a video promoting the availability and benefits of treatment aimed at those people diagnosed with hepatitis C and at health professionals. Needle and syringe programs continue to be an essential component of hepatitis C prevention, with new services established in the Goldfields and a needle and syringe dispensing machine implemented in the Great Southern region.
In 2016, the Australian Government endorsed the *Global Health Sector Strategy on Viral Hepatitis 2016–2025*, which proposed targets to globally eliminate viral hepatitis (hepatitis B and hepatitis C) as a major public health threat by the year 2030. The goals and targets of the *WA Hepatitis C Strategy 2019–2023* are based on those detailed within the *Fifth National Hepatitis C 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 to reach the goals.

The actions within this strategy are driven by our focus on achieving significant progress towards eliminating hepatitis C as a public health threat. This will, in turn, have a significant impact on reducing the transmission of and mortality and morbidity caused by hepatitis C. The personal and social impact of hepatitis C among affected target populations must also be minimised, including the elimination of the negative impact of stigma, discrimination, and legal and human rights issues impacting on the health of people living with hepatitis C.

As we move forward, it is crucial that we implement this strategy with inspiration from our strong collegial work with health professionals, government departments, community and public health organisations, researchers and members of our communities affected by hepatitis C. 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 C Strategy
2019–2023

Strategy at a glance

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

Targets
1. Reduce the number of newly acquired hepatitis C infections by 60%, with a focus on priority populations.
2. Increase the proportion of people living with hepatitis C who are diagnosed to 90%.
3. Increase the cumulative proportion of people living with chronic hepatitis C who have initiated direct-acting antiviral (DAA) treatment to 65%.
4. Reduce hepatitis C attributable mortality by 65%.
5. Reduce the reported experience of stigma among people living with hepatitis C, and the expression of stigma, in respect to hepatitis C status.
6. Increase the use of sterile injecting equipment for every injecting episode.

Key actions
1. Implement education initiatives focusing on transmission risk, harm reduction strategies, testing process and awareness of DAA treatment.
2. Increase the availability, range and distribution of sterile injecting equipment among people who inject drugs (PWID), especially in regional and remote areas and for Aboriginal PWID.
3. Increase routine and opportunistic testing through primary health care, community-based services and allied health and within custodial services.
4. Increase access to DAA treatment for people living with chronic hepatitis C.
5. Provide ongoing support and information to the healthcare workforce, to educate on prevention, accurate testing processes and the pathway to treatment for people living with hepatitis C.
6. Establish and maintain supportive environments within health and community care settings for people living with hepatitis C, or those at risk of hepatitis C.
7. Conduct meaningful research, surveillance and evaluation to increase our understanding of the burden of disease caused by hepatitis C, and plan for future prevention, diagnostic and treatment initiatives.

Priority populations
- people living with hepatitis C
- PWID
- people who have previously injected drugs
- people in or recently exited custodial settings
- Aboriginal people
- people from culturally and linguistically diverse backgrounds.
Other related strategies

- Fifth National Hepatitis C Strategy 2018–2022
- Humanitarian Entrant Health Service – policies and information
- National Drug Strategy 2017–2026
- 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 B 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

