



viral GOLD COAST 2016 HEPATITIS 10TH AUSTRALASIAN CONFERENCE

29 SEPTEMBER – 1 OCTOBER 2016

GOLD COAST CONVENTION & EXHIBITION CENTRE, QUEENSLAND

Conference Report

@ashmmedia



#VH16





“Data without storytelling is uninterpretable, storytelling without data is unactionable.”

Dr Krispin Hajkowicz
Conference Convenor

10TH AUSTRALASIAN VIRAL HEPATITIS CONFERENCE 2016 REPORT

“There are moments in time, and this is one of them. Very rarely do we ever get an opportunity to cure a chronic disease. Very rarely do we get to be involved in the elimination of a disease which is causing death to millions globally. Don't miss it, get on board.”

Professor Margaret Hellard, Burnet Institute

The [10th Australasian Viral Hepatitis Conference](#) marks a moment in history. Just a few months earlier, Australia became the first country in the world to offer unrestricted, subsidised access to revolutionary Direct Acting Antiviral drugs for hepatitis C. At the time of the conference, around 100 Australians were being cured of hepatitis C every day.

The Conference - held from Thursday 29 September to Saturday 1 October on the Gold Coast, Queensland - provided a forum to share lessons learned and identify challenges ahead.

The 444 attendees from the fields of health, community, policy and advocacy experienced unparalleled networking and training opportunities, fostering the collaboration and evidence-based policy development that is the hallmark of Australia's success. They came from across Australia, New Zealand, Europe, Asia, the Americas and beyond, bringing their own experiences and research to share.

This report provides a snapshot of highlights, with links to [speaker presentations](#), [abstracts](#), [audio recordings](#) and [video](#).

“Conferences like this are a manifestation of the collaboration that has resulted in Australia's ground breaking progress towards eliminating hepatitis C.”

Melanie Eagle, CEO, Hepatitis Victoria

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"Spaces for collaboration are so very important. The mix of community and specialists, health professionals and advocates that I have seen here at the Australasian Viral Hepatitis Conference is truly exceptional. I will leave here inspired, and determined to take home and implement some of the revolutionary approaches shared here."

Zoe Dodd, Keynote Speaker, Toronto Community Hep C Program, Canada

Don't miss out on the 2017 Australasian Viral Hepatitis Elimination Conference.
Find out more at www.avhec.com.au or follow @ASHMmedia on twitter.



Thursday 10 - Friday 11 August 2017 • Pullman Cairns International • www.avhec.com.au

Take Home Messages

“We have been given the enormous good fortune of having access to these new hepatitis C medications. We are the only country in the world offering them to everyone without restriction. We must use them well, and we must use them wisely.”

Professor Margaret Hellard, Burnet Institute

Media Release: 100 Hundred Australians Cured Of Hepatitis C Every Day

[Calls for increased health worker education and outreach to meet viral hepatitis elimination goals](#)

Australia is making great progress towards eliminating hepatitis C, with record numbers now being cured of the disease. The challenge now is how to effectively engage diverse populations in both prevention and treatment programs, and to overcome barriers in the health system preventing many people living with both hepatitis C and hepatitis B from coming forward for testing and treatment. [Read the 2016 Australasian Viral Hepatitis Conference media release.](#)

SNAPSHOT: KEY MESSAGES FROM VH16

- We need a diversity of models of care to reach diverse populations. One size does NOT fit all.
- Stigma is killing people. Stigma and discrimination by the health work force is one of the most profound barriers to care for people with viral hepatitis.
- Engaging marginalised and “difficult-to-engage” populations is key.

HCV

- The explosive uptake of HCV treatment will not be maintained.
- Expect to see reinfections. Make sure those who are reinfected aren’t stigmatised.
- Be prepared for viral resistance.
- HCV antibody testing is high in Australia, but there still exists a large undiagnosed HCV RNA pool and people are not linked to care.
- Enhanced screening is required in addition to new diagnostic tools such as Point of Care tests. Successful components of interventions/models to enhance HCV testing/care need to be disseminated, shared and translated.
- The future of upscaling lies in the community.
- Challenges: Cost of drugs, war on drugs, remote and rural communities, mental health, co morbidities, poverty.



