Access to Hepatitis B Vaccination for People Who Inject Drugs and Sex Workers in Australia

Policy Discussion Paper

Australian Injecting and Illicit Drug Users League
and
Scarlet Alliance, Australian Sex Workers Association

About the Authors:

The Australian Injecting and Illicit Drug Users League (AIVL) is the national peak organisation representing the state/territory peer-based drug user organisations and issues of national importance for people who use or have used illicit drugs. AIVL is a peer-based, drug user-led organisation with a primary focus on representing the needs and interests of people with a history of injecting drug use in relation to blood borne viruses (BBVs) and sexually transmissible infections (STI) prevention, treatment and care. Scarlet Alliance is Australia's national peak body representing a membership of individual sex workers, and sex worker networks, groups and community-based projects and organisations from around Australia. Scarlet Alliance is an organisation of sex workers and has been active in promoting the principles and approaches which have been effective in minimising the transmission of HIV, BBVs and STIs amongst sex workers and our clients.
Executive Summary

Aims of the Policy Discussion Paper:

The aims of this discussion paper were to identify potential gaps and ‘disconnects’ between stated policy and ‘on-the-ground’ practice; meet stated goals of the National Hepatitis B Strategy: to promote national consistency in groups and communities eligible for funded vaccination; increase the uptake of hepatitis B vaccination among priority populations; identify barriers to people who inject drugs (PWIDs) and sex workers accessing hepatitis B vaccination programs; and to reduce the transmission of hepatitis B.

Approach:

This co-authored policy discussion paper emerged from the recognition that vaccination is the most effective means of preventing the transmission of hepatitis B, and the need to improve hepatitis B vaccination as important strategic priority. The discussion paper seeks to document good policy and practice where it exists, and the authors hope to work collaboratively with other relevant stakeholders to ensure consistent coverage of free vaccination for sex workers and PWIDs as priority populations across Australia.

Methodology:

Scarlet Alliance and the Australian Injecting and Illicit Drug Users League (AIVL) had different starting points and methodological approaches to establishing the baseline data to support our policy conclusions. There is an abundance of existing research on hepatitis B vaccination and PWIDs, however there is little or no action based on the findings from this research. In contrast, there is a distinct lack of existing research about hepatitis B vaccinations and sex workers, so Scarlet Alliance undertook further primary research in the form of a survey (in addition to standard consultations with member organisations) to make up for a lack of research attention in this area.

In addition to this survey material, these policy conclusions are based upon assessments by peer-based drug user and sex worker organisations and projects; available evidence and reporting provided by state and territory health departments; anecdotal reports and consultation with PWIDs and sex workers; and a review of existing jurisdictional policies and programs.

Background:

The National Hepatitis B Strategy is one of five strategies aiming to reduce the transmission of sexually transmissible infections (STIs) and blood borne viruses (BBVs) developed in partnership with affected communities and Government. Both PWIDs and sex workers are listed as ‘population(s) of interest’ in the Strategy. The Strategy promotes national consistency in groups and communities eligible for funded vaccination, and lists increasing the uptake of hepatitis B vaccination among priority populations as a ‘priority action in prevention.’ Hepatitis B vaccination for both PWIDs and sex workers is also recommended by the National Health and Medical Research Centre’s Australian Immunisation Handbook.
The introduction of a National Immunisation Program in Australia has had significant impact on the incidence of hepatitis B infections. However there remains consistent and unacceptably high levels of incident infection among PWIDs. Research indicates that unsafe injecting practices account for at least 50% of new infections, that adolescent catch-up vaccination programs are missing young people engaged in ‘high-risk’ behaviours, and that there is a need for a more targeted response rather than relying on the universal vaccination program to address this issue ‘over time’.

Reducing hepatitis B infection rates remains a priority – majority of infections among PWIDs are acquired as adults, most PWIDs who become infected will develop an immune response, and others go on to develop chronic infection. This is further complicated by PWIDs’ access to health systems, knowledge about status and vaccination, co-infection with hepatitis C, social stigmas around injecting drug-use, and incarceration for drug-related offences. Despite PWIDs being identified as an ‘at-risk’ population for over two decades, the research documented below represents a burden of disease among this population that is unnecessary and preventable.

There is no comprehensive research on rates, prevalence or incidence of hepatitis B among sex workers, or on access to or completion of hepatitis B vaccinations. However both the National HIV Strategy and National STI Strategy note that the incidence of HIV/STIs among sex workers is among the lowest in the world. Research in Australia from the Law and Sex worker Health Study, Kirby Institute and Roberta Perkins consistently shows that sex workers have high rates of condom use, high rates of testing, and low rates of HIV/STIs. Although voluntary testing remains the optimal model to HIV/STI testing in Australia’s National Strategies, sex workers face mandatory testing in some jurisdictions. Sex workers also face barriers to accessing vaccinations, information and health services in criminalised and licensed settings. Despite this, sex workers successfully manage risks and have lower rates of STIs/HIV than the general population. The National HIV Strategy speaks about ‘maintaining’ these low rates through peer education, community led health promotion and continued investment in programs for priority populations. However, current state and territory hepatitis B funding programs are ad hoc in their recognition of sex workers as an eligible group for funded vaccinations.

The development of the National Hepatitis B Strategy – which notes that vaccination is the most effective means of preventing the transmission of hepatitis B – brings a new opportunity to review and assess existing jurisdictional policies and programs aimed at hepatitis B prevention.

Findings:

State and territory policies on PWIDs and sex worker access to hepatitis B vaccinations remain inconsistent and ad hoc, with significant variation across jurisdictions. These inconsistencies translate into increased barriers to sex workers’ and PWIDs awareness of, access to and completion of the vaccine.

Each state and territory differs according to who is considered a priority population, and again on who is eligible for funded vaccinations. Although sex workers are a ‘population of interest’ in the National
Hepatitis B Strategy, they are rarely recognised as a priority population at a state level, and where they are, this does not necessarily mean that they are eligible for subsidised or free vaccinations. Although PWIDs are more consistently recognised as a priority population eligible for subsidised or free vaccination at the state and territory level, inconsistencies remain in the promotion, availability and implementation of such programs. In some jurisdictions, hepatitis B is addressed in broader policy documents rather than in specific hepatitis B policies. There remain inconsistencies in the promotion, availability and implementation of hepatitis B vaccination programs.

Data collected by AIVL and Scarlet Alliance indicates a range of potential barriers to hepatitis B immunisation for PWIDs and sex workers including:

- low levels of knowledge among PWIDs about hepatitis B;
- problems with the availability of and access to hepatitis B vaccination;
- specific issues relating to cost of vaccination and the needs of people in regional/remote areas;
- the need for further IDU and sex worker peer education;
- regulatory frameworks around sex work, illicit drugs and injecting drug use, including criminalisation and licensing;
- stigma and discrimination in accessing health or service providers;
- concerns over disclosure of sex work or IDU status to access vaccinations;
- inconsistencies between who is eligible for funded vaccinations across states and territories; and
- potential gaps and ‘disconnects’ between state policy and ‘on-the-ground’ practice.

There is a general lack of knowledge about the existence, availability and kinds of hepatitis B vaccination among PWIDs. Research reflects a lack of knowledge among PWIDs about their sero-status, mistaking HBV and HAV vaccinations, and believing HBV vaccination protects from HCV. Hepatitis B vaccination uptake and completion rates among PWIDs are strongly correlated to service models and how and when information and access to vaccination is provided.

In contrast, sex workers surveyed demonstrated high rates of knowledge and awareness of vaccines, however less were aware about the cost or availability of vaccinations for sex workers in their state or territory. This reflects the ad hoc and inconsistent nature of hepatitis B programs, funding and priority populations across Australia. Even though vaccinations may be ‘recommended’ for sex workers under a policy, they may not be funded for sex workers, or they may only be accessible through certain access points.

Regulatory frameworks around injecting drug use and sex work impact on both PWIDs and sex workers’ knowledge of and access to these programs. Sex worker surveyed in Queensland and Victoria, where licensing jurisdictions were in place, consistently showed lower levels of knowledge and access than in
NSW, where sex work is decriminalised. Similarly, sex workers in NSW were far more likely to have received information on hepatitis B vaccination than sex workers in Queensland or Victoria.

High levels of stigma and discrimination, reluctance to engage with the health system due to past negative experiences, and fears about disclosing sex worker status or injecting drug use for risk of prosecution continue to act as barriers to hepatitis B vaccination. Many people are reluctant to admit they inject or have injected drugs due to high levels of stigma and discrimination and the potential legal consequences. (Trauma from discrimination in a sexual health clinic was given as a reason for one sex worker not completing a vaccination course). Particularly in regional areas, sex workers surveyed were reluctant to ‘out’ themselves to health or service providers, meaning that service providers may overlook significant proportions of priority populations. If people wished to access the vaccination without disclosing their status, the cost could be a substantive deterrent to vaccination. Criminalisation of sex workers with an STI means that sex workers who suspect they may have contracted STIs may be reluctant undergo testing for fear of discrimination from their workplaces. There remain inconsistent policies across jurisdictions on the availability of free or subsidised vaccines for sex workers, Transport costs and concerns about confidentiality were obstacles to vaccination in remote locations. Several drug user organisation representatives expressed frustration over the apparent mismatch between access points for free hepatitis B vaccination as detailed in policy documents and actual availability in practice.

There is a clear need for a more comprehensive national approach to hepatitis B vaccination, to bring states and territories in line with the National Hepatitis B Strategy. This includes a need to develop a more systematic policy approach to ensuring post-vaccination follow-up and testing to confirm immunity while still ensuring that fundamental rights in relation to confidentiality, informed consent and voluntary testing are at the basis. Hepatitis B prevention among PWIDs and sex workers can be seen as a cost-effective opportunity to reduce the burden of disease and improve access to primary health care for highly marginalised groups within the community.

**Innovative Evidence-Based Hepatitis B Immunisation Approaches:**

Over the past 15-20 years peer-based drug user organisations have implemented programs aimed at improving access to hepatitis B vaccination among PWIDs. These peer-driven clinical models have been undertaken as pilot projects in collaboration with other services (such as Divisions of General Practice) and as ongoing programs within drug user organisations via in-house clinics. By providing access to hepatitis B testing and vaccination in a more ‘user-friendly’ environment, these programs were specifically developed to address some of the main barriers to hepatitis B vaccination identified above. Specific approaches adopted or piloted (both on their own and in combination) include peer support models, locum clinics attached to peer-based NSP services, contingency management protocols, nurse-administered hepatitis B vaccination within drug user organisations and accelerated/rapid schedules. The successes and limitations of these innovative evidence-based immunisation models provide useful consideration for future approaches and possibilities. Future action in this area should include investment in new action
research collaborations and peer-based demonstration projects to further explore the application of these innovative models and approaches in other jurisdictions and contexts.

**National Key Issues:**

In Australia we have had a safe, efficacious and cost-effective vaccine for hepatitis B for over 20 years yet we still have unacceptably high levels of new hep B infections among key priority populations. This situation is entirely unnecessary and needs to be addressed as a priority.

Currently, the National Hepatitis B Strategy is not effectively implemented across states and territories. There are significant variations between policies across jurisdictions, gaps between policy and practice, and divergent rates of knowledge and access.

This policy discussion paper demonstrates the need for a single standardised hepatitis B policy in each state and territory, the need to address barriers to increase course completion, and the need to address wider structural barriers through the decriminalisation of sex work and drug use across Australia and the introduction of federal anti-discrimination laws.

**Outcomes and Recommendations:**

New hepatitis B infections do not need to be occurring at the rate they currently are. We can and must address this situation by removing barriers to appropriate prevention, information and services (including peer education and needle and syringe programs); ensuring an enabling policy and legislative environment (including the proactive removal of systemic and structural barriers); and improving access to an existing safe, efficacious and cost-effective vaccine (including a standardised hepatitis B policy and consistency in the availability of free vaccinations for priority populations).