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Services</td>
</tr>
<tr>
<td>ACIR</td>
<td>Australian Childhood Immunisation Register</td>
</tr>
<tr>
<td>AHCWA</td>
<td>Aboriginal Health Council of WA</td>
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<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
</tr>
<tr>
<td>AHS</td>
<td>Aboriginal Health Service</td>
</tr>
<tr>
<td>AHW</td>
<td>Aboriginal health worker</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMR</td>
<td>antimicrobial resistant</td>
</tr>
<tr>
<td>ANSPS</td>
<td>Australian Needle and Syringe Program Survey</td>
</tr>
<tr>
<td>APNA</td>
<td>Australian Primary Health Care Nurses Association</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral treatment</td>
</tr>
<tr>
<td>ASHM</td>
<td>Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine</td>
</tr>
<tr>
<td>AOD</td>
<td>alcohol and other drug</td>
</tr>
<tr>
<td>BBV</td>
<td>blood-borne virus</td>
</tr>
<tr>
<td>BBVSS</td>
<td>Blood-borne Viruses and Sexually Transmissible Infections Standing Committee</td>
</tr>
<tr>
<td>CALD</td>
<td>culturally and linguistically diverse</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Protection</td>
</tr>
<tr>
<td>CDCD</td>
<td>Communicable Disease Control Directorate</td>
</tr>
<tr>
<td>CLAI</td>
<td>condomless anal intercourse</td>
</tr>
<tr>
<td>CSRH</td>
<td>Centre for Social Research in Health</td>
</tr>
<tr>
<td>DAA</td>
<td>direct-acting antiviral</td>
</tr>
<tr>
<td>GDHR</td>
<td>Growing and Developing Health Relationships</td>
</tr>
<tr>
<td>GIPA</td>
<td>greater involvement of PLWH</td>
</tr>
<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>
</tr>
<tr>
<td>HTLV1</td>
<td>human T-cell lymphotropic virus type 1</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</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>
</tr>
<tr>
<td>MIPA</td>
<td>meaningful involvement of PLWH</td>
</tr>
<tr>
<td>MSM</td>
<td>men who have sex with men</td>
</tr>
<tr>
<td>NCHECR</td>
<td>National Centre in HIV Epidemiology and Clinical Research</td>
</tr>
<tr>
<td>NGO</td>
<td>non-government organisation</td>
</tr>
<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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<tr>
<td>NSP</td>
<td>needle and syringe program</td>
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<tr>
<td>NSEP</td>
<td>needle and syringe exchange program</td>
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<tr>
<td>OTP</td>
<td>opioid treatment programs</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<tr>
<td>PEP</td>
<td>post exposure prophylaxis</td>
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<tr>
<td>PGCPs</td>
<td>Perth Gay Community Periodic Survey</td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
</tr>
<tr>
<td>PIS</td>
<td>Patient Information System</td>
</tr>
<tr>
<td>PLWH</td>
<td>people living with HIV</td>
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<tr>
<td>POCT</td>
<td>point-of-care testing</td>
</tr>
<tr>
<td>PrEP</td>
<td>pre-exposure prophylaxis</td>
</tr>
<tr>
<td>PWID</td>
<td>people who inject drugs</td>
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<tr>
<td>RDT</td>
<td>Rapid diagnostic test</td>
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<tr>
<td>RNA</td>
<td>ribonucleic acid</td>
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<tr>
<td>RSE</td>
<td>relationships and sexuality education</td>
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<tr>
<td>RTO</td>
<td>Registered Training Organisation</td>
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<tr>
<td>SASA</td>
<td>Structured Administration and Supply Arrangement</td>
</tr>
<tr>
<td>SHBBVP</td>
<td>Sexual Health and Blood-borne Virus Program</td>
</tr>
<tr>
<td>SiREN</td>
<td>WA Sexual Health and Blood-borne Virus Applied Research and Evaluation Network</td>
</tr>
<tr>
<td>SMS</td>
<td>short message service</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmissible infection</td>
</tr>
<tr>
<td>s100</td>
<td>section 100</td>
</tr>
<tr>
<td>TAFE</td>
<td>Technical and Further Education</td>
</tr>
<tr>
<td>TasP</td>
<td>treatment as prevention</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNSW</td>
<td>University of New South Wales</td>
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</tbody>
</table>
UTI urinary tract infection
U=U Undetectable = Untransmissable
VL viral load
WA Western Australia
WACHS WA Country Health Service
WA health system The WA health system consists of the Department of Health, Child and Adolescent Health Service, North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service and WA Country Health Service, and Health Support Services.
WANIDD WA Notifiable Infectious Diseases Database
WHO World Health Organization
WA SHaBBVAC WA Sexual Health and Blood-borne Viruses Advisory Committee
WA SORG WA Syphilis Outbreak Response Group

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 C in Western Australia

What is hepatitis C?
Hepatitis C 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.

Most hepatitis C infections in Australia result from the sharing of needles and other equipment used for injecting drugs.

Other risk factors for hepatitis C transmission include:
- tattooing or body piercing with unsterile equipment
- sharing personal hygiene items, such as razors, toothbrushes and dental floss
- being a recipient of an organ transplant, tissues, blood or blood products prior to February 1990
- engaging in high risk sexual activity, where blood is present.

What health issues can it cause?
Without treatment, acute infection progresses to chronic disease in up to 75% of cases and around 20–30% of people with chronic infection will develop cirrhosis of the liver. In some cases, those with cirrhosis will develop complications such as liver failure and liver cancer.

By the end of 2017, an estimated 13,434 people living with chronic hepatitis C in WA had early to moderate fibrosis (stages F0–F2), 2,410 had severe fibrosis (stage F3), 1,036 had hepatitis C-related cirrhosis (stage F4), and 154 had decompensated cirrhosis or hepatocellular carcinoma.

How is it managed?
While there is no vaccine against hepatitis C, new and effective direct-acting anti-viral (DAA) treatment is available that is short in duration, has few side effects, and can be prescribed by a general practitioner (GP). DAA treatment can result in a cure for over 95% of people.

