NO ONE LEFT BEHIND

KEY FINDINGS REPORT

13 - 15 AUGUST 2018
ADELAIDE CONVENTION CENTRE

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www.hepatitis.org.au
We are in an exciting time. We have the opportunity to impact viral hepatitis in a way never before possible. However, as with every great endeavor, there is the risk that some people will miss the opportunities afforded by recent advances in therapeutics, implementation and policy. Worse, those who miss out may be the people who could benefit most.

Our conference was inspired by the 2030 Agenda for Sustainable Development and its focus on inclusion and health for all. The program showcased and critically examined ways to effectively reach everyone living with viral hepatitis, while being inclusive of their experiences and concerns.

“The conference delivered an excellent recap on the progress to date and, importantly, a reflection on what will be required to meet the ambitious global elimination targets. Inspiring lived experience speakers provided critical insights into their needs and challenges faced when accessing services.”

ERIN FLYNN
South Australian Health and Medical Research Institute

“We have the knowledge and insight to simplify hepatitis C treatment to improve the uptake and outcomes in various population groups. This, combined with holistic care models and peer support as well as a continuing focus on prevention over cure is vital moving forward.”

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If you care about viral hepatitis, you should care about social inequality.

The 11th Australasian Viral Hepatitis Conference was held in Adelaide in August 2018. Many of the presentations within the Community and Social Research stream acknowledged that marginalisation as a result of politics, culture and drug use essentially affect contact with health care services. In Australia, we are living in the era of a commitment made by the Australian government to eliminate hepatitis C through providing access to curable treatments for all adults with hepatitis C, and where hepatitis B clinical management effectively reduces deaths resulting from this infection.

Key to reducing preventable deaths from viral hepatitis is to ensure that all people with or at risk of these infections understand that they are at risk; that this risk can be reduced, and that they are able to access the services that will support reducing this risk.

People living with either hepatitis B or hepatitis C provided conference participants with an insight of living with the respective viruses including how living with viral hepatitis affected their lives outside of the clinical settings, and the myriad of other ways that viral hepatitis affected their lives. This included formal presentations from Anne, a Kaurna, Narangga and Ngadjuri woman living with hepatitis C, and an Afghani man living with hepatitis B. Other people living with viral hepatitis participated in the conference and provided both their professional and personal expertise and experience.

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KEYNOTE SPEECH:
No One Left Behind?
The Role of Social Policy in Viral Hepatitis

KYLIE VALENTINE
Associate Professor, Social Policy Research Centre, UNSW Sydney

“If you care about viral hepatitis, you should care about social inequality.”

In the Opening Plenary, kylie valentine from the Centre for Social Research in Health at UNSW provided an overview of the role of social policy, and how social policy essentially affects national responses to viral hepatitis. The presentation identified that social policy recognises the problems considered as important and being worthy of being addressed, and defines how the problems are understood. The role of social policy research highlights how different groups of people are affected by these choices. In relation to viral hepatitis, kylie noted that social policy research highlights particular differences affecting the communities most at risk of hepatitis:
These perspectives framed many of the presentations within the Community and Social Research theme.

While Kathryn Leafe, Executive Director at New Zealand Needle Exchange Programme noted that hepatitis C is the gateway for better health for people who inject drugs, Anne Mitchell noted that her experience as an Indigenous woman, “they treated me like I had the plague.”

Dr Sunil Solomon, an Associate Professor from the John Hopkins Hospital and described “(Sunil’s) Steps to eliminate hepatitis C from people who inject drugs”. These steps included taking the clinic to the people; simplifying diagnostics and monitoring, and where possible reducing the length of time that people need to use hepatitis C treatments – “8 – 12 weeks is amazing!, but 4 – 6 weeks could be even more AMAZING!!!”

Keynote Speech:
Health Equity = Doing More for our Community

Kathryn Leafe
Executive Director, New Zealand Needle Exchange Programme, New Zealand

“The war on drugs underpins the stigma and discrimination for people who inject drugs face.”

“No one left behind is not just about equal treatment.”

Keynote Speech:
Elimination of Hepatitis C in People Who Inject Drugs in Low and Middle Income Countries: The Final Frontier

Sunil Solomon
Associate Professor of Medicine, Johns Hopkins University School of Medicine, Baltimore, USA

Keynote Speech:
The Potential Impact of a Cure for Chronic Hepatitis B (CHB) Infection: A Population Health and Economic Analysis in Australia

Mehlika Toy
PhD, DSc, Stanford University School of Medicine, USA
“We are in the middle of a medical revolution...but none of that is going to make a huge impact unless people get tested and treated.”

Michael Ninburg
ELIMINATION OF HEPATITIS C IN PEOPLE WHO INJECT DRUGS IN LOW AND MIDDLE INCOME COUNTRIES: THE FINAL FRONTIER

Dr Sunil Solomon, Associate Professor Of Medicine Johns Hopkins University School Of Medicine

Presentation Notes  Audio Clip

Sunil’s steps to Eliminate Hepatitis C among People Who Inject Drugs:

• Begin with Data, Education, Harm reduction
  • “Data is not good enough at one point and time.*
  • Harm reduction is the “crux” of hepatitis C virus (HCV) programs – it requires 300 needles/syringes distributed per people who inject drugs (PWID) per year to achieve 2030 target

HARM REDUCTION HCV CARE MODEL

• Take the clinic to people who inject drugs who don’t come to the clinic
• Leverage networks – “a little money can go a long way.”

RESPONDENT-DRIVEN SAMPLING (RDS) IN KANPUR

How much did it cost?
• Cost of RDS without testing: USD 14,000
• Cost of HIV testing (USD 3/test): USD 3,000
Cost per unaware HIV infection: USD 40

If you added HCV
• Cost of HCV testing (USD 405/test): USD 4500
• Number unaware of HCV status: 674
• Cost per unaware infection identified: USD 7

• Simplify diagnostics and monitoring
  “This is my wish list - rapid diagnostic test for HCV core antigen or HCV RNA could be offered on the field. So you could imagine, on those clinics, you would just go out of the field, do a finger prick, check, core antigen positive, start them on treatment right away.”

• Shorten treatment
• Advocacy/ activist groups are critical to funding/ political buy-in
• “Treat individual instead of individual disease”
Over 70% of people living with HCV infection and over 80% of people living with HBV infection live in lower middle income countries (LMICs)

Problems in lower middle income country setting

- Lack of access to the latest treatment, monitoring and health insurance programs;
- Lack of continuing medical education programs to update knowledge among physicians

Potential opportunities in lower middle income country setting

- Generic medication is cheap
- Human resources, labour force, infrastructure for HIV and/or tuberculosis and campaign via mobile phones

Prospected strategies in lower middle income countrres: integration of diseases; task-shifting; incentivizing health care visits; capitalising upon mobile platforms

Thinking out of the box

- Get rid of confirmatory HCV RNA testing? depends on the setting, population, cost of DAA and HCV RNA; requires surveillance data
- Get rid of SVR assessment?