This policy discussion paper recommends a nationally consistent approach specifically aimed at improving access, reducing barriers, improving completion rates, and increasing demand for vaccination. Such steps would meet the main stated goals of the *National Hepatitis B Strategy* – to promote national consistency in groups and communities eligible for funded vaccination; increase the uptake of hepatitis B vaccination among priority populations; and to reduce the transmission of hepatitis B.
Access to Hepatitis B Vaccination for People Who Inject Drugs and Sex Workers in Australia

Identifying Gaps in Policy and Practice: Aims and Approach of the Policy Discussion Paper:

This is a discussion paper jointly authored by AIVL and Scarlet Alliance. AIVL and Scarlet Alliance have prepared the following paper on access to and uptake of hepatitis B testing, vaccination and follow-up among people who inject drugs (PWIDs) and sex workers primarily for the membership of the Blood Borne Viruses & Sexual Transmitted Infections (BBVS) Sub-Committee of Australian Population Health Development Principal Committee (APHDPC).

Anecdotal reports from people who inject drugs and sex workers, assessments by peer-based drug user and sex worker organisations and projects, available evidence and reporting from jurisdictions indicate a range of potential barriers to hepatitis B immunisation for PWIDs and sex workers. In the context of the First National Hepatitis B Strategy, AIVL identified an opportunity to undertake a brief review of existing jurisdictional policies and programs and assess these against the available data and other information gathered through consultations with drug user organisations on access to and uptake of hepatitis B vaccination among PWIDs. Scarlet Alliance also reviewed jurisdictional policies and conducted a survey to assess sex workers’ knowledge and access to free/subsidised hepatitis B vaccinations compared with state policies and programs, with view to improving the national hepatitis B response.

The aim of this process was to identify potential gaps and ‘disconnects’ between stated policy on the one hand, and ‘on-the-ground’ practice on the other, with the overall intention of reducing barriers and improving access to timely and relevant hepatitis B prevention services for PWIDs and sex workers. AIVL and Scarlet Alliance are not alone in having identified the need to review the operationalisation of policies targeting high risk groups for hepatitis B vaccination. Australian research studies have also noted problems between policy and practice in relation to hepatitis B vaccination among PWIDs and the need to respond to these issues in the interest of increasing access to and completion rates for hepatitis B vaccination among this group. By identifying certain problems in relation to current hepatitis B vaccination policy and practice AIVL and Scarlet Alliance do not wish to appear overtly critical of the efforts of policy makers or the many ‘on the ground’ practitioners who are often well aware of the gaps and barriers within the system. Rather, we are seeking to document good policy and practice where it exists and encourage members of BBVS Sub-Committee to view the need to improve hepatitis B vaccination among PWIDs and sex workers as not only a policy and programmatic challenge but as an important strategic priority.

Through an increased understanding of current policy frameworks and the clinical environment AIVL and Scarlet Alliance hope to work collaboratively with other relevant stakeholders over the life of the National

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Strategy to reduce the current level of new hepatitis B infections among PWIDs, and ensure consistent coverage of free vaccination availability for sex workers and PWIDs as priority populations across Australia. Given the safety, efficacy and cost-effectiveness profile of hepatitis B vaccination, AIVL and Scarlet Alliance believe this is not only entirely achievable but would meet one of the main stated goals of the National Hepatitis B Strategy – to reduce the transmission of hepatitis B.²

National Hepatitis B Strategy 2010-2013:

The National Hepatitis B Strategy is one of five strategies aiming to reduce the transmission of sexually transmissible infections (STIs) and blood borne viruses (BBVs). A partnership approach has been central to the development of this strategy between affected communities, governments, health sectors, community organisations, researchers and clinicians. As part of the Guiding Principles, the Strategy notes that ‘vaccination is the most effective means of preventing the transmission of hepatitis B. Vaccination, education and prevention programs, together with access to the means of prevention, are prerequisites for adopting and applying prevention measures.’³

The Strategy lists both sex workers and PWID as a ‘population of interest’ for the prevention of hepatitis B transmission and at higher risk of infection if not vaccinated. Of course, people may fall under a range of ‘priority population’ categories – these categories intersect and are not necessarily distinct. The Strategy lists a number of ‘priority actions in prevention’, including to:

- Promote national consistency in groups and communities eligible for funded vaccination, giving priority to communities at greatest risk of hepatitis B infection.
- Increase the uptake of hepatitis B vaccination among priority populations, thereby reducing the social impact, morbidity and mortality associated with undetected or untreated infection.⁴

The analysis of information and consultation presented in this paper by AIVL and Scarlet Alliance demonstrates that the priority actions outlined in the National Hepatitis B Strategy are currently not effectively applied. Instead, implementation is inconsistent and ad hoc, with significant variation across states and territories. Review of state and territory policies reveals that although sex workers are a ‘population of interest’ in the National Strategy, they are rarely recognised as a priority population at a state level, and where they are, this does not necessarily mean that they are eligible for subsidised or free vaccinations. Although PWIDs are more consistently recognised as a priority population eligible for subsidised or free vaccination at the state and territory level, inconsistencies remain in the promotion, availability and implementation of such programs. These inconsistencies translate into increased barriers to sex workers’ and PWIDs awareness of, access to and completion of hepatitis B vaccination. There is a clear need for a more comprehensive national approach to hepatitis B vaccinations, to bring states and

⁴ Ibid, p.22.
territories in line with the National Strategy.

**Background – Hepatitis B & People Who Inject Drugs in Australia:**

*The impact of the National Immunisation Program*

The National Immunisation Program (NIP) has had a significant impact on incident infections with more than a 50 per cent decrease in newly acquired hepatitis B notifications over the past 10 years.\(^5\) Despite this situation however, surveillance data on hepatitis B infections in Australia also show that unsafe injecting practices account for at least 50 per cent of all new hepatitis B infections.\(^6\) Importantly, this unacceptably high level of incident infection among PWIDs has remained consistent over the past ten years indicating the need for a more systematic approach to addressing hepatitis B prevention among PWIDs -particularly increasing access to, uptake of and completion rates for hepatitis B vaccination.

There are indications that adolescent catch-up and targeted vaccination programs may be having an impact on hepatitis B infection rates among PWIDs. A recent Australian study showed higher levels of vaccine-induced immunity and lower levels of prior infection among study participants than in previous Australian studies of PWIDs.\(^7\) Having said this however, the same study also found a number of participants, who would have been eligible for the adolescent catch-up program when it was introduced in NSW in 2004, who either did not show serological evidence of prior vaccination or had no HBV serological markers -therefore remaining susceptible to infection.\(^8\)

Previous sero-surveys into the adolescent catch-up program have also shown low coverage rates (56%) and, with the exception of the first dose, poor completion rates for the full schedule (20%).\(^9\) These findings suggest that adolescent catch-up vaccination programs are almost certainly missing young people engaged in ‘high-risk’ behaviours and/or those who are not regularly attending school, have dropped-out, etc., and that a good deal more time will be needed (perhaps more than a decade) before we could confidently claim majority coverage through the adolescent programs. When taken together, the above evidence strongly suggests the need for a more targeted response to addressing hepatitis B vaccination among PWIDs (particularly new initiates and young users) rather than a simply relying on the universal vaccination program to address this issue ‘over time’.

**Why reducing hepatitis B infection rates among PWIDs remains a priority**


\(^7\) White, B. Dore, G. Lloyd, A. Rawlinson, W. Maher, L. Ongoing susceptibility to hepatitis B virus infection among people who inject drugs in Sydney, NCHECR, APSAD 2011 Abstract – as yet unpublished data.

As the majority of infections among PWIDs are acquired as adults, most PWIDs who become infected with hepatitis B will develop an effective immune response, resulting in ongoing immunity within six months of infection. It is estimated however that approximately 5% of those adults infected with hepatitis B will go on to develop chronic hepatitis B infection. In addition, in Australia more than 160,000 people are estimated to be chronically infected with the hepatitis B virus and estimates suggest that 5% of these chronic infections occur in PWIDs.10

Route of infection however is not current systematically recorded, testing rates for hepatitis B are very low among PWIDs and even if tested, many people are reluctant to admit they have injected drugs due to high levels of stigma and discrimination. This is further complicated by the sexual transmissibility of hepatitis B which can result in multiple risk factors for PWIDs and further discrepancies in relation to identifying and recording route infection. In addition, recent Australian research into ongoing susceptibility to HBV infection among PWIDs showed that 15% of the total sample where people born in high prevalence countries – a factor that could further complicate accurate recording of route of infection.11 Even among those PWIDs who are tested and subsequently vaccinated there continues to be problems with lack of follow-up testing to ensure immunity to hepatitis B.

Although there is no reference in the NHMRC Handbook section on Post Vaccination Procedures that recommends follow-up testing for immunity generally, there is a recommendation for ‘serological confirmation of post-vaccination immunity.’ Post-vaccination serological testing 4 to 8 weeks after completion of the primary course is recommended only for those in the certain categories, including ‘those at significant occupational risk (e.g. healthcare workers whose work involves frequent exposure to blood and body fluids).’12 Sex workers and PWIDs arguably fall under this category because of their frequent exposure to blood and body fluids. Post-vaccination testing for immunity is something AIVL and Scarlet are highlighting here as a potential issue for discussion and policy development (in the Immunisation Handbook, National Strategies and state/territory policies) because vaccine completion rates remain low and many PWIDs and sex workers surveyed did not know if they had finished their course. In this discussion paper AIVL cite people having misinformed assumptions about their supposed immunity (because of prior infection), and this assumption also appeared in the Scarlet survey (respondents assumed immunity after 2 injections).

AIVL believes the above combination of factors may mean the level of chronic hepatitis B infection among PWIDs is higher than the current estimate of 5% of chronic infections. This situation is further complicated

11 White, B. et al., above n 7.
by research showing PWIDs may not have a good understanding of their hepatitis B status\textsuperscript{13} including whether or not they have been vaccinated, assumptions about immunity following previous infection and for older users, being encouraged to believe they are “healthy carriers”. In a recent Australian study, only half of those chronically infected with hepatitis B were aware of their status.\textsuperscript{14} Even if we were to set aside all of the above factors however, the current estimate alone still represents an unacceptable and unnecessary burden of disease. Five per cent of over 160,000 chronic infections still equates to many thousands of PWIDs living with chronic hepatitis B, who may also be co-infected with hepatitis C and almost certainly will have very poor contact with and access to the health system.

Research has also confirmed that chronic hepatitis B/C co-infection has a significant impact on the rate of hepatitis disease progression with major implications for the individual, social consequences for families and communities and economic implications for the health system.\textsuperscript{15} In addition to the above, people entering custodial settings have higher rates of previous hepatitis B infection than the general community with only approximately 50% of those new prisoners having immunity to hepatitis B.\textsuperscript{16} Given the high rates of people incarcerated for drug related offences, any approaches aimed at increasing hepatitis B testing and vaccination rates among PWIDs must include appropriately designed programs for custodial environments.

The need to address the unacceptably high levels of incident hepatitis B infection among PWIDs is also supported by the new national strategies for hepatitis B, hepatitis C and Aboriginal and Torres Strait Islander BBVs & STIs. The “Guiding Principles” section of the national strategies acknowledges that vaccination is the most effective means of preventing the transmission of hepatitis B and that access to education, vaccination and the means of prevention are prerequisites for health.\textsuperscript{17} Hepatitis B vaccination for PWIDs is also recommended by the NHMRC’s \textit{Australian Immunisation Handbook} (9\textsuperscript{th} edition).

\textbf{Immunisation coverage rates and hepatitis B prevention among PWIDs}

Hepatitis B is \textit{preventable} through a safe and efficacious vaccine. As stated by Baral, et al however: “A \textit{consistent and disturbing finding in reviewing the published work on vaccination in IDUs is that they are at high risk for vaccine preventable infections, but generally have among the lowest immunization coverage rates}”.\textsuperscript{18} This finding has also been demonstrated in recent Australian cohort studies showing high susceptibility and low immunisation coverage – conclusions which are also supported by US studies among PWIDs.\textsuperscript{19} There is a point at which we must seriously ask “why are the immunisation coverage

\textsuperscript{15} Department of Health and Ageing, above n2, p.17.
\textsuperscript{16} Department of Health and Ageing, above n2, p9.
rates for hepatitis B so consistently poor among PWIDs when this group has now been identified as an “at-risk” population for targeted vaccination programs for over two decades?”