New diagnoses
The number of newly acquired hepatitis C notifications in WA in 2017 (n = 121) was 13% lower than the 2012 to 2016 five-year average of 143 notifications per year and represented 11% of total hepatitis C notifications in 2017. The notification rate was 28 times higher among Aboriginal people compared to non-Aboriginal people. There were also marked differences between Aboriginal and non-Aboriginal people in terms of reasons for testing and risk factors for hepatitis C.
The total number of hepatitis C notifications (newly acquired and unspecified) for WA in 2017 was 1032.

**Prevalence**

In Australia, the prevalence of hepatitis C remains high among people who inject drugs (PWID), prisoners with a history of injecting drug use, and people from high-prevalence countries. By the end of 2017, an estimated 17,075 people in WA (0.67% of the total population) were living with chronic hepatitis C.¹

**Treatment and care**

Between March 2016 and March 2018, an estimated 4560 individuals initiated DAA treatment in WA, accounting for around 22% of those living with chronic hepatitis C in the state.
The listing of DAA treatments on the Pharmaceutical Benefits Scheme (PBS) in March 2016 has significantly impacted on the number of people in WA accessing hepatitis C treatment. The treatments were listed as both section 100 (Highly Specialised Drugs Program) and section 85 (General Schedule). This means they are now able to be prescribed by medical practitioners and authorised nurse practitioners.

Face-to-face and online training opportunities for the primary health workforce have been promoted and well received. By March 2018, 30% of prescriptions for DAA treatment in WA were written by GPs, one of the highest proportions across Australian jurisdictions. Access to treatment for people in prison is limited to section 100, which presented some particular challenges for WA. However, models have now been developed and implemented in all prisons across the state, with good treatment uptake rates being reported.

A non-government agency has been supported to establish a nurse-led GP project, which supports GPs who have notified a case of hepatitis C to be able to treat the patient. Public health units have also been providing information to GPs who notify hepatitis C cases. Alongside this, clinics have been established in several agencies to provide community-based treatment services for priority populations. A short video promoting the availability and benefits of treatment has also been produced for people diagnosed with hepatitis C and for health professionals working with people affected by hepatitis C. All of these initiatives have contributed to substantially higher numbers of people accessing treatment and being cured of hepatitis C.

Needle and syringe programs (NSPs) continue to be an essential component of hepatitis C prevention, with new services established including a needle and syringe exchange program in the Goldfields and a needle and syringe dispensing machine successfully trialled and implemented in the Great Southern region. Online training packages for NSP providers have been updated, and face-to-face training continues to be provided.

While needle and syringe distribution has seen some annual fluctuations from 2015 to 2018, the number of needles and syringes distributed increased from 5,623,477 in 2015 to 5,769,914 in 2018. Despite this, rates of receptive needle sharing were higher in 2017 than in 2013 among Western Australian participants in the Australian Needle Syringe Program Survey.

Prevention initiatives have also included a social marketing campaign, Look After Your Blood, which aims to increase awareness and knowledge about blood-borne viruses among young Aboriginal people. New service agreements have been entered into with non-government agencies for the continuation of services for people with viral hepatitis and for PWID, and for NSPs in the Hedland and Mandurah areas. An Eliminate Hepatitis C Working Group was established for WA in 2018, which will continue to guide initiatives in this area.
The Guiding Principles for this strategy reflect those in the *Fifth National Hepatitis C Strategy 2018–2022*, adapted for the Western Australian context.

1. **Meaningful involvement of priority populations**
   People living with or at risk of hepatitis C should be central to the public health response to hepatitis C, 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 C, or those at risk of hepatitis C, 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, socioeconomic 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 C transmission, the provision of clinical services, and ongoing support and care for those at risk of or living with hepatitis C should reflect the Ottawa Charter for Health Promotion.

5. **Prevention**
   The transmission of hepatitis C 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 forwards, 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 C.

7. **Harm reduction**

Harm reduction approaches strengthen effective measures to prevent the transmission of hepatitis C, and minimise the health and social burden of hepatitis C in the community. Approaches include 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 C. 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 C 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 C 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 *Fifth National Hepatitis C 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 C as a public health threat.
2. Reduce the transmission of and morbidity and mortality caused by hepatitis C.
3. Minimise the personal and social impact of hepatitis C.
4. Eliminate the negative impact of stigma, discrimination, and legal and human rights issues affecting the health of people living with hepatitis C.