Management of HBV – “cost of inaction”?

- Simplify treatment decisions based on HBsAg +/- ALT?
- Use generic medication

OVER 70% OF HCV VIREMIC PERSONS LIVE IN LMICS!

OVER 80% OF HBsAg POSITIVE PERSONS LIVE IN LMICS!
CLINICAL MANAGEMENT UPDATE

AUSTRALIAN CONSENSUS STATEMENT ON HEPATITIS B MANAGEMENT DURING IMMUNOSUPPRESSION FOR HAEMATOLOGICAL AND SOLID-ORGAN MALIGNANCIES

Dr Joseph Doyle, Infectious Diseases Physician Monash University and The Alfred Health

1. Who to test
   - All patients undergoing therapy for haematological malignancy and solid tumours should be tested for hepatitis B infection

2. When to start antiviral agents
   - HBsAg positive
   - HBsAg negative
   - anti-HBc positive
   - anti-HBc negative
   - Higher risk chemotherapy: Haematopoietic stem cell transplantation therapy
   - B cell depleting agents
   - Bone marrow transplantation
   - Liver transplantation
   - Lower risk chemotherapy
   - HBV antivirals
   - No HBV antivirals

3. When to stop antivirals
   - 18-24 months post cessation of B cell depleting or haematopoietic stem cell transplantation therapy
   - 6-12 months post cessation of other cancer therapy (that is not B cell depleting / HCT)
   - Patients should remain on antiviral therapy if they fulfil treatment criteria for chronic hepatitis B

4. How to monitor
   - ALT and HBV DNA should be used to monitor patients receiving antiviral prophylaxis
   - Clinicians should consider hepatitis B infection if there is an unexplained elevation of ALT for any patients on cancer therapy
   - All cases of HBV reactivation should be urgently referred to a viral hepatitis specialist for treatment

MANAGEMENT OF CHRONIC HEPATITIS B: CHALLENGING THERAPEUTIC PARADIGMS?

Associate Professor Gail Matthews, Viral Hepatitis Clinical Research Program, The Kirby Institute, UNSW Sydney

- Endpoints of HBV antiviral therapy: functional cure - HBsAg loss; absolute cure - cccDNA loss.
- Current guidelines: Who to treat? What treatment? When to stop?
  - Who to treat?
    - No evidence to treat broader outside the current recommendations
  - What treatment?
    - Single NA vs. Combination NAs vs. NA + IM?
    - TAF - entered the AASLD and EASL guidelines; TAF is comparable to TDF on efficacy, HBsAg loss, ALT normalisation and safety on renal and bone toxicity; TAF is not recommended in pregnancy or HIV comorbidity.
Current guidelines: HBeAg positive

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<td>* AASLD suggests indefinite therapy for HBeAg-positive adults with cirrhosis who seroconvert to anti-HBe on NA therapy</td>
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<td>HBeAg-positive</td>
<td>HBeAg seroconversion + 12m of consolidation (preferably 3yrs)</td>
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Current guidelines: HBeAg negative

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<td>HBeAg-negative</td>
<td>Confirmed HBsAg loss +/- anti-HBs seroconversion</td>
<td>Indefinite treatment is recommended (unless compelling rationale)</td>
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<td>Suppression if close monitoring guaranteed</td>
<td>Stopping “MBC” in persons with HBsAg loss</td>
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<td>Cirrhosis:</td>
<td>Stopping “MBC” in cirrhotic patients with a careful off-therapy monitoring plan</td>
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<td>i) after at least 2 years with undetectable HBV DNA on three separate occasions, 6 m apart (B1).</td>
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A public health approach is needed to overcome the challenges with the tools we’ve already have - vaccine coverage, timely birth dose, linkage and stay in care, affordable drugs.

NOVEL BASIC SCIENCE ON HEPATOCELLULAR CARCINOMA (HCC) SCREENING

INVESTIGATING THE USE OF A URINARY METABOLITE PANEL AS A SCREENING TEST FOR DIAGNOSIS OF HEPATOCELLULAR CARCINOMA IN A REMOTE ABORIGINAL SETTING

Jack Wang and Kelvin Muller, Medical Student Flinders University

- HCC in the Northern Territory: lack of diagnostic resources; median survival from HCC diagnosis to death for Aboriginals within the NT is 64 days.
- Preliminary results from 54 participants (Control vs. CHB vs. CHB + cirrhosis vs. HCC) showed the compositional difference between samples from HCC group and other groups.
PREDICTING RISK OF HEPATOCELLULAR CARCINOMA FOR PATIENTS WITH CHRONIC HEPATITIS B USING SERUM LEVELS OF SPLICED HEPATITIS B VIRUS DNA

Peter Revill, Senior Medical Scientist Victorian Infectious Diseases Reference Laboratory

Splice variants in serum were associated with liver cancer from the previous study; results validated in REVEAL study

- Subjects with spliced HBV DNA level $>20\%$ were over 23 times more likely to develop HCC than patients with lower levels of splice variants
- In most HCC patients with elevated spHBV levels, splice levels increased in the five years before HCC diagnosis

SYNTHESIS OF HBEAG-SPECIFIC EPITOPE-CLONED HBV BIO-NANOPARTICLES

Yianni Droungas, Phd Student, Victorian Infectious Diseases Reference Laboratory

- Successfully synthesis of chimeric viral-like particles encoding an HBeAg epitope in-vitro
- The bio-nanoparticles aim to trigger immune response in non-spontaneous immune responding individuals living with chronic hepatitis B to facilitate HBeAg seroconversion

NEW DIAGNOSTIC ASSAY/ ALGORITHMS FOR DECENTRALISED SERVICES

EVALUATION OF A HEPATITIS C VIRUS CORE ANTIGEN ASSAY IN DRIED-BLOOD SPOTS: A COHORT STUDY

Tanya Applegate, Senior Lecturer, Viral Hepatitis and Clinical Research Program The Kirby Institute, UNSW Sydney

- HCV core antigen testing - an alternative to HCV RNA
- The sensitivity and specificity of the DBS HCVcAg testing is 90.7\% and 100\%, respectively, among participants with high viraemia (HCV RNA $>3,000$ IU/ml)
- Potential use: surveillance, large-scale screening or one-step alternative in high prevalence settings
CAPACITY OF NON-INVASIVE HEPATIC FIBROSIS ALGORITHMS TO REPLACE TRANSIENT ELASTOGRAPHY TO EXCLUDE CIRRHOSIS IN PEOPLE WITH HEPATITIS C VIRUS INFECTION: A MULTI-CENTRE OBSERVATIONAL STUDY
Melissa Kelly, Infectious Diseases Physician The Albion Centre

- A multi-centre observational study with 850 patients (780 with HCV mono-infection) compared FibroScan (retrospective or prospective data) and seven non-invasive algorithms including APRI, FIB-4, GUCI, King’s, CDS, Forn’s Index and Lok Index
- Newly derived cut-offs, APRI< 0.49 or FIB-4< 0.93, can reliably (NPV 99%) exclude cirrhosis.
- The newly derived cut-offs for non-invasive algorithms could improve HCV assessment efficiency.

