Informing Viral Hepatitis Elimination Efforts in British Columbia: What We Heard

Final Report
June 2026

Acknowledgements

Land Acknowledgement

This report was developed on the unceded, ancestral, and occupied territories of many distinct Indigenous nations in what is colonially known as British Columbia (BC). We are grateful to all the First Nations, Métis, and Inuit communities who have cared for and nurtured the lands and waters around us since time immemorial.

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Executive Summary

The British Columbia (BC) Centre for Disease Control (BCCDC) and the BC Hepatitis Network launched a multisectoral collaborative initiative in 2023 to identify priorities and actions required to achieve the elimination of viral hepatitis as a public health threat in BC by 2030. Through a year-long consultation process, more than 500 individuals—including clinicians, service providers, researchers, public health professionals, and people with lived and living experience (PWLLE) of viral hepatitis—shared their perspectives on progress, priorities, and ongoing challenges. These engagements were intended to inform future planning and strengthen alignment across partners working toward elimination goals.

The insights summarized in this report reflect a broad and diverse provincial conversation about the current state of hepatitis B virus (HBV) and hepatitis C virus (HCV) prevention, testing, care, and treatment across a range of settings and populations in BC. They were interpreted by subject-matter experts, including clinicians, researchers, and PWLLE, to identify key themes and priorities that can inform the ongoing work of governments, health authorities, and community partners.

Context and Purpose

Elimination of viral hepatitis by 2030 is an ambitious but attainable goal that requires coordinated, sustained action across multiple sectors. Global strategies led by the World Health Organization and national efforts such as the Canadian Network on Hepatitis C (CanHepC) Roadmap Project have established guiding frameworks for this work including targets across prevention, testing, treatment, and care. In BC, hepatitis elimination aligns closely with B*ritish Columbia's Population and Public Health Framework: Strengthening Public Health* and provincial priorities related to health equity, harm reduction, and communicable disease prevention. Consultations that generated the input presented in this report were designed to identify perceived strengths, challenges, and emerging opportunities from the perspectives of communities and practitioners across the province to inform future planning efforts in relation to achieving the goal of elimination of viral hepatitis as a public health threat in BC by 2030.

Current Landscape

BC has made notable progress toward viral hepatitis elimination goals to date. The province benefits from universal hepatitis B vaccination, wide availability of curative hepatitis C therapies, and decades of innovation in harm reduction and community-based programming. Dedicated clinicians, researchers, community organizations, and peers have advanced testing, linkage to care, and treatment outcomes across diverse populations. These efforts have contributed to high testing rates, improved linkage to care, and substantial reductions in HCV transmission over time in BC.

At the same time, progress has been uneven across populations and regions. Input from the consultations reported here describes ongoing challenges, including declining rates of hepatitis C treatment initiation, persistent stigma and discrimination, and inequitable access to services in rural, northern, and marginalized communities. System-level factors—such as administrative complexity, fragmented service delivery, and limited integration between harm reduction and infectious disease programs—were identified as ongoing barriers to accessing care.

Shared Insights and Moving Forward

Throughout consultations and engagements, a shared commitment to viral hepatitis elimination goals and a strong desire for continued collaboration was expressed across all sectors and regions. Input emphasized that sustainable progress will depend on:

- increasing equitable access to viral hepatitis testing, prevention, and treatment across all regions of BC;
- strengthening integration between harm reduction, infectious disease, and primary care;
- reducing stigma and discrimination in health and community settings; and
- ensuring that the voices of people with lived and living experience and Indigenous Rights Holders remain central to decision-making processes.

Conclusion

This report captures the collective reflections of hundreds of partners who are working toward viral hepatitis elimination in BC. The findings highlight both the significant progress made and the complex challenges that remain. By drawing on these shared insights, policy and program leaders can continue to align efforts, strengthen partnerships, and identify opportunities for action to ensure that BC remains on a path toward eliminating viral hepatitis as a public health threat by 2030 and beyond.

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Glossary

Allied healthcare workers: Health professionals who work outside of medicine and nursing. This includes laboratory staff, pharmacists, epidemiologists, social workers, and clinical assisting occupations.

Cultural safety: An approach ensuring that healthcare environments are free from racism or discrimination. Cultural safety goes beyond cultural awareness and sensitivity by addressing power imbalances and systemic inequities. Through self-reflection on their own biases, healthcare providers can create respectful environments that foster safety and trust between provider and client.[1,2]

Distinctions-based approach: An approach that respectfully engages Indigenous peoples, including First Nations, Métis, and Inuit, by recognizing their unique rights, interests, priorities, and concerns. It honors the diverse cultures, histories, rights, laws, and governments of each individual nation and peoples.[3]

Endemic: A disease that is considered endemic is one that consistently occurs in a specific region or population. It has a stable prevalence and predictable spreading over time.[4]

Gender equity: A process that ensures fair access to resources, opportunities, and decision-making for people of all genders. This is achieved through addressing systemic barriers such as policies that disadvantage certain genders. Gender equity implements tailored solutions for the diverse needs of all individuals.[5]

Harm reduction: A holistic and comprehensive approach to minimizing harm related to substance use and sexual activity.[6] In the context of this roadmap, harm reduction refers to the delivery of viral hepatitis care through a multidisciplinary program of engagement to include specific measures (prescription medications, provision of sterile drug use equipment, safer sex supplies, and other interventions) to reduce the consequences of ongoing drug use and/or sexual activity, and in so doing enhance the effectiveness of viral hepatitis care. Harm reduction includes increasing protective factors, stigma reduction and addressing the detriments of health.[7]

Healthcare providers: A term referring to people who provide health services, such as clinic staff, clinicians, nurses, and physicians. This term also includes community health services.

Indigenous medicines and traditional healing: A healthcare approach referring to health practices and knowledge rooted in Indigenous ways of knowing. It uses holistic methods, such as ceremony, natural medicines, and hands-on techniques to support health outcomes for Indigenous communities. For example, Central Interior Native Health (CINHS) offers both soap berries (a traditional blood cleanser) alongside clinician prescribed medications for hepatitis C treatment, such as sofosbuvir/velpatasvir or glecaprevir/pibrentasvir. By incorporating traditional healing with western medicine, holistic healing is fostered while increasing representation of Indigenous knowledge within healthcare systems.[8]

Intersectional approach: An intersectional approach to public health considers how systems of oppression, such as racism, ableism, colonialism, and sexism, interact to create unique health challenges for people with intersecting identities. For example, a woman new to Canada working in a lower-income job may face increased barriers accessing HCV and HBV testing, due to language differences, racial discrimination or poverty.[9]

Non-primary care: Refers to specialized healthcare services to address specific health conditions (e.g., surgeons, cardiologists, dermatologists).

Older people: A term referring to people who are in the advanced stages of their life. People age at different rates and have varying levels of frailty and health needs, irrespective of their chronological age. Using the term ‘seniors’ or ‘elderly’ can be exclusionary to people who have a different course of

aging, as these terms are frequently associated with restrictive chronological age brackets, due to use in government or pension policies. In this report, 'older people' refers to people born prior to 1965.[10]

Priority populations: Refers to the populations significantly impacted by viral hepatitis. This includes Indigenous people, people with incarceration experience, immigrants and newcomers, people who use drugs, 2SLGBTQ+ people, older people, women, pregnant people, children, and youth and underhoused people. See pages 22 to 29 in this report for full priority population descriptions.

Primary care: Refers to generalized healthcare providers (general practitioners, nurse practitioners) who are often the first point of contact for patients when accessing healthcare .

Proportionate universalism principle: Public health actions should be universal, not targeted, but with a scale and intensity that is proportionate to the level of disadvantage experienced by a particular group of people.[11] As an example, Indigenous peoples experience significant disadvantages and health inequities due to colonial violence, therefore public health interventions specific to their communities' experiences is required.

Systemically marginalized: Systemically marginalized groups are excluded from participation in society, often pushed to the margins of the mainstream by deeply rooted institutional policies, practices, and cultural norms. These create additional barriers like access to employment, education, housing, and healthcare. These barriers are frequently upheld by unexamined practices that reinforce the status quo.[12]

Trauma and violence informed care: This approach acknowledges how historical trauma and ongoing colonial violence impacts health and addresses structural, intergenerational, and interpersonal violence to increase safety and support in healthcare. For example, in viral hepatitis treatment programs, staff can use non-stigmatizing language and offer flexible appointment schedules to reduce re-traumatization, prevent further harm, and increase access to care.[13,14]

Two-Eyed-Seeing approach: Etuaptmumk is a Mi'kmaw word meaning Two-Eyed-Seeing. The term was first shared by Mi'kmaw Elder Albert Marshall as a guiding principle to realize greater benefits through seeing from both Indigenous and western perspectives. A Two-Eyed-Seeing approach harmonizes strengths and insights from both Indigenous and western knowledge systems to encourage collaboration in personal, political, health and research settings.[15,16]

Underhoused: A term referring to individuals without stable, safe, or adequate housing. This includes people who are experiencing homelessness (e.g. living on the street) and temporary housing (e.g. couch-surfing, shelters, transitional homes, treatment centres, correctional centres).[17]

Undetectable = Untransmittable [U=U]: A term referring to a person living with HIV who is receiving treatment, who cannot transmit HIV to another person through sexual activity. This is due to the amount of HIV in their blood being so low that it cannot be detected by standard tests (known as an undetectable viral load).[18]

Viral hepatitis: A condition characterized by inflammation of the liver caused by infection with a virus which can infect hepatocytes (liver cells).[19] Viral hepatitis includes five different viruses named A through E, however only three can cause chronic infection; HBV, HCV and HDV, which are discussed in this report.

Whole person approach: Instead of just treating a specific disease, a whole person approach focuses on restoring and integrating physical, behavioral, and social health, aiming to promote overall wellbeing and prevent disease across the lifespan. It also considers all factors of a patient's identity, history and socio-economic status.[20]

Acronyms

2SLGBTQ+: Refers to sexual and gender-diverse communities. 2S recognizes Two-Spirit people as the first within these communities, specific to Indigenous-identifying individuals. The letters represent Lesbian, Gay, Bisexual, Transgender, and Queer. The "+" is inclusive of individuals who use additional terminology to describe their identities.[17]

DBS: Dried blood spot, which is a type of specimen that can be used to collect capillary blood from a finger prick, similarto blood sugar monitoring for diabetes. The DBS specimens can then be used for serological and molecular testing to screen for viral hepatitis, HIV, and syphilis infection.

DAAs: Direct Acting Antivirals are aa class of prescribed drugs highly effective for treating viral infections, such as HCV, HBV, and HIV. DAAs target specific viral components to disrupt viral replication or cell entry. Some DAAs like Lamivudine and emtricitabine (nucleoside reverse transcriptase inhibitors), effectively treat HBV and HIV. Other DAAs, like glecaprevir (a protease inhibitor), treat only HCV. Currently, DAAs are the primary HCV treatment in Canada.[21,22]

gbMSM: An inclusive acronym referring to gay, bisexual, and other men who have sex with men. This term is commonly used in public health contexts to address the specific needs of men engaging in same-sex activities, regardless of their sexual identity.[23]

HBeAg: A hepatitis B e-antigen, which is a marker of hepatitis B virus replication and infectiousness.[24]

HBIG: Hepatitis B immune globulin. A medication that provides temporary protection against hepatitis B virus infection and can be administered immediately after birth to infants born to a person with chronic infection.

HBV: Hepatitis B virus.

HCV: Hepatitis C virus.

PrEP: Pre-exposure prophylaxis, typically referring to prescribed medications which can be taken to prevent HIV infection.

POCT: Point of care testing, referring to screening or diagnostic testing provided during initial patient care encounters. Typically, POCT provide a result faster than a typical laboratory-based test, supporting rapid or accelerated clinical decision-making.[25]

PWUD: People who use drugs, which refers to people who use non-prescribed psychoactive substances for any purpose, including recreational, medicinal, or otherwise. This term is inclusive of all substance use, including illegal or unregulated drugs and controlled drugs such as tobacco, nicotine, cannabis, or alcohol. While blood-borne infections such as viral hepatitis or HIV can be easily transmitted through injection drug use, other methods of drug use, such as inhalation or rectal administration ("booty bumping"), are also associated with increased risk of HCV and HBV transmission.[26]

PWID: People Who Inject Drugs, which specifically refers to people who inject non-prescribed psychoactive substances. PWID may also use drugs through non-injection routes. Sharing of injection related equipment, including hypodermic needles or syringes, as well as preparations of drugs, filters, swabs or tourniquets, is the most common route for transmission of HCV in British Columbia.

PWLLE: People With Lived or Living Experience, which refers to people who self-identify as having personally experienced a particular health, behavioural or social condition or issue. Their knowledge and understanding of a disease, health condition or social issue is based on their firsthand experiences, personal perspective, history, and identities, rather than professional or educational experience. This gives them unique insights that can help inform and improve health systems, research, policies, practices, and programs.

RNA: Ribonucleic acid is a type of genetic material found in many types of living organisms, as well as in viruses like HCV. An HCV RNA test detects the presence of the virus in the blood and is used to confirm an active (current) HCV infection.

STBBIs: Sexually transmitted and blood-borne infections.

Background

Chronic infection from HBV or HCV are leading causes of death and illness resulting from an infectious disease. HBV is vaccine preventable and there are effective medications which can prevent viral replication, while HCV can be cured through highly effective, short course antiviral medications. These two tools **- vaccination and curative treatments -** when coupled with effective strategies tailored for specific populations and regions, make the elimination of viral hepatitis as a public health threat highly attainable. The availability of these two tools prompted the creation of goals and targets to eliminate viral hepatitis as a public health threat by 2030 in both global[27] and national strategies.[28]

Viral Hepatitis in Canada and British Columbia

While estimating the prevalence of acute and chronic infection is challenging, these viruses are responsible for a considerable burden of morbidity and mortality in Canada. HBV and HCV still have a major impact on people in Canada and the healthcare services that look after them.