### Targets – by 2023

1. Reduce the number of newly acquired hepatitis C infections by 60%, with a focus on priority populations.
2. Increase the proportion of people living with hepatitis C who are diagnosed to 90%.
3. Increase the cumulative proportion of people living with chronic hepatitis C who have initiated DAA treatment to 65%.
4. Reduce hepatitis C attributable mortality by 65%.
5. Reduce the reported experience of stigma among people living with hepatitis C, and the expression of stigma, in respect to hepatitis C status.
6. Increase the use of sterile injecting equipment for every injecting episode.
Australia signs on to global elimination targets

In 2016, the Australian Government endorsed the Global Health Sector Strategy on Viral Hepatitis, 2016–2021,\(^5\) 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**

<table>
<thead>
<tr>
<th>By 2020</th>
<th>By 2030</th>
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<tbody>
<tr>
<td>▶ 30% reduction in new cases</td>
<td>▶ 90% reduction in new cases</td>
</tr>
<tr>
<td>▶ 10% reduction in the number of hepatitis-related deaths.</td>
<td>▶ 65% reduction in hepatitis-related deaths.</td>
</tr>
</tbody>
</table>

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 C

All people living with hepatitis C who have been fully diagnosed should be offered DAA treatment. Those who are undiagnosed or only partially diagnosed (only antibody tested) should be engaged by the healthcare workforce to test according to the relevant clinical guidelines, or referred appropriately to a testing service.

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

- fully diagnosed (evidence of positive hepatitis C ribonucleic acid (RNA) test)
- partially diagnosed (no evidence of RNA test completion)
- undiagnosed
- living with hepatitis C who also inject drugs
- living with hepatitis C who also have human immunodeficiency virus (HIV) and/or hepatitis B
- living in regional and remote areas
- within custodial settings who are living with hepatitis C
- Aboriginal people who are living with hepatitis C
- gay and bisexual men, and men who have sex with men (MSM)
- from culturally and linguistically diverse (CALD) backgrounds who are living with hepatitis C.

People who inject drugs

Sharing injecting equipment is the main risk factor for hepatitis C transmission. Strategies aimed at educating and preventing hepatitis C transmission should be tailored to suit PWID. Testing and treatment initiatives should also target PWID specifically, with all clinical activities undertaken in accordance with the relevant clinical guidelines.

Key subpopulations of PWID include those who are:

- young
- new initiates to injecting
- living in regional and remote areas
- Aboriginal
- in custodial settings
- from CALD backgrounds
- gay and bisexual men, and MSM.
People who have previously injected drugs

Previous practices (including sharing injecting equipment) may put a significant number of people who have previously injected drugs at risk of hepatitis C. People who no longer inject drugs, despite having potentially put themselves at risk, may be disengaged from health and community services. Therefore, it is vital to target this at-risk population group. Similarly, people who have previously injected and/or are currently accessing alcohol and other drug treatment programs, are also a key subpopulation group to target for prevention, testing and treatment initiatives.

People in or recently exited custodial settings

A disparately high prevalence of hepatitis C exists within custodial settings. Risk factors include receptive needle and syringe sharing, unsterile tattooing and body piercing, and other blood-to-blood contact prior to entering and within custodial settings. It is important to target strategies not only for those imprisoned, but also to those on remand, awaiting sentencing and exiting custodial settings.

Aboriginal people

In WA in 2017, the hepatitis C notification rate for Aboriginal people compared to non-Aboriginal people was 28 times higher for newly acquired notifications (62.1 compared to 2.2 per 100,000 population) and nine times higher for unspecified hepatitis C notifications (248.7 compared to 27.4 per 100,000 population). 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 C.

People from cultural and linguistically diverse backgrounds

From February 1990, all blood products and organs are routinely screened for hepatitis C in Australia, which has reduced the risk of transmitting hepatitis C via receiving blood products/organisms in Australia to almost nil. In other countries, the same precautions may not have been taken; therefore, this may pose a transmission risk to those who have received blood products/organ transplant overseas. In addition, unsterile medical procedures, tattooing and body piercing, as well as receptive use of injecting equipment pose transmission risks for people from some other countries. People from CALD backgrounds, who are at risk of or living with hepatitis C, require culturally secure services and messaging to assist them in engaging with testing, treatment and care for hepatitis C.

Key sub-populations of people from CALD backgrounds include those who are:

- born in countries with a high prevalence of hepatitis C, especially countries located within Africa, the Middle East, the Mediterranean, Eastern Europe and South Asia
- PWID or have ever injected
- refugees and humanitarian entrants.
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, Aboriginal health services (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 2109–2023*.

**Consultation findings**

Through these consultations, you told us that:

- There is a need to facilitate a coordinated response to hepatitis C in WA, including government and non-government agencies, involvement of primary and tertiary health services, community-based services, peer-based organisations, corrective services, educational institutions and researchers.