In relation to hepatitis B and PWIDs, the case is sometimes made that although this group represents at least half of all incident infections, we are still “only” talking about 300 or 400 notifications per year. This is further exacerbated by inaccurate stereotypes characterising PWIDs as not caring about their health and/or disinterested in hepatitis B vaccination or otherwise they would be accessing free vaccination already. AIVL believes however that such views have no place in good practice public health medicine. The data clearly shows a burden of disease for PWID that can be significantly compounded by the potential for high rates of co-infection with hepatitis C. These reasons alone are sufficient to prioritise hepatitis B testing, vaccination and follow-up among PWIDs.

**Creating an enabling environment for hepatitis B vaccination among PWIDs**

In line with the guiding principles in the National Hepatitis B Strategy 2010-2013, addressing current barriers to hepatitis B vaccination access, uptake and completion among PWIDs, will require the “formulation and application of law and public policy that support and encourage healthy behaviours and respect human rights.” Creating such an enabling environment will involve the proactive removal of the now well-documented systemic and structural barriers that prevent many PWIDs achieving even the most basic level of health empowerment and health literacy. Any approach that simply seeks to provide more access to hepatitis B vaccination without addressing the reasons why PWIDs are not accessing and completing hepatitis B vaccination now will do very little to change the current situation. In particular, there is a need to address the impact of stigma and discrimination and illegality and criminalisation on the health and lives of PWIDs. Addressing these factors will be central to creating an environment where PWIDs can feel a genuine sense of safety, trust and confidence in accessing the health system.

**Background – Hepatitis B and Sex workers in Australia:**

Sex workers in Australia are diverse. Sex workers do not necessarily fall into one distinct population priority – sex workers include communities who are Culturally and Linguistically Diverse (CALD), Men who have Sex with Men (MSM), Aboriginal and Torres Strait Islander (ATSI), Sex and/or Gender Diverse (SGD) and PWIDs. CALD and ATSI sex workers fit within the three priority populations listed in the National Hepatitis B Strategy for the prevention of hepatitis B. MSM, PWID and sex workers are all listed among the ‘unvaccinated adults at higher risk of infection’. The strategy states that ‘Both men who have sex with men and sex workers are at increased risk of infection’.

**Survey methodology**

There is no comprehensive research on rates of hepatitis B among sex workers. The *HIV, Viral Hepatitis*
and Sexually Transmissible Infections in Australia Annual Report by the Kirby Institute provides statistics on a range of priority populations, including ATSI and MSM populations, but does not have specific information on sex workers.\(^{24}\) Due to the lack of available evidence on the prevalence, incidence, access, uptake and completion of hepatitis B vaccinations among sex workers, Scarlet Alliance conducted an anonymous online survey to gather information. The survey was conducted in October 2011 and 32 sex workers completed the survey. Respondents came from both city (27) and regional areas (5). Respondents came from NSW (15), ACT (1), VIC (4), QLD (8), NT (1), SA (2) and WA (1). 84.4\% of respondents resided in the city. 15.6\% of respondents resided in a regional area. Respondents did a range of different kinds of sex work. The results of the survey are detailed throughout this paper. Scarlet Alliance’s ability to gather this information within a short period demonstrates our connection to community and a high level of sex worker involvement. Because the survey was small scale, those surveyed are generally already in contact with services and may not be representative of the broader experience of awareness amongst sex workers.

**Sex workers have consistently low rates of STIs**

Both the *Sixth National HIV Strategy 2010-2013* and the *Second National STI Strategy 2010-2013* note that ‘the incidence of HIV/STIs in sex workers in Australia is among the lowest in the world. This is largely because of the establishment of safe-sex as a norm, the availability of safe-sex equipment, and community-driven health promotion and peer-based interventions.’\(^{25}\) Sex workers consistently have very high rates of prophylactic use\(^{26}\) - the LASH (Law and Sexual Health) report to the NSW Health Department in 2011 found that condom use at work approaches 100\% in Sydney brothels\(^{27}\) - and act as role models and safer sex educators to our clients and the wider community. Sex workers have been at the forefront of the Australian response to HIV, established longstanding partnerships with governments and community sectors, and continue to engage in health promotion activities through peer education, outreach and the implementation of safer sex practices.

**Voluntary testing is the best-practice approach to STI testing**

Voluntary testing remains the optimal approach to STI and HIV testing in Australia as outlined in the National Strategies. The *National STI Strategy* recommends voluntary patient-initiated testing as a successful approach to detecting STIs, and warns that mandatory testing has ‘potential to limit access to services for higher risk groups’.\(^{28}\) The burdens of mandatory or compulsory STI and HIV testing as have

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\(^{26}\) Roberta Perkins and Francis Lovejoy, *Call Girls*, University of Western Australia Press, 2007.


been in place for sex workers in licensing jurisdictions have been disastrous for sex workers, and placed a burden upon sex workers that is not placed upon other workers who engage in risk activities. Mandatory testing has had consequences upon sex worker confidentiality, human rights and industrial rights. Recent studies indicate that current mandated testing frequency for sex workers are already ‘excessive’ and that the use of resources in screening and providing certificates to sex workers could be better spent. The National HIV Strategy states that ‘principles for informed consent and confidentiality underpin high rates of voluntary testing’, and aims to increase the number of people voluntarily seeking testings. Importantly, research illustrates that despite more mandatory testing in Victoria, STI prevalence is uniformly low among sex workers in Sydney and Perth where screening is voluntary and negotiated between the worker and their clinician on an individual basis. In New Zealand, the New Zealand Prostitutes Collective stated that since decriminalisation, nearly 97% of sex workers have voluntary sexual health checks.

**Sex workers must be recognised as a priority population to maintain low rates of STIs**

Sex workers successfully manage risks due to the continued funding and implementation of peer education and outreach services. The National HIV Strategy speaks about ‘maintaining low rates of HIV among priority groups (sex workers and drug users) through the implementation of peer education and community led health promotion.’ One of the priority actions in prevention is to ‘continue to invest in and monitor prevention programs for priority risk populations.’ Sex workers need to be recognised as a priority population for hepatitis B vaccination funding programs in all states in order to maintain the current low levels of BBVs. Despite being recognised as a ‘population of interest’ at ‘increased risk of infection’ in the National Hepatitis B Strategy, state and territory hepatitis B funding policies and programs are ad hoc in their recognition of sex workers as an eligible group for funded vaccinations. Hepatitis B vaccination for sex workers is recommended by the NHMRC’s Australian Immunisation Handbook (9th edition).

**Sex workers experience barriers to access in criminalised and licensed jurisdictions**

It is vital that sex workers are specifically included as a priority population, because sex workers already face barriers to accessing vaccinations, information, health services and peer education because of licensing and criminal regulatory models and experiences of discrimination and stigma. In states where licensing models are in force, sex workers may be required to register their legal name and address on a

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35. Ibid, emphasis added.
permanent police or government register. Registration limits sex workers’ access to health services for fear of being ‘outed’,\(^{38}\) or for fear of prosecution.\(^ {39}\) Criminalisation also means that HIV positive sex workers, or sex workers who suspect they may have contracted HIV or STIs, may be reluctant to disclose our status or undergo HIV testing for fear of discrimination from our workplaces, communities and health providers. The *National Needs Assessment of Sex Workers who Live with HIV* in 2008 found that many health organisations ‘are judgmental and critical of the involvement of HIV positive people in sex work and often attempt to dissuade them from continuing.’\(^ {40}\) Participants in the study reported that ‘[i]nstances of disclosure of both HIV status and sex work generally lead to very poor treatment and harassment, and in one reported case included physical violence by a health care worker.’\(^ {41}\) Others reported ‘misinformation’ being provided to them about the legality of participating in commercial sex,\(^ {42}\) or felt health services were ‘taking on more of a law enforcement role.’\(^ {43}\)

**Funding vaccinations creates an enabling environment in line with international best practice**

These barriers mean that it is increasingly important for sex workers to be recognised as a priority population in state and territory policies on hepatitis B. Increasing evidence supports targeted investments for key affected populations as a strategy to change the trajectory of national epidemics.\(^ {44}\) The Ottawa Charter on Health Promotion states the importance of creating an ‘enabling’ environment to reduce differences in health status by ensuring equal opportunities and resources.\(^ {45}\)

**Service Models and Regulatory Frameworks Affect Knowledge and Accessibility:**

*The impact of regulatory frameworks on knowledge and accessibility*

Throughout the available research a general lack of knowledge about hepatitis B vaccination is well-documented among PWIDs.\(^ {46}\) AIVL and its member organisations have long been aware that many PWIDs do not know there is a vaccine for hepatitis B and/or are frequently confused about the forms of viral hepatitis for which vaccines are available. This is supported by research reflecting the fact that those most at risk of hepatitis B infection seem to be those least likely to be offered or to take-up the opportunity to be vaccinated for hepatitis B.\(^ {47}\) As stated above, the literature also suggests that PWIDs have a lack of knowledge in relation to their sero-status and frequently think they have been vaccinated when they

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\(^{39}\) Jan Jordan, *The Sex Industry in New Zealand: A Literature Review*, Ministry of Justice, 2005


\(^{41}\) Ibid, p.32.

\(^{42}\) Ibid, p.24.

\(^{43}\) Ibid, p.32.


haven’t. In focus groups, AIVL has documented PWIDs mistaking HAV and HBV vaccinations and thinking HBV vaccination protects them from HCV. These findings are consistent across all states and territories and AIVL believes this is largely because the main, well-documented barriers to accessing health services for PWIDs such as stigma, shame and fear of discrimination are primarily driven by a consistent approach to the criminalisation of PWIDs across all jurisdictions.

For sex workers surveyed, rates of knowledge and awareness of vaccines were relatively high. This is expected as generally sex workers have high levels of access to screening services however there were significant barriers to completion of a course of vaccinations and dramatic differences according to state and territory policy. A high level of knowledge and awareness did not necessarily result in finalising a course of vaccination. 90.6% of surveyed sex workers knew there was a vaccination for hepatitis B. But only 50% were aware of vaccinations available to sex workers in their state, reflecting the lack of recognition of sex workers as a priority population for funded hepatitis B vaccinations. This knowledge also differed significantly between states and territories where different regulatory models were in place. Respondents in Queensland and Victoria, where licensing jurisdictions were in place, consistently showed lower levels of knowledge and access than in NSW, where sex work is decriminalised. Respondents in regional areas also had lower levels of knowledge and access. Overall there was less awareness about the cost of hepatitis B vaccinations for sex workers: Only 28.9% of respondents knew how much sex workers were charged for vaccinations. This reflects the ad hoc and inconsistent nature of hepatitis B programs, funding and priority populations across Australia. Even though vaccinations may be ‘recommended’ for sex workers, they may not be funded for sex workers. Where funded vaccinations are available, they may only be accessible through some limited access points (such as certain sexual health centres). These statistics reveal the need for a consistent, comprehensive national approach to hepatitis B vaccinations as well as the alignment of regulatory models.

The National Hepatitis B Strategy 2010-2013 specifically identifies the need to address poor levels of knowledge about hepatitis B and the availability of hepatitis B vaccination among PWIDs and sex workers. The Strategy also highlights the importance of national consistency in relation to information on and access to hepatitis B vaccination for at risk communities and identifies the need for IDU peer education in relation to hepatitis B prevention and vaccination. Both of these issues are identified as a priority actions under the Strategy.

The impact of service models on knowledge and accessibility

Whether someone is likely to take up the opportunity to be vaccinated or not, and our inability to make the most of those opportunities to engage PWIDs in hepatitis B immunisation has been linked in literature to a discrepancy between “efficacy” and “effectiveness”. This critical distinction is explained best by Maher when she states:

49 Department of Health and Ageing, above n 2, pp. 21-22.
50 Ibid.
As Imrie, Elford, Kippax and Hart (2007) have recently reminded us, efficacy (health improvement under ideal circumstances, in expert hands) is not the same as effectiveness (impact on health, under real-world conditions, for entire populations). The fact that hepatitis B is still an issue 25 years after the first vaccines became commercially available represents a teachable moment in harm reduction. At the end of the day it really doesn’t matter how efficacious a particular prevention technology is – whether it is a vaccine, a condom or a clean syringe – if it is not accessible to the target group.\textsuperscript{51}

Hepatitis B vaccination uptake and completion rates among PWIDs are strongly correlated to service models and how and when information and access to vaccination is provided.\textsuperscript{52} Having said this however, multiple factors can simultaneously impact on hepatitis B vaccination access, uptake and completion among PWIDs. For example, an Australian study has shown that accessible primary health care environments and/or rapid delivery schedules either used alone or in combination, may not be sufficient to guarantee high completion rates among PWIDs.\textsuperscript{53} This is also consistent with the findings in other studies on hepatitis B vaccination uptake and completion among PWIDs.\textsuperscript{54} The Scarlet Alliance survey showed that only (72.7\%) of those sex workers who were vaccinated had completed their vaccination course of three injections. Reasons for not completing the course included ‘travel’, ‘fear of needles’ belief in antibodies or immunity, and ‘trauma’ from previous discrimination in a sexual health clinic.