EVALUATION OF THE HOLOGIC APTIMA HCV QUANT DX ASSAY FOR DETECTION OF HCV RNA FROM DRIED BLOOD SPOTS
Beth Catlett, DBS Coordinator/PhD Candidate St Vincent's AMR/UNSW Sydney Kirby Institute

- 107 paired EDTA plasma and DBS samples to test HCV RNA showed a good sensitivity and specificity, especially in individuals with high viremia (>=1,000 IU/ml).
- The assay contributes to implementing simplified diagnostic strategies in PWIDs with the home collection or assisted collection via registered decentralised services available.

AN IMMUNOCHROMATOGRAPHIC TEST FOR MEASUREMENT OF ALANINE AMINOTRANSFERASE (ALT) AT POINT-OF-CARE
Associate Professor David Anderson, Deputy Director, Partnerships Burnet Institute

- Measure ALT1 only with a reference line of 40 U/L (R line)
- 40 µl whole blood/ 15 µl plasma + buffer + 20 min reaction time
- Tested in 106 samples in China, and 293 plasma samples in Melbourne - sensitivity 85%, specificity 90%, accuracy 89% by 40 µl whole blood; sensitivity 94%, specificity 85%, accuracy 88% by 15 µl plasma.
SIMPLIFY DIAGNOSIS AND TREATMENT FOR HEPATITIS B & C

THE DEVELOPMENT OF NEW SIMPLIFIED DX TECHNOLOGIES TO REACH THOSE IN NEED – OUR CHALLENGES FOR THE NEXT 5 YEARS

Associate Professor David Anderson, Deputy Director, Partnerships Burnet Institute

Unmet needs in HBV and HCV diagnostics

- Developed countries – high cost and long turnaround time for HBV and HCV virological tests and capacity issue
- LMICs – cost, quality, capacity and access issues

Alternative biomarkers for triage?

- Hepatitis B – do we really need viral load?
- Hepatitis C – can we rely on APRI, Fib-4 or other tests to triage for FibroScan?
- Can we move towards true POC tests for triage?

POC for ALT: facilitate monitoring CHB, but barriers in translation and commercialisation

Example results for BioPoint® lateral flow ALT1

SIMPLIFICATION OF HCV TREATMENT TO REACH EVERYONE – WHAT TOOLS DO WE NEED TO ENGAGE CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES?

Dr Jane Davies, Menzies, Infectious Diseases Specialist Menzies School Of Health Research

- Some common myths in NT both in healthcare providers and patients
- Complicated guidelines, terminologies, multiple diagrams, different international working groups are confusing to practitioners in primary care.
- Make optimise the impact of what we have - "Let’s look at what we do have, let’s look at the environment that we are in, and let’s do what we can do to optimise and make the best use of those things."
- hepatitis B PAST – Partnership Approach to Sustainably eliminating CHB in the NT
  - The three S’s approach: systematic, simplified, sustainable (partnership) approach
  - Education: hepatitis B story app, translated to >10 aboriginal languages and languages for CALD communities as well. Use education resources appropriately, individualise the education to clients, train local community practitioners and workers.
Why prioritise diagnostics?
- Cost of diagnostics can outweigh treatment or no access
- 1st WHO model list of essential in vitro diagnostics – hepatitis B and C among the top 7
- Centralised diagnostics in labs - decentralised services (DBS, rapid diagnostic test, POC, liver staging)
  - DBS- a chance to reach further. Advantages include better linkage to care; easy and cheap to collect; no medical training required. Disadvantages include low sample volume; and reduced sensitivity.

How to optimise?
- EASL and WHO recommendations: flexibility to adapt and reach more peoplePoint of care RNA/ core antigen only is ok depending on the setting
- Every unnecessary test = one less person treated
- Should we go further and remove SVR12?

The reality- conservative local guidelines in LMICs; testing in Australia is still too complicated.

Barriers to implementation of testing
- Centralised testing – lab capacity, distance, sample transport, platform access, delivery of results
- Decentralised – training of use and interpretation, reporting
  - it's now or never- a global paradigm shift in diagnostics
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Presentation Notes
• Systematic: systematically go through the primary care list and identify every single person’s hepatitis B status and follow up those in need.
• Sustainable: (sustainable) foundation + (sustainable) core clinical care group in place + (sustainable) education in their first language in place.
• Simplify the guideline – break down to each unit: ‘no need for treatment’, ‘need to see a specialist’, ‘definitely need treatment’.

Tanya Applegate, Senior Lecturer, Viral Hepatitis and Clinical Research Program The Kirby Institute, UNSW Sydney

SIMPLIFICATION AND IMPLEMENTATION OF EXISTING DIAGNOSIS TOOLS – HOW CAN WE USE WHAT WE HAVE?

TEST AND TREAT! – A COMMUNITY BASED VIRAL HEPATITIS SCREENING AND TREATMENT SERVICE IN A SYDNEY BASED NEEDLE AND SYRINGE PROGRAM (NSP)
Virginia McMahon, NSP Supervisor, KRC South

• A community-based hepatitis screening and treatment services in KRC South NSP (partnership with St George liver clinic);
• Word of mouth referral and an incentive-based approach was used to recruit participants; pre-treatment survey collected; treatment offered onsite.
• Started in April 2017, the service evolved into a monthly clinic in the NSP. Over the past year, 51 clients were assessed with 43% were diagnosed with chronic hepatitis C, 17 were treated for hepatitis C.

A flexible model of care, including daily or weekly dosing of DAAs through an OST program, can achieve high treatment completion and cure rates for marginalised clients.
Marginalised people who are injecting drugs usually face stigma, poverty, homelessness, incarceration and mental health issues in the community setting.

The TAP study: one-stop shop using a nurse-led model (using a mobile van) to engage PWIDs in the community setting

Key messages when trying to engage PWIDs:
• What works - reimbursement; taking the treatment to the person; the drop-in session; rapport-building; the constant presence in the site each week in the same place.
• What doesn’t work - schedule appointments; the follow-up in the community;

Over 350 people have been screened, more than two-thirds eligible has been treated.

One of the comments – “everything was really easy, really well done, well-organised. Everyone was nice, friendly, welcoming, supportive, yeah. Better than hospital, better than doctor, better than anything else like a rehab or detox facility. I recommend this as the best treatment you can get. I reckon it should be mandatory for everyone.”

A self-administered online survey conducted in 2016-2017; it used a validated questionnaire (DDPPQ) bundled into domains of role adequacy, role support, role legitimacy, role self-esteem and job satisfaction.

Main findings: 151 responses; a considerable amount of ambivalence around ‘I feel I know how to counsel drug users over the long term’ and ‘I feel that I can appropriately advise my patients about drugs and their effects’.