Hepatitis B (HBV)

An estimated 216,000 (95% uncertainty interval of 125,000 to 366,000) people are living with chronic HBV infection in Canada as of 2022, with overall HBV infection prevalence of 0.6%.[29] However, **HBV prevalence is likely higher in BC compared to the Canadian prevalence**. A study among first-time blood donors across Canada from 2005 to 2022 found that chronic HBV was most common among donors in BC, with 0.7% prevalence among this group.[30] Additionally, a study conducted in BC found that chronic HBV infection was present among 0.86% of people who enrolled in the provincial HIV Pre-Exposure Prophylaxis (PrEP) program from 2018-2019.[31]

Despite the introduction of a universal childhood vaccination program in the 1990s[32], **HBV continues to be a major cause of morbidity and mortality in BC.** Research conducted in BC highlights that people with HBV were at greater risk of liver-related mortality, as well as other non-liver cancers.[33] Morbidity and mortality related to HBV can be mitigated through increased diagnosis and treatment of chronic HBV infection.[34]

In 2019, 4,912 new HBV cases were reported in Canada, at a rate of 13.1 per 100,000 people. Of these, there were 3,790 chronic cases for a rate of 10.2 per 100,000 people; 178 acute cases for a rate of 0.5 per 100,000 people; and 944 unspecified cases for a rate of 4.7 per 100,000 people.[35] **In 2019, BC reported the highest rate of chronic HBV** (Figure 1) at 14.7 per 100,000 people (followed by Ontario at 11.9 per 100,000 people). This may be related to international immigration trends in Canada, as a high proportion of immigrants from HBV-endemic regions settle in these two provinces.[36]

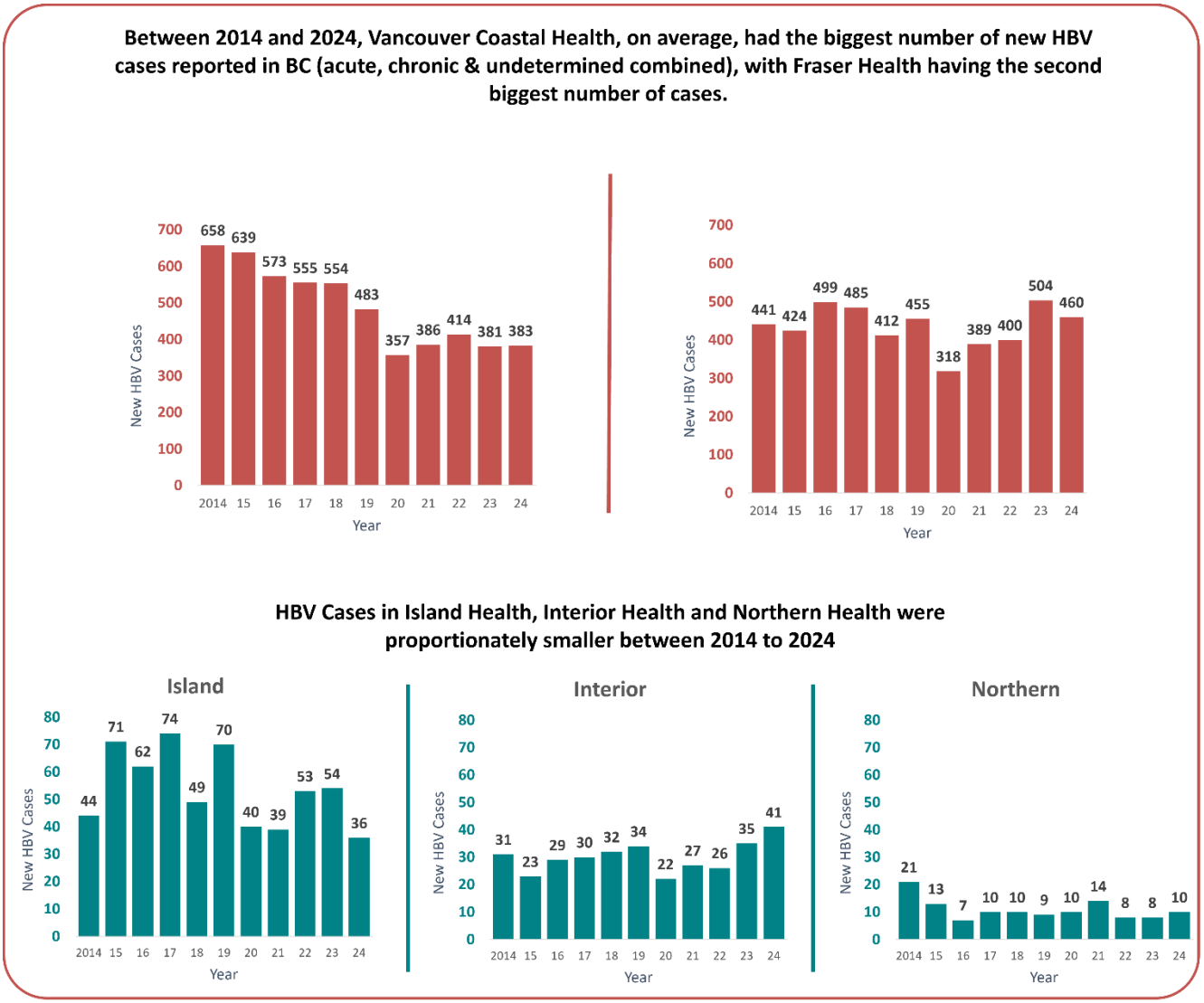


Figure 1. New HBV Cases Reported by RHA in BC. HBV surveillance data extracted from BC Communicable Disease Mart, February 2025. Provided by BC Centre for Disease Control.

While the number of new HBV infections reported in BC has declined over the last decade, **the province continues to experience a substantial burden of chronic infection**. This reflects historical patterns of HBV exposure and ongoing population dynamics, with an **estimated 30,000 people living with chronic HBV in BC as of 2022**.[35,36] Currently available HBV treatments, which suppress the virus from replicating, but cannot cure the infection completely, have been demonstrated to reduce the risk of hepatocellular carcinoma (HCC), a primary liver cancer, in addition to reducing the progression of liver cirrhosis and liver decompensation.[34] **Several promising treatments that aim to deliver a "functional cure" from chronic HBV infection are currently in development**, with more than 90 drugs reported to be in development as of 2024 and up to six new HBV drugs expected to launch in global markets by 2027.[37] New guidelines were published in 2025 by the Canadian Association for the Study of the Liver on the management of chronic HBV.[38] This new expert guidance recommends several changes in clinical practice for already approved therapies, including expanding the recommended criteria for commencement of therapy.

Hepatitis C (HCV)

HCV infection was the second most common primary diagnosis after cancer for liver transplant recipients in Canada (not including Quebec) from 2009 to 2018.[39] In 2019, there were an estimated 9,500 new HCV infections and approximately 388,000 people who had ever had HCV infection in Canada.[40] In 2021, BC reported 26.2 new HCV infections per 100,000 population, which was the fifth highest rate nationally.[41] An estimated 204,000 people in Canada were living with chronic HCV infection as of 2019.[42] The rate of new HCV infections reported in BC decreased substantially between 2000 and 2019,[43] which may represent decreased transmission of HCV or people living with undiagnosed HCV due to less testing among certain priority populations.

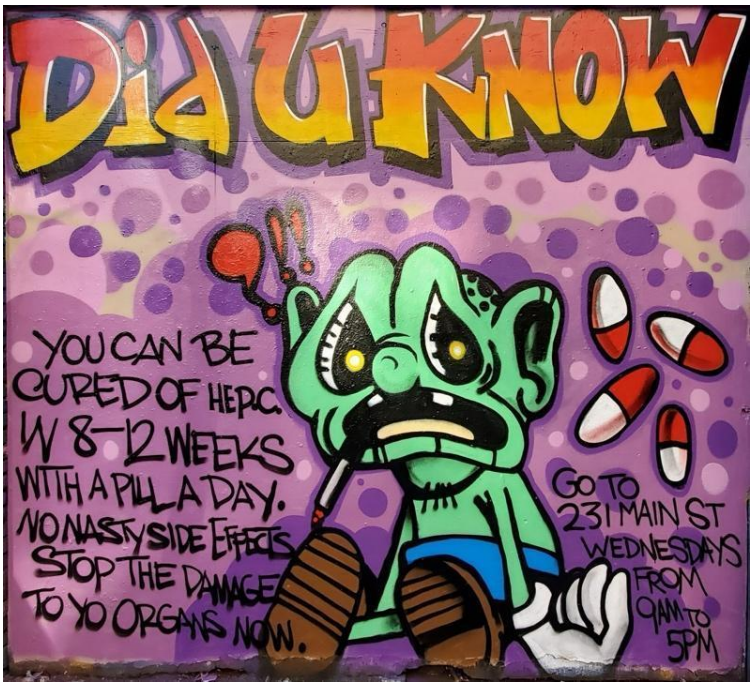


Image: Street art by Smokey D (James Hardy) and Trey Helten. The artists use visual storytelling to share important messages with and on behalf of their community in the Downtown Eastside (DTES) of Vancouver. This piece captures experiences of people with lived and living experience of hepatitis C. Painted in April 2023. Located at Carrall and East Pender Street in Vancouver. Image credit: Sofia Bartlett.[44]

There continues to be inequities in the HCV cascade of care experienced by PWUD, in particular PWID (Figure 2). Previous studies in BC have found that there are high HCV testing rates in BC, particularly among PWUD, and the proportion of people with chronic HCV infection in BC who are undiagnosed is estimated to be approximately 10%.[45] Therefore, observed declines in new HCV cases in BC appear to reflect declining rates of HCV transmission. This declining trend is likely a result of increases in the provision of services aimed at reducing blood-borne infection transmission among PWID, and increased HCV treatment initiation, particularly from 2016-2019. Mortality among PWUD related to accidental illicit drug poisoning may also have a role in further reducing the rate of new HCV cases in BC.[46]

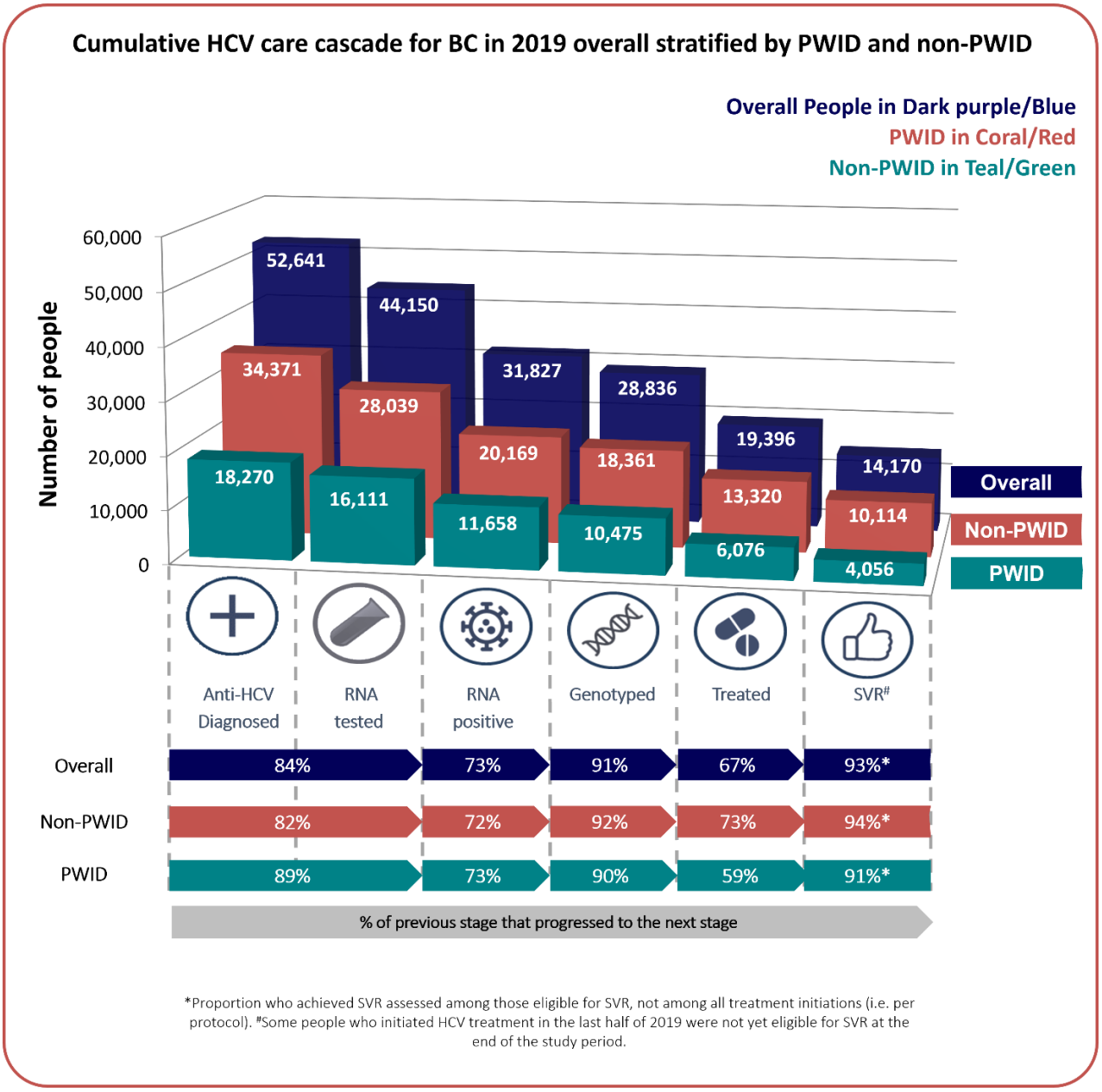


Figure 2. HCV Care Cascade in BC as of 2019. *Care cascade stages are stratified overall and among people with and without a history of injecting drug use.*[47]

While significant improvements in progression along the HCV care cascade in BC since 2000 have been identified,[48] gaps in treatment initiation continue,, especially among younger birth cohorts.[49,50] Despite high rates of HCV testing and diagnosis, it is estimated that in 2018 only 40% of all people in BC who have chronic HCV infection had initiated treatment.[48] While BC has seen historically high HCV treatment initiation rates relative to other provinces and territories in Canada,[51] the overall number of HCV treatment initiations have been declining in BC steadily since a peak in 2018 (Figure 3).
The trend in declining HCV treatment initiations in BC was exacerbated by the impacts of the COVID-19 pandemic, however analyses suggest the trend may have stabilized as of 2022[52] and a slight

increase was observed in 2023. All-cause mortality has also steadily increased among people diagnosed with HCV in BC since 2000, with mortality rates being highest among the older birth cohorts and people with HIV and/or HBV co-infections.[53]

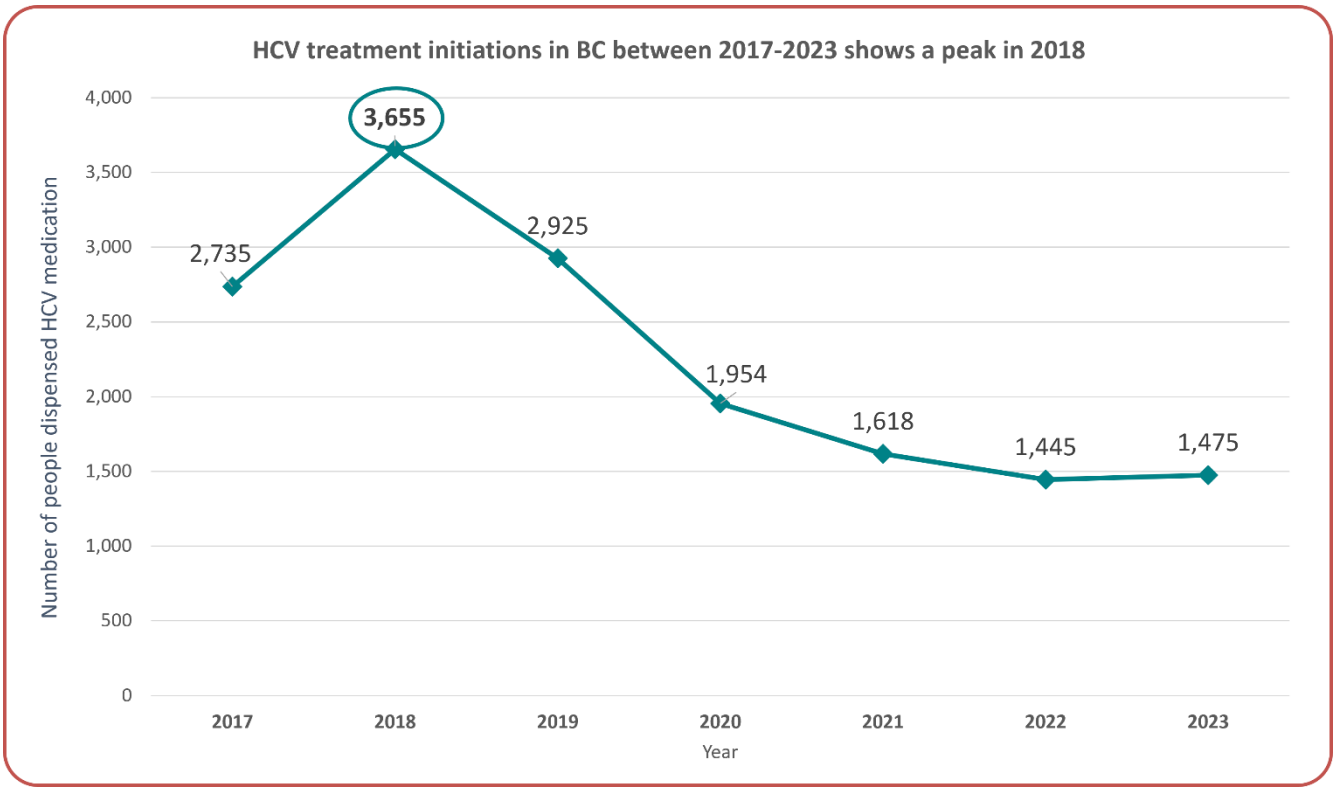


Figure 3. Number of unique HCV prescriptions in BC, 2017 - 2023. Data extracted from BC Pharmanet via BC COVID-19 Cloud Cohort, January 2024.[54] Courtesy of BC Centre for Disease Control.