While gaining a better understanding of the policies, programs and practices that will be needed to improve access, uptake and completion of hepatitis B vaccination among PWIDs is a laudable goal in its own right, there are also the potential added benefits of how these models can be applied in other areas of IDU health. These include the urgent need to improve access to primary health care generally, but also to potentially inform the more effective delivery of other existing and possible future vaccines such as HPV and candidate HIV and hepatitis C vaccines, etc. As Maher stated in a 2008 editorial in the International Journal of Drug Policy on hepatitis B vaccination and injecting drug use:

\begin{quote}
\textit{… efforts to encourage uptake and coverage of prevention technologies in vulnerable sub-populations will continue to fail unless we invest in understanding the social, cultural and economic drivers of risk and protective behaviours, and the barriers and facilitators of real-world effectiveness.}\textsuperscript{55}
\end{quote}

Hepatitis B prevention among PWIDs and sex workers cannot be viewed in isolation, but rather seen as a cost-effective opportunity to reduce the burden of disease and improve access to primary health care for highly marginalised groups within the community. Achieving this however will not be a matter of simply ‘intensifying our current efforts’. A much greater and more detailed understanding of PWIDs and sex

\begin{flushleft}
\textsuperscript{51} Maher, L., above n.47, p. 426.
\textsuperscript{53} Maher, L. above n.47, p. 425.
\textsuperscript{54} Day C, et al. (2010), above n.14.
\textsuperscript{55} Maher L. above n.47, p.427.
\end{flushleft}
workers in Australia and the factors associated with their ongoing susceptibility to hepatitis B infection is needed. Some work is progressing in this area in relation to PWIDs with the recently completed HAVIT\textsuperscript{56} study looking at characteristics and correlates across the three key groups of those susceptible to infection, those previously exposed and those previously vaccinated. Such studies will be crucial in designing programs and services to target potential susceptibility factors such as age, gender, drug use patterns, history of accessing drug treatment, previous incarceration, cultural background, etc.

Addressing the ongoing infection susceptibility yet low vaccination uptake rates among PWIDS will also require a commitment to addressing the well-documented systemic barriers to health care access for this group - particularly stigma and discrimination. This is supported by research into viral hepatitis testing among PWIDs that strongly identifies fear of disclosing IDU status due to an expectation of subsequent poor treatment in the clinical setting as a major driver of testing behaviour.\textsuperscript{57} This has certainly been the case for sex workers, who report discrimination and stigma from service providers. Such negative attitudes have presented barriers to sex workers accessing essential services. It must be acknowledged that simply expanding current approaches will not address the negative impact that poor attitudes are having on the health seeking behaviours of PWIDs. New thinking and approaches will be required. In this regard, evidence of an improvement in access to and demand for hepatitis B vaccination among PWIDs will in itself be a sign that we have improved service models and engagement with PWIDs at a much broader level.

**National Policy Framework for Testing & Vaccination of PWIDs and Sex Workers:**

The current National Immunisation Program Schedule (2007) outlines the recommended vaccines by age group which are funded by the Immunise Australia Program. With regard to hepatitis B vaccination, the Commonwealth funds and monitors only the birth dose for infants and the adolescent catch up scheme.

At risk population vaccination is recommended in *The Australian Immunisation Handbook*,\textsuperscript{58} with no specific funding, the cost being absorbed by the state and territory public health systems. The purpose of the Handbook is to provide clinical guidelines for health professionals on the safest and most effective use of vaccines in their practice. Part 2 deals with ‘Vaccination for Special Risk Groups’ with a section on “vaccination of injecting drug users” stating that: “Injecting drug users are at risk of acquiring hepatitis A and hepatitis B, and should be vaccinated against these infections.” Sex workers are considered to be ‘at occupational risk’ and are included under ‘Others exposed to human tissue, blood, body fluids or sewage’

\textsuperscript{56} HAVIT – Hepatitis B Acceptability and Vaccination Incentive Trial – a randomised controlled trial for the efficacy of incentive payments in increasing hepatitis B vaccination, uptake and completion among PWIDs – based on presentation at the 7\textsuperscript{th} Australasian Viral Hepatitis Conference, Sept. 2010.


as recommended for vaccinations.\textsuperscript{59} 

In the hepatitis B section the Handbook goes on to state: "Injecting drug users who have not been infected with hepatitis B should be vaccinated"\textsuperscript{59} and with regard to individuals with chronic liver disease and/or hepatitis C: "Hepatitis B vaccination is recommended for those in this category who are seronegative for hepatitis B", indicating that testing for hepatitis B is recommended for PWIDs. Sex workers are included again in this section as ‘others at risk’.\textsuperscript{60}

Testing for hepatitis B is treated differently in policy and practice across Australian jurisdictions for both PWIDs and sex workers. For example, Western Australia provides very clear guidance in order that PWIDs receive the first dose of vaccine and have their hepatitis B immunity tested simultaneously. The Northern Territory and South Australian policy supports testing before vaccination, while other jurisdictions, (ACT, NSW, and Tasmania) appear to provide no specific guidance around testing high risk populations for hepatitis B. (The Tasmanian Agenda for Action prepared in 2011 notes the need for specific guidance.) In Victoria, informal feedback suggests that some medical practitioners find it difficult to order and interpret appropriate hepatitis B virus (HBV) pathology to assess infection status and it is not clear if or how many people being immunised are tested.

In the survey conducted by Scarlet Alliance 57.1% of sex workers vaccinated were given no recommendation as to the best time of testing. None were recommended testing after the vaccination. From our investigation it appears that confirmatory testing for hepatitis B immunity following a course of vaccination is not specified for PWIDs or sex workers in any jurisdiction. 68.2% of vaccinated sex workers surveyed had had follow-up testing anyway. Currently, the national recommendations calling for consistency of approach is not translated to state policies in regards to testing and vaccination procedures.

There are valid arguments to support each of the above approaches to testing for hepatitis B (i.e. no testing, testing beforehand or testing simultaneously with first vaccine), depending on what is most relevant as determined by the individual, whether or not they inject drugs or do sex work. Additionally, testing post vaccination can be considered as it then becomes easier to detect whether or not the person is carrying HBV. Ideally the range of approaches can be presented to people to choose from on a case by case basis. In any event, AIVL and Scarlet Alliance believe there is a need to develop a more systematic policy approach to ensuring post-vaccination follow-up and testing to confirm immunity while still ensuring that fundamental rights in relation to confidentiality, informed consent and voluntary testing are at the basis of any policy framework developed. While sex workers’ access to HIV and STI testing is high throughout Australia and increased testing is not necessary, follow up of course completion and immunity as part of existing testing services should be clarified and/or reviewed.


\textsuperscript{60} Ibid.
**National Surveillance and Monitoring:**

Routine surveillance of service policies and clinical practice in relation to hepatitis B vaccine uptake among PWIDs and sex workers is not attempted at the national level\(^6^1\) and addressed variably, if at all, at the state and territory level. In most jurisdictions, monitoring of clinical policies, practice and data is based on vaccine orders or inventory management systems which do not necessarily specify risk population category, making it impossible to extrapolate or accurately infer potential numbers of PWIDs or sex workers who are completing the hepatitis B vaccination schedule. Queensland, where all adult vaccinations are recorded, is the exception - although vaccine uptake among PWIDs in Queensland is yet to be examined. (See Table 1 below). Of the Queensland sex workers surveyed by Scarlet Alliance, 37.5% had commenced the vaccination process, 50% had not, and 12.5% didn't know if they had had a vaccination.

Problems with measuring vaccine uptake according to dose orders include:

- accounting for wastage;
- not knowing how many doses reach their used by date and are destroyed rather than delivered;
- that vaccine orders do not indicate course completion; and
- that individuals may fit under more than one risk category (for example, a person who injects drugs may also have chronic hepatitis C infection and be a sex worker).

A recent Western Australian study was undertaken to examine vaccination uptake of hepatitis C patients through the funded hepatitis A and B vaccines program.\(^6^2\) Hepatitis C notifications and hepatitis A and B vaccine orders received were reviewed to 'determine' the rate of vaccine uptake and course completion (with no mention of out-of-date dose wastage or assumptions about schedule completion). The study found that uptake of hepatitis A and B vaccination was higher than that of “similar populations”. The study however did not reveal anything of the nature of the 'similar' populations or how their respective vaccine uptake was measured. In conclusion it was determined that vaccination course completion was low, and that GPs need to emphasise to their patients the importance of completing a vaccine course. The above methodology concerns however, limits the value of this study and the recommendation drawn could apply equally to any individual undertaking hepatitis B vaccination, whether or not they have hepatitis C.

It is important to note the above issues relating to monitoring of vaccine uptake are equally relevant for many other vaccines available in Australia – not just hepatitis B vaccination. The issue of ‘end-point’ monitoring is a reoccurring theme in an area where it may be possible to have ‘recommended approaches’ but no real means of checking whether that approach is adopted and/or monitor the true impact of the approach in practice. Some jurisdictions have attempted to utilise routine, randomised

\(^6^1\) The Australian Institute of Health and Welfare conduct periodic adult vaccination surveys for a range of vaccines excluding Hepatitis B (rather they are whooping cough, swine flu, influenza and pneumococcal).

surveys such as ‘Computer Automated Telephone Interviews’ (CATI) to improve tracking in relation to the delivery of mainstream vaccination programs such as the flu vaccine, etc. The problem with these approaches however is that they necessarily rely on personal recall and self-report – raising questions about the reliability of the data provided. The other major problem with adopting such approaches in relation to selective/targeted hepatitis B vaccination programs is the obvious barriers to disclosure about being from risk group particularly identifying as a sex worker or a person who injects drugs.

The National Hepatitis B Strategy recommends the need for a National Hepatitis B Surveillance Strategy under the supervision of CDNA. This Strategy has been developed, but as it currently stands it does not include a sufficient focus on improving the current approaches to data and monitoring in relation to recording of route of infection (acute and chronic) and the numbers of PWIDs and people on pharmacotherapy programs vaccinated for hepatitis B in each period. As evidenced in this paper, there is significant research and anecdotal information to suggest that route of infection is not routinely recorded and although free hepatitis B vaccine may be provided to health services for high risk groups; there is inadequate monitoring of whether vaccine doses are reaching the intended target communities, particularly PWIDs. AIVL recognises the barriers to monitoring the usage of vaccine doses but there is a need to create strategies to improve our understanding of whether available doses of hepatitis B vaccine are actually reaching the intended ‘high risk groups’ such as PWIDs or not. It is a challenge for sure -but this should not mean that policy makers and health care providers wash their hands of the ‘need to know’.

Having outlined the above problems with ‘end-point’ monitoring of approaches to the delivery of hepatitis B vaccination above, both Scarlet Alliance and AIVL believe it is important to emphasise that we are in no way suggesting that increased surveillance of sex workers and PWIDs themselves is the solution to ensuring higher levels of vaccination, course completion or confirmatory testing. Sex workers already face high levels of surveillance and regulation, particularly in licensing and criminalised jurisdictions, which include police or government registration and mandatory health testing. Sex workers already demonstrate low rates of STIs, high rates of knowledge and awareness, and high rates of testing. PWIDs are extremely reluctant to identify as drug users to health care providers and other services due to fear of stigma, discrimination, poor treatment and police attention and/or arrest. PWIDs have also demonstrated their preference for adopting safer injecting practices when access to injecting equipment and education is provided in a safe and non-judgemental context. In this regard, above all else it is the removal of barriers that will encourage more sex workers and PWIDs to seek hepatitis B vaccinations, complete courses, and access health services but better monitoring of clinical practices and policies will assist us in eliminating unnecessary dose wastage.