Increased knowledge and support may contribute positively to role satisfaction, which was reflected as a poor “understanding” of drug users in general.
HEPATITIS C WORK-UP AND TREATMENT: INNOVATION IN CORRECTIONAL NURSING PRACTICE
Susan O’Neill, Nurse Consultant, South Australian Prison Health Services

Barriers of HCV management in SA correctional setting:
1. Lack of priority for hepatitis C or competing for priority such as diabetes among prisoners
2. Low health literacy
3. Access to Medicare
4. Technology in prison (still using paper record)
5. Hard to chase prisoner movement

How to conquer the barriers: resources, assets and allies
- Resources: A passionate, educated nurses team across seven public prisons, connected with clinical staff, hepatologists and pharmacy staff
- Video conference to upskill nurses and mentoring
- The key was nurses were connected across seven public prisons, and treatment was consistent even when prisoners move.
- “What we did: new drugs, new change, practice development.”
- “For us, the game-changing is the APRI score.”
- From March 2016 to December 2016, a four-fold increase in prisoner-patients engaged in the treatment of HCV using direct acting antivirals (DAAs) compared to interferon era

ADHERENCE AND VIROLOGICAL OUTCOMES FOR HEPATITIS B ANTIVIRAL THERAPY AMONGST INDIGENOUS AUSTRALIANS IN THE REMOTE TOP END, NORTHERN TERRITORY
Caroline Lee, Medical Student, Menzies School of Health Research

Why prioritise diagnostics?
- Hepatitis B in indigenous Australians: 4 times higher prevalence and 2-8 times higher rates of HCC (vs. non-Indigenous Australians): unknown proportion on treatment.
- Hep B in Northern Territory: 6-12% HBsAg prevalence: universal HBV immunisation since 1990.
- A retrospective audit of pharmacy data matched to clinical records in 07/2012 – 10/2015 through Royal Darwin Hospital Pharmacy: HBV antiviral therapy is feasible and can achieve reasonable virological response (76% complete or partial viral response) in remote Indigenous patients.
- Medication access is a challenge in some remote area in Northern Territory – “Medications need to be shipped or flew into the local community”. 
A hepatitis C remote consultation pathway in the Barwon South West region

- Development - Health Pathway, consultation request and response form; developed by a working group of local stakeholders in 02/2016;
- Implementation: GP education session of peer-based teaching and cases sharing + GP events;
- Outcome: 169 patients referred for remote consultation by 74 GPs in 06/2016 - 06/2017, 95 patients commenced DAA treatment; DAAs written by GPs increased

Towards micro-elimination – the proposed strategies:

- **Health promotion**
- Re-engage PHN primary health consultants
- Increase links between hepatitis C and mental health services

**NEVER FEAR PENCAT IS HERE – A NATIONALLY AVAILABLE TOOL FOR CHRONIC HEPATITIS B MANAGEMENT IN GENERAL PRACTICE**

Lisa Dowdell, St George Hospital

- **Pen CAT** – a Clinical Audit Tool developed by Pen CS.
- **Pen CAT** is a software which can be integrated with clinical software thus can: extract and analyse data from clinical software; identity missing patient data - put a reminder note in the patient’s file - record status at the patient’s next visit; identify patients by risk factors; help clean GP software data.
- Originally used in primary care for diabetes management, Pen CAT was added hepatitis B filter.
  - The screening page (fig.1) provides an overview of the hepatitis B screening/ vaccination status of at-risk patients;
  - The management page (fig.2) provides an overview of ‘next steps’ to manage patients who are living with CHB;
  - Both screening and management page link to a worksheet of patients data.
• Using Pen CAT in GP settings – in one GP test site, the software identified 18 patients for recall with raised ALT and sent out 63 messages in software practice because of their LFTs due.
• A GP engagement model- integrated with community liver nurse consultant, education, PenCAT audit and recall patients, in-house FibroScan and linkage to specialists.
RECALL CAN INCREASE TREATMENT UPTAKE: AN AUDIT OF POSITIVE HEPATITIS C PCR TESTS AT THE KIRKETON ROAD CENTRE

Rebecca Lothian, Clinical Nurse Consultant-Hepatitis C Treatment Coordinator, Kirketon Road Centre

- A retrospective audit of HCV PCR tests results at KRC in 07/2014 - 06/2017 identified 344 patients with positive HCV RNA, and recall was made to 177 clients not yet treated; the active recall engaged a further 17% of those not yet treated into treatment.
- The timely recall is essential to engage clients in hepatitis C treatment.

QUIET ACHIEVERS – A MULTI-DISCIPLINARY APPROACH TO HCV TREATMENT AND MANAGEMENT IN MARGINALISED POPULATIONS – THE QuIHN OUTREACH MODEL

Mary Fenech, Nurse Practitioner, Quihn Ltd

- “Some of the lessons I’ve learned- that I am much more useful serving this community by taking treatment to the people; the care that is provided by this outreach service is enhanced by the team approach - synergistic & Gestalt. IT NEEDS A TEAM, anything less is suboptimal.”
- “There are clinicians (e.g. GPs) who don't want to do this or shouldn't do this - leave them alone.”
- “I'll be referring my patients to you...they are much better served by you guys...I don't have the skills or the resources to deal with these issues” (an ID Physician said to the team)
HIGH EFFICACY OF 8 WEEKS PARITAPREVIR/ RITONAVIR/ OMBITASVIR AND DASABUVIR AMONG PEOPLE WITH RECENT GENOTYPE 1 HCV INFECTION
Marianne Martinello, Lecturer, The Kirby Institute, UNSW

An open-label single arm trial among 30 adults with recent Gt1 HCV infection (duration of infection <12 months) showed shortened duration (8 weeks) paritaprevir/ritonavir/ombitasvir and dasabuvir (with ribavirin) was highly effective, regardless of HIV serostatus.

HEPATITIS C VIRUS (HCV) REINFECTION AND INJECTING RISK BEHAVIOR FOLLOWING ELBASVIR (EBR)/GRAZOPREVIR (GZR) TREATMENT IN PARTICIPANTS ON OPIATE AGONIST THERAPY (OAT): CO-STAR PART B
Gregory Dore, Program Head, VHCRP, The Kirby Institute, UNSW

• CO-STAR Part A: a phase 3 trial of 12-week EBR/GZR in participants on OAT; a reinfection rate of 3.4 per 100 person-years in follow-up week 24.
• CO-STAR Part B: 58%-61% reported drug use with positive USD; reinfection rate was 2.3 per person-years among participants enrolled in part B from end of treatment to follow-up month 24.
• HCV reinfection among participants on OAT following EBR/GZR is uncommon, despite ongoing drug use.