In BC, HCV disproportionately affects certain populations of people, in particular PWUD, people who are incarcerated, Indigenous peoples, gay, bisexual and other men who have sex with men (gbMSM), immigrants from high prevalence countries, and the 1945-1975 birth cohort.[55–57] Further, HCV surveillance data from BC (Figure 4) demonstrates that HCV cases are not distributed equally across the province. The Fraser Health region in BC consistently records the highest number of new HCV cases, whereas the Northern Health region consistently reports the lowest number of new cases. However, when the number of new cases is adjusted for the size of the population residing in that region, in 2023 Northern Health had the highest rate of new HCV cases, at 27.3 cases per 100,000 population, and all other regions had a similar rate of new cases, all reporting between 19.4 and 23.5 cases per 100,000 population that year.[58]

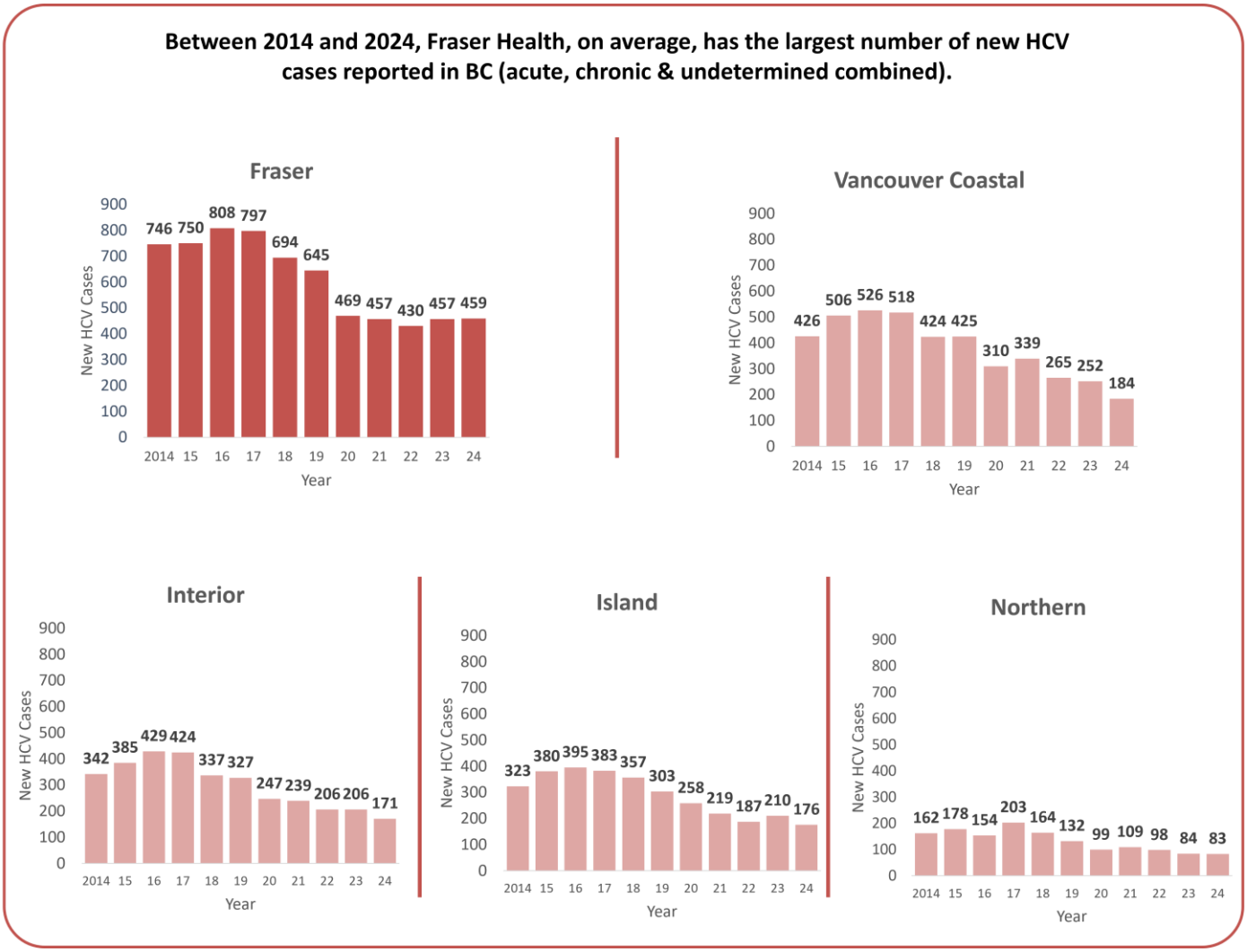


Figure 4. New HCV Cases Reported by RHA in BC. HCV surveillance data extracted from BC Communicable Disease Mart, February 2025.60 Provided by BC Centre for Disease Control.

The Movement to Eliminate Viral Hepatitis by 2030

The World Health Organization (WHO) outlined a goal of eliminating viral hepatitis as a public health threat by 2030 and called on all countries to develop action plans on how to reach this goal.[59] The Canadian federal government, in alignment with these global efforts, set out targets through the Public Health Agency of Canada[60] with the aim of eliminating both HBV and HCV as a public health threat by 2030. The health systems in Canada are a provincial responsibility, making a national action plan challenging to develop. Instead, each province is working to develop tailored and relevant viral hepatitis elimination strategies that will produce results by 2030.

The Canadian Network on Hepatitis C Roadmap Initiative

In continuing the efforts of the 2019 *Blueprint to Inform Hepatitis C Elimination Efforts in Canada* (Blueprint)[61], the Canadian Network on Hepatitis C (CanHepC) launched the Hepatitis C Elimination

Roadmap Project in 2020[62]. The goal of the CanHepC Roadmap Project is to guide the development and implementation of jurisdictional HCV elimination plans, including:

- Contextualize and adapt the Blueprint recommendations to each region, province or territory.
- Reach a multi-collaborator consensus on the recommendations and actions to prioritize and reach elimination.
- Address the specific barriers, challenges and enablers to HCV elimination that pertain to regions and communities.
- Assess each region's progress towards elimination.

Two Regional Roadmaps have been publicly released to date, one for Ontario[63] and one for the Prairies[64], with others at different phases of development. Each Regional Roadmap is being led by independent groups made up of different provincial, territorial, and national leaders, including Indigenous leaders. In alignment with the CanHepC Roadmap initiative, the BCCDC and the BC Hepatitis Network launched this multisectoral collaborative Project in 2023 to seek input from partners across the province on what would be needed to achieve the elimination of viral hepatitis as a public health threat in BC by 2030, the results of which are outlined in this report.

BC Health System Priorities

In September 2024, the Ministry of Health released the *British Columbia's Population and Public Health Framework: Strengthening Public Health*, which outlines provincial priorities and strategies to address public health concerns. Communicable disease prevention and response (including sexually transmitted infections) using an upstream approach and primordial prevention strategies are highlighted as one of the pillars of the framework. Additionally, the BC Health Minister's mandate letter also includes the improvement of cancer care initiatives as a priority, while the Ministry of Health's Service Plan highlights a focus on a cancer-free future. As viral hepatitis is associated with 80% of liver cancer cases, and liver cancer accounts for the 5th highest number of cancer deaths in BC, the elimination of viral hepatitis as a public health threat is a crucial component of achieving a cancer-free future in BC. Reducing health inequities, addressing the determinants of health, intersectoral collaboration and community mobilization and providing public health strategies that offer the best start in life for pregnant people, children and their families are all identified as provincial priorities.[7]

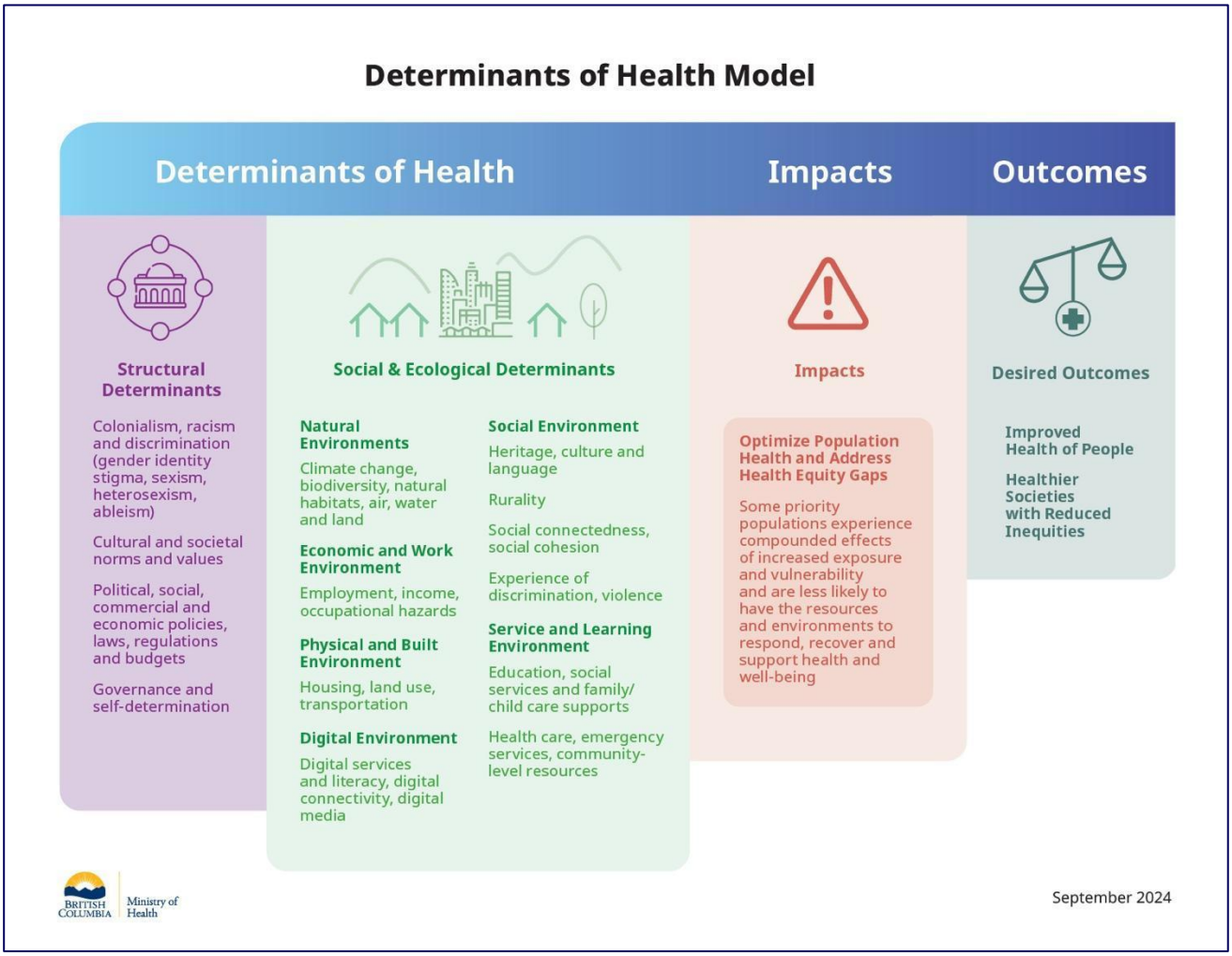


Figure 5. Key Determinants of Health and Impact on Health Outcomes in British Columbia. Source: BC Population and Public Health Framework

Previous Viral Hepatitis Strategies in BC

BC has had a strategic and integrated approach to viral hepatitis prevention and response since 2007, when the Healthy Pathways Forward strategy was first released.[65] The Healthy Pathways Forward progress report released in 2011 found that the strategy was achieving the intended objectives.[66] It found that the current evidence supported continuing to develop programs that support individuals affected by HBV and HCV across a range of healthcare needs with an integrated approach, to address the syndemic effects of viral hepatitis and other infectious diseases. Consultation to refresh the Healthy Pathways Forward strategy was conducted in 2015/16.[67] This again found that while some strategies for HBV and HCV should be different from each other, an overall syndemic approach to viral hepatitis was favoured by both community and health system partners.

Viral Hepatitis Priority Populations in Canada

INDIGENOUS PEOPLES

Indigenous peoples experience **5x higher** HCV rates.

PEOPLE WITH INCARCERATION EXPERIENCE

In federal facilities, **30% of individuals** have lived or living experience of HCV infection.

IMMIGRANTS AND NEWCOMERS

Immigrants and newcomers account for **30% of all current or historical HCV infections** and **60-80% of HBV infections in BC.**

PEOPLE WHO USE DRUGS

PWUD account for **≈ 85% of new HCV infections**.

2SLGBTQ+ PEOPLE

Within the 2SLGBTQ+ community**, ≈ 5% of gbMSM** have a past or current HCV infection

OLDER PEOPLE

Older people comprise an estimated **66%-75% of people living with HCV,** and they experience a high proportion of complications related to advanced liver disease.

WOMEN

In cisgender women, acute HBV infections **increased by 41%** in 2009-2018, while HCV rates **doubled** in 2013-2019. There are limited data on HBV and HCV rates among transgender women in Canada or BC.

PREGNANT PEOPLE

While Canadian guidelines recommend universal HBV and HCV screening during pregnancy, it is not always done in practice and there are gaps in follow-up testing and treatment.

CHILDREN AND YOUTH

> 90% of acute HBV infections in infants become lifelong, yet **20.7%** of children born to HBV-positive parents in BC lack documented vaccine completion. Children exposed to HCV during pregnancy or birth experience multiple barriers to accessing follow-up care.

UNDERHOUSED PEOPLE

Underhoused people are **disproportionately affected** by HCV and have a **higher chance** of contracting HBV.

Indigenous Peoples

HCV rates are **5x higher** in Indigenous peoples.

HCV rates among Indigenous Peoples are estimated to be five times higher than the rest of Canada's population.[68,69] This disproportionate rate is shaped by systemic factors, including racism, colonialism, intergenerational trauma, and systemic abuse, which contributes to decreased trust in viral hepatitis services and increased vulnerability to HCV. Challenges in healthcare delivery further exacerbate the inequities experienced by First Nations people, particularly due to fragmented distribution of responsibility for funding, governance, and service delivery between federal, provincial and First Nations governments. Although the establishment of the First Nations Health Authority (FNHA) in BC has improved coordination and culturally grounded care in many areas, evidence shows that jurisdictional gaps persist,[70–73] particularly for First Nations people living off reserve, who are more likely to rely on regional health authorities that may not consistently provide services aligned with First Nations needs and preferences. This fragmentation can result in unclear accountability, barriers to accessing care, delays in service provision, and a continued undermining of First Nations self-determination in health. Addressing these intersecting structural and systemic barriers through collaborative, coordinated, distinctions-based and culturally informed approaches is essential to reducing HCV rates and supporting long-term health and wellness in Indigenous communities.[60]

People with Incarceration Experience

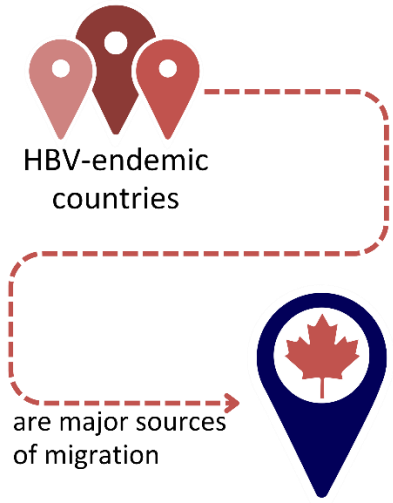
In federal facilities, **30% of individuals** have lived or have living experience with HCV.

In federal facilities, 30% of individuals have lived or have living experience with HCV. In provincial facilities, HCV rates are 15% for cisgendered men and 30% for cisgendered women.[74] Risk factors, such as lack of supplies for safer drug use or tattooing increase the risk for HCV infection among people who are incarcerated. Protective factors, such as access to education, testing, and treatment can vary due to jurisdictional differences.

For example, 66 HCV-related policies and practices vary between provincial, territorial, and federal jurisdictions. Even with policies in

place, people with incarceration experience face significant barriers to care. There is stigma from other people who are incarcerated and staff (including healthcare providers), interruptions in provincial drug benefit programs, poor follow-up on inter-facility transfers or upon release, and difficulty in being referred to HCV specialists or knowledgeable providers.[75]

Immigrants and Newcomers



Cultural and language barriers, racism, and fear of deportation present barriers to care and disclosure.