MJA OPED LEVINIA CROOKS

Health workforce discrimination undermines hepatitis C success

Australia is currently enjoying international acclaim for its revolutionary response to hepatitis C. Yet despite this success, stigma and discrimination by the health workforce threaten to prevent us from optimising these achievements. [Read the Oped by ASHM CEO Levinia Crooks.](#)

The Data: Surveillance Reports 2016

VH 2016 delegates were the first to receive the latest national viral hepatitis statistics for Australia with the launch of The Kirby Institute's [Hepatitis B and C in Australia Annual Surveillance Report Supplement](#) and the UNSW Centre for Social Research in Health's [Annual Report of Trends in Behaviour Supplement 2016 on Viral Hepatitis](#).

KIRBY SURVEILLANCE REPORT – FINDINGS FROM 2015

- **232 600** with **HBV** yet only **62%** of those **diagnosed** and only **6%** had received **treatment**.
- **227 306** with **HCV**, with **82% diagnosed** and **22%** having received anti-viral **treatment**.
- **HCV** rates in Aboriginal and Torres Strait Islander population are **4 times** greater than non-Indigenous population and have **increased by 43%** in the five past years. **HBV** rates were **3 times** higher.
- The number of people with liver **cirrhosis** has **doubled** in a decade.

HCV

- Close to **30 000 people were cured** of HCV in the first 3 months after subsidised DAAs were introduced in March 2016 – approximately **100 per day**. Uptake has been particularly high in people with advanced liver disease.
- However, the vast majority of people with HCV remain at increased risk of serious liver disease without treatment.

Priorities for HCV

- Increased diagnosis
- Expanded treatment coverage
- Prevention strategy scale up e.g. NSP that also reaches Aboriginal and Torres Strait Islander populations

Priorities for HBV



- Scale up of diagnosis and treatment
- Enhanced culturally specific strategies
- Priority populations: People from Asia and the Pacific, Aboriginal and Torres Strait Islander peoples, MSM engaged in high risk sexual activity, PWID.


CSRH TRENDS IN BEHAVIOUR REPORT

- A mistrust of the health system and ongoing stigma from health workers against injecting drug users are two significant barriers to HCV treatment.
- Only 35% of gay and bisexual men are aware of the existence of an HCV cure.
- HIV status influenced their knowledge and attitudes.
- Suggests HCV education + prevention for gay men should be tailored according to HIV status
- HBV management in primary care would be improved through greater community-based outreach programs and education programs for health professionals.

IN THE NEWS

Read [Systemic barriers, stigma and discrimination preventing people living with viral hepatitis or HIV accessing care](#) in the [onthewards.org](#) blog.





SYSTEMIC BARRIERS, STIGMA AND DISCRIMINATION PREVENTING PEOPLE LIVING WITH VIRAL HEPATITIS OR HIV ACCESSING CARE

Posted by Levinia Crooks | Nov 6, 2016 | ontheblogs, patient centred care | 0 Comments

Author: Levinia Crooks

Editor: Petrana Lorenz, Duncan Campbell

Australia enjoys international acclaim for its revolutionary response to HIV, and most recently, hepatitis C. And rightly so. Not only are we the only country in the world to offer universal access to new, highly effective hepatitis C cures, but our willingness to embrace the latest research – and build evidence-based responses founded on multisector collaboration – are the envy of the world.

Yet despite these successes, stigma and discrimination by the health workforce threaten to prevent us from optimising these achievements.

It is the responsibility of all health professions, including junior doctors, to educate themselves and take the time to understand the needs of these diverse and often vulnerable populations.

In Focus – HCV Better Services

PRESCRIBING IN PRIMARY CARE

“All clinicians with the skills and experience to manage HCV should be able to initiate treatment”

Read [ASHM’s Position Statement of Hepatitis C Prescribing](#).