REAL-WORLD OUTCOMES OF DIRECT-ACTING ANTIVIRAL THERAPY FOR CHRONIC HEPATITIS C FOLLOWING UNRESTRICTED ACCESS IN AUSTRALIA: THE SOUTH AUSTRALIAN EXPERIENCE
Dr James Haridy, Gastroenterologist / Research Fellow, Royal Melbourne Hospital

Key findings: 1909 patients data included in analysis (representing 90%-95% total patients treated in SA in 03/2016 -02/2017); SVR 12 in SA is 80% among all patients intended for DAA treatment; Prison and remote consultation treatment were independent predictors for loss to follow-up; there’s a significant decrease in treatment initiation over the 12 months which highlights the needs of additional strategies to link patients to treatment.
In a Community Engagement symposium, a range of presentations highlighted some of the interventions developed, lessons learned, and challenges involved in projects targeting priority populations.

**DEADLY LIVER MOB: ESTABLISHING NEW SERVICES TO ENGAGE ABORIGINAL PEOPLE WHO INJECT IN HEPATITIS C AND STI SCREENING**

Melinda Walker, Assistant Researcher, The Centre for Social Research in Health, UNSW Sydney

Melinda Walker, a Gumbaynggirr woman from the Centre for Social Research in Health, UNSW Sydney presented on the “Deadly Liver Mob”. This project promotes the testing and treatment of Aboriginal people for hepatitis C and sexually transmitted infections using “yarnin” - culturally appropriate storytelling, that support the development of sustainable relationships and checking understanding of education interventions. Through the use of incentives, Indigenous people participate in education, screening, vaccination, and treatment when required, with additional incentives for education and referral of peers to the program.

**BEYOND INFORMATION - HEPATITIS B ENGAGEMENT WITH THE CHINESE COMMUNITY IN ADELAIDE**

Cecilia Lim, Coordinator Information And Resources, Hepatitis SA

People born in China are at particular risk of having chronic hepatitis B infection, and as a result are at greater risk of dying from liver disease, including cancer.

Cecilia Lim, Coordinator Information and Resources at Hepatitis SA and Margery Milner, a Viral Hepatitis Nurse from the Queen Elizabeth Hospital jointly presented on the experience of raising awareness of hepatitis B within the Chinese community living in Adelaide. The presentation commenced with a very practical example of providing this education with the lived experience of an elderly Chinese couple, one of whom had hepatitis B, was diagnosed early with liver cancer, and as a result of this early diagnosis, treated successfully, and who had subsequently become an advocate for testing and diagnosis. The project targeted older people and women through antenatal clinics with some key challenges being:

- Getting access to networks – real world and online
- Gaining trust of community members
- Differences of the dynamics of Chinese communities from across the world
- While older people face barriers such as language, transport and a lack of understanding of the health care system, younger people were hard to engage as a result of busy family lives and careers.
TOO SOON FOR BACK-SLAPPING AND COUNTING CHICKENS: ENGAGEMENT WITH SUB-POPULATIONS OF PEOPLE WHO USE DRUGS

Melanie Walker, Coordinator Information And Resources, Hepatitis SA

Melanie Walker is the Chief Executive Officer of the Australian Injecting and Illicit Drug Users League, and described the need for continued engagement with sub-populations of people who inject drugs. In this presentation, Melanie acknowledged that 100% of people using alcohol and other drug services were living with hepatitis C, while in many of these settings few hepatitis C related services were provided. There was also a call to recognise that while there is a strong focus on increasing the delivery of hepatitis C treatment, this should not come at the expense of increasing and improving prevention interventions, that are proven to work and much cheaper than the cost of treatments.

BARRIERS AND FACILITATORS FOR ENSURING EQUITABLE ACCESS TO DAAS: A CLINICAL PERSPECTIVE

Philip Read, Director, Kirketon Road Centre

Both Phillip Read, the Director of the Kirketon Road Centre in Sydney, and Janice Pritchard-Jones highlighted the need for a real rather than tokenistic engagement with people living with hepatitis C, particularly with a focus on people who inject drugs. For Dr Read, the Kirketon Road Centre has successfully treated around 300 people in the “DAA era”, with 70% of these people currently injecting drugs, 37% being homeless, 26% being Aboriginal, and 40% having a mental health diagnosis. This success in targeting what many people would describe as a “hard to reach” population has occurred after recognising and responding to the particular needs of the client group. A clear set of principles has been established within the service including accessibility, affordability, acceptability and equity with a description of the facilitators to addressing these principles. Dr Read noted that the elimination of viral hepatitis will only occur with the re-orientation of clinical services with the provision of a range of models of care, and that while multiple barriers can exist, small and inexpensive initiatives that respond to the needs of vulnerable clients can make a big difference.

COLLABORATIVE PARTNERSHIPS ARE NEEDED TO ELIMINATE HEPATITIS C IN MARGINALISED POPULATIONS

Janice Pritchard-Jones, Hepatitis Coordinator, SLHD

INNOVATIONS IN HEPATITIS B

A Proffered Paper session on Innovations in Hepatitis B highlighted a broad range of interventions and modalities being used across Australia to support the engagement of communities and people with hepatitis B related activity. These included the use of theatre, with a project from Hepatitis NSW seeking to increase diagnosis and treatment access among Chinese Australian community. This theatre production sought to specifically present hepatitis B as an issue without shame, with the presenter noting that if you don’t address the shame associated with hepatitis B with Chinese communities, “it’s a job that isn’t concluded”. Other presentations in this session highlighted the:

- Challenges, risks and benefits involved in the development of peer support services for people from culturally and linguistically diverse backgrounds
- Overcoming language and cultural barriers through engaging people from non-English speaking backgrounds through the use of bilingual health workers
• Essential elements in delivering an outreach education and vaccination program to culturally and linguistically diverse communities
• Use of HipHop as a hepatitis B and liver cancer awareness and informational educational tool targeting young people from the South Sudanese communities
• That health promotion campaigns targeting culturally and linguistically diverse communities need to tailor specific messages for each community and be clear about not only language, but how language and grammar is used
• Processes used in the development of a video targeting the Vietnamese community to increase awareness and knowledge of hepatitis B.

HEPATITIS C CARE & TREATMENT

Responding to the challenges in hepatitis C care and treatment was the theme of a proffered paper session held on the second day of the conference. In this session presentations highlighted some of the specific challenges involved in the delivery of hepatitis C treatments, in an era where there is a government commitment to hepatitis C elimination. The presentations looked at:

• Improving the awareness of hepatitis C treatments availability, using multiple interventions, simple and clear messaging such as the "cure" rather than "treat" with less text, simple imagery and faces representing the scope of affected communities
• The impact of cure on people who had accessed treatment including an improved sense of psychological wellbeing; relief about no longer being infectious and reduced anxiety about developing liver disease and cancer. These benefits were recommended for engaging people with hepatitis C who were not already engaged in seeking treatment.
• The reasons that some people who inject drugs have chosen not to access treatment include a fear of side effects; a lack of priority within the broader context of their life, the lack of symptoms, and concern about the impact of stigma.
• Common issues raised by people who inject drugs reducing treatment access include that treatment is seen as not being accessible to people who inject, that treatment work-up is difficult, and that staff from some needle and syringe programs are unaware that treatment is available.