Canada is a major destination for people from countries where HBV and HCV are highly prevalent. As a result, newcomers and immigrants account for approximately 30% of all current or historical HCV infections and 60-80% of HBV infections in Canada, reflecting differences in global disease distribution rather than increased risk following arrival.[76]

Many newcomers are diagnosed at more advanced stages of viral hepatitis infection, often due to gaps in timely screening and linkage to care.[60] Although viral hepatitis screening is recommended for individuals arriving to Canada from higher-prevalence regions during the immigration process, this screening is not universally done. For individuals with a positive test result during the immigration process, they need to take many steps to receive appropriate follow-up care and treatment, this process is difficult to navigate, particularly with unfamiliarity with the BC health system and language and cultural differences. Experiences of systemic and interpersonal racism can further limit engagement with the healthcare system in BC, particularly for individuals who are temporary residents or who are uninsured.[61]

People Who Use Drugs

85% of new infections in Canada are among PWUD, specifically PWID.

PWUD, specifically PWID, experience the highest rates of new and existing HCV infections, accounting for approximately 85% of new infections in Canada. Furthermore, two-thirds of PWUD have lived or living experience with HCV.[55,77,78] Access to opioid agonist therapy (OAT) has been demonstrated in Canada to both prevent HCV infection among PWID,[79] as well as increase HCV treatment uptake among PWID[80] who already acquired HCV infection.

Despite this, PWUD are less likely to have accessed curative treatment for their HCV infection in BC.[46,80] Lower HCV treatment uptake among PWUD has been linked to several factors in BC, including experiencing stigma related to HCV and substance use, both in health and social situations,[81,82] lack of access to healthcare and health-care systems designed to meet their social and addiction needs.

2SLGBTQ+ People

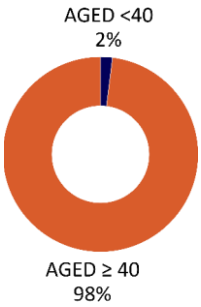
⇒ **Increased HCV transmissions** within gbMSM.

Approximately 5% of gbMSM have a past or current HCV infection. The primary risk factors include sexual and/or drug transmission. Reinfection rates within gbMSM are also increasing.[61] HIV prevention strategies such as PrEP and HIV treatment as prevention, also referred to as 'undetectable = untransmittable' [U=U] may unintentionally contribute to HCV transmission due to a lack of awareness around HCV risks, leading to increased HCV transmissions amongst gbMSM.[61] Enhanced education and prevention strategies tailored to gbMSM are important in addressing these challenges.

Older People

The highest HCV rates in Canada are found among people born between 1945 and 1975, who comprise an estimated 66% to 75% of people living with HCV. This cohort is five times more likely than the general population to be at risk for experiencing severe complications, such as cirrhosis, cancer, and premature

98% of HCV-related liver transplants occur in people **aged ≥ 40**.

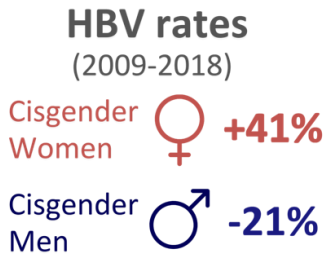


death. Despite this substantial risk, testing rates for older people remain low. Increasing testing in this population is essential, as HCV is the main cause for liver transplants in Canada, with 98% of HCV related transplants occurring in people aged 40 or older.[83]

Many infections within older people are due to past injection drug use, however receiving unscreened blood products, or having a medical procedure prior to implementation of universal precautions, sterilization, and aseptic techniques have also contributed to substantial nosocomial transmission of HCV among this cohort.

Stigma surrounding past activities, such as drug use, may contribute to this cohort not disclosing potential exposures and therefore not accessing testing and treatment.

Women



Trans Women experience a **higher prevalence** of HBV and HCV.

The rates of acute HBV and HCV are rapidly increasing in cisgender women compared to cisgender men. From 2009 to 2018, acute HBV infections increased by 41% in cisgender women compared to a nearly 21% decrease in cisgender men. For HCV, rates in cisgender women doubled from 2013 to 2019. These trends align with rising rates of new HIV and syphilis infections reported among cisgender women living in Canada over the past decade, likely associated with increased substance and drug use via injection in some groups of cisgender women.[39] Disparities in access to and uptake of HCV testing and treatment among cisgender women, compared to cisgender men, have been identified in BC.[84]

HBV and HCV prevalence is higher among trans women compared to cisgender women due to increased barriers to accessing healthcare services.[85] Levels of systemic marginalization are also higher for women who use drugs or who are involved in sex work. These societal factors have been linked to women who inject drugs being more likely to share injecting drug use equipment, compared to men who inject

drugs, which is a key driver of elevated viral hepatitis prevalence among women overall, compared to men.[86]

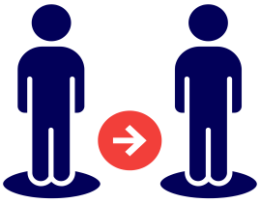
Pregnant People

⇒ **HBV: Gaps** in follow-up testing for **HBV**
⇒ **Inadequate testing** for **HBeAg** and **viral load**
⇒ **Lack of** universal **HCV screening**

National and provincial guidelines recommend HBV screening during every pregnancy,[87] regardless of prior immunity status. Regional screening rates vary from 80% to 100% and gaps remain in follow-up testing and treatment.[88,89] There is inadequate testing for HBeAg (HBV e-antigen) and viral load, which are key to preventing vertical transmission (transmission of infection to a child during pregnancy or birth). Prevention efforts of vertical transmission could be improved with HBeAg and/or viral load reflex testing.[77] Universal HCV screening during pregnancy was recently recommended by the Society of Obstetricians and Gynecologists of Canada,[90] however this is yet to be implemented widely in practice.

Children and Youth

20.7% of children born to pregnant people living with HBV did not have a documented completion of HBV vaccine series, highlighting significant **gaps in follow-up care.**[6]



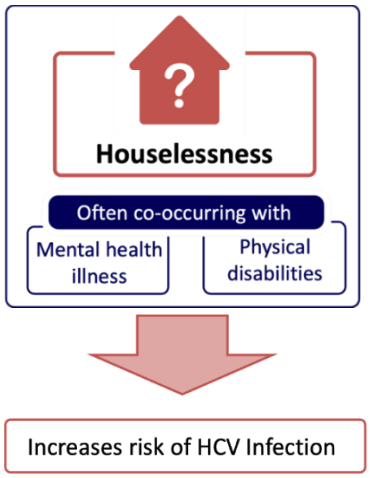
Street-involved youth, particularly youth who inject drugs, experience the **majority** of **horizontally acquired HCV transmissions** in Canada.

Over 90% of acute HBV infections that occur in infants and young children will progress to lifelong chronic infections, whereas immunocompetent adults have a 95% clearance rate. Vertical transmissions (transmission of an infection from a parent to infant during pregnant) can be reduced with administration of HBIG and a birth dose of HBV vaccine within 24 hours of birth, followed by two more vaccine doses in infancy.[91] Despite Canada's universal HBV vaccine program, HBV cases are still found prior to adolescent vaccination in Canadian-born children. Assuming a high rate of prenatal screening, transmissions were likely due to vaccine failure or horizontal (non-parental) transmission. A BC study found that 20.7% of children born to pregnant people living with HBV did not have a documented completion of HBV vaccine series, highlighting significant gaps in follow-up care.[92]

Most pediatric HCV infections result from vertical transmission with rates of 5.8% from HCV-positive pregnant people without HIV-1 co-infection and 10.8% from HCV-positive pregnant people with HIV-1 co-infection that is suboptimally controlled. Approximately 20% to 30% of infants who acquire HCV through vertical transmission spontaneously clear the virus by age two

or three, with the rare recurrence of viremia (the presence of viruses in the bloodstream).[93]

Underhoused People



Underhoused people are disproportionately affected by HCV and have a higher chance of contracting HBV. Activities that increase the risk for HCV (e.g. drug use) may be exacerbated by houselessness, co-occurring mental health illness and physical disabilities. Underhoused people face significant barriers to care, including previous treatment options for HCV (interferon and ribavirin weekly injections and pills) which often caused multiple side effects and was not an accessible or sustainable treatment method for this population. However, data suggests that houselessness does not have a significant impact on the treatment outcome for the new DAAs regime.[94]

Intersectionality Within Priority Populations

Systemically marginalized groups in BC face disproportionate impacts from viral hepatitis. Overlapping factors across groups further increase risks and complicate response strategies, e.g. an older person, who uses drugs with experience of incarceration. Thus, to eliminate viral hepatitis at the population level, it is essential to consider the multiple lived experiences of these priority populations and to take an intersectional approach to testing, care, and treatment strategies.

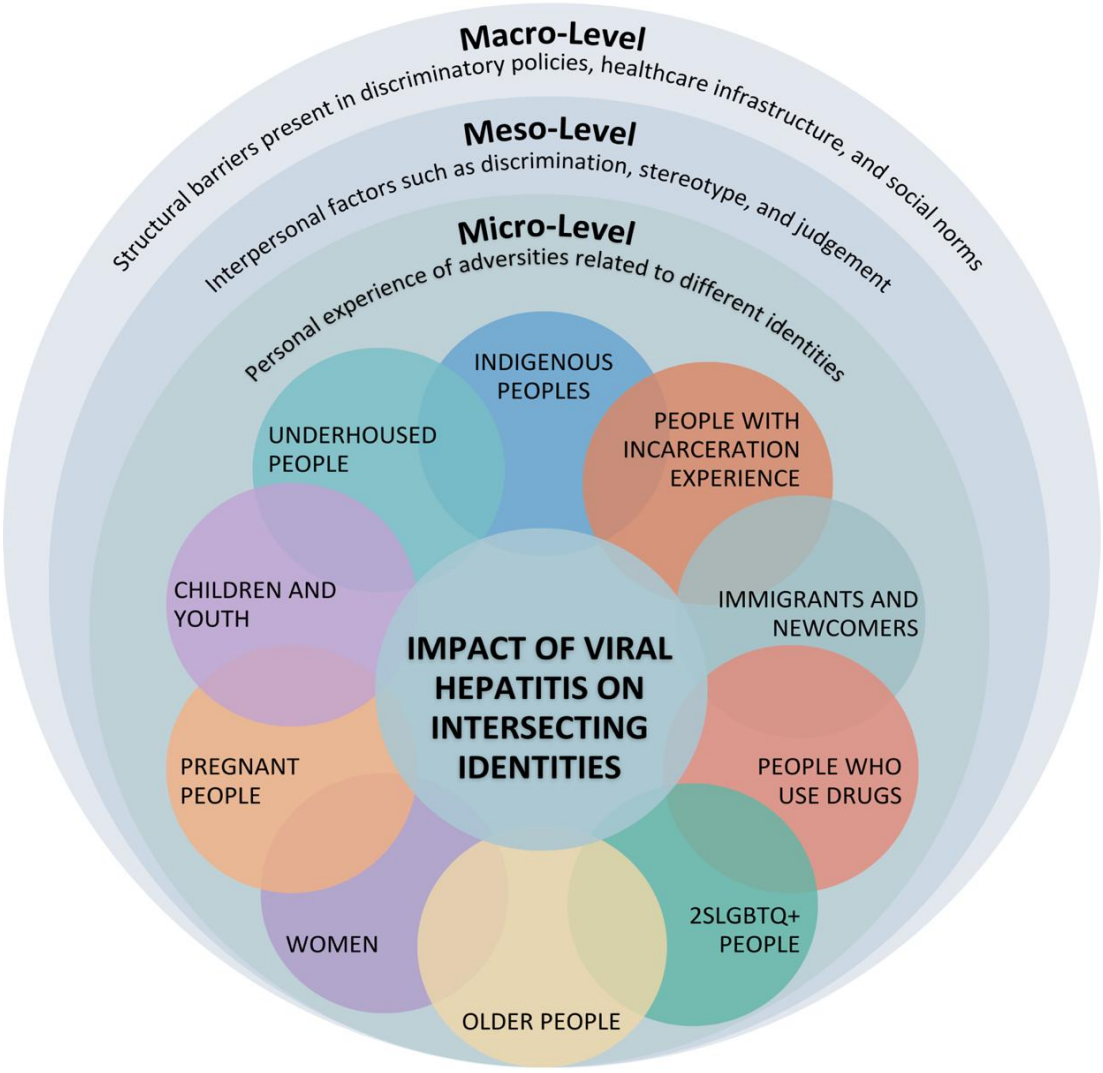


Figure 5. Impact of viral hepatitis on intersecting identities. Developed by project team.

The Project Process

How the Project was Developed

To inform future planning efforts in relation to achieving the elimination of viral hepatitis as a public health threat in BC by 2030, it was identified that partners across the province needed to be engaged and consulted to identify required priorities and actions. A Project to carry out this engagement and consultation was conceived by the BCCDC and BC Hepatitis Network. After funding was secured, the Project began in early 2023, led by the BCCDC in partnership with BC Hepatitis Network and a multi-partner Executive Committee, including representatives from government, health-care providers, researchers, community organizations and subject matter experts. By mid-2023, a Project Team was established, composed of staff from BCCDC Clinical Prevention Services, the BC Hepatitis Network, and independent consultants.[95]

Over the summer of 2024, five Working Groups were established, consisting of 27 experts from across BC representing clinical, community, and PWLLE. Each was tasked with meeting to review and interpret the data gathered from consultations, and synthesize the key learnings from what was heard, focussing on these specific priority populations:

- Indigenous peoples
- Immigrants, newcomers and older people
- 2SLGBTQ+, youth, children and women
- People who use drugs, people with incarceration experience and underhoused people
- Data, monitoring and evaluation

Representatives from each Working Group were nominated to the Project Steering Committee, which acted as a bridge between the Working Groups, the Project team, and the Executive Committee. A full list of members is provided in Appendix A.

The Project sought to gather input regarding both HBV and HCV, reflecting the overlapping priority populations affected by both viruses as well as the shared social and health inequities they face.[56] By integrating HBV, the Project scope aligned with the WHO's global targets[27] for eliminating both HBV and HCV by 2030, supporting comprehensive and equitable approaches to addressing the province's burden of viral hepatitis. To foster an inclusive approach, four key steps (Figure 7) were undertaken to engage diverse groups impacted by or working to address viral hepatitis throughout BC. It is hoped that insights and themes from these engagements will serve as the foundation for shaping future recommendations and action plans aimed at eliminating viral hepatitis as a public health threat in BC by 2030 and beyond.

Figure 7. Consultation Strategy Graphic. Developed by the project team.

Project Framework Design

The Project began with a review of existing literature. The Project team synthesized key targets, strategies, and action items from various sources, including WHO and Public Health Agency of Canada reports[27,60] building on the significant work already completed to support viral hepatitis elimination in BC, Canada, and globally. This process started with a general focus on HBV and HCV and then shifted to specific analyses of priority populations. The lack of clear targets and action items for HBV elimination in BC and Canada emerged as a critical gap during the literature review and synthesis

process, which highlights the importance of prioritizing their development as part of the collective effort to eliminate viral hepatitis. The Project Framework (Figure 8) was developed as part of this synthesis to provide a structured approach to inform consultations and future elimination efforts. The framework outlines the context, inputs, outputs, and outcomes across the cascade of care, emphasizing equity and collaboration. It integrates system components like harm reduction, testing, care, and treatment with tailored strategies for HBV and HCV, while addressing the unique needs of priority populations.