By mid 2012 data should be available from the national sero-study on hepatitis B that has been conducted by the National Centre for Immunisation Research and Surveillance. While this study will not answer all of the above questions in relation to hepatitis B vaccination among PWIDs, it should provide a reasonable
overall picture in relation to hepatitis B vaccination in Australia across all age spans. Such data, in addition to the above research evidence from other relevant studies needs to inform the further development of both policy and practice at the jurisdictional level to significantly improve the current levels of hepatitis B vaccination among PWIDs and sex workers.

**Summary of State/Territory Policies & Programs:**

Following a request through the BBVSS Committee, AIVL received information on current arrangements for hepatitis B vaccination from all states and territories. In order to provide the most comprehensive and accurate picture of jurisdictional arrangements however, AIVL augmented the information provided by state and territory health departments with information provided by jurisdictional centres for communicable diseases and/or immunisation departments. Much of the latter information was distilled from telephone and/or email communications. Scarlet Alliance also reviewed the information and accessible state strategies/plans as they relate to arrangements for hepatitis B vaccination for sex workers.

All jurisdictions reported they have policy frameworks in place in relation to hepatitis B testing and vaccination for at risk populations including PWIDs. The specificity of these policies however did vary across the jurisdictions with a minority of jurisdictions identifying that hepatitis B was addressed in "broader policy documents" rather than in specific hepatitis B policy statements. Funding arrangements and access points for hepatitis B vaccination for PWIDs also varied across jurisdictions however in all cases where the vaccine is provided free of charge or at a reduced rate to 'high risk groups', funding is from the state/territory level. While the majority of states and territories reported they provide free access to hepatitis B vaccination for PWIDs, a minority of jurisdictions do not fund such access and there was a reasonable degree of variation in where and how vaccination is provided. A more detailed comparison of the key policies and programs for each jurisdiction is included below.

Similar discrepancies were identified for sex workers. Policy documents in each state differ according to who is considered a priority population, and then again on which groups among those priority populations are eligible for funded vaccinations. In the one policy document, there might be several differing definitions of who is included as a ‘high risk’ group – those considered high risk, those ‘recommended’ for vaccinations and those eligible for free or subsidised vaccinations. Sex workers may be ‘recommended’ as a group to be vaccinated, but if they are not included in the list of high risk groups, they may not be eligible for vaccination. Because there is often no specific hepatitis B policy, broader policy documents within a state can be inconsistent on sex worker coverage. For example, in one jurisdiction, sex workers might be considered a priority group in the STI policy, but they may not be considered a priority group in that state’s HIV or hepatitis C policy. State policies on sex worker access to hepatitis B vaccinations are piecemeal, confusing and contradictory.

**ACT**

ACT Health has very limited policy specifically addressing the issue of hepatitis B vaccination, however
the issue is mentioned within broader policy documents, particularly The ACT Immunisation Strategy 2007–201064 which aims to “promote opportunistic hepatitis immunisation for intravenous drug users and other high risk groups” and “consider funding the recommended vaccines for people in high risk groups, such as ... intravenous drug users”. Sex workers are not mentioned in this section. A second reference of relevance is made in HIV/AIDS, Hepatitis C and Sexually Transmissible Infections: A Strategic Framework for the ACT 2007-201265 where the following suggestion is made: “Offering hepatitis A and B vaccination to all people with, or at risk of, hepatitis C”. Lastly, the ACT Alcohol, Tobacco and Other Drug Strategy 2010-201466 supports improved access to hepatitis B vaccination. No specific guidance on testing PWIDs for hepatitis B is provided. Monitoring uptake of the vaccine is not attempted; no data is kept on uptake or dose orders. Access points for the free hepatitis B vaccine are currently limited to the Sexual Health Centre at the Canberra Hospital, opioid pharmacotherapy clinics, the Interchange General Practice and prisons.

The HIV/AIDS, Hepatitis C and Sexually Transmissible Infections: A Strategic Framework for the ACT 2007-2012 lists sex workers as a ‘priority population’ and ‘at risk’ population.67 The ACT Immunisation Strategy intends to ‘promote opportunistic hepatitis immunisation’ for ‘high risk groups’, but doesn’t specifically name who is a high risk group.68 One of the future directives is to ‘Consider funding the recommended vaccines for people in high risk groups69 but there is no specific funding for sex workers. Information from relevant health departments suggests that there are individual funding agreements between ACT Health and partner agencies – so sex workers may be offered a free hepatitis B vaccination from the Canberra Sexual Health Centre if they are considered in any way to be in a risk category, but not from all service providers.

NSW

The NSW Hepatitis B Vaccination Policy (2005)70 states that injecting drug users, who are clients of NSW Area Health Service Sexual Health Clinics and clients of NSW ‘Public Methadone Clinics’ may be offered a course of hepatitis B vaccine free of charge. The vaccination information webpage71 is updated more regularly than the policy document and there has been some work to promote the enhanced vaccination program to service providers, encouraging them to order vaccines, including the hepatitis B vaccine, for a range of groups including PWIDs. No guidance is offered for testing prior to, with or at the conclusion of vaccination. The ordering forms for sexual health and MMT clinics was designed to monitor uptake of the vaccine by PWIDs and other high risk groups, but the practice of requesting information on the number of

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69 Ibid, emphasis added.
persons vaccinated was stopped some years ago as the data was not considered useful. Currently, the monitoring of vaccine uptake is inferred through stock order only, and then under the general category of 'high risk groups'. It should be noted however that due to a concern that the ordering process through the Public Health Units might be creating unintentional barriers to hepatitis B vaccination, current ordering procedures will cease in 2011. From this point, hepatitis B vaccine will be freely available for all GPs for any reason other than vaccinating people travelling to high risk overseas countries. This will remove any capacity to monitor uptake among PWIDs through inventory management. This new approach will be monitored for a 12 month period but despite the impact on monitoring it is believed the removal of barriers will result in better vaccination rates among target populations. Official access points for the free of charge hepatitis B vaccine are opioid pharmacotherapy prescribers, sexual health clinics, Community Health Centres, Aboriginal medical Services, GPs and Justice Health. Outreach based programs are also provided in youth services, emergency accommodation and homelessness shelters, etc. Sex workers are eligible for vaccinations funded by the NSW Government and provided by immunisation service providers.\cite{BBVS2011}

**NT**

The *Northern Territory Hepatitis B Vaccination Policy and Public Health Management Guidelines (2010)* currently under review, notes that the hepatitis B vaccine is provided free of charge for PWIDCs. No monitoring of vaccine uptake can be calculated or inferred as the standard order form does not indicate risk population categories. Pre-vaccination testing for hepatitis B is recommended for injecting drug users in the Northern Territory, and post-test 1-2 months after the third dose of vaccine is recommended for people living with hepatitis C and/or HIV. It is not clear to what extent this guidance is carried out in practice. Officially, access points include sexual health units, community care centres and GPs (who may or may not identify high risk groups for free access).

The current (2000) Management Guidelines in the Northern Territory list ‘population groups [that] are at higher risk of hepatitis B infection than the general population’. These include ‘clients of sexually transmitted disease clinics’ but not sex workers specifically.\cite{NT2000} Later in the document, the Guidelines state that the NT has vaccination programs to prevent HBV infection in ‘selected occupational risk groups’. Sex workers are listed as part of an ‘occupational group’ at risk, but they are ‘authorised to receive hepatitis B vaccine at health centres’ only where it is paid by their employer or the individual.\cite{NT2000} The guidelines specifically that that ‘[ Territory Health Service] does not provide free HB vaccination services for adults not included in the above groups. They should be referred to a medical practitioner.’\cite{NT2000}

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\cite{BBVS2011} BBVS, *Current Policy and Arrangements for Hepatitis B Vaccination*, policy document provided internally to Scarlet Alliance and AIVL, 2011.
\cite{NT2000} Ibid, p.2.
QLD

The Queensland policy framework is currently under review. Queensland Health provides funded vaccines for high risk groups including PWIDs and people with hepatitis C or chronic liver disease and inmates of long-term correctional facilities. Unique to Queensland, hepatitis B vaccination uptake among PWIDs is possible as, since 1996, all vaccinations, adult and child, are recorded on a special database (called VIVAS - Vaccination Information and Vaccination Administration System or VIVAS76). The database records initial and follow up vaccinations, with high risk populations broken down as identified (intravenous drug users, hepatitis C positive etc.). With regard to issues associated with vaccination and PWIDs however, the database has yet to be investigated by epidemiologists or others. PWIDs can access the free hepatitis B vaccine at sexual health clinics, drug dependence services, pharmacotherapy clinics (public and private prescribers) and in prisons. The vaccine is not available through hepatitis C treatment clinics as, in Queensland (and indeed all jurisdictions across Australia), vaccination delivery is largely the domain of the primary care which in Australia’s case is predominantly general practice-based.

In the Queensland hepatitis B Situation Analysis, sex workers are not listed as a group for which Queensland Health provides funded vaccinations, despite the report noting that the Commonwealth Department of Health and Ageing recommends funding for sex workers.77 Sex workers are considered a targeted population in Queensland’s HIV, Hepatitis C and STI Strategy 2005-2011 for STIs, but not for HIV or HCV.78 The Situation Analysis reports that about 40% of sexual health clinics list sex workers as a ‘major focus’, but notes that viral hepatitis clinics ‘do not identify with the target groups as strongly’.79

SA

The Access to Free Hepatitis B Vaccine Policy for South Australia80 is brief, but details ‘intravenous drug users’ along with people who have hepatitis C and people in prisons - if they are hepatitis B negative - as eligible for the free of charge vaccine (and implies that testing before vaccination should be routine for high risk groups). While actual uptake of the vaccine is not monitored, dose distribution for high risk populations is recorded. Requests for vaccines for particular high risk groups are made, and vaccines sent to GPs are documented as for ‘high risk groups’ but not broken down into specific population categories. In 2009/10, a total of 9,491 doses of hepatitis B vaccine were distributed to high risk groups through the publicly funded hepatitis B vaccination program but there is no way of knowing how many of these went to PWIDs. Access points for the free vaccine include sexual health clinics, Second Story (a young adult health unit), GPs, prisons and remand centres. Drug and Alcohol Services of South Australia (DASSA) provided the authors with the Clinical Procedure for Hepatitis A and B Immunisation for Clients. The

79 Queensland Government, above n 77, p.50.
document states that its purpose is to ‘provide free immunisation for both Hepatitis A and B to clients of DASSA, who are injecting drug users and hepatitis C positive. Clients who are not hepatitis C positive but are injecting drug users, will be offered free hepatitis B immunisation but not hepatitis A immunisation’.\textsuperscript{81}

This was confirmed by DASSA’s immunisation control nurse. The Clinical Procedure states that clients should be tested for immunity prior to being immunised, and serology to confirm immune response is taken one month after the first dose. DASSA is about to trial a rapid HBV vaccine trial for PWID in SA.

The information provided by relevant health departments indicates that ‘commercial sex workers’ are listed as a group ‘with high prevalence [who] are vaccinated as part of more targeted programs’ in the state. In the \textit{Immunisation Guidelines for Health Care Workers in South Australia}, ‘sex industry workers’ are listed as a group ‘recommended’ for hepatitis B vaccination.\textsuperscript{82} However, the South Australian \textit{Immunisation Policy Document on Access to Free Hepatitis B Vaccine} which is available publically online, does not list sex workers as one of the defined categories to be eligible for free vaccination.\textsuperscript{83}

\textbf{TAS}

Tasmania’s approach, in practice, differs from all other states in that, while recommending the vaccine for PWIDs, it is not available free of charge unless the person is a prisoner (incarcerated for at least 6 months) or is living with chronic liver disease or haemodialysis (as provided by the clinician). The Tasmanian policy framework is currently being developed, but a description of current practice provided to BBVS in January 2011 states that for “intravenous drug-users” there is "no ongoing formally funded program. One-off programs have provided the vaccine to NSP clients, in some instances with funding from their (DHHS-provided) operating costs. Additional opportunities for vaccination exist through other avenues and GPs". The extent to which most of the high risk groups receive hepatitis B vaccine is not known. Generally no testing for hepatitis B is undertaken before or during vaccination for PWIDs. Access points for receiving the vaccination (with cost charges) are mainly through sexual health services and GPs.