THE KOMBI CLINIC – IT’S THE END OF THE ROAD FOR HEP C!

Matthew Young, Medeco Inala Medical Centre / Hep C Kombi Clinic

The Kombi Clinic, a culturally appropriate and accessible treatment service operating through various locations around Brisbane. Some of the issues vital in its success other than the (reputed) “two (roguishly handsome) GPs, a (world’s best) fibroscanning RN, and a (world class) QML phlebotomist (world class)” included starting people on treatment as soon as possible; addressing blood drawing concerns; minimising ‘out of pocket’ expenses, and address fears of side effects.
STIGMA STORIES: SPEAKING UP TO STOP THE SILENT KILLER

Jack Gunn, Hepatitis Victoria

Stigma: quantifying and reducing its impact. A presentation from Hepatitis Victoria highlighted a year-long 12-part anti-stigma campaign seeking to raise awareness and challenge stigmatising community, professional, and institutional attitudes towards viral hepatitis.

THE NATIONAL STIGMA INDICATOR PROJECT: KEY FINDINGS AND LESSONS REGARDING PEOPLE LIVING WITH HCV AND PEOPLE WHO INJECT DRUGS

Timothy Broady, Research Associate, Centre For Social Research In Health, UNSW

Timothy Broady reported on the development of an Australian Government funded stigma indicator which in the long term will provide simple comparisons of stigma prevalence, while acknowledging that there are significant challenges in reducing stigma into a single measure.

WORKING WITH MARGINALISED COMMUNITIES

A THOUGHTFUL AND COLLABORATIVE APPROACH TO HEPATITIS B IS ESSENTIAL WHEN WORKING IN REMOTE ABORIGINAL COMMUNITIES

Paula Binks, Program Manager, Menzies School Of Health Research

The final proffered paper session emphasised the need to work effectively within specific communities, some of whom are marginalised from the broader community. Paula Binks from the Menzies School of Medical Research with her colleagues, George Gurruwiwi, Roslyn Dhurrkay and Melita McKinnon presented on the stages of learning in working in outreach liver clinic services with remote Aboriginal communities in the Northern Territory. The projects, in which implementation is led by Indigenous Health Workers recognise that “When Balanda (non-Indigenous) tells the story, Yolgu doesn’t understand whole story, they don’t know about hepatitis B, don’t hear story right and get confused” (Roslyn Dhurrkay, 2018). The Indigenous workers essentially understand culturally appropriate ways of communication including the social and cultural obligations of the communities in which they work.
Other presentations in the session including projects that investigated:

- The collaboration between Hepatology Nurses and peer workers increasing access to hepatitis C treatment within opiate substitution, homelessness, drug health, community and residential rehabilitation services
- Methods used to engage with people with hepatitis C living within correctional institutions including the provision of counselling and case management services, and an arts related project;
- The targeting of people living in rural areas in Murray Bridge, a rural town in South Australia, and in Townsville, Queensland;
- The benefits and challenges involved in the provision of point of care testing;
- Research conducted with sexually adventurous men who have sex with men
- Supporting Aboriginal and Torres Strait Islander health workers provide fibrosan services.

THE SOCIAL BENEFITS OF SUCCESSFUL DAA THERAPY BEYOND CURE: A STRUCTURAL COMPETENCY APPROACH

Carla Treloar, Director, Centre For Social Research In Health, UNSW

Carla Treloar highlighted the need to better understand how people with hepatitis C experience being cured, outside that of a clinical understanding. This presentation noted that to promote cure among people with hepatitis C, "we need different ways of measuring success, not just cure". The presentation highlights the use of ‘patient recorded measures’ which focus on what matters to patients, rather than what matters to clinicians and other stakeholders. The presentation noted that "Leaving no one behind is hard work".

HEPATITIS B COMMUNITY PARTNERSHIPS – DANCING WITH CINDERELLA

Kathryn Stewart, Program Manager - Hepatitis B, Hepatitis Australia

The findings from the most substantial Australian Government commitment to community education in relation to hepatitis B were presented by Kathryn Stewart from Hepatitis Australia: Hepatitis B Community Partnership – dancing with Cinderella. The presentation defined that “Cinderella” means one whose attributes were unrecognised, or one who achieves recognition or success, after a period of unjust obscurity and neglect."

The project distributed 40 grants across Australia with communities targeting including various cultural and linguistically diverse communities (65%), Aboriginal and Torres Strait Islander peoples (25%) with the remaining targeting men who have sex with men, children, families and pregnant women, and prisons.

Success factors for the grants included:
1. Clinical service integration
2. Strong partnerships
3. Cultural competence
4. Adaptive education
5. Community engagement
6. Communication style
7. Personal story telling

The project will be completed by December 2018.
KEY FINDINGS REPORT:  
EPIDEMIOLOGY, PUBLIC HEALTH AND PREVENTION

Research informing epidemiological understanding of, and public health responses to viral hepatitis, such as epidemiological studies including cohort studies, research, surveillance, evaluations and outbreak investigations, evaluations of public health programs, policy reviews were included in the Epidemiology, Public health and Prevention stream.

MEASURING PROGRESS TOWARDS VIRAL HEPATITIS ELIMINATION GOALS – DATA FOR ACTION

The initial symposium of the Epidemiology, Public Health and Prevention stream, Measuring Progress Towards Viral Hepatitis Elimination Goals – Data for Action sought to:

• Understand the optimal set of indicators for measuring hepatitis B and hepatitis C elimination progress and the available sources of data in Australia that can be feasibly accessed to measure these indicators
• Assist health services and local health areas to understand hepatitis B and hepatitis C indicators could be measured and tracked at the local level;
• Understand the challenges in measuring and in achieving elimination targets

HBV AND HCV ELIMINATION TARGETS: WHICH ARE FEASIBLE?