- It is important to educate the public, particularly the identified priority populations, about the availability and benefits of DAA treatment for hepatitis C, not only to increase treatment rates, but also to encourage more people to present to clinical services for testing.

- There is a need to research and implement innovative preventative, diagnostic and treatment services in various settings, including regional areas and custodial settings.

- Relevant community-based organisations should be utilised to engage clients – from preventative measures such as operating NSP and needle and syringe exchange programs (NSEPs) to diagnostic and treatment services, or to educate staff and volunteers at these organisations to refer patients appropriately to important health and social services as required.

- Peers and people from relevant priority populations should be engaged within all stages of the program design, delivery and evaluation.

- There is an opportunity to utilise nurse practitioners further to conduct and assist with testing and treatment initiatives, as well as to support the healthcare workforce within practices.

- There needs to be appropriate and ongoing development for the healthcare workforce to support preventative, diagnostic and treatment initiatives.

- There is a need to address stigma and discrimination, and to ensure that patient rights are maintained throughout the patient’s journey accessing support services, diagnostic services and progressing into treatment as required.
Evidence to support actions

Prevention and education

Receptive sharing of injecting equipment

- Receptive sharing of injecting equipment has long been identified as the primary risk factor for hepatitis C transmission.\(^8\)

- Despite recognition of PWID as a high priority population group and various initiatives in place to prevent transmission, surveyed attendees at participating WA NSEP sites reported that the prevalence of receptive sharing of needles and syringes increased from 19% in 2013 to 25% in 2017.\(^3\)

- Among those surveyed, the prevalence of sharing drug preparation equipment remained stable over this period (from 39% to 40% over the five-year period).\(^3\)

- Among Aboriginal PWID, the rate of receptive needle and syringe sharing reported in 2017 was much higher than for non-Aboriginal PWID (37% compared to 22%) (Iversen J. Personal communication via email, 2019 Feb 21).

Cost and social effectiveness of NSP

- The National Centre in HIV Epidemiology and Clinical Research (NCHECR) estimated that over a 10-year period more than 96,000 hepatitis C infections were averted and that for every one dollar invested in NSPs more than four dollars was returned in direct healthcare savings.\(^9\)

- The accessibility of NSPs is vital in combating hepatitis C, allowing the provision of sterile injecting equipment to PWID as well as increasing opportunities to educate clients on preventative strategies and other health topics.\(^9\)

Testing and diagnosis

Use of new testing technologies and ensuring appropriate testing is undertaken

- As evidence suggests, many people who test positive for hepatitis C antibodies do not receive confirmatory RNA testing to diagnose hepatitis C infection; therefore, appropriate testing procedures must be followed if elimination of hepatitis C is to be achieved.\(^10\)

- Evidence has been building to support the use of rapid diagnostic tests (RDTs) and enhanced dried blood spot testing, which have benefits for PWID where venepuncture may be difficult.\(^11,12\)

- The use of hepatitis C RNA point-of-care testing (POCT) also presents benefits compared to current antibody and RNA testing procedures, and may assist in improving accurate diagnosis and timely pathways to treatment and care.\(^13\)

Disproportionate rates of hepatitis C among Aboriginal people in WA

- Aboriginal and Torres Strait Islander people comprise 3% of the Australian population, but they accounted for at least 11% of all hepatitis C notifications in 2017, reflecting a disproportionate burden of disease.\(^2\)
In WA in 2017, the hepatitis C notification rate for Aboriginal people compared to non-Aboriginal people was 28 times higher for newly acquired notifications (62.1 compared to 2.2 per 100,000 population) and nine times higher for unspecified hepatitis C notifications (248.7 compared to 27.4 per 100,000 population).\(^7\)

**High rates of hepatitis C in custodial settings**
- Australian research has shown that hepatitis C prevalence is between 30 to 40 times higher among prisoners compared with the general community.\(^6\)
- Combining a history of injecting drug use with imprisonment reveals a prevalence of hepatitis C antibodies 50 times higher than without injecting drug use present as a historical risk factor.\(^6\)