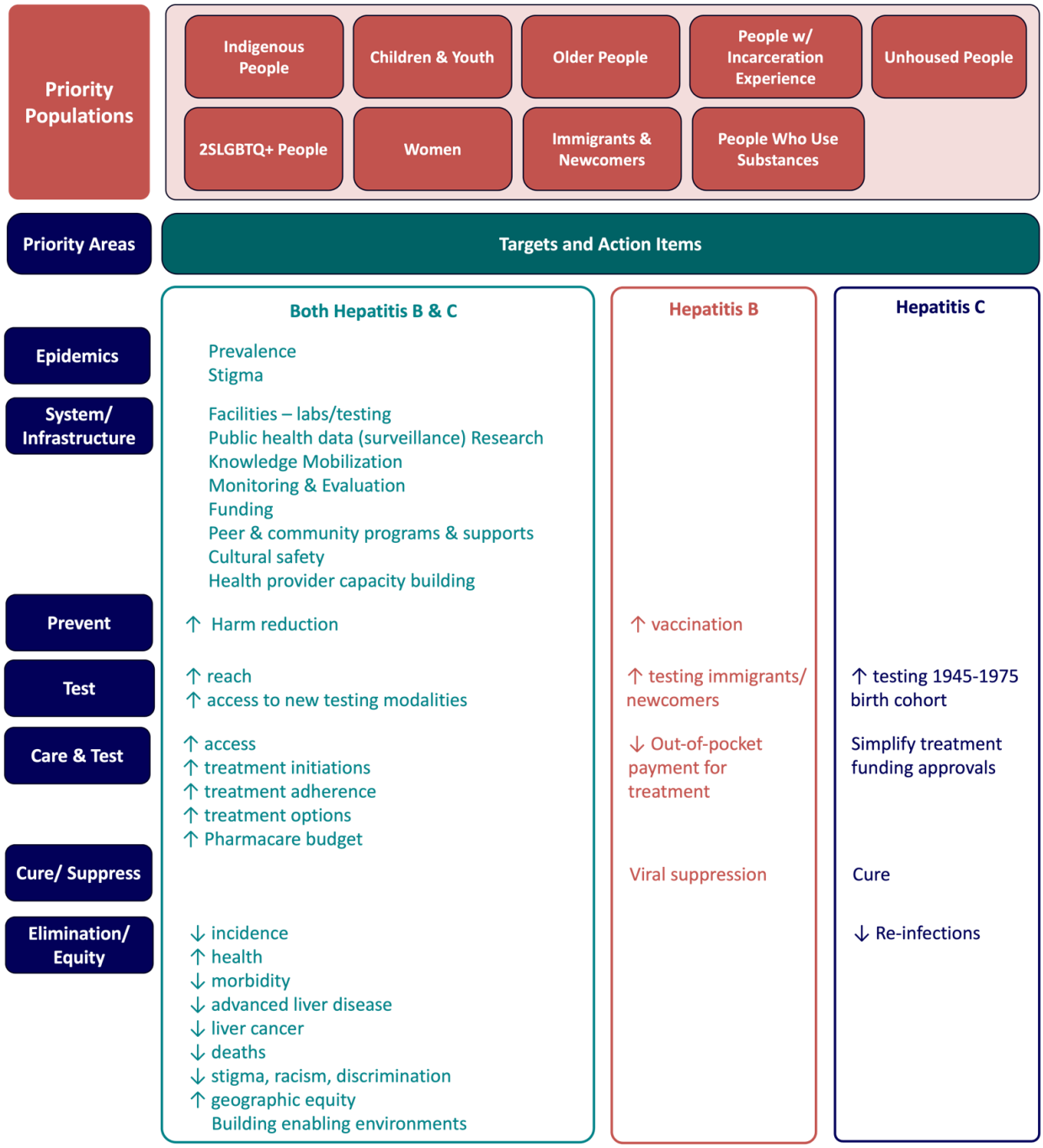


Figure 8. Framework for Development of the Project. Developed by Janice Duddy Consulting

Conducting the Consultations and Engagement

The Project consultants, in partnership with the Project team, designed the consultation strategy, ensuring that the tools used were aligned with the overall planning process. The Project incorporated a variety of consultation tools designed to gather feedback from diverse partners including community members, health-care providers, and PWLLE. These tools were created to build on existing knowledge and ensure that the needs and perspectives of those most impacted by viral hepatitis in the province were reflected. The data collection and community engagement was led by the Executive and Steering Committees in collaboration with Working Group members, who played an active role in reaching out to individuals throughout BC, including inviting input from regional health authority partners through public health leadership groups including STIBBI Task Group. These consultations were aimed at gathering insights into the current state of the viral hepatitis epidemic in BC, the services available to address it, and areas for improvement. Key consultation tools included a community engagement tracker (Appendix B), a service provider survey (Appendix C), interviews with PWLLE (Appendix D), and Indigenous community dialogues. Following the data collection, summary reports were created for each tool.

Community Engagement

From December 2023 to May 2024, the Project team, members of the Executive and Steering Committee, and Working Groups organized and attended key community meetings, events, and visited specific sites to gather input on viral hepatitis services across BC. In total, 25 community engagement events were held. The most common form of engagement was through key informant interviews, which were conducted both in-person and virtually. Focus groups and relational meetings also played significant roles in gathering insights. Engagement took place across all regional health authorities, with the Interior Health and Vancouver Coastal Health regions having the highest number of events. A total of 312 individuals participated in these community engagement activities, with the largest group being PWLLE of viral hepatitis. Other key participants included nurses and non-health-care service providers, such as those working at community-based organizations, and harm reduction workers. Project team members and Working Group members facilitated or attended all 25 events. PWLLE of viral hepatitis were involved in 80% of engagements, while nurses and non-health-care service providers participated in 40% of the events.

Service Provider Engagement

A service mapping survey was conducted to gather insights from health-care providers throughout BC (Appendix C). The survey was launched on March 14, 2024, and closed on April 10, 2024. The goal of the survey was to collect data from individuals whose work is related to viral hepatitis or directly impacts people affected by the condition. This included roles in harm reduction, prevention, testing, treatment, community-based services, advocacy, public health, regulatory efforts, research, and other relevant functions. A total of 104 out of 177 eligible participants completed the survey, yielding a 59%

completion rate. Participants represented a diverse range of roles, with the majority identifying as nurses (51%). Other participants included individuals working in community-based organizations (15%), government-based organizations (15%), and health authorities. There was good geographic representation from across the province among people who completed the service mapping survey, with 24% of respondents from Interior Health, 19% from Northern Health, 19% from Vancouver Coastal Health, 15% from Island Health, 14% from Fraser Health, 5% from First Nations Health Authority, and 12% from provincial or national health organisations. Regarding the size of the communities where participants worked, 26% were based in Metro Vancouver (population greater than 400,000 people), while the majority worked in smaller communities (74%) with populations under than or equal to 40,000 people. Additionally, 15% of participants worked across multiple regions or provincially.

People with Lived & Living Experience Engagement

In April and May of 2024, a series of confidential interviews were conducted to gather insights from PWLLE of viral hepatitis in BC. The goal of these interviews was to capture the unique perspectives of service users to inform ongoing efforts to improve care and treatment access. The interview process was organized by the Project team, with participation from members of the Working Group and the Executive and Steering Committees to identify and invite PWLLE to participate in an interview. A total of 11 individuals with experience of HBV and/or HCV were interviewed. The participants interviewed represented nearly all the Project's priority populations, though it is important to note that they did not include children and youth. The participants included:

- 7 individuals with experience of HCV
- 3 individuals with experience of HBV
- 1 individual with experience of both HCV and HBV

The interviews included a combination of demographic questions, open-ended semi-structured questions, and several Likert scale questions. While the interviews were not recorded verbatim, a virtual form was created to allow team members to document key insights and notes during each interview (Appendix D). The participants came from various health regions within BC, with the majority representing the Fraser Health region:

- 7 participants from the Fraser Health region
- 2 participants from the Interior Health region
- 2 participants from the Vancouver Coastal Health region

Indigenous Peoples Engagement

During the engagement process, it was essential to understand the needs and unique experiences of Indigenous peoples in BC living with or having lived with viral hepatitis. To support this engagement, the Project team hired an Indigenous consultant, who facilitated a community dialogue circle in May 2024 in Prince George, BC designed with the input from the Indigenous Working Group. Hosted by Central Interior Native Health Society (CINHS), the engagement event gathered local Indigenous

people with lived experience of viral hepatitis together to share their knowledge, experience, and recommendations for viral hepatitis elimination. Working in partnership with the Project team, the Indigenous consultant crafted an agenda that encompassed Indigenous cultural safety, flexibility, and transparency. This methodology was adopted to encourage a decolonial structure for the day and to allow participants to choose the topics to discuss, thereby highlighting the issues that were most important to them. A local Elder provided an opening prayer and welcoming words to start the day in a good way. After the Elder's welcome and opening words, the facilitator shared a consent agreement for participants. Part of the decolonial structure and intentions of the day were to let participants know that the information they were providing would be utilized in the Project report and their identities would be kept confidential.

Interpretation of Input Gathered

Following the completion of the consultation and engagements, data collected was summarized and shared with the Working Groups, who then engaged in a collaborative process to interpret the input gathered and synthesize the key learnings. The aim was to build upon the insights gained from gathered input, integrating these with the expertise of those conducting research and providing services for viral hepatitis testing, care, and treatment. Each Working Group reviewed the summary reports from the consultations and data that was recorded, identifying themes mapped to the Project framework (Figure 17). Each Working Group independently synthesized key insights from the consultations and previously published literature. The Steering Committee and Executive Committee then consolidated these insights and identified overarching themes and collective takeaways that could inform future recommendations and actions aimed at achieving the elimination of viral hepatitis as a public health threat in BC by 2030.

What We Heard

Input from Community

While participants highlighted many strengths in BC's response to viral hepatitis—including strong harm reduction programs, committed providers, and expanding access to treatment—much of the input focused on persistent gaps and opportunities for improvement. The community engagement sessions identified various factors that influence the effectiveness of hepatitis care and treatment within communities across BC. In terms of regional representation, most community engagement participants were working, volunteering, or living in the following regions:

- Interior Health and Vancouver Coastal Health (26% each)
- Island Health and Northern Health (26% each)
- Cross-regions, provincial, or national participants (11%)
- Fraser Health (7%)

Key themes included the importance of harm reduction services, the need for stable housing, the pervasive issue of stigma within the healthcare system, and the crucial role of peer workers. Informants highlighted that these elements interplay to create a complex landscape that requires coordinated, culturally safe, and flexible approaches to meet the needs of individuals affected by hepatitis C and, in some cases, hepatitis B. Suggestions and feedback from participants included:

1. **Prescribed Alternatives to the Unregulated Drug Supply and Harm Reduction**
   - **Continued supports and expansion:** Prescribed alternatives and harm reduction services are essential in preventing and reducing infection rates.
2. **Outreach Services and Pop-Up Clinics**
   - **Important services**: These services are crucial as they meet individuals "where they are," encouraging engagement in healthcare and testing. Outreach services can triage health-care needs, support system navigation, assist with income, and help initiate treatments.
3. **Role and Support of Peer Workers**
   - **Essential team members:** Peer workers are important team members in hepatitis care, peer workers help build trust and relationships, navigate complex systems, share common stories to reduce self-stigma, and support larger teams of service providers. Peer workers need adequate support, including housing and community services, to remain engaged and healthy in their work.
   - **Equal team members:** Peer workers should be recognized as equal members of health-care teams, contributing significantly to service delivery and client support.
4. **Addressing Stigma in the Health-care System**
   - **Stigma in healthcare:** Stigma and discrimination in hospitals, labs, and other health-care facilities deter people from seeking care. Educating health-care providers and implementing universal testing in hospital emergency departments, similar to how HIV and syphilis opt-out testing is done, are suggested to reduce stigma and increase testing uptake.

- **Outreach preference:** Service users are more likely to engage with outreach teams that provide non-judgmental care compared to traditional health-care settings.

5. **Supporting People to Reduce Self Stigma**

   - **Isolating:** People who had tested positive for hepatitis sometimes feel self-stigma, feeling like they were a risk to their friends and family because of a positive hepatitis test. Some isolated themselves, which negatively impacted their health and wellness.

6. **Access to Testing**

   - **Education to promote testing and treatment:** Many people don't know they have hepatitis C or that there are new treatments that can cure it. There is a need to expand the reach of testing and communicate more about testing and treatment to the public.

   - **Testing modalities:** Innovations like dried-blood spot (DBS) sampling and point-of-care testing (POCT) for both antibodies and RNA) should be expanded to increase accessibility. Offering choices in testing methods and integrating automatic hospital testing can improve engagement. Community-based services need support in providing follow-up and linkage to care resources when using low-barrier testing methods.

   - **Shortening wait times:** Reducing the time between testing and receiving results is critical for engaging individuals in care and treatment promptly.

7. **Care and Treatment**

   - **Improving re-engagement of people lost to care:** Need to improve follow-up of people after diagnosis and re-engagement of people who have been "lost to care". Some people have received a positive HCV or HBV antibody test many years ago and did not receive follow-up confirmatory testing or linkage to care. Some did not know they had spontaneously cleared the virus or had better treatment options available to them.

   - **Empower people as equal partners in their own care:** People affected by HBV and HCV need to have access to the information they need to make decisions and be actively involved in making decisions about their own care and treatment. Doctors need to support patient-led decision-making.

   - **Multiple opportunities for treatment:** People who need treatment for hepatitis should be offered multiple opportunities to access treatment at different times. In the case of re-infection, it is critical that health-care providers do not stigmatize or discriminate people who have had multiple HCV infections, as this may discourage them from engaging in needed care. Customize care and treatment plans to individuals.

   - **Multidisciplinary teams:** Expanding the pool of health-care providers involved in hepatitis care, including OAT providers, pharmacists, and social workers, can support multidisciplinary teams and improve care delivery.

   - **New implementation methods:** Need to explore new implementation methods for providing hepatitis care and treatment such as virtual or telehealth care, along side simplifying administrative processes involved in HCV treatment. Getting approval of publicly funded drug coverage for HCV or HBV treatment should be as 'simple' as the clinical decision making involved most of the time in providing these treatments.

8. **Engaging People who Have Found Services Hard to Access**

- **Making health services easier to access:** Reduce barriers to accessing healthcare services through exploring expansion of operating hours and flexible appointment scheduling at treatment clinics, as well as locations in more communities. Providing small incentives, like gift cards, for engaging in services like testing or picking up medication have been shown to increase uptake and adherence and could be explored to further improve engagement.
- **People with experience of incarceration:** For people who are incarcerated, nurse-led interventions have been successful as have peer-led services. Providing supportive care and discharge planning is important.
- **Improving access to primary care:** Addressing the shortage of general practitioners, including family physicians and nurse practitioners, who provide full spectrum longitudinal care in communities will greatly improve people's access to health-care services including hepatitis testing and follow-up.
- **Accessing care in small towns:** People expressed challenges with anonymity and stigma when accessing care in small towns or rural communities.

9. **Health-care Infrastructure and Coordination**
    - **Coordination:** Enhanced coordination (and adequate resourcing to support coordination) is needed between services, health-care providers, and community-based programs to support people with complex needs.
    - **System supports:** Dedicated funding and priority setting from health authorities for hepatitis services, distinct from larger STBBI portfolios, is essential to advance these efforts.
    - **Nimble and flexible services:** Health services need to be nimble and flexible to support people with complex needs to go through viral hepatitis treatment.
10. **Mental Health and Social Determinants of Health**
    - **Mental health support:** Training for frontline staff on the mental health effects of substance use and related interventions is essential. Providing life skills support can help individuals continue with treatment and navigate the health-care system.
    - **Holistic care approach:** Addressing social determinants like housing and employment alongside health-care needs is vital for improving overall health outcomes.
11. **Cultural Safety in Care**
    - **Culturally safe practices:** Involving Elders in health-care settings, providing peer support during appointments, and aligning priorities with First Nations and Métis organizations can enhance cultural safety and respect in care.
    - **Community engagement:** Leveraging the priorities of First Nations and Métis organizations can increase engagement in hepatitis testing and care.
    - **Indigenous-led services:** Supporting Indigenous-led services for hepatitis is essential in ensuring Indigenous people have access to culturally safe care.
12. **Stable and Secure Housing**
    - **Housing supports health:** Stable housing is essential for optimal health and wellbeing, allowing individuals to focus on engaging in healthcare and other services to improve health and wellness. There is a need for a variety of housing models and options to meet diverse needs.

- **Support for peer workers**: Peer workers require stable housing to remain effective in their roles, highlighting the interconnectedness of housing and health-care outcomes.

Input from Service Providers

The service provider survey asked health care providers and community-based service providers from across BC—including clinicians, public health staff, and individuals working in outreach, harm reduction, and support services— about the accessibility of viral hepatitis-related services in their communities. Understanding service providers' perspectives on access helps identify where services are available, where gaps may exist, and where awareness of available services may be limited, all of which can inform planning and resource allocation.

Table 1 outlines the service areas alongside the access category most frequently reported by respondents. For example, 48% of respondents indicated there was **easy** access to harm reduction services in their community, while 64% reported **limited** access to family physicians. Several participants were unsure about the accessibility of public funding for HBV treatment, ongoing support for antiviral adherence, and care for liver cancer. These categories had the highest proportion of "I don't know" responses, which may reflect gaps in service availability, variability across regions, or limited awareness of existing services among providers.