Information provided to us by relevant health departments indicates that in Tasmania, hepatitis B vaccinations for sex workers (listed under an ‘other occupational groups’) are ‘recommended or considered’. However, the document indicates that vaccinations for sex workers are ‘self-funded or (if provided) workplace-funded’. Because brothels are illegal in Tasmania, workplace-funded vaccinations are not available to sex workers. The provided report states that ‘Sex workers may have access to vaccine via sexual health services’, however it goes on to state that ‘the extent to which many of these

\textsuperscript{81} Government of South Australia, SA Health, Drug and Alcohol Services, ‘Clinical Procedure: Hepatitis A and B Immunisation for Clients’, November 2009.


groups receive hepatitis B vaccine is not known.\textsuperscript{84}

**VIC**

There are a number of key strategic documents that define the current policy context regarding access to and use of hepatitis B vaccine in Victoria. The most relevant appears to be the *Immunisation Strategy 2009 – 2012\textsuperscript{85}*, which recognises the importance of immunising people at high-risk of vaccine preventable illness and notes access to free hepatitis B vaccine for “people who inject drugs or those on methadone”. Provision of free HBV vaccine to people living with HCV has been approved for implementation from late 2011. Although recommended, it is not clear if or how many PWIDs being immunised are tested prior to vaccination. Doses requested for PWIDs are calculated together with those ordered for household contact related vaccinations, so it is currently not possible to identify the total number of free of charge doses ordered for PWIDs in Victoria. The relatively small number of doses of vaccine delivered under the Victorian scheme shows that uptake of free vaccine for at-risk populations is low. Access points for the free of charge hepatitis B vaccine include the 5 primary care centres for PWIDs, HCV treatment providers, opioid pharmacotherapy clinics, GPs and prisons.

The *Victorian Immunisation Strategy* aims to improve data and immunisation coverage among high risk groups, and includes sex workers as a ‘high-risk or special needs group’.\textsuperscript{86} This is reflected in the BBVS Jurisdictional Report on Activities Related to Hepatitis B provided by the relevant health department. However, in that document, sex workers are not included in the list of ‘high risk groups’ who can access free vaccinations.\textsuperscript{87}

**WA**

The Western Australian Department of Health has developed a specific operational directive titled *Guidelines for the Provision of Hepatitis A and B Vaccine to Adults in Western Australia at Risk of Acquiring these Infections by Sexual Transmission and Injecting Drug Use (2008)* \textsuperscript{88} People who inject drugs are eligible to receive free hepatitis A and/or B vaccination in certain circumstances. Testing for hepatitis B with the first dose of vaccine is recommended (with detailed guidance on rationale, when and how to also vaccinate for hepatitis A, whether to complete vaccination courses, and recommendations for the use of the accelerated schedule), but it is not clear to what extent the guidance is applied. Estimates on vaccine uptake are based on vaccine orders -and generally calculated together in the wider category of ‘high risk groups’. There are designated access points (specialist drug and BBV agencies, homeless

\textsuperscript{87} BBVS Jurisdictional Report, Report on Activities Relating to Hepatitis B.
support organisations, etc.) authorised to provide hepatitis A and/or B vaccination to high risk groups free of charge. General Practitioners who notify of a new case of hepatitis C may provide funded hepatitis A and/or B vaccination. However, in other circumstances, GPs are not empowered to order the free vaccine (due to concern about ‘leakage’ to non-high risk groups). The Department of Justice provides free hepatitis B vaccination for prison officers and inmates, and free combined hepatitis A/B vaccine for prisoners who are hepatitis C and/or HIV positive.)

The policy document provided indicates that in Western Australia, ‘people with multiple sex partners, e.g. sex workers’ are ‘eligible to receive free hepatitis B vaccination’. The document lists certain not-for profit and government agencies funded by the WA Department of Health who are authorised to give these free vaccinations.89

Table 1: Hepatitis B vaccination funding and uptake monitoring by jurisdiction.

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Funded vaccine for PWID?</th>
<th>Funded vaccine for SWs?</th>
<th>SWs a priority population?</th>
<th>Monitoring capacity</th>
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<tr>
<td>ACT</td>
<td>Very limited free access to different degrees through a few access points</td>
<td>Unclear</td>
<td>Unclear</td>
<td>No data collation for uptake or dose orders</td>
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<td>NSW</td>
<td>Free of charge through designated access points</td>
<td>Yes – designated access points</td>
<td>Yes</td>
<td>'High risk groups' data from dose orders only</td>
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<tr>
<td>NT</td>
<td>Free of charge</td>
<td>No</td>
<td>Unclear</td>
<td>'High risk groups' data from dose orders only</td>
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<td>Qld</td>
<td>Free of charge</td>
<td>No</td>
<td>Unclear</td>
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<table>
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<tr>
<th>State</th>
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<tr>
<td>SA</td>
<td>Free of charge through designated access points</td>
<td>No</td>
<td>Yes</td>
<td>'High risk groups' data from dose orders only</td>
</tr>
<tr>
<td>Tas</td>
<td>No free access, very limited subsidised access.</td>
<td>No</td>
<td>Yes</td>
<td>'High risk groups' data from dose orders only</td>
</tr>
<tr>
<td>Vic</td>
<td>Free of charge</td>
<td>No</td>
<td>Yes</td>
<td>Dose order data for PWID grouped together with 'household contacts'.</td>
</tr>
<tr>
<td>WA</td>
<td>Free of charge at designated access points or through GP if newly diagnosed with HCV.</td>
<td>Yes -designated access points</td>
<td>Yes</td>
<td>'High risk groups' data from dose orders only</td>
</tr>
</tbody>
</table>

Despite the ad hoc nature of state policies and practices on hepatitis B vaccination, sex workers surveyed had relatively high awareness of the availability of hepatitis B vaccines. 68.8% of surveyed sex workers been offered information on hepatitis B vaccinations. This information came from a range of places, including in the workplace, sexual health clinics, opioid pharmacotherapy clinic, General Practitioners, hospitals, university medical centres, during STI training for LGBTQI community service volunteers, community health organisations (such as ACON), sex worker organisations (such as the Sex Worker Outreach Project NT), sex worker magazines (such as SIN in South Australia and The Professional in NSW), and the Scarlet Alliance STI Handbook.

**Issues Identified by State/Territory Drug User Organisations and Sex Workers:**

In addition to the above jurisdictional reports, AIVL also approached its member organisations at the state and territory level to gather information from clients on their understanding and experience of hepatitis B vaccination at the local level. Despite some states/territories reporting better understanding and access than others, there was a high degree of consistency across jurisdictions in relation to the barriers,
problems and gaps they identified in relation to hepatitis B vaccination. Scarlet Alliance’s survey of sex workers across Australia also revealed similar issues of access. Some of the general themes and issues included:

**Availability sometimes overstated in policy documents**

Several drug user organisation representatives expressed frustration over the apparent mismatch between access points for free hepatitis B vaccination as detailed in policy documents and actual availability in practice. For example, where one would otherwise assume pro-active promotion and delivery of the vaccine (such as opioid pharmacotherapy clinics or prisons) in practice, availability may not be promoted and delivery ultimately driven by request. Of the sex workers who had had a vaccination, 61.9% received it at a sexual health clinic, 33.3% from a General Practitioner, and 4.8% from a hospital. None reported that they had received a vaccination from a community centre, prison or remand centre, opioid pharmacotherapy clinic, youth services, homeless shelter or emergency accommodation. This reflects the sporadic availability of vaccinations across states where only some service providers are authorised to give free/subsidised vaccinations. It illustrates a need for a range of different service providers accessible to sex workers and PWID who are funded for hepatitis B vaccinations.

In Tasmania, while information provided to BBVS in January 2011 states the availability of funded, one-off hepatitis B vaccination programs for NSP clients, an experienced NSP worker of 4 years had never heard of such programs for PWIDs in Tasmania. While it is acknowledged this is the experience of one NSP worker, this experience is consistent with both the levels of continued hepatitis B infection susceptibility and low vaccination rates among PWIDs routinely documented in the available research evidence.

Victoria, Western Australia and ACT drug user organisations also reported that, while prisoners are supposed to be offered hepatitis B screening and vaccination, anecdotal information indicates that access is too often driven by prisoner request alone. In the ACT, other reports from prisoners indicate some had experienced a long wait between asking for and receiving the vaccine.

In the ACT and Victoria, drug user organisations also noted very few clients appear to be being offered hepatitis B vaccination at opioid pharmacotherapy clinics and there is very low vaccination uptake through clinics. Few clients seem to know the vaccine is available and rather than being proactively offered the vaccine, there appears to be an expectation that clients will or should ask for it.

Varying levels of sex worker knowledge of and access to hepatitis B vaccinations can be linked to state policies and practice. Awareness and access was consistently lower amongst sex workers in states with licensing regimes such as Victoria and Queensland, compared to in New South Wales where decriminalisation is the regulatory model. For example, in the survey, only 75% of Queensland and Victorian respondents knew a vaccine was available, compared to 100% of NSW sex workers. Only 25% of VIC and QLD sex workers knew of free/subsidised vaccinations available to them, compared to 53% of NSW sex workers. Only 75% of VIC and 50% of QLD sex workers had been offered a hepatitis B
vaccination, compared with 93% of NSW respondents. Only 25% of VIC sex workers surveyed and 0% of QLD sex workers surveyed knew what sex workers would be charged for the vaccination, compared to 40% in NSW.

High percentages of sex workers had received information on hepatitis B across all states and among both city and regional sex workers (including 80% of NSW sex workers) except for VIC and QLD. Only 50% of VIC and 37.5% of QLD sex workers had received information. There are clear on-the-ground impacts of inconsistent policy oversights. Discrepancies between states illustrate the need for a nationally consistent approach in line with the National Hepatitis B Strategy that recognises sex workers in all states as a priority population and provides free vaccinations from a range of different service providers.

**Hepatitis B vaccine access issues in general practice**

In many jurisdictions, respondents from the drug user organisations felt that GPs seem to have low awareness of the availability of the free vaccine and a general attitude towards hepatitis B as something that has been/or should be addressed through the childhood vaccination program. In NSW, while GPs can deliver the free vaccine, PWIDs may not know this and there is a concern that many GPs do not tend to promote it. Of the sex workers who had received a hepatitis B vaccination, 22.7% had to request it themselves.

Feedback from drug user organisations indicates that disclosing injecting status in order to access the free vaccine is (slightly) less of an obstacle at community health centres than with GPs in terms of real or perceived potential for stigmatisation. The issue of disclosure of injecting status acting as a significant barrier to BBV testing in primary health care settings has also been identified in research examining reasons for never being tested. Fear of disclosure and the subsequent likelihood of discrimination or being treated poorly by doctors was one of the main barriers identified.90

Among the sex workers surveyed, only 37.5% usually ‘outed themselves’ when accessing health or service providers, meaning that even where sex workers are entitled to receive funded vaccinations, service providers may have the capacity to overlook significant proportions of the priority population. 40% of regional sex workers never disclosed their sex work status among health or service providers. In deciding whether to disclose their work, sex workers considered whether it was relevant to the service being provided, the attitude of the service provider, who else was in earshot, the confidentiality protocols, whether the provider had been recommended as ‘sex worker friendly’, whether it was peer run, the providers ‘value judgments’, their ‘vibe’, the sex worker’s HIV status, whether their sex work was full-time or casual, and whether it felt ‘safe’. 40.6% of surveyed sex workers had faced discrimination, stigma or negative attitudes from health or service providers because they were a sex worker. However, others believed in ‘being honest with my health care service providers’ or felt it was ‘important to have open-minded communication with regular health care workers’, had sought ‘queer friendly GPs’, had being

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going to their GP for a decade.

It appears that in many jurisdictions it has been decided that targeted access points for hepatitis B vaccines will be more appropriate for PWIDs than GP access (Western Australia, Tasmania, and New South Wales). The Tasmanian Agenda for Action acknowledges the need to facilitate access to BBV prevention (including vaccination), and the desirability of doing so via existing agencies who are already working with at risk persons. While a targeted access point approach rightly acknowledges the advantages of involving specialist agencies, it should not be assumed that all PWIDs prefer to obtain services through non-GP services. Indeed, excluding GPs from the list of access points for the free hepatitis B vaccine cannot be said to improve vaccine access and uptake among PWIDs. Information provided to us from Tasmania identifies a range of potential access points, including correctional health services and Alcohol and Drug Services, but notes the importance of facilitating access via GPs, the cost of consultation also being an important consideration.