**Disease management and clinical care**

**Treatment uptake**
- Between March 2016 and March 2018, an estimated 58,280 people initiated DAA treatment for hepatitis C across Australia, with an estimated 4,560 individuals initiating treatment in WA, accounting for around 22% of those living with chronic hepatitis C in the state.\(^2\)
- Despite the large uptake of treatment following PBS listing of DAAs, with 38,470 people initiating treatment across Australia within the first year, evidence suggests that treatment initiation has dropped since then, including within WA.\(^1,14\)
- Research has concluded that those most at risk of hepatitis C, especially people who may have previously injected, young PWID and those not engaged in NSPs, were less likely to initiate treatment.\(^15\)
- Barriers to commencing and adhering to treatment include:
  - lack of suitable treatment settings to cater for the needs of priority populations
  - fear of stigma and discrimination when accessing mainstream treatment services
  - limited infrastructure in place to support greater roll-out of treatment programs
  - lack of knowledge and confidence in both the clinical and non-clinical workforce in providing treatment or referral.\(^16\)
- Evidence has suggested that utilising multidisciplinary teams within settings people living with hepatitis C or at risk of hepatitis C are already accessing, may increase uptake of and adherence to treatment.\(^17\)
- Examples have been documented where successful integration of hepatitis C treatment services have been experienced within opioid treatment programs (OTPs), addiction treatment programs, community-based health clinics and NSEPs.\(^18,16\)
- There has also been ample research into the provision of hepatitis C treatment within the primary care setting, utilising adequately trained GPs and clinical nurses,\(^19\) as well as utilising peers within all stages of the treatment process, especially for PWID.\(^18\)
Workforce development

- All members of the healthcare workforce benefit from culturally secure education that is delivered in a variety of flexible methods.\(^\text{18}\)

- Education for the diverse healthcare workforce must focus on strengthening capacity within the workforce and on the delivery of non-stigmatising service throughout all stages of the hepatitis C cascade of care, from testing to diagnosis, treatment to cure, and follow-up and monitoring of pre-existing liver conditions if required.\(^\text{18}\)

- Learning how to engage effectively with PWID needs to remain a high priority for all members of the healthcare workforce.\(^\text{10}\)

- Research has supported the transition of clients into the healthcare workforce, along with adequate supervision, training and education.\(^\text{20}\)

Enabling environment

Stigma and discrimination

- In 2016, in an online survey of people who had ever lived with hepatitis C or had injected drugs, more than half of those completing the survey had experienced stigma or discrimination within the previous 12 months.\(^\text{21}\)

- Of the WA cohort with a history of injecting drug use, 78% indicated that they had experienced stigma or discrimination within the past 12 months.\(^\text{22}\)

- In additional research, among the WA general public, over 86% of those surveyed indicated that they would behave negatively towards other people due to their injecting drug use.\(^\text{23}\)

- Efforts to increase engagement with health services, including increasing uptake of DAA treatment, must focus on reducing stigma and discrimination while maintaining patient/client rights.\(^\text{24}\)

Peer-based strategies

- Studies have concluded that an appropriately experienced, trained and supported PWID peer worker can be influential among their peers, helping them to overcome barriers to hepatitis C testing, diagnosis, assessment and treatment.\(^\text{25}\)

- Peer-based strategies to prevent, test and treat for hepatitis C are highly specialised due to the experience of the peers involved, particular knowledge of the topic area, the empowerment built among peers and high levels of engagement with priority populations.\(^\text{20}\)

- Peer-based approaches can have the freedom to be flexible in their service delivery method, and in the way they align with, adapt to and influence the social and political environment in order to achieve improved health and social outcomes.\(^\text{26,18}\)
Removing barriers

- Regulatory health and system policies must be revised, especially concerning stigma and discrimination, the definition of the healthcare workforce and rights of those accessing appropriate health care.\textsuperscript{27}

- Alternative models of care and settings for care, such as through community-based health and social support services, NSPs and OTPs, should be enhanced to meet the needs of priority populations in the community.\textsuperscript{14}

Data collection, research and evaluation

- There is a need to capture enhanced data on the progression of PWID through the cascade of care for hepatitis C in order to provide evidence for future public health planning.\textsuperscript{28}

- Similarly, there is a gap in research on reinfection rates post successful DAA treatment, although some recent research has explored potential risk factors for reinfection. For example, PWID who are involved in OTPs may have lower risk of reinfection than those not engaged in OTPs.\textsuperscript{29}

- Building strong partnerships with public health researchers, the healthcare workforce and policymakers has the potential to improve evidence generation and translation.\textsuperscript{30}

- Open and transparent sharing of relevant research and evaluation findings with those identified previously could enable greater understanding of and action on hepatitis C.\textsuperscript{30}
The key actions for the *WA Hepatitis C Strategy 2019–2023* are condensed into six action areas to align with the *Fifth National Hepatitis C Strategy 2018–2022*. These action areas are not discrete categories but may frequently overlap and can exist on a continuum. A successful approach towards reducing the transmission of and the morbidity, mortality and social impact of hepatitis C requires focus on all action areas.

**Prevention and education**

The facilitation of appropriate education, targeted towards both priority populations and the general public, as well as implementation of evidence-based harm reduction initiatives can aid in preventing the transmission of hepatitis C and in informing people of the testing and treatment options for hepatitis C.