There were notable differences in service accessibility between providers within Metro Vancouver (communities with populations of > 400,000) and providers outside of Metro Vancouver. A higher proportion of participants working within Metro Vancouver rated access to vaccinations for hepatitis B and ongoing monitoring for hepatitis C as easy, and rated ongoing monitoring for viral load for hepatitis C as limited. Comparatively, a higher proportion of participants working *outside* of Metro Vancouver rated access to the following categories as moderate: vaccinations for hepatitis B, public funding for hepatitis C treatment, and testing for virologic response for hepatitis C. A higher proportion of participants working *outside* of Metro Vancouver also rated access to categories as limited for: specialist care for hepatitis, care for advanced liver disease, social and community services in support of people with viral hepatitis, starting hepatitis B treatment, and care for liver cancer.

These results highlight both the strengths and gaps in the availability of services for those impacted by viral hepatitis across different regions in BC, providing a foundation for further improvements in service delivery.

Service	Category with most respondents:	%
Harm reduction	Easy	48%
Vaccinations for hepatitis B	Moderate	44%
Hepatitis B testing	Moderate	42%
Hepatitis C testing	Moderate	42%
Starting hepatitis C treatment	Moderate	38%
Ongoing monitoring for hepatitis C (bloodwork)	Moderate	37%
Public funding for hepatitis C treatment	Moderate	36%
Ongoing monitoring for viral load for hepatitis B (bloodwork)	Moderate	34%
Support for hepatitis C treatment adherence	Moderate	32%
Family physician/primary care	Limited	64%
Access to new testing modalities	Limited	49%
Specialist care for hepatitis	Limited	46%
Social and community services in support of people with viral hepatitis	Limited	35%
Public funding for hepatitis B treatment	Don't Know (DK)	57%
Ongoing support for antiviral adherence for hepatitis B	DK	42%
Care for liver cancer	DK	42%
Care for advanced liver disease	DK	38%
Starting hepatitis B treatment	DK	34%
Hepatitis C testing for sustained virologic response	DK	33%

Table 1. Accessibility of Viral Hepatitis Services in BC Communities. Developed by Janice Duddy Consulting.

High-level themes were also identified from the narrative responses in the survey. Participants were asked, given limited resources where they would invest time and energy to have the biggest impact on viral hepatitis in BC and to identify the biggest gaps or opportunities for improvement. The most common responses (i.e., greater than five respondents) fell under the following themes:

- Invest in more outreach care
- Focus on increasing testing, and more testing in different locations (e.g., emergency departments, correctional facilities, etc.)
- Focus on increasing the number of providers and services outside of large urban centres
- Increase access to primary care

- Increase training for primary care providers on HCV treatment, including on processes for publicly-funded medication coverage for HCV treatment (i.e. PharmaCare plans)
- Simplify administrative processes required for providers to get reimbursement of HCV treatment approved through the provincial publicly funded PharmaCare plan
- Increase access to community-based testing and DBS sampling
- Create low-barrier health-care services that integrate harm reduction and STBBI screening and treatment to increase access to care
- Need to address increase in stigma and discrimination towards people impacted by hepatitis
- Focus on basic screening – e.g., newcomers, 1945-1975 birth cohort, universal screening.
- Invest in hepatitis awareness campaigns, educating the general population.

Input from People with Lived and Living Experience

A key finding from the interviews with PWLLE was the significant delay that many participants faced in accessing viral hepatitis care and treatment. Only 9% of participants reported waiting less than one year from diagnosis to receiving care, highlighting that reducing barriers to timely treatment and care is a critical area for improvement in public health strategies. Time reported from diagnosis to receiving viral hepatitis care among all PWLLE interviewed was:

- Under 1 year: 9%
- 1 to 3 years: 27%
- 3 to 10 years: 9%
- 10 to 15 years: 36%
- More than 15 years: 18%

Participants were asked about both supportive factors and barriers to accessing care after diagnosis. Access to a primary care provider was a supportive factor for accessing care after diagnosis of either hepatitis B or C. Peers and peer-led organizations, including those that support reintegration of people released from correctional facilities, were highlighted as supportive factors for accessing care after a hepatitis C diagnosis in particular. A common barrier to receiving treatment after a hepatitis B diagnosis noted by participants was lack of information and support, including lack of support from physicians and from family members who did not disclose their status. Substance use was a reason cited for being denied care for hepatitis C. When asked about barriers, gaps or opportunities for improvement for hepatitis in BC, participants noted the stigma associated with both hepatitis B and C as well as lack of awareness and education as key issues.

Image: Street art by graffiti artists Smokey D (James Hardy), Trey Helten and Kyle Shipman, created in collaboration with the BC Centre for Disease Control, BC Hepatitis Network, and with financial support from AbbVie Corporation. The artists use visual storytelling to share important messages with and on behalf of their community in the Downtown Eastside (DTES) of Vancouver, created this piece about HCV to mark World Hepatitis Day 2024. Image credit: Nate Canuel.

While the 11 interviews conducted with PWLLE provided key insights, the Working Group members who reviewed the input gathered from them highlighted that it is important to consider these contributions as case studies rather than a representative sample of the broader population of PWLLE of viral hepatitis in BC. The small sample size and the specific populations represented in this interview process mean that the barriers and supportive factors identified here may not be generalizable to the wider population of individuals affected by viral hepatitis in BC.

Input from Indigenous Peoples

The community dialogue circle hosted in Prince George by CINHS highlighted many health-care system challenges and structural barriers experienced by Indigenous people impacted by viral hepatitis who are living in northern and rural BC. Circle participants shared how lived experiences with the criminal justice system and precarious housing impacted access to viral hepatitis testing, care, and treatment. Participants also noted how education, social supports, and wrap-around services were essential for viral hepatitis elimination efforts. The graphic illustration (Figure 9) provides a summary of the findings of the Indigenous community dialogue.

Participants in the Indigenous community dialogue circle highlighted systemic marginalization and significant barriers to viral hepatitis services faced by Indigenous peoples in northern BC, including lack of housing, inadequate access to healthcare , insufficient public transportation, and limited harm

reduction services. These challenges are compounded for those who have been incarcerated, as they often face further discrimination and lack access to employment or support for reintegration. Participants also highlighted the desire and need to be able to access traditional medicines, alongside western medicines, within the health-care system, which is a protected right under BC's Declaration on the Rights of Indigenous Peoples Act.[96]

The intersection of systemic issues, such as anti-Indigenous racism in healthcare and limited services in small towns, further exacerbates inequities related to viral hepatitis. Addressing these challenges requires culturally sensitive, Indigenous and community-led solutions that integrate housing, healthcare, peer support, and traditional medicines to improve outcomes for Indigenous people, particularly those who experience further structural and systemic marginalization, such as Indigenous people who are also PWUD or who have been incarcerated.

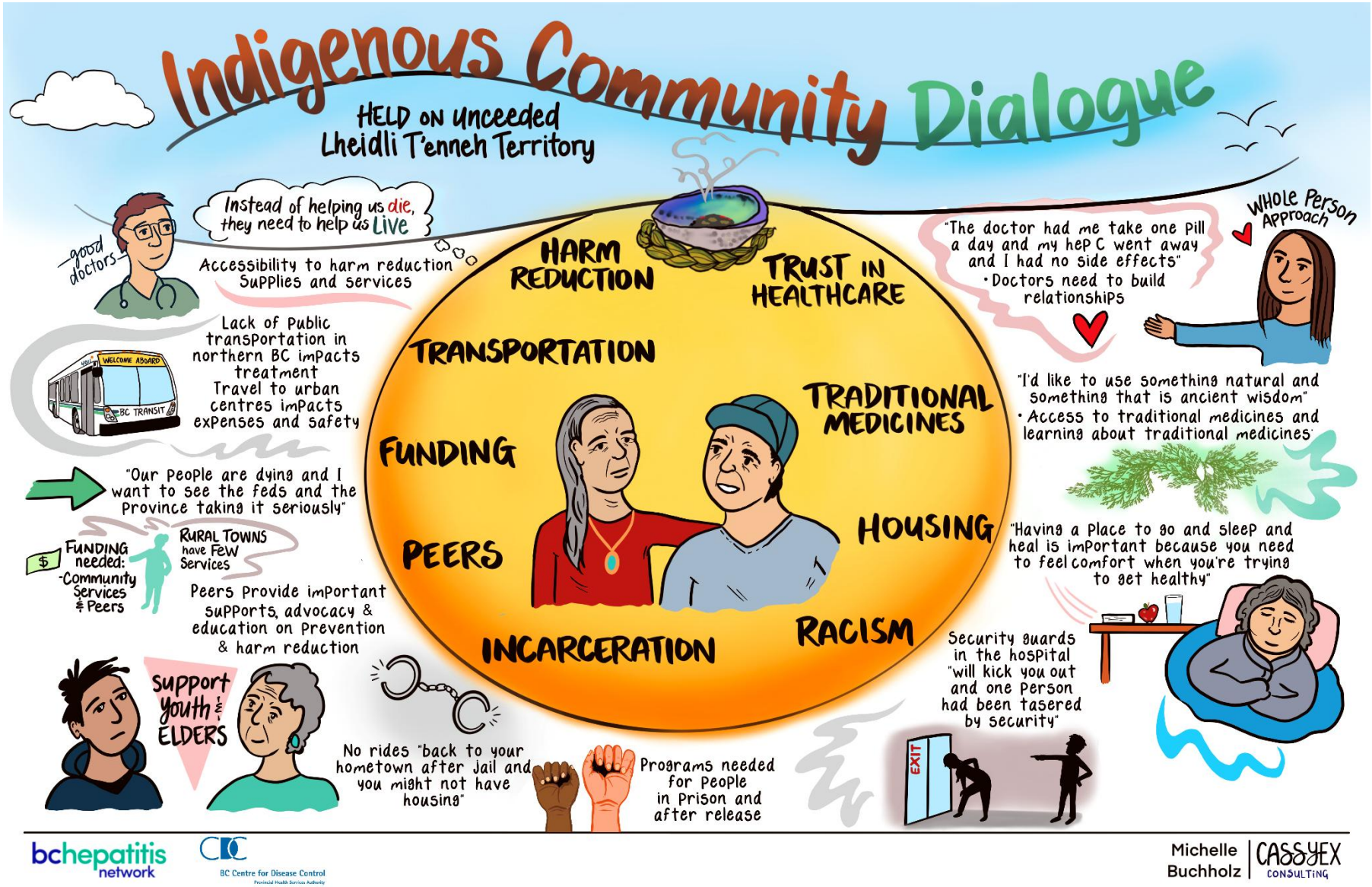


Figure 9. Graphic illustration summary of the Indigenous community dialogue findings. Developed by Michelle Buchholz, CasseyEx Consulting

Project Limitations

While this Project met or exceeded many of the goals for engagement, participation by PWLLE from more rural and remote communities in Northern B.C., sex workers, Indigenous Peoples, children, and youth was more limited than other populations. The challenges experienced engaging some populations highlights the importance of investing in ongoing work that builds trust and relationships over time. Ongoing engagement that is culturally safe and done with humility is required when programs, projects, or updated clinical practices are developed to support viral hepatitis elimination efforts in BC. This Project initiated relationship building with varying degrees of success, but a key lesson learned is that community engagement needs to be prioritized, resourced, and valued to reach viral hepatitis elimination in the province.

Engagement of sex workers

Sex workers were not a group that was specifically identified to be engaged in the Project, predominantly due to the lack of research and health surveillance data indicating that viral hepatitis rates are elevated among people in the sex working community. This gap has been partially attributed to barriers that sex workers face, such as not having legal protection when they disclose their work to public officials, which may limit their participation in data collection for public health surveillance. Consultation with the Working Groups identified that sex workers require tailored testing, care and treatment services, and further efforts to engage with this community to understand their priorities, preferences and needs with respect to viral hepatitis prevention, testing and treatment are warranted.

Engagement of Indigenous peoples

The Project did not have enough time or resources available to meaningfully and adequately engage with Indigenous Peoples, communities, and organizations. The report summarizes the consultation that took place through one community dialogue circle, and Indigenous people were also included through other consultation tools (e.g., survey of service providers). Ideally, these time-limited engagement strategies would have been complemented by longer-term relationship building. Further engagement is needed to inform the development of tailored viral hepatitis services and programs for Indigenous people living both on and off-reserve in BC, prioritising Indigenous-led engagement.

Engagement of Children and Youth

Engaging this priority population was challenging due to the limited number of youth-focused viral hepatitis service providers across BC. Encouragingly, youth make up a small number and proportion of the people who have been identified with viral hepatitis infection in BC over the last decade. However, youth who are living with chronic HBV or HCV infection may face overlapping and intersecting health issues and barriers to care. Therefore, it is crucial that efforts to eliminate viral hepatitis in BC consider the unique needs and preferences of youth.

Engagement on HCV vs. HBV

It was challenging for the Project to engage on issues relating to HBV. For example, it was easier to connect with PWLLE of HCV through community-based organizations, or to directly identify and engage PWLLE of HCV within healthcare networks than PWLLE of HBV. This may highlight a difference in culture between the two types of hepatitis. PWLLE of HCV may have more opportunities to come together in community or may have a history of a collective culture (e.g. peer-based programs, peer navigator networks, drop-in programs that serve PWLLE of HCV), whereas PWLLE of HBV may be more isolated or not as connected with others in the community also living with HBV. There are some important lessons to be learned from the Project's interviews with PWLLE of HBV. Future engagement with providers and PWLLE of HBV will be essential to ensure the success of BC's viral hepatitis elimination goals.

With the availability of universal vaccination for HBV in Canada for several decades, the prevalence of chronic HBV infection is very low among people born in BC after 1980. Conversely, there is a much higher prevalence of chronic HBV among immigrants and newcomers to Canada, particularly those who were born or lived in an HBV-endemic region.[32] For most immigrants and newcomers, HBV testing on arrival in Canada is not required, as it is only required for those who test positive for HIV or syphilis.[97] This population may also be less aware of the healthcare and community-based services that are available to them in Canada if they are already aware of their HBV status. Given the high burden of HBV and barriers to routine care, HBV screening and linkage to treatment at entry to Canada could help prevent downstream complications. While the Project team did attempt to engage this priority population, further engagement and relationship building with immigrant and newcomer organizations is warranted.

People who have been diagnosed with 'inactive HBV infection', also sometimes referred to as 'carriers' or 'inactive carriers', are commonly understood to be people who have HBV infection but are asymptomatic and have a low viral load. They can however still transmit the virus, and they make up a significant proportion of people living with HBV infection.[98] It seems there is little knowledge among the general population about HBV, particularly HBV carriers, and there is no consistent approach employed by primary care providers to monitor people identified as HBV carriers. As an example, two of three people living with HBV indicated in the PWLLE interviews that they are currently, or were previously, not monitored by a healthcare provider during carrier stage of their infection.

Overarching findings

The following overarching findings reflect the collective interpretation of input gathered through the provincial consultation process, representing the shared perspectives of diverse partners on the key enablers and barriers to achieving viral hepatitis elimination in British Columbia by 2030.

More support for low-barrier, community-based screening, and testing is needed

Innovative testing modalities such as DBS sampling and POCT have increased access to viral hepatitis testing, particularly in rural, remote, and underserved communities. However, the absence of a provincial framework for quality assurance and consistent operational support limits their sustainable scale-up. Establishing shared approaches to quality oversight, data integration, and workforce training could help embed these tools as core components of equitable, community-based testing across BC.

Integrating harm reduction and infectious disease services

Consultations revealed ongoing gaps between harm reduction services and STBBI care. While several successful integrated models exist—combining screening, treatment, and linkage-to-care within opioid agonist therapy, supervised consumption, or addiction treatment settings—these remain localized and resource-dependent. Expanding opportunities to align harm reduction and infectious disease services would improve care continuity, engagement, and outcomes for people who use drugs.

Reducing administrative barriers to timely care

While treatment for hepatitis B and C has become simpler and more effective, administrative processes for public drug coverage and reimbursement remain complex. Participants noted that aspects of the current approval processes are not medically necessary, can delay treatment initiation, and place avoidable strain on providers. Streamlining these administrative steps was identified as an opportunity to improve access and efficiency across the care continuum.