Confidentiality

Where the free hepatitis B vaccine is available through sexual health clinics, hospitals and prisons, people are required to disclose their injecting status and this need for disclosure functions as a deterrent for many who might otherwise benefit from the vaccination. In the ACT and the Northern Territory, access points for the free vaccine include sexual health clinics for existing clients. If PWIDs wish to access the free vaccine at these clinics, they must first draw attention to their injecting status to become eligible. Similarly, Queensland feedback highlighted that health care centres advertise the free vaccine, but some people may be reluctant to identify as PWIDs in order to qualify.

Of all sex workers surveyed, 34.4% said that having to disclose their sex work status would affect their decision to access the vaccine. Sex workers stated ‘stigma’, concerns over whether the information would be ‘documented’ and whether the doctor would be ‘whorephobic’ as affecting their decision. One said it was a ‘no brainer, not worth the risk for a small amount of money’. Another said ‘If I was somewhere I felt comfortable disclosing, I wouldn’t hesitate. But if my only option was a GP, I would rather pay than disclose, if I could afford it.’

High/low threshold access and delivery models

In the Northern Territory there are limited hepatitis B vaccine access point locations and it was stressed that having more services under one roof would definitely enable clients to receive more care. The lack of any ‘one-stop-shop’ for related services for PWIDs was also noted as a limitation for Tasmania. In previous years in South Australia, PWIDs could and did avail themselves of ready access vaccine through the public drug treatment programs however this is no longer available. At the time of finalising this discussion paper, AIVL was unable to confirm the reason for the discontinuation of the program but we have requested this information from the appropriate SA Health officials. The Western Australian drug user organisation, following the state Hepatitis B Vaccination Policy, offers the accelerated vaccination
schedule as some clients might prefer it over the alternatives. In general, across Australia, access to the vaccine is not made easy and well promoted, ready access does not exist in most jurisdictions.

Sex workers were asked if the place they received their vaccination was located next to any other peer-based environments, such as harm-reduction, health, support, outreach or referral services. Some reported that sexual health clinics had sex worker resources and personal protective equipment (PPE), or reported Needle and Syringe Programs or a ‘political hangout’ nearby. However most said no, there was none that they were aware of. Only 13% of those sex workers who had received a vaccination had attended for the sole purpose of vaccination – 86.4% had attended for something else.

**Awareness and understanding of hepatitis B vaccination**

High levels of awareness of the free vaccine and where it can be accessed were reported among drug user organisation members and clients of peer run NSPs in WA, NSW, SA, QLD, VIC and NT (Darwin), especially among older clients, people on opioid pharmacotherapies and PWIDs who work in health care settings. Although not funded to do so and generally without specialist resources to promote access to the vaccine, Australian drug user organisations are informed about hepatitis B and, when possible, promote the benefits of and opportunities for immunisation. However, promotion of hepatitis B related issues are included among the extensive litany of BBV/STI related topics being addressed and is not always prioritised. Nonetheless, drug user organisations and peer based services are an important if not primary source of information on issues associated with hepatitis B for PWIDs. Sex workers surveyed showed high levels of awareness of the existence of hepatitis B vaccines but little awareness of specific programs or eligibility for subsidised/free vaccines. As noted earlier, this can be traced to inconsistent policies and lack of information on subsidy or eligibility for free vaccinations.

In the ACT and Tasmania it was suggested that generally both awareness of access points for the free vaccine along with understanding of the need for vaccination is low among PWID. Contacts suggested the same was the case in Alice Springs with few PWID aware of the availability of free hepatitis B vaccine. In Queensland, South Australia and Western Australia it is thought that PWIDs who are not connected with peer based services may not be aware of the advantages of vaccination, the free vaccine or how to access it. In Victoria it was noted that some PWIDs are confused about the differences between hepatitis B and C. It is AIVL’s view that this is a common confusion outside of Victoria with national focus testing conducted by AIVL as part of developing educational resources routinely indicating high levels of confusion about the differences between hepatitis A, B and C.

**Vaccination schedule completion or compliance**

In general the issues raised under in this area related to the promotion, awareness and understanding of the hepatitis B vaccine. It is important to note that compliance with the hepatitis B vaccination schedule is problematic across the board rather than simply with PWIDs with for example, a 70% completion rate among adolescents in school (a relatively 'captive' target population). In Western Australia it is thought
that the use of an accelerated schedule may improve compliance among high-risk groups (see below for further discussion of this issue). In Victoria, some PWIDs were asked about their experience of the hepatitis B vaccination: some thought that because they had, had one of the 3 injections in the schedule they therefore enjoyed a partial protection from hepatitis B. Transient people in particular may need additional support in order to complete the vaccination schedule. Across all jurisdictions understanding of hepatitis B and the vaccination schedule needs significant improvement among PWIDs.

**Cost of vaccination**

The current cost of an unsubsidised complete course of hepatitis B vaccination is approximately $60-$90, with each of three injections costing around $20-$30. If accessing the vaccine through a GP who does not bulk bill, then consultation fees are also to be paid for each injection received, putting vaccination for hepatitis B beyond the financial means of many PWIDs particularly those on low incomes. In all jurisdictions the cost of the unfunded hepatitis B vaccine was identified as a significant obstacle for people who may be experiencing financial hardship. Further, where people wish to access the vaccine without disclosing their injecting drug use status, costs can be a substantive deterrent to vaccination. Consultations with some service providers Tasmania identified that the cost of vaccination can vary between services. Some client inquiries at NSPs also indicated the desire to have access to the vaccine, but cost was identified as a potential obstacle. In NSW and the NT, the cost associated with transport in order to reach vaccine access points was also noted as an obstacle for some PWIDs.

Although sex workers had high levels of knowledge about hepatitis B vaccinations (90.6% knew there was a vaccination available) there was less awareness about the specific free/subsidised vaccinations available to them (only 50% of respondents knew if a free/subsidised vaccination was available to sex workers in their state), and even less knew about the cost or subsidy available for sex workers (only 28.1% said they knew how much sex workers were charged for vaccination). This can be linked to inconsistent policies on the availability of free or subsidised vaccines for sex workers across Australia.

13.6% of surveyed sex workers who had been vaccinated had to pay other consultation costs (for example, GP fees) in addition to the vaccination cost. One reported that the place they got their vaccination was no longer convenient because they now charge.

**Prioritising health in a criminalised environment**

Hepatitis B and C related issues can be a low priority among a proportion of PWIDs who may be facing more imminent and pressing concerns such as financial, legal or housing issues. All jurisdictions pointed out the obstacles faced by PWIDs in accessing hepatitis B vaccination as often being the same as those faced in accessing primary health services in general including stigma and discrimination, reluctance to engage with the health system due to past negative experiences, poor case management and the impact of high threshold access prerequisites on access.

Criminalisation of sex work has consistently been proved to create barriers to sex workers accessing
health, outreach and support services. The decriminalisation of sex work and the introduction of anti-discrimination laws would significantly assist sex workers’ capacity to access health providers free from stigma or discrimination, encourage the dissemination of information and increase the likelihood of course completion.

**Regional/remote area issues**

Confidentiality, and related concerns over stigma and discrimination were reported as a significant barrier to hepatitis B vaccination across all jurisdictions and especially so for PWIDs in smaller towns and remote areas. Transport costs and concerns about confidentiality are also obstacles in remote locations. Northern Territory, Western Australia and Queensland feedback indicated that completion of the vaccination schedule can be a particular challenge for people who live or work in remote areas. In Western Australian regional areas the hepatitis B vaccine is proactively offered to Aboriginal and Torres Strait Islander people but less so to other risk populations. NSW also offers free hepatitis B vaccination to all Aboriginal and Torres Strait Islander people including those living in regional or remote areas. Regional sex workers generally had lower rates of knowledge and access than city sex workers. However, 100% of regional sex workers who had received a hepatitis B vaccination had been offered the vaccination rather than requesting it. When asked whether the vaccination location was convenient, sex workers who had been vaccinated said that often clinics were located in the CBD or inner city. Some said they ‘have to wait for ages to be seen’.

**Innovative Evidence-Based Hepatitis B Immunisation Approaches for PWIDs:**

**Peer-Based Primary Health Care Models**

Over the past 15-20 years peer-based drug user organisations have implemented both programs aimed at improving access to hepatitis B vaccination among PWIDs. These clinical models have been undertaken as pilots projects in collaboration with other services (such as local Divisions of GP) and as ongoing clinical programs within drug user organisations. By providing access to hepatitis B testing and vaccination in a more ‘user-friendly’ environment, these programs were specifically developed to address some of the main barriers to hepatitis B testing and vaccination identified above. Although there have been a number of such programs over the history of peer-based drug user organisations, this discussion paper will focus on two peer-based approaches that have been formally documented through evaluation and/or ongoing reporting.

a) **In-House BBV/STI Health Clinic: WA Substance Users Association (WASUA)**

This program has been operating at WASUA since for approximately 10 years and although it has received multiple funding sources for various service components over that time it is currently funded by the WA Health Department. The clinic provides free and anonymous access for PWIDs to BBV and STI testing and referral. Specific services include hepatitis A, B, C and HIV testing, syphilis, chlamydia and gonorrhoea testing, liver function testing, referrals to tertiary liver clinics for hepatitis C treatment, vein
care and other health information. Hepatitis A & B vaccinations are provided free of charge for PWIDs and referrals as required and appropriate to specialist health services and other WASUA services. The WASUA clinic is staffed by a registered nurse and has arrangements with Royal Perth Hospital for testing arrangements, vaccines and prescribing.

One of the unique aspects of the WASUA Health Clinic is the fact that it operates from the same building as the main primary NSP in Perth (also operated by WASUA). This co-location allows PWIDs to access hepatitis B testing and vaccination in a familiar, peer-based environment, at the same time as they are accessing other harm reduction services and without the need for referrals and the additional costs that can be associated with travelling to and accessing other health services. As evidenced above, many of these factors have been documented in research as some of the main barriers to hepatitis B vaccination for PWIDs.

The WASUA health clinic has consistently demonstrated high levels of referral from the WASUA NSP and other WASUA projects into the health clinic including for hepatitis B vaccination. Regular reporting has also shown high levels of schedule completion rates with approximately 50% of clients who initiated hepatitis B vaccination completing the full schedule. This compares to 20% in a recent Sydney study and even lower rates in many general practice environments. This outcome demonstrates the positive benefits of providing hepatitis B testing and vaccination in an environment where there is a high degree of rapport and trust between service user and service provider. Higher completion rates may be related to the fact that the WASUA clinic nurse can follow-up with clients on their regular visits to access the NSP and other WASUA services.

In addition to the ‘in-house’ clinic, WASUA also provides an outreach based service at other appropriate health services that have contact with PWIDs. These services include hepatitis and AIDS councils, prison aftercare services, mental health outpatient clinics, youth and emergency accommodation services and mobile NSP services. The WASUA outreach-based clinical service has been effective in allowing clinical staff to access PWIDs who are not currently clients of the main service which is reflected in differences in client profiles (age, gender and risk practices). Reporting has also reflected high levels of return visits for follow-up testing, immunisation, results and referrals. Together, the in-house and outreach based components of the WASUA BBV/STI clinic combine to provide a comprehensive peer-based harm reduction program that both target and reduce many of the factors that lead to ongoing susceptibility to hepatitis B infection among PWIDs.

b) Pilot Immunisation Clinic: Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) and the Territory Opioid Program (TOP), ACT Division of General Practice

This pilot project was designed as a collaboration between CAHMA and TOP to provide a series of

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92 Maher, L. above n.47, p. 425.
opportunistic hepatitis B immunisation clinics for PWIDs. The main aim of the pilot was to provide at-risk PWIDs with the opportunity to be immunised against hepatitis B in their own environment. The project sought to determine if opportunistic immunisation in a peer-based environment was possible and to test the uptake of free hepatitis A & B vaccination including whether clients completed the vaccination schedule.

The pilot was informed by a peer-driven research phase conducted by CAHMA whereby 136 CAHMA clients were surveyed across a range of relevant health issues. This survey showed that:

- 44% were receiving treatment for AOD problems;
- 29% were receiving treatment for mental health issues;
- 48% were hepatitis B immunised;
- 12% did not know their hepatitis B status;
- 67% had a GP that they had visited in the past 6 months;
- 29% self-identified as homeless.