Gregory Dore, Program Head, VHCRP, The Kirby Institute, UNSW

Gregory Dore from the Kirby Institute detailed the global and national challenges in achieving viral hepatitis elimination targets established by the World Health Organization:

• Diagnosis of hepatitis B needs to increase from 9% to 90%, while diagnosis of hepatitis C needs to increase from 20% to 90%
• Treatment for hepatitis B needs to increase from 8% to 80% of eligible people, while hepatitis C treatment needs to increase from 7% to 80% of eligible people
• Needle and syringe distribution needs to increase from a global average of 27 needles/syringes distributed per year for each person who injects drugs to 300 needles and syringes per year for each person who injects

The presentation summarised that while several service coverage targets had been already achieved in Australia such as hepatitis B vaccination, blood safety, and needle and syringe coverage, and that hepatitis C elimination was “on track”, the slowdown in the number of people initiating hepatitis C treatment was a concern for the mortality indicator. In relation to hepatitis B, achieving the hepatitis B mortality reduction will require enhanced diagnosis and linkage to care/treatment.
THE ROLE OF GEO-MAPPING OF VIRAL HEPATITIS IN MONITORING CARE CASCADE AND DRIVING LOCAL RESPONSES

Ben Cowie, Epidemiologist, The Doherty Institute

Ben Cowie described the role of geographic mapping of viral hepatitis in driving local responses and monitoring the cascade of care. The National Viral Hepatitis Mapping Project was funded by the Australian Government in 2012 to provide locally relevant, geographically specific estimates of the burden of disease and of access to treatment and care for hepatitis B, and expanded to include hepatitis C in 2016. This mapping identifies priority areas, progress, gaps and disparities, and for health services can identify the local areas that have the highest burden of viral hepatitis. The mapping has identified several local success stories including:

- Increased hepatitis C treatment uptake in Adelaide with South Australia viral hepatitis nurses providing impetus for this
- The South Western Sydney being the only Public Health Network achieving the National Hepatitis B Strategy 2014-2017 treatment targets, and where the B Positive Program had been operating for several years
- NT hepatitis B response – access to care/monitoring among highest in the country by Public Health Network
- Increased focus on chronic hepatitis B in Far North Queensland.

Attendees of needle and syringe programs showed the significant impact of access to DAAs, with a comparison between the findings of their viraemic status in 2015 and 2017.

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**Viraemic status of ANSPS respondents**

<table>
<thead>
<tr>
<th>Year</th>
<th>Status</th>
<th>Non-exposed</th>
<th>Spont. cleared</th>
<th>Cured with treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Pre DAAs</td>
<td>43%</td>
<td>12%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>45% active infection</td>
<td>Non-viraemic</td>
<td>Viraemic</td>
</tr>
<tr>
<td>2017</td>
<td>Post DAAs</td>
<td>51%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% active infection</td>
<td>Non-exposed</td>
<td>Spont. cleared</td>
</tr>
</tbody>
</table>

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HEPATITIS TREATMENT AND ITS IMPACT

In the Proffered Papers session, Hepatitis Treatment and Its Impact, presentations focused on the impact of hepatitis C treatments, including limits to the impact. The presentations covered issues including:

- That while high DAA uptake and cure rates among people with fibrosis scores of F3/4, mortality from decompensated cirrhosis, hepatocellular cancer and other liver related disease will still occur despite reduced individual risk. Overall DAA uptake needs to be between intermediate (13,677/year) and optimistic (21,370/year) to achieve a 65% mortality reduction
- Predictors of treatment uptake include geographic, socioeconomic and health service factors
- Reinfection following successful DAA therapy does occur, to the same degree as occurred in the era of interferon treatment, and more frequently among people who inject
- People who inject who access needle and syringe programs report ‘considerably higher’ rates of treatment success than the broader population living with hepatitis C, suggesting that NSP attendees may be provided with greater opportunities and support to access testing and DAA treatment than other sub-populations of people living with chronic HCV.
- Treatment is available through a broad range of clinical services without significance difference in efficacy, including for people with HIV and hepatitis C co-infection

PRIORITISING HEPATITIS B – EPIDEMIOLOGY & PROGRAM NEED

The Proffered Papers - Prioritising hepatitis B - Epidemiology and Program Need session highlighted various elements needing to be addressed to ensure that no person with hepatitis B was left behind.

INVESTIGATING TRENDS IN HEPATITIS B EPIDEMIOLOGY WITHIN INDIGENOUS POPULATIONS IN THE NORTHERN TERRITORY

Ashleigh Qama, Epidemiologist, The Doherty Institute

Read the Abstract  Presentation Notes  Audio Clip

Ashleigh Qama presented on an investigation of epidemiological trends in hepatitis B in Indigenous populations in the Northern Territory and confirmed that hepatitis B is still an issue for the Northern Territory with a higher yearly point prevalence than the national average, and a greater prevalence among Indigenous Australians than in the non-Indigenous population.

MODELLING HEPATITIS B IN AUSTRALIA: IMPROVED ESTIMATES OF THE BURDEN OF DISEASE

Karen McCulloch, Research Fellow, The Doherty Institute

Read the Abstract  Presentation Notes  Audio Clip

Karen McCulloch from the Doherty Institute, WHO Collaborating Centre for Viral Hepatitis presented on the development of a mathematical model that better reflects the natural history of hepatitis B in Australia using a wide range of data sources.

The model provided updated estimates for 2017 of the:

- Number of people living with hepatitis B = 248,811 people
- Proportion of people living with hepatitis B who have not been diagnosed = 60.82%
• Proportion of people living with hepatitis B being treated for hepatitis B = 7.58%
• Number of deaths attributed to hepatitis B = 391
• Number of deaths due to hepatitis B related liver cancer = 307
• Number of deaths attributed to hepatitis B related decompensated cirrhosis = 84

Additional estimates included a state and territory breakdown in which NSW lead in the numbers of people living with hepatitis B, but with a higher proportion of people with hepatitis B diagnosed, and accessing treatment for their infection. This contrasted with estimates from WA which had the lowest diagnosis and treatment rates.

Identifying the “magic number” of hepatitis B treatment in Australia sought to identify the aims to ascertain the natural history and hepatitis B phases of Australians living with the infection and to use mathematical modelling to estimate the proportion who require antiviral treatment. This recognises that understanding chronic hepatitis B phase distribution in Australia is essential to inform decisions about who needs treatment at individual and population target levels. Modelled estimates show that 27% of people living with chronic hepatitis B are eligible for treatment, under the current guidelines with treatment eligibility differing according to population groups (age, region).

MORBIDITY AND MORTALITY ASSOCIATED WITH VIRAL HEPATITIS IN VICTORIA
Chelsea Brown, Epidemiologist, Peter Doherty Institute for Immunity and Infection

Data were presented by Chelsea Brown that identified the morbidity and mortality associated with viral hepatitis in Victoria, and found that of 123,805 notifications, most were for hepatitis C (61.1%) with 45,103 (36.4%) notifications of hepatitis B, with a further 3,110 (2.5%) individuals coinfected with hepatitis B and hepatitis C. There were 1,558 (1.3%) individuals with a notification linked to a liver cancer diagnosis, almost two-thirds (63%) of whom were infected with hepatitis C, one-third with hepatitis B (33%) and 4% coinfected. There were 15,601 (12.6%) people with a viral hepatitis notification linked to a death, predominantly those infected with hepatitis C (79.3%). Of the 16,007 individuals diagnosed with liver cancer and/or deceased, 3,026 (19%) had a late diagnosis of viral hepatitis.