Key points re Primary Care

- Clinicians should be able to initiate treatment across the range of primary care settings: Aboriginal Medical Services, Drug and Alcohol Services, Sexual Health Services, youth, migrant, women's or men's health services, mental health services or corrections/juvenile justice services.
- Patients without advanced or complicated disease can be managed in primary care.
- All GPs need ongoing education in order to diagnose and treat or refer.
- Additional training and support is required for experienced and trained GPs to prescribe independently.
- There is significant scope for nurse-led care.
- Main barriers include education and access to FibroSCAN. A Victorian study by the Burnet Institute and Monash University found most GPs were interested in prescribing DAAs but half were unsure if active IDU were eligible for treatment and only 10% had access to FibroSCAN. Read the [abstract](#) or [view the slides](#) from Dr Amanda Wade's presentation.
- **Related study:** Curing Hepatitis C in General Practice: The First 60 Days - [Read the abstract](#) or [view the slides](#) by Dr David Baker.
- **Note:** both presentations are available for viewing as video on [Conference Connect TV](#).

Training was run from the conference for primary care medical practitioners to prescribe new DAA treatments. For more information about courses and resources visit www.ashm.org.au.


FRIDAY 30 SEPTEMBER

Viral Hepatitis Mentoring Program

MORNING TEA | 11:00 am - 11:30 am

Interested in supporting/being supported in your work with patients with hepatitis B and C? ASHM's Viral Hepatitis Mentoring Program brokers professional 1-to-1 relationships in which an experienced viral hepatitis clinician and a GP working with patients with viral hepatitis share knowledge, answer questions and offer clinical advice and support. This program was officially launched in a NSW information evening on 1 June 2016 in Sydney with 20 participants joining the initial round. ASHM will continue to roll-out the launch of this program in Western Australia, South Australia, Victoria, and Queensland in 2016-17. Come find out about this program that aims to strengthen the partnership and collaboration between tertiary and primary care.

For further info visit: <http://viralhepatitismentoring.ashm.org.au>



Treating HCV in General Practice – Q+A session with Dr. David Baker


LUNCH | 12:30 pm - 1:30 pm

Are you working in primary health and treating patients with new HCV direct acting antiviral medication? In this intimate 15-minute Q&A session, Dr. David Baker (General Practitioner at East Sydney Doctors; and ASHM clinical advisor) will field your questions and share patient case experiences. Be updated with a range of ASHM HCV resources which are available to support you in your practice.


Note that Dr. David Baker is also presenting an abstract Curing Hepatitis C in General Practice: The First 60 Days as part of the concurrent symposia – Hepatitis C Antiviral Therapy: Reaching out in the new Era on Saturday 31 September (11:30 am-1:00 pm in Room 5).

Further links: HCV Management + Treatment
<http://www.ashm.org.au/HCV/management-hepc>

Download the Primary Care Providers and Hepatitis C booklet:
<http://www.ashm.org.au/resources/Pages/978-1-920773-42-7.aspx>



29 September - 1 October 2016
Gold Coast Convention Centre, Queensland

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ENHANCING DIAGNOSIS AND LINKAGE TO CARE

No one left behind

How do we reach and link to care the estimated 63 000 undiagnosed Australians with HCV?

“We have to understand that people requiring treatments are not going to come to the tertiary hospitals, they're not going to come to us. We need to think about how we provide treatment and care in the places that are acceptable and accessible to those who are at most risk, to the people who are most affected.”