1. Implement innovative hepatitis C public education initiatives with a focus on transmission risk and harm reduction strategies and to raise awareness of DAA treatments.

2. Increase the availability, range and distribution of sterile injecting equipment among PWID, especially in regional and remote areas and for Aboriginal PWID.

3. Increase access to health, safer injecting and safe disposal information for PWID, including the utilisation of peer-based initiatives and education tailored to priority populations.

4. Facilitate a coordinated partnership approach towards prevention and education initiatives, and share the successes of these approaches with service providers.

5. Support the continued provision of and equitable access to evidence-based OTP for priority populations.

**Testing and diagnosis**

Increasing the diagnosis rate of those living with hepatitis C will be a key target to achieve by the end of this strategy, and into the future. Accurately assessing the true prevalence rate of hepatitis C within WA, and measuring the success of this strategy, will depend on the delivery of non-discriminatory, innovative and complete testing processes.

1. Increase awareness of the importance of testing among priority populations including engagement in all stages of the testing process (antibody testing, confirmatory hepatitis C RNA and monitoring of liver condition).
2. Increase routine and opportunistic testing, through primary health care, community-based services, allied health services and within custodial services.

3. Investigate the use of emerging technologies including RDT and POCT to increase testing rates.

4. Develop and maintain peer-based strategies that include utilising the skills and experience of people living with hepatitis C and PWID to encourage people to test and progress into treatment and ongoing management of their condition as required.

5. Identify opportunities to improve the application of recommended testing procedures for hepatitis C by clinicians, including patient follow-up post antibody test and application of confirmatory hepatitis C RNA testing.

**Disease management and clinical care**

Since the inclusion of DAA treatment for hepatitis C on the PBS in March 2016, Australia has been leading the way globally as a nation where elimination of hepatitis C is a realistic prospect. Enhancing awareness of these revolutionary treatments, increasing rates of treatment for those affected by hepatitis C and providing timely and relevant referral to treatment services and ongoing care will be vital within WA to ensure treatment remains a priority and people are engaged throughout the hepatitis C cascade of care.

1. Increase public awareness of the availability of and the effectiveness of DAA treatment for hepatitis C.

2. Provide support and information to GPs and practice nurses to increase the number of DAA prescribers treating through general practice.

3. Establish new community service led treatment clinics and enhance current clinics operating within community-based services to target priority populations.

4. Maintain and improve partnerships between primary healthcare workers, specialists, allied health services, community-based services (including alcohol and other drug (AOD) services), AHS and custodial services to ensure appropriate pathways into treatment and management or care is available for those diagnosed with chronic hepatitis C.

5. Enhance current treatment projects and introduce innovative strategies to increase access to DAA treatment for hepatitis C for those within custodial settings or those recently exited the custodial setting.

6. Support the healthcare workforce to identify and engage people living with hepatitis C in treatment and ongoing care, including improving patient management systems, conducting patient recall and ongoing monitoring for patients with pre-existing liver disease issues.
Workforce development

The facilitation of appropriate and successful prevention, testing and treatment initiatives will continue to rely on a highly skilled and adequately trained healthcare workforce. Support and education for staff and volunteers working with people at risk of or living with hepatitis C, in a variety of settings, will be central to the response to hepatitis C in WA.

1. Provide ongoing support and information to GPs, nurse practitioners and the wider healthcare workforce on prevention, accurate testing processes and the pathway to treatment for patients living with hepatitis C.

2. Facilitate innovative workforce education and training initiatives to build a highly skilled healthcare workforce, including increasing use of online learning, videoconference and teleconference, information sharing platforms and face-to-face learning opportunities.

3. Provide innovative and tailored education for the Aboriginal healthcare workforce on hepatitis C transmission risk and prevention methods and the ability to appropriately conduct or refer patients for hepatitis C testing and treatment.

4. Support community-based organisations, custodial settings, NSP sites and relevant peer networks to increase their engagement with priority populations in order to improve health literacy and their connection to diagnostic services, treatment and ongoing care.

5. Promote relevant clinical guidelines on testing, treatment, care and support for people living with hepatitis C.

Enabling environment

In relation to the Guiding Principles of Human Rights, referring to safeguarding the human rights of priority populations, and to access and equity in ensuring health and community care in WA is accessible to all, supportive and enabling environments must be provided to anyone living with or at risk of hepatitis C. This will include participation of priority populations in service design and implementation, addressing stigma and discrimination within the healthcare workforce and upholding client rights and responsibilities as well as addressing regulatory health and systemic barriers to service access.