CULTURAL AND LINGUISTIC DIVERSITY OF PEOPLE LIVING WITH CHRONIC HEPATITIS B, 2011-2016: CHANGING MIGRATION, SHIFTING EPIDEMIOLOGY
Jennifer MacLachlan, Epidemiologist, The Doherty Institute

Jennifer MacLachlan from the Doherty Institute reported on the changing epidemiology of hepatitis B, with a focus on people from culturally and linguistically diverse backgrounds. The presentation noted that the total number of people living with hepatitis B in Australia had increased by 20% between 2011 and 2016, outpacing overall population growth. While there was an increase in the Aboriginal and Torres Strait Islander population living with hepatitis B, the most common country of birth continued to be China, which experienced a 60% increase in the number of people living with hepatitis B, with other source countries reporting disproportionate increases included Taiwan, Myanmar, and Afghanistan. Decreases occurred in those born in countries in the European region primarily as a result of the ageing population.
HEPATITIS B AND IMMIGRATION IN AUSTRALIA
Zindia Nanver, Project Officer, ASHM

The intersection between the communities experiencing a greater prevalence of hepatitis B and the immigration process was the focus of a presentation from Zindia Nanver from ASHM. This presentation highlighted the development of a simple resource for clinicians who play a key role for patients with hepatitis B applying for permanent residency. The resource provides guidance on what information should be provided in a medical report to the Medical Officer of the Commonwealth and noted that the provision of a supportive medical report can assist in favourable outcomes for patients.

TAKING HEPATITIS C CARE TO THE COMMUNITY AND BEYOND

As acknowledged in the Community and Social Research stream, while the Australian Government commitment in funding DAAs is fundamental to elimination, this intervention will only succeed with the development and implementation of novel projects to improve health service access by people who inject drugs.

The Proffered Papers - Taking Hepatitis C Care to the Community and Beyond presentations highlighted a variety of interventions, including:

- The development of a partnership between liver clinics, peer educators and a large opioid substitution therapy (OST) clinic in the inner-west of Sydney
- Hepatitis C point of care testing through needle and syringe programs in Melbourne, which was identified as being feasible and acceptable, although it was noted that while the testing helped link people who inject into the hepatitis C care cascade, currently available testing is too slow to provide reliable same-day diagnosis
- The use of hepatitis C point of care testing in three needle and syringe programs and where of 204 people tested, 63.5% were diagnosed, with a peer-based and led service increasing access to meaningful engagement with health care
- Providing hepatitis C treatment in prison setting, with the successful elimination of hepatitis C in three NSW correctional centres, although this success will be challenged by the lack of effective implementation of harm reduction interventions within these settings
- The screening of people presenting to an inner-city Emergency Department in Melbourne, with 13% of patients screened over three-month period were reactive to point of care testing, while linkage to care was challenging with a need for new clinical pathways.
- Improving access to testing and treatment of clients of a homeless service in Sydney which over an 8 day non-concurrent period, diagnosed 47 people with 19 initiating treatment and 13 being cured.

PEOPLE LIVING WITHIN CORRECTIONAL SETTINGS

Another priority population, people living within correctional settings were the focus of a specific symposium, with several presentations highlighting the challenges of ensuring that this vulnerable group are not left behind in the elimination of viral hepatitis. The symposium sought to focus on the hepatitis C transmission and care delivery challenges, including facilitators and barriers to treatment uptake within the prison setting, novel hepatitis C models of care, and hepatitis C transmission and risk behaviours. Some of the issues highlighted for this population included that:

- People in prison at risk of hepatitis C infection see that there are specific benefits for prison-based hepatitis C treatment, and that while Correctional and Justice Health personnel can be supportive of prisoner access to HCV treatment, staff knowledge and support are paramount for supporting treatment scale up initiatives.
• Continued need for improved hepatitis C prevention interventions within correctional settings, as a result of an increase in high risk injecting for people entering prison settings.
• The challenges in implementing a nurse led model of care within prison settings included the large numbers of prisoners incarcerated who are on remand with little knowledge of how long this incarceration will last.
• That while treatment is available within correctional settings, the lack of effective harm reduction and reduction of exposure to blood, means that “reinfection was considered an almost inevitable outcome of injecting drug use while incarcerated”.

Australasian Viral Hepatitis Elimination Conference 2019

Novotel Sydney Brighton Beach
Brighton-Le-Sands, NSW, Australia

Monday 5 - Tuesday 6 August 2019

Please mark the dates for the Australasian Viral Hepatitis Elimination Conference 2019 in your diary and share this information with colleagues.

Abstract Deadline: 7 April 2019
Early Bird Registration: 26 May 2019
Accommodation: 31 June 2019
Standard Registration: 21 July 2019

AVHEC Conference Secretariat
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With the availability of effective vaccines and treatments for hepatitis B and a cure for hepatitis C, the elimination of viral hepatitis is achievable. With close to half a million Australians living with chronic hepatitis B and C, it is vital for primary care providers to know the risk factors, test and diagnose people living with hepatitis, to enable management and treatment to start early enough to halt serious liver damage.

ASHM encourages all clinicians with the skills and experience to manage and to initiate treatment across the range of primary care settings: general practice, community pharmacy, Aboriginal Medical Services, Drug and Alcohol Services, Sexual Health Services, youth, migrant, women’s or men’s health services, mental health services and corrections/juvenile justice services. Visit the ASHM website for more information about our training courses and resources – www.ashm.org.au

Locate ASHM training in hepatitis B and C near you or education events scheduled as an online webinar. Ask us about our Hepatitis C in Primary Care and Drug and Alcohol Settings program and Viral Hepatitis Mentoring program. Both programs support increased screening, linkage-to-care and broad treatment access for all patients. Visit www.ashm.org.au/training/

Become a HBV s100 Prescriber: Our hepatitis B prescriber program enables General Practitioners to prescribe Highly Specialised Drugs for the treatment of chronic hepatitis B www.ashm.org.au/HBV/prescriber-programs/


These estimates can be used to assess the progress Australia has made towards the National Hepatitis B Strategy 2014-2017 targets, as well as the WHO Global Health Sector Strategy on Viral Hepatitis 2016-2021. [www.ashm.org.au/HBV/hepatitis-b-mapping-project/](http://www.ashm.org.au/HBV/hepatitis-b-mapping-project/)


Locate an Hepatitis B Prescriber via our online map facility – allowing you to filter listings by Australian states and territories and also by languages spoken by the General Practitioner.


The Fourth National Hepatitis B Mapping Project Report contains updated estimates for 2016 on the prevalence, diagnosis, monitoring and treatment of hepatitis B at the SA3, Primary Health Network and State/Territory level. These estimates can be used to assess the progress Australia has made towards the National Hepatitis B Strategy 2014-2017 targets, as well as the WHO Global Health Sector Strategy on Viral Hepatitis 2016-2021.

www.ashm.org.au/HBV/hepatitis-b-mapping-project/

Access a range of hepatitis B and C resources for clinicians and patients. Visit:

www.ashm.org.au/resources/

Pictured: Australian recommendations for the management of hepatitis C virus infection: a consensus statement.

www.hepcguidelines.org.au/

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A thank you is extended to all our sponsors for their generous support.

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