Expanding decentralized and flexible service delivery models

Centralized care models are unable to meet the needs of all populations affected by viral hepatitis, particularly in rural, remote, and Indigenous communities. Service providers described the effectiveness of decentralized approaches such as mobile health units, telehealth, and peer-led outreach. Broader coordination, workforce education, and resource support would enable these approaches to reach more communities and sustain local capacity for testing and treatment.

Addressing stigma, discrimination, and racism in care

Although progress has been made in reducing stigma related to viral hepatitis, experiences of discrimination persist, particularly at the intersections of Indigeneity, substance use, and poverty. People with lived and living experience described how stigma within healthcare settings undermines trust and discourages engagement in care. Strengthening culturally safe, trauma-informed, and anti-racist practices—alongside peer and Indigenous leadership in service design—will be essential to achieving equitable outcomes across BC.

Next Steps

Throughout British Columbia, there has been substantial progress toward viral hepatitis elimination, including expanding access to curative HCV therapies, implementing universal HBV vaccination, and supporting innovative clinical and community-based programs.. Building on these successes, participants engaged through this Project identified key areas where further action is needed to address declining hepatitis C treatment initiations, persistent stigma, inequitable access to testing and follow-up in rural and remote regions, and gaps in service coordination. Populations disproportionately affected—such as people who use drugs, Indigenous Peoples, people experiencing incarceration, and newcomers from HBV- and HCV-endemic regions—continue to experience systemic and structural barriers to care. While promising examples of innovative, low-barrier, and integrated models exist, these approaches remain localized and inconsistently supported across the province.

The consultations conducted in this Project reflected a strong shared commitment to viral hepatitis elimination goals, but also highlighted the need for ongoing coordination, sustainable resourcing, and community-driven approaches that align with BC's broader public health and health equity priorities. Ongoing prioritization and leadership from health authorities, community organizations, clinicians, and people with lived and living experience is needed to continue to support advances in harm reduction, outreach-based testing, and linkage to care across diverse communities.

Continued progress toward eliminating viral hepatitis in BC will depend on maintaining this collective momentum and commitment. The insights gathered through this consultation process demonstrate that the expertise, innovation, and partnerships needed to reach elimination goals already exist across the province. By continuing to share knowledge, strengthen coordination, and embed equity and lived experience at the centre of program and policy design, BC can build on its achievements to date and ensure that every person—regardless of where they live or the circumstances they face—has equitable access to prevention, testing, treatment, and care.

As BC continues on the path toward elimination, these shared perspectives offer a foundation for reflection, dialogue, and collaboration across all sectors. By drawing on what has been learned and sustaining collective focus on equity, integration, and partnership, the province can continue to move closer to the vision of a future free from the burden of viral hepatitis.

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Appendices

Appendix A- Persons involved in designing the consultation process

Project Team

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Executive Committee Members

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Deb Schmitz, BC Hepatitis Network (Co-Chair)

Dr. Brian Conway, VIDC, SFU

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Dr. Alnoor Ramji, Pacific Gastroenterology Associates, UBC

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Lesley Gallagher, Canadian Association of Hepatology Nurses

Dr. David Truong, VIDC

Dr. Marion Selfridge, Cool Aid Clinic, UVIC

Dr. Kate Salters, BCCfE, SFU

Jennifer Demchuk, PAN

Jennifer van Gennip, Action Hepatitis Canada

Carl Swanson, BC Ministry of Health (Observer)

Robin Yates, BC Ministry of Health (Observer)

Dominique Garreaud, BC Ministry of Health (Observer)

Working Group Members

Indigenous Peoples

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Judy Sturm (Pelltíq't), Chee Mamuk, BCCDC

Flo Ranville (Pine Creek First Nation & Woodland Cree), PWLLE advisor

2SLGBTQ+, Youth, Children & Women

Dr. Hin Hin Ko, Pacific Gastroenterology Associates, UBC

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Immigrants, Newcomers & Older People

Kate Fish, BC Hepatitis Network

Daryl Luster, (PWLLE, Peer Worker, Advocate)

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Data, Monitoring & Evaluation

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People who use drugs, experience incarceration, or are underhoused

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Dr. Marion Selfridge, Cool Aid Clinic, UVIC

Dr. Kate Salters, BCCfE, SFU

Alannah Hannigan, BCCfE

Mo Korchinski, UTG

Pam Young, PWLLE advisor

Tamara Barnett, Cool Aid Clinic

Elisha Hamilton, ASK Wellness

Appendix B - Community Engagement Tracker

Name of person completing this form:

Date of community engagement event:

Type of engagement:

☐ Community dialogue/event

☐ Regularly standing meeting (Roadmap invited to attend)

☐ Special meeting (held specifically for the Roadmap or Roadmap team was invited to present/engage/share)

☐ Tabling event (table set up as part of a larger event; engagement is usually quick)

☐ Focus group (in-person or online)

☐ Informant interview (in-person or online)

☐ Help4Hep helpline

☐ Informal conversations (in-person or online)

☐ Other

☐ Pop-ups, mobile, outreach testing

Community engagement meeting/event name:

Who was engaged (check all that apply):

☐ People with lived and living experiences of viral hepatitis

☐ Family members or friends of people with lived or living experiences of viral hepatitis

☐ Nurses

☐ Doctors

☐ Other frontline healthcare providers (i.e. pharmacists, physical therapist, lab techs)

☐ Non-healthcare service providers (i.e. harm reduction workers, social workers, staff from community-based organizations)

☐ Policymakers, decision-makers or non-clinical staff who work at health authorities

☐ Academics or researchers

☐ Students

☐ Industry (pharmaceutical companies, other for-profit companies)

☐ Others:

With which priority population(s) do the people at this engagement most align? (check all that apply):

☐ All of the categories below

☐ Indigenous peoples

☐ 2SLGBTQ+ people

☐ Children and youth

☐ Women

☐ Older people

☐ Immigrants and newcomers

☐ People with incarceration experience

☐ People who use drugs

☐ Underhoused people

☐ None of these categories

How many people were in attendance at the event/did you engage?

While health region did the engagement take place in:

○ Fraser Health

○ Interior Health

○ Island Health

○ Northern Health

- O Vancouver Coastal

Which region were the majority of the community engagement participants from (where they work, volunteer, live):

- ☐ Fraser Health
- ☐ Interior Health
- ☐ Island Health
- ☐ Northern Health
- ☐ Vancouver Coastal
- ☐ Living on reserve or within the jurisdiction of the First Nations Health Authority
- ☐ Cross-regional, provincial or national
- ☐ Don't know

What type of viral hepatitis do the take aways most align?

- O Hepatitis B
- O Hepatitis C
- O Both hepatitis B and C

With which priority population(s) do the take aways most align? (check all that apply):

- ☐ All of the categories below
- ☐ Indigenous peoples
- ☐ 2SLGBTQ+ people
- ☐ Children and youth
- ☐ Women
- ☐ Older people
- ☐ Immigrants and newcomers

☐ People with incarceration experience

☐ People who use drugs

☐ Underhoused people

☐ None of these categories

What Roadmap Action Planning Framework component do the take aways most align? (check all that apply):

☐ Epidemics (prevalence)

☐ System/Infrastructure (i.e. public health data, funding, research and evaluation, cultural safety)

☐ Prevention

☐ Testing

☐ Care and Treatment

☐ Cure or suppression

☐ Elimination and Equity (i.e. incidence, disease, death, discrimination, geographic equity)

Why did you decide to engage this group of person:

What was discussed:

How did you engage this group or person (method):

What were the key take aways, learnings, action items from this engagement? Include any direct quotes that highlight key take aways, include key programs or successful approaches happening across the province (in support of service mapping), pay attention to urban vs. rural issues, think about capturing key action items, strategies, or targets (5,000 characters)

Were there any documents, materials or resources that you took away from this event/community engagement that would be helpful to share with the Working Groups? If yes, please email to community engagement lead.

○ Yes

- O No

If yes, if this was a piece of work created by an individual (e.g. art, photo, poem) did you get consent from this person for the Roadmap to use this material?

- O Yes
- O No
- O Don't know

Are there any action items or next steps that came out of this engagement process?

- O Yes
- O No
- O Not sure

If yes, please describe:

Appendix C - Service Provider Survey

Survey Introduction

Hello, thank you for participating in this service provider survey for the BC Viral Hepatitis Elimination Roadmap.

The bigger roadmap project is building momentum in our continued efforts to eliminate both hepatitis C and hepatitis B as public health threats in BC by 2030. The project brings together individuals with lived experience, community organizations, healthcare providers, academics, and advocates to develop recommendations toward a BC free from viral hepatitis.

In this survey we are engaging people whose work (paid, volunteer or academic) have functions related to viral hepatitis or who work directly with people who are impacted by viral hepatitis. This could include work related to harm reduction, prevention, testing, treatment, community-based services, advocacy, public health, regulatory efforts, data or surveillance, research, laboratory, and other functions.

We want to hear from a broad range of services providers including:

- People in clinical, community or peer-based roles who are working in viral hepatitis;
- People in leadership or decision-making positions;
- People in public health roles;
- People working at health authorities;
- People working in laboratories;
- People working in Corrections;
- Academics, researchers;
- Students; and
- And others doing work on viral hepatitis.

This survey has a combination of checkbox and open-ended questions related to the services in your community or area of work. It should take you approximately 20-30 minutes to complete and your responses will not be connected to your name or contact information in any way,
This service mapping exercise will allow us to understand the current context of viral hepatitis services in BC and to examine where there are potential gaps or changes needed. We will be keeping the survey open until Monday, April 8, 2024. If you have any questions, please be in contact with Janice Duddy, Deb Schmitz or Sofia Bartlett. Thank you!

Survey Questions

Does your work (paid, volunteer or academic) have functions related to viral hepatitis (public health, regulatory, data, research, laboratory, prevention, care, etc.) or requires you to work directly with people impacted by viral hepatitis?

- ○ Yes
- ○ No
- ○ Unsure

What region(s) do you primarily work:

- □ Fraser Health
- □ Interior Health
- □ Island Health
- □ Northern Health
- □ Vancouver Coastal Health
- □ On reserve or within First Nation's Health Authority's or other Indigenous health jurisdiction or programs (i.e. First Nations communities, Nisga'a health authority)
- □ Provincial or national

What is your role in relation to viral hepatitis? (check all that apply)

- □ A person with lived and living experiences of viral hepatitis
- □ Nurse
- □ Doctor
- □ Nurse Practitioner
- □ Other frontline healthcare providers (pharmacists, dieticians, laboratory technicians...)
- □ Non-healthcare service providers (i.e. harm reduction workers, staff from community-based organizations, peer workers)
- □ Work at a health authority, Ministry of Health or other government-based organization (in decision-making, public health or other roles like surveillance, provincial laboratory etc.)
- □ Academics or researcher
- □ Student
- □ Staff in Corrections
- □ Community Health Representative/Director, on reserve
- □ Other (please describe):

What is the population size of your community where the majority of your work happens?

- ○ More than 400,000 people (Metro Vancouver – Burnaby, Surrey, Coquitlam, Richmond, Langley, Delta)

- 300,000 – 399,999 people (Greater Victoria – Saanich, Langford, Oak Bay, Esquimalt, Colwood, Sooke, Sidney)
- 100,000 – 299,999 people (i.e. Kelowna, Abbotsford-Mission, Nanaimo, Kamloops, Chilliwack)
- 50,000 – 99,000 people (i.e. Prince George, Vernon, Courtenay)
- 20,000-49,000 people (i.e. Duncan, Penticton, Campbell River, Parksville, For St. John, Cranbrook, Port Alberni, Quesnel, Dawson Creek)
- 10,000-19,999 (i.e. Squamish, Nelson, Williams Lake, Salmon Arm, Powell River, Terrace, Prince Rupert)
- Less than 10,000 people (i.e Castlegar, Revelstoke, Hope, Smithers, Port Renfrew, Bella Coola)
- I work across large regions or provincially
- Don't know

What are your primary areas of work related to viral hepatitis and other related conditions (check all that apply)?

	Hepatitis B	Hepatitis C	HIV	Other STIs	General/ primary care	I don't do work in this area	Prefer not to answer
Harm reduction	☐	☐	☐	☐	☐	☐	☐
Prevention	☐	☐	☐	☐	☐	☐	☐
Vaccination	☐	☐	☐	☐	☐	☐	☐
Testing	☐	☐	☐	☐	☐	☐	☐
Care and treatment	☐	☐	☐	☐	☐	☐	☐
Stigma reduction	☐	☐	☐	☐	☐	☐	☐
Laboratory - for testing	☐	☐	☐	☐	☐	☐	☐
Public health functions, including data and surveillance	☐	☐	☐	☐	☐	☐	☐
Research	☐	☐	☐	☐	☐	☐	☐
Knowledge mobilization/ translation	☐	☐	☐	☐	☐	☐	☐
Monitoring and evaluation	☐	☐	☐	☐	☐	☐	☐

Policy and guidelines	□	□	□	□	□	□	□
Peer and community programs or support	□	□	□	□	□	□	□
Health provider capacity building or training	□	□	□	□	□	□	□
Community-based education or capacity-building	□	□	□	□	□	□	□
Building enabling environments in support of viral hepatitis (legal, institutional, community, addressing inequities or social determinants)	□	□	□	□	□	□	□
Advocacy	□	□	□	□	□	□	□
Outreach support (nursing, social work)	□	□	□	□	□	□	□
Other (please describe):	□	□	□	□	□	□	□

Please describe:

Which of the following priority populations does your work most align with? (check all that apply)

□ Indigenous people
□ 2SLGBTQ+ people
□ Children and youth
□ Women
□ Older people
□ Immigrants and newcomers
□ People with incarceration experience
□ People who use drugs
□ Underhoused people
□ Other, please describe:
□ Prefer not to answer

Are there any eligibility criteria for people accessing your programs or services?

- ○ Yes (please describe)
- ○ No
- ○ Sometimes (please describe)
- ○ Prefer not to answer

Please describe:

What is your assessment of access to viral hepatitis cascade of care services in your community? Please consider each step in the care cascade and rate whether you think people in your community have:

Easy access – there is a high degree of awareness of services available, people can get services when they need them or want them in their own community (close to home) at no costs, people can access service providers who have experience and knowledge of viral hepatitis, in a safe and comfortable manner.

Moderate access – there is a moderate degree of awareness of services available, people can sometimes get services when they need them or want them in their own community (close to home) at low cost, people have some access to service providers who have experience and knowledge of viral hepatitis, in a safe and comfortable manner.

Limited access – there is low awareness of services available, people cannot get services when they need or want them in their own community – i.e. there are long wait times or the need to travel for services, there are costs involved with services, and there is a lack of knowledgeable or experienced service providers. There are no safe or comfortable services.

	Easy access	Moderate access	Limited access	Don't know
Harm reduction	○	○	○	○
Vaccinations for hepatitis B	○	○	○	○
Hepatitis B testing	○	○	○	○
Hepatitis C testing	○	○	○	○
Access to new testing modalities (like point-of-care testing or dried blood spot sampling)	○	○	○	○
Ongoing monitoring for viral load for hepatitis B (bloodwork)	○	○	○	○
Ongoing monitoring for hepatitis C (bloodwork)	○	○	○	○
Starting hepatitis B treatment	○	○	○	○

Starting hepatitis C treatment	o	o	o	o
Ongoing support for antiviral adherence for hepatitis B	o	o	o	o
Support for hepatitis C treatment adherence	o	o	o	o
Public funding for hepatitis B treatment	o	o	o	o
Public funding for hepatitis C treatment	o	o	o	o
Testing for sustained virologic response for hepatitis C	o	o	o	o
Care for advanced liver disease	o	o	o	o
Care for liver cancer	o	o	o	o
Social and community services in support of people with viral hepatitis	o	o	o	o
Family physician/primary care	o	o	o	o
Specialist care for hepatitis	o	o	o	o

In your community or area of expertise/practice how would you rate the progress on each of these outcomes/impacts relating to viral hepatitis? Please consider how things have changed over the last six years, since 2018.

Some key markers in 2018:
For hepatitis B -- Tenofovir alafenamide (TAF) treatment for chronic hepatitis B was added to BC PharmaCare in December 2018.
For hepatitis C -- all restrictions on DAAs were lifted for hepatitis C treatment in March of 2018.