1. Engage with priority populations to identify the greatest barriers to accessing appropriate and timely health care, and involve priority populations in devising strategies to address these issues.

2. Educate the healthcare workforce on the stigma and discrimination issues faced by PWID and other priority populations, the appropriate language to use and strategies to engage people who are living with hepatitis C or who are at risk of hepatitis C transmission.

3. Ensure clients and patients have access to information about their rights and responsibilities when accessing health care.
4. Review and address institutional, regulatory and system policies that create barriers to equality of prevention, testing, treatment, care and support for people living with hepatitis C and at-risk priority populations.

Data collection, research and evaluation

Improvement in consistent collection of relevant data and responsible use of data is required to orient health services and drive actions within this strategy and beyond. Gaps in surveillance data exist across the priority populations, with the true prevalence of hepatitis C and burden of disease within the community still unknown. Collection of enhanced behavioural data and relevant research will be vital in moving forwards, including continual monitoring of risk factors, treatment uptake and evidence and impact of stigma and discrimination on people at risk of or living with hepatitis C. The use of relevant evaluation methods must also be built into the program design and implemented accordingly.

1. Improve the consistency of data collection and increase the completeness of priority population specific data, including PWID, Aboriginal people, people from CALD backgrounds and those currently in or recently exited custodial settings.

2. Contribute towards, and continue to support national research and evaluation projects.

3. Increase surveillance on behavioural trends and risks for hepatitis C including injecting drug use and receptive needle sharing, as well as maintaining data on treatment commencement and adherence.

4. Investigate and monitor stigma and discrimination, as well as related issues that impact on the decisions people at risk of hepatitis C or those living with hepatitis C may face.

5. Build competence within the sector to appropriately evaluate current and future projects to ensure alignment with relevant action areas within this strategy.

6. Investigate opportunities to participate in and conduct data linkage projects utilising relevant state and national datasets to further explore prevalence, incidence, reinfection and treatment rates.

7. Share relevant research, evaluation and surveillance data with the sector to inform future planning and projects.
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>
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</thead>
<tbody>
<tr>
<td>1. Reduce the number of newly acquired hepatitis C infections by 60%, with a focus on priority populations.</td>
<td>Annual rate of newly acquired hepatitis C 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 C notifications</td>
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<tr>
<td></td>
<td>Denominator: Australian Bureau of Statistics (ABS) Estimated Resident Population, Aboriginal and non-Aboriginal, all ages</td>
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<td>2. Increase the proportion of people living with hepatitis C who are diagnosed to 90%</td>
<td>Estimated annual proportion of people living with chronic hepatitis C who have been diagnosed</td>
<td>Indicator to be developed</td>
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<td></td>
<td>Annual rate of unspecified hepatitis C notifications</td>
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<td></td>
<td>Numerator: Number of unspecified hepatitis C notifications</td>
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<tr>
<td></td>
<td>Denominator: ABS Estimated Resident Population, Aboriginal and non-Aboriginal, all ages</td>
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<td>3. Increase the cumulative proportion of people living with chronic hepatitis C who have initiated DAA treatment to 65%</td>
<td>Proportion of people living with hepatitis C dispensed DAA treatment for hepatitis C infection</td>
<td>PBS treatment data</td>
</tr>
<tr>
<td></td>
<td>Numerator: Number of people dispensed DAA treatment for chronic hepatitis C infection</td>
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<tr>
<td></td>
<td>Denominator: Modelled estimate of the number of people living with chronic hepatitis C</td>
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<tr>
<td>4. Reduce hepatitis C attributable mortality overall by 65%</td>
<td>Estimated number of deaths attributable to chronic hepatitis C</td>
<td>Data linkage study</td>
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<td>Targets by the end of 2023</td>
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<td>Sources</td>
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<td><strong>5.</strong> Reduce the reported experience of stigma among people living with hepatitis C, and the expression of stigma, in respect to hepatitis C status</td>
<td>Proportion of people living with hepatitis C who report experiencing stigma and discrimination in respect to hepatitis C status</td>
<td>Centre for Social Research in Health, University of New South Wales (UNSW)</td>
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<td></td>
<td>Proportion of the general public who report feelings of stigma and discrimination towards people living with hepatitis C</td>
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<tr>
<td></td>
<td>Proportion of health professionals who report feelings of stigma and discrimination towards people living with hepatitis C</td>
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<tr>
<td><strong>6.</strong> Increase the use of sterile injecting equipment for every injecting episode</td>
<td>Prevalence of receptive syringe sharing by WA participants in the Australian Needle and Syringe Program Survey (ANSPS)</td>
<td>ANSPS, The Kirby Institute</td>
</tr>
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</table>
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