Leaving 52% of respondents eligible for hepatitis B immunisation.\textsuperscript{93}

In all, 10 monthly clinics were provided at the CAHMA premises in the centre of Canberra city which also operated a primary NSP outlet and a range of peer education, support and referral services for PWIDs. One of the most difficult aspects of establishing the pilot project was identifying and confirming a local GP to attend and prescribe for each clinic. With this issue addressed, the clinics were able to commence in early 2005.

The clinical model employed for each monthly clinic included:

- CAHMA peer staff advertising, educating and recruiting and undertaking a vaccine checklist with each client wishing to access to the clinic;
- 2 nurses (1 AOD and 1 MH nurse) to complete consent process, temperature, health history and pre-vaccination triage;
- A local GP would attend each monthly clinic at a pre-arranged time period to check all forms and prescribe vaccine;
- 1 nurse would carry out the vaccinations while the 2\textsuperscript{nd} nurse and CAHMA peer staff would scout, recruit and under-take post immunisation observations.

The main outcomes and findings from the CAHMA/TOP Pilot Immunisation Clinics were that of the 113

\textsuperscript{93} Data taken from a presentation on the CAHMA/TOP Opportunistic Immunisation Clinics for IDU to the 2006 Drug & Alcohol Nurses Association (DANA) Conference, Sydney, Australia, 21-23 June 2006.
clients who initiated vaccination, 39% completed all or at least 2 of the 3 vaccinations. As noted above, this vaccination completion rate compares favourably with accepted completion rates in other primary health care settings particularly general practice. The total cost of the project was less $10,000 including the cost of vaccines, equipment and wages. With all costs taken into consideration, the CAHMA/TOP project was able to deliver a per person vaccination cost of $80 compared to a cost of $111 per person vaccinated in general practice. These outcomes highlight the savings and cost benefits associated with peer-based opportunistic immunisation models for hepatitis B.  

In addition to the model showing itself to be highly cost effective in comparison to the current primary health care approach, other cost benefits included:

- improving herd immunity and reducing morbidity and mortality in this group;
- using an accessible, flexible and mobile community-based approach;
- cost-effective for both patients and the health system as the low GP bulk billing rate in the ACT means most patients are unable to afford the cost of hepatitis B immunisation;
- it was cheaper than secondary and tertiary vaccine delivery methods; and
- the model reached a group not ‘normally’ available (30% self-reported no GP).

This pilot project demonstrated the effectiveness and cost-effectiveness of primary health care models that access PWIDs in a peer-based environment where clients feel safe and where the opportunity to conduct follow-up and discuss other health needs is supported by the model. The project also allowed for the development of strong working relationships between the local drug user organisation and the Division of General Practice with GPs and nurses working outside of their usual context.

**Contingency Management Protocols**

**a) Incentive-Based RCTs:**

In addition to the two peer-based primary health care models outlined above, the use of contingency management protocols or motivational incentive models have also been shown to be effective at reaching PWIDs and maximising hepatitis B vaccine course completion. A number of hepatitis B vaccination research trials using motivational incentive models among PWIDs have achieved promising results in relation to improved completion rates. Seal et al conducted a randomised control trial to compare the relative effectiveness of monetary incentives vs. outreach based models in enhancing adherence to hepatitis B vaccination course completion among PWIDs. Multivariate analysis showed that receiving monetary incentives was independently associated with vaccine completion with 69% of participants in the monetary incentive arm completing all three vaccine doses compared to 23% in the enhanced outreach

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94 Ibid.
95 Ibid.
In addition to higher completion rates, the financial incentives were also shown to be more cost-effective than using outreach workers to improve completion rates.\textsuperscript{96} A further study into drug user adherence to a 6-month vaccination protocol and the effects of motivational incentives by Stitzer et al at John Hopkins University also showed that 77\% of participants in the incentive arm versus 46\% of the control received all scheduled injections. These results suggest that monetary incentives may be useful for addressing adherence and allowing participants to reap the full benefits of newly developed medications.\textsuperscript{97} Two Australian studies (the completed Sydney-based HAVIT study and a Melbourne-based study commencing in early 2012) are also focused on the potential role of motivational incentive approaches in improving hepatitis B vaccination course completion among PWIDs. In line with the findings from the above research, the as yet unpublished findings from the Hepatitis Vaccine & Incentives Trial (HAVIT) show a significantly higher proportion of participants in the incentive arm completed the vaccine series.\textsuperscript{98}

Specific strategies used/or planning to be used in both the published, unpublished and upcoming studies referred to above include:

- **Monetary or ‘Prize-based’ Incentives** – participants are randomised to the incentive or control ‘standard care’ arms with those in the incentive arm receiving monetary payments. These payments are often staggered on a sliding scale to increase gradually, up to a pre-determined maximum amount, as participants move through the vaccination and monitoring schedule;\textsuperscript{100} and

- **Assertive Outreach Methods** – involving vaccination ‘in the field’ by nurses trained in vaccine administration and using assertive outreach methods to follow-up participants in addition to motivational incentives with the aim of maximising course completion.\textsuperscript{101}

Although the above incentive approaches are routinely used in many other areas of clinical research, providing payments of any kind to research participants who are PWIDs inevitably attracts an extraordinary level of discussion and consternation. The ethics of providing incentive payments to PWIDs and concerns about what participants might ‘do with the money’ provided seem to dominate discussions on this issue. An important question raised by these discussions however is: “Why do we think it is appropriate to pay women incentive payments to immunise their children but view providing a modest monetary incentive for PWIDs to complete a course of hepatitis B vaccination as unethical?"

Of course, ethical considerations and protecting the rights of vulnerable populations should always be

\textsuperscript{97} Ibid.  
\textsuperscript{99} Topp, L. et al. A randomised controlled trial of contingency management to increase hepatitis B vaccination uptake and completion among people who inject drugs in Australia – unpublished findings from study abstract.  
\textsuperscript{100} Ibid.  
\textsuperscript{101} Higgs, P. et al. The B-vax Project: Providing hepatitis B vaccinations to people who inject through assertive outreach. Project Proposal Concept Sheet. This project will commence in January 2012.
prioritised when developing and implementing research protocols, but this does not and should not mean that contingency management and incentive-based approaches cannot be used in research and service provision involving PWIDs. This has been supported by the UK National Institute for Health and Clinical Excellence which has recommended the use of modest material incentives to encourage specific harm reduction objectives such as BBV screening.\textsuperscript{102}

\textbf{b) Nurse-Administered Hepatitis B Vaccination:}

Some jurisdictions, including NSW but also the “B-vax Project” above are using “authorised” registered nurses as a way to increase the capacity of enhanced vaccination programs and improve the ability to both reach and follow-up PWIDs for hepatitis B vaccination. In some instances the greater use of nurse-led models has developed from a recognition that many access points for enhanced or targeted programs such as sexual health clinics, opioid pharmacotherapy dosing points, NSPs, etc., often do not have a doctor on-site. This can act as a significant barrier to even offering hepatitis B vaccination to targeted populations. PWIDs are frequently present with multiple health and social issues and, where resources are limited, service providers are likely to give priority to those issues that are considered most pressing and within their means to address. In this context, complex ordering and referral protocols to off-site physicians can move hepatitis B vaccination down the list of priorities for both service providers and PWIDs.

Training nurses particularly in sexual health and opioid pharmacotherapy services to deliver hepatitis B vaccination ‘without medical direction’ is one strategy that is being used to address the lack of access to/shortage of doctors. While this approach can help to improve access to hepatitis B vaccination for high priority populations, the requisite training is expensive. NSW has trialled reimbursement scholarships to alleviate this situation but as it currently stands it seems unlikely that this type of training will be adopted as a mainstream approach outside high case load services. In addition to cost, ‘training overload’ can also act as a barrier to operationalising nurse administered hepatitis B vaccination. For example, in opioid pharmacotherapy programs there are often many competing training and service provision priorities and the relative ‘prioritising’ of hepatitis B vaccination can be an issue even if nurses have completed the appropriate training.

\textbf{c) Accelerated/Rapid Schedules:}

The routine schedule for combined hepatitis A and B vaccination in adults is three doses administered at 0, 1 and 6 months. Research into the use and efficacy of accelerated hepatitis B vaccination schedules such as (0, 1 and 2 months) have been shown to be as effective as the standard schedule and to be more likely to achieve series completion.\textsuperscript{103} The WA hepatitis B Vaccination Policy states that in high-risk groups, the use of a rapid/accelerated schedule (four dose schedule at 0, 7, 21 days, with a booster dose after 12 months) may improve compliance and the speed at which immunity is achieved. A number of

\textsuperscript{102} Maher, L. (2008), above n.47, p.426.
\textsuperscript{103} Ibid.
research trials have also recommended the use of rapid schedules to improve hepatitis B vaccination uptake and coverage in PWIDs.\textsuperscript{104} The recent HAVIT study discussed above, also adopted an approach using a 0, 7, 21 day rapid protocol.\textsuperscript{105}

While AIVL recognises the potential value of accelerated vaccination schedules, such protocols should not be viewed as a ‘scientific quick fix’ for the often complex social reasons why many PWIDs do not have adequate access to primary health care. AIVL is also concerned about the potential for people to assume they have been fully vaccinated following the completion of the first 3 stages of a rapid schedule. This is particularly significant given that rapid (0, 7, 21) schedule without the 12 month booster will not result in life-long immunity. In this regard, while AIVL supports the development of innovative approaches to increase access to and completion of hepatitis B vaccination among PWIDs, these must be evidence-based and fully grounded in ‘real world’ rather than ‘idealised’ research conditions. Policies and practices which presume that PWIDs are an itinerant or ‘less reliable’ population should be questioned. Instead, we need to acknowledge and address the failure of the health system to protect PWIDs from this vaccine preventable infection.

**National Key Issues:**

The analysis in this paper demonstrates that the National Hepatitis B Strategy is not effectively implemented across states and territories. Significant variations between policies across jurisdictions, gaps between policy and practice, and divergent rates of knowledge and access demonstrate the need for a more comprehensive and consistent national approach. Not all states have a hepatitis B policy, and the information on priority populations and subsidisation is ad hoc, confusing and contradictory. Currently, recognition as a priority population or ‘high risk group’ does not necessarily mean eligibility for subsidised or free vaccinations. Eligibility for subsidised or free vaccinations does not mean those vaccinations will be available from all service providers. More monitoring of service policies, clinical practices and data collection would provide evidence of whether vaccinations are reaching priority populations.

In line with the *National Hepatitis B Strategy*, states and territories should ensure that sex workers and PWIDs are specifically listed as a priority population in all policy documents. Having a single, standardised hepatitis B policy in each state and territory would streamline the approach and detail responsibilities of service providers.

Criminalisation, licensing, stigma, discrimination, travel, and cost all then impact upon a person’s capacity to access those limited service providers. Addressing these barriers would assist in increasing course completion. Decriminalisation of sex work and currently illicit drugs and drug use across Australia, the introduction and implementation of federal antidiscrimination laws protecting sex workers and PWIDs from discrimination, and further steps to reduce cost, stigma and inconvenience are important steps to reducing the barriers that PWID and sex workers face to accessing hepatitis B vaccinations.

\textsuperscript{104} ibid.

\textsuperscript{105} Topp, L. et al., above n.99.
Outcomes & Recommendations:

This mapping process has revealed the need for a more strategic and comprehensive and nationally consistent approach to addressing hepatitis B prevention among PWIDs and sex workers. The *National Hepatitis B Strategy 2010-2013* has also prioritised hepatitis B prevention among PWIDs and sex workers with a specific focus on addressing: the levels of knowledge about hepatitis B; the availability and access to hepatitis B vaccination; the importance of national consistency in information on hepatitis B and the need for IDU and sex worker peer education in relation to hepatitis B prevention and vaccination.\(^\text{106}\) The available evidence also supports strategic action in these areas. In this context, the BBVS Sub-Committee has a formal role in ensuring the implementation of a range of strategies to address the key barriers to hepatitis B vaccination identified in this paper including:

1. Improving access;
2. Reducing barriers;
3. Improving completion rates; and
4. Increasing demand.

*Recommendation:*

*That a future meeting of the BBVSS set time to discuss the implications of this paper and to identify recommendations for action.*

\(^{106}\) Department of Health and Ageing, above n.2, p.21-22.