	Getting a lot better	Made some progress	Stayed the same	Lost some progress	Getting a lot worse	Don't know
Hepatitis B vaccination rates	o	o	o	o	o	o
Reach of hepatitis B testing	o	o	o	o	o	o
Reach of hepatitis C testing	o	o	o	o	o	o
Access to new testing modalities/	o	o	o	o	o	o

technologies for hepatitis B						
Access to new testing modalities/ technologies for hepatitis C	o	o	o	o	o	o
Hepatitis B testing with immigrants and newcomers	o	o	o	o	o	o
Hepatitis C testing with 1945-1975 birth cohort	o	o	o	o	o	o
Access to hepatitis B treatment	o	o	o	o	o	o
Access to hepatitis C treatment	o	o	o	o	o	o
Hepatitis B treatment options	o	o	o	o	o	o
Hepatitis C treatment options	o	o	o	o	o	o
Pharmacare budget for hepatitis B treatment	o	o	o	o	o	o
Pharmacare budget for hepatitis C treatment	o	o	o	o	o	o
Incidence of hepatitis B	o	o	o	o	o	o
Incidence of hepatitis C	o	o	o	o	o	o
Morbidity from viral hepatitis	o	o	o	o	o	o
Advanced liver disease	o	o	o	o	o	o
Deaths attributable to viral hepatitis	o	o	o	o	o	o
Experiences of stigma, racism, discrimination relating to hepatitis and related issues	o	o	o	o	o	o
Geographic equity of viral hepatitis services and healthcare	o	o	o	o	o	o

Consider the questions above (access and progress) given, limited resources where would you invest time and energy (which outcomes or key areas would you prioritize) to have the biggest impact on viral hepatitis in BC? (Please identify if you are referring to hepatitis B, hepatitis C or both)

What do you think is working well in relation to viral hepatitis in BC?

What do you think are the biggest gaps or opportunities for improvement in relation to viral hepatitis in BC?

The next section is an opportunity for us to hear from you on viral hepatitis services or programs that are working well in your community or across the province. Please share up to three positive examples.

Do you have an example of a service that is working well in your community to address any aspect of viral hepatitis? If yes, please provide further information.

- ○ Yes
- ○ No

Please describe this positive example (name of service/program/action, where it is operating, what is it doing, who is it serving)

Please tell us what the positive example is accomplishing and why it is working well.

What type of viral hepatitis does this positive example most align?

- ○ Hepatitis B
- ○ Hepatitis C
- ○ Both hepatitis B and C

Is this positive example led/implemented by a/n...

- □ Health authority
- □ Hospital
- □ Government ministry
- □ Non-health authority clinical resource (doctor or NP's office, clinic)
- □ Laboratory
- □ Pharmacy
- □ Outreach service
- □ Community-based organization
- □ Indigenous community-based organization
- □ Indigenous community
- □ Peer-based service
- □ Other: [please describe}

Who is funding the positive example?

□ Health authority
□ PHAC/ Health Canada/FNIHB
□ CIHR/ Other research funding
□ Private philanthropy/ Foundation
□ Industry (specialty pharmacy, pharmaceutical)
□ Ministry of Health or other provincial ministry
□ Other (please describe):
□ Don't know

Where does the positive example operate (check all that apply)?

□ Fraser Health
□ Interior Health
□ Island Health
□ Northern Health
□ Vancouver Coastal
□ On-reserve or within the jurisdiction of the First Nations Health Authority or other Indigenous health authority
□ Provincial or national
□ Don't know

Which of the following components does this positive example most align? (check all that apply)

□ Epidemics (prevalence)
□ System/Infrastructure (i.e. public health data, funding, research and evaluation, cultural safety)
□ Prevention
□ Testing
□ Care and Treatment
□ Cure or Suppression
□ Elimination and Equity (i.e. incidence, disease, death, discrimination, geographic equity)
□ Don't know

Does this positive example align with a specific priority population?

o Yes
o No
o Don't know

If yes, which priority population(s) does this positive example most align with? (check all that apply)

□ All of the categories below
□ Indigenous peoples
□ 2SLGBTQ+ people

- □ Children and youth
- □ Women
- □ Older people
- □ Immigrants and newcomers
- □ People with incarceration experience
- □ People who use drugs
- □ Underhoused people
- □ None of these categories

Do you have another example of a positive example of a viral hepatitis service you want to share?

- ○ Yes
- ○ No

Appendix D - PWLLE Interview Questions

Interview Introduction

This interview is helping to gather feedback to support the development of the BC Viral Hepatitis Elimination Roadmap. The Roadmap is building momentum in our continued efforts to eliminate both hepatitis C and hepatitis B as public health threats in BC by 2030. It is being led by the BCCDC and the BC Hepatitis Network. This project brings together individuals with lived/living experience, community organizations, healthcare providers, academics, and advocates to develop recommendations toward a BC free from viral hepatitis. The information we collect from the interviews will help us understand the current context of viral hepatitis services in BC and identify the strengths and gaps of the current services and policies and guide the development of this provincial strategic document.

People with Lived & Living Experiences Interviews: To hear from people with lived and living experiences of hepatitis B and hepatitis C, members of the Roadmap Working Groups will be conducting interviews. Thank you for participating, you and for your time will receive a $25 honoraria for both your time and expertise.

What is involved: The interview is anonymous in that your name will not be recorded anywhere. No voice or video recording will take place, and very high-level notes capturing key thoughts and ideas will be taken by hand only or by typing into an online form. These notes will be entered into a Canadian-based online survey platform and analyzed along with other interview notes. The online survey database stores all of its data on Canadian servers in accordance with the Health Information Protection Act, which means it is not subject to American laws like the Patriot Act and provides an extra layer of confidentiality.

The interview may take about an hour, depending on the how much detail you would like to provide and whether you skip questions.

Voluntary consent: It is important that you consent to this interview voluntarily. Please know you can ask questions any time, you can skip any questions you do not want to answer, and you can stop the interview at any time. You will still be paid the honoraria if you stop the interview part way through. Because we are not collecting any names, we are not able to withdraw the information you shared once it is entered online – as we will not be able to tell which interview is who's.

Questions or Concerns: If you have any questions or concerns now or after the interview please reach out to the project leads:
Sofia Bartlett, BCCDC -
Deb Schmitz, BC Hepatitis Network

Or questions about honoraria/administration Joel Harnett
Interview Questions
Do you consent to starting the interview?
- Yes
- No

A little information about the person who is leading/conducting the interview. This is to help the Roadmap team in case we have any questions or follow-ups. Please be very careful NOT to record the name of the person you are interviewing anywhere on this online form).
Name of the person who facilitated the interview (do not record the name of the person interviewed):

What language was the interview done in:

REMINDER: to make sure we are working in an ethical way please do not record the interview. Please take notes into this online form. Do NOT record the participant's name or any personally identifiable data.

Information about the interview participant
What region do you live in:
- Fraser Health (I.e. Burnaby, Surrey, Abbotsford, Chilliwack, Mission...)
- Interior Health (i.e. Kamloops, Kelowna, Nelson, Revelstoke, Quesnel...)
- Island Health (i.e. Victoria, Nanaimo, Port Alberni, Campbell River...)
- Northern Health (i.e. Prince George, Terrace, Fort St. John, Prince Rupert...)
- Vancouver Coastal (i.e. Vancouver, Richmond, Squamish...)
- Prefer not to answer

What is the population size of your community?
- More than 400,000 people (i.e. Metro Vancouver – Burnaby, Surrey, Coquitlam, Richmond, Langley, Delta)
- 300,000 – 399,999 people (i.e. Greater Victoria – Saanich, Langford, Oak Bay, Esquimalt, Colwood, Sooke, Sidney)
- 100,000 – 299,999 people (i.e. Kelowna, Abbotsford-Mission, Nanaimo, Kamloops, Chilliwack)
- 50,000 – 99,000 people (i.e. Prince George, Vernon, Courtenay)
- 20,000-49,000 people (i.e. Duncan, Penticton, Campbell River, Parksville, For St. John, Cranbrook, Port Alberni, Quesnel, Dawson Creek)
- 10,000-19,999 (i.e. Squamish, Nelson, Williams Lake, Salmon Arm, Powell River, Terrace, Prince Rupert)
- Less than 10,000 people (i.e. Castlegar, Revelstoke, Hope, Smithers, Port Renfrew, Bella Coola)
- Don't know

- Prefer not to answer

Which hepatitis virus does your lived or living experience apply to?

- Hepatitis B
- Hepatitis C
- Both
- Prefer not to answer

Do you have other health-related lived experiences (aside from hepatitis B and/or C) that you would like to self-describe (please share if you feel comfortable)
[INTERVIEWER PROMPT: did you experience dual diagnose, HIV, chronic health issues, STBBIs or sexually transmitted and blood borne infections]:

Which of the following priority populations does your experience most align with? (please check all that apply or "prefer not to answer")
[FOR INTERVIEWER – If person being interviewed has questions about why we are asking this, please provide this background: As you know, this project is trying to see how we can eliminate hepatitis B and C as public health threats in BC. There are some key populations that are affected by hepatitis, and we have formed working groups dedicated to each of these populations within this project. It's helpful to know if your experience relates to any of these groups so we can provide your contributions to that working group.]

- □ Indigenous People
- □ 2SLGBTQ+ people
- □ Children and youth
- □ Women
- □ Older people – born before 1965
- □ Immigrants and newcomers
- □ People with incarceration experience
- □ People who use drugs
- □ Underhoused people
- □ Prefer not to answer

Questions for Indigenous Participants Only - All others skip this page:

Are you:

- □ First Nations
- □ Métis
- □ Inuit

Do you live:

- □ On reserve or on a traditional territory
- □ On a Métis settlement

□ In a town or a city (off reserve)

Time to access care
How long was it from when you had your first positive hepatitis result to when you accessed care and treatment?

[INTERVIEWER – if the person accessed care ask this follow-up]: What supported you in accessing care and treatment for hepatitis?
[INTERVIEWER – if the person did not access care ask this follow-up]: If you did not access services after you were diagnosed, how come/why?
[POTENTIAL FOLLOW-UP QUESTIONS/PROBES/GUIDES FOR INTERVIEWERS not required -- what kind of positive test result did you receive? An antibody/screening test or a diagnostic test? If have not received a diagnostic test you can find hepatitis testing resources
here: https://bchep.org/learn/hepatitis-testing/how-to-get-tested/]

When you were first diagnosed with hepatitis, what services did you need and access?
[POTENTIAL FOLLOW-UP QUESTIONS/PROBES/GUIDES FOR INTERVIEWERS - not required]: Ask people about what services they needed vs. what services they were able to access. What was your experience accessing these services – what made it easier to access these services? What were barriers or challenges to accessing services? Did you receive a referral for treatment assessment (whether you should start treatment)?]

What services would have been helpful to you that you could not access?
[POTENTIAL FOLLOW-UP QUESTIONS/PROBES/GUIDES FOR INTERVIEWERS - not required]: What were your needs when you were first diagnosed? Are there examples of services that they have heard of in other places that would have been helpful?]

When thinking about your community, what actions or services would best support them in preventing hepatitis?
[POTENTIAL FOLLOW-UP QUESTIONS/PROBES/GUIDES FOR INTERVIEWERS - not required]: What are helpful tools, resources and services? How are these best provided? By whom?]

Given your experience, what would be the most helpful ways to encourage people to test and get ongoing care and treatment for hepatitis?
[POTENTIAL FOLLOW-UP QUESTIONS/PROBES/GUIDES FOR INTERVIEWERS - not required]: What resources need to be in place to make people feel safe in accessing care? Where should testing be focused? How should testing be happening? From whom or where do you think people would be comfortable receiving hepatitis treatment? What works, what is challenging about care and treatment? Did you access ongoing care and testing after receiving treatment, being cured of hepatitis C?]

Please rate the following statements on an agreement scale:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	N/A
There is good access to hepatitis prevention services in my community (harm reduction, such as needle exchange, overdose prevention, safe supply… vaccination for hepatitis B...)	○	○	○	○	○	○	○
I can access hepatitis testing in my community	○	○	○	○	○	○	○
I feel safe accessing hepatitis testing in my community	○	○	○	○	○	○	○
I would know how to advise someone on where to access testing in my community	○	○	○	○	○	○	○
I can access ongoing monitoring and bloodwork for viral hepatitis in my community	○	○	○	○	○	○	○
I can access hepatitis treatment in my community	○	○	○	○	○	○	○
I have to travel outside my community to access hepatitis care and treatment	○	○	○	○	○	○	○

I feel safe accessing treatment in my community	o	o	o	o	o	o	o
I would know how to advise someone on where to access treatment in my community	o	o	o	o	o	o	o
I have access to a primary healthcare provider	o	o	o	o	o	o	o
I am/would be open with a primary healthcare provider about my hepatitis diagnosis	o	o	o	o	o	o	o
I feel like my primary healthcare provider is knowledgeable on hepatitis	o	o	o	o	o	o	o
I have access to specialist healthcare provider for my hepatitis, if I needed it	o	o	o	o	o	o	o
I feel like my specialist healthcare provider is knowledgeable on hepatitis	o	o	o	o	o	o	o
If I needed more complex hepatitis or liver care I could access this in my community [PROMPT FOR INTERVIEWER: cirrhosis, liver cancer, transplant]	o	o	o	o	o	o	o
My healthcare services or healthcare provider accommodated my	o	o	o	o	o	o	o

family, friends, or other supports when I requested it							
Healthcare services I have accessed are culturally safe, culturally appropriate, or culturally reflective (i.e. inclusive, gender-informed, focus on anti-racism, Indigenous inclusive, queer-friendly)	O	O	O	O	O	O	O
I have access to community-based services in my community [PROMPT FOR INTERVIEWER: education, prevention, social services, support, advocacy]	O	O	O	O	O	O	O
Community-based services are important to my hepatitis journey	O	O	O	O	O	O	O
I have access to peer-led services in my community	O	O	O	O	O	O	O
Peer-led services are important to my hepatitis journey	O	O	O	O	O	O	O
I have access to culture, spiritual services, or supports available when accessing hepatitis services	O	O	O	O	O	O	O
I have experienced stigma or discrimination when	O	O	O	O	O	O	O

accessing hepatitis services							

From your experience what do you think is working well in relation to hepatitis B and C in your community or in British Columbia?

From your experience, what do you think are the biggest barriers, gaps or opportunities for improvement in relation to hepatitis B and C in your community or in British Columbia? [POTENTIAL FOLLOW-UP QUESTIONS/PROBES/GUIDES FOR INTERVIEWERS not required – do you think stigma plays any role in creating barriers for people accessing testing or care?]

Do you have an example of a hepatitis B or C service that is working well in your community? If yes, please provide more information.

- ○ Yes
- ○ No

Can you please describe this positive example
[For interviewer: (name of service/program/action, where it is happening, what is it doing, who is it serving)

Can you please tell us what is accomplishing and why it is working well.

Is this positive example led by:

- □ Health authority
- □ Hospital
- □ Non-health authority clinical resource (doctor's office, clinic)
- □ Laboratory
- □ Pharmacy
- □ Community-based organization
- □ Indigenous community-based organization
- □ Peer-based service
- □ Indigenous community, on-reserve health centre
- □ Service that is culturally safe and provides competent care
- □ Other, please describe:

In what region does this positive example operate or where do the majority of service users come from?

- ○ Fraser Health
- ○ Interior Health

- Island Health
- Northern Health
- Vancouver Coastal
- In a First Nation or Métis community, on reserve, or within the jurisdiction of the First Nations Health Authority
- Cross-regional, provincial or national
- Don't know

Which of the following components does this positive example most align? (check all that apply)

- □ Epidemics (prevalence)
- □ System/Infrastructure (i.e. public health data, funding, research and evaluation, cultural safety)
- □ Prevention
- □ Testing
- □ Care and Treatment
- □ Cure or Suppression
- □ Elimination and Equity (i.e. incidence, disease, death, discrimination, geographic equity)

What type of viral hepatitis does this positive example most align?

- Hepatitis B
- Hepatitis C
- Both hepatitis B and C

Does this positive example align with a specific priority population?

- Yes
- No

If yes, which priority population(s) does this positive example most align with? (check all that apply):

- □ All of the categories below
- □ Indigenous peoples
- □ 2SLGBTQ+ people
- □ Children and youth
- □ Women
- □ Older people -- born before 1965
- □ Immigrants and newcomers
- □ People with incarceration experience
- □ People who use drugs
- □ Underhoused people
- □ None of these categories