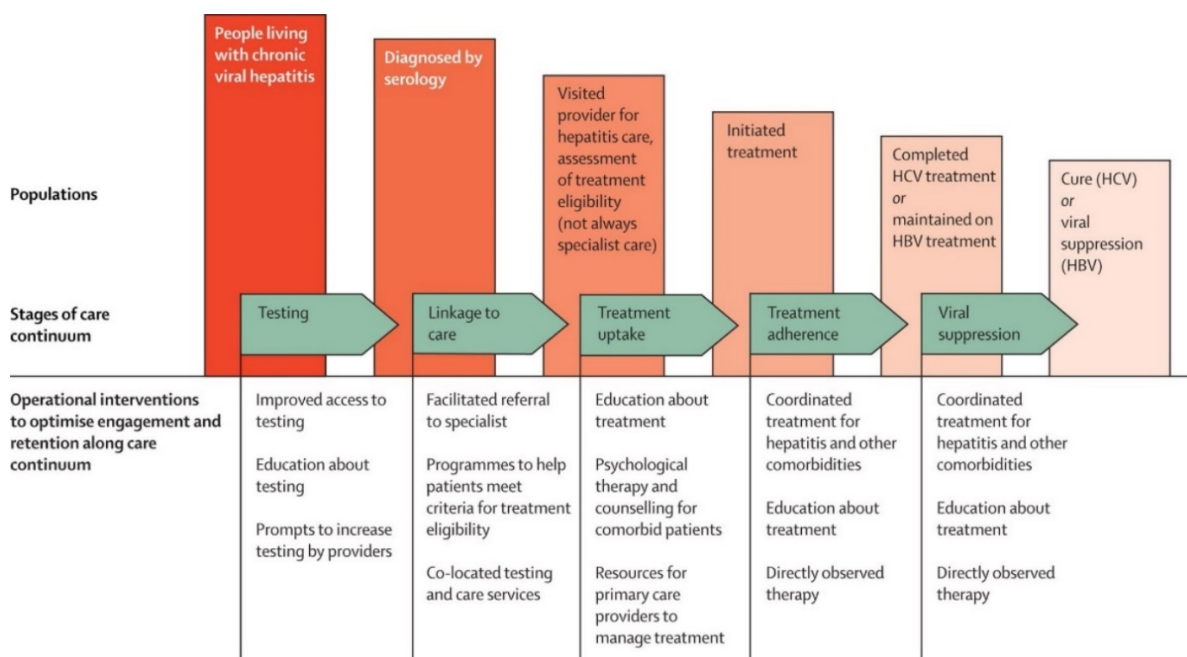
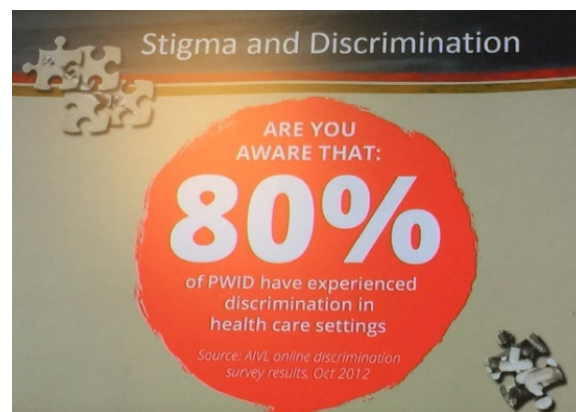


Image: Key review of HBV and HCV interventions to enhance testing, care linkage and treatment.

PRIORITY POPULATION: PWID

From the *Hepatitis B and C in Australia Annual Surveillance Report Supplement*

- 57% of PWID attending NSP have HCV
- Among PWID w prior exposure to HCV, 12% reported ever receiving HCV treatment and 2% had received treatment in the last 12 months.
- 16% of PWID reported sharing needles and syringes in the last year.
- The majority of new infections are attributed to injecting drug use.



Key findings

- Discrimination from health workers lessens the likelihood of PWID engaging in future treatment.
- Many PWID have received highly stigmatised care and remain alienated from health services.
- Peer support plays a valuable role in HCV treatment access in OST settings.
- Peer services should be offered to all PWID with HCV.
- People with the “lived experience” should be involved in development of care.

Case Study: Lessons from a community-based, client-driven program in Canada – Keynote Speaker Zoe Dodd

- Future of HCV treatment lies in primary care
- Multiple services in one place worked extremely well for this project, with community garden, NSP, HCV treatment, health centre all located together.
- Word of mouth important promotion tool - accounted for 1/3 of new clients.
- PWID are not homogenous: different people have different needs and different levels of support are required.
- Stigma is alienating PWID from health facilities and excluding them from care.
- It's not just about HCV, or drugs. There are bigger things at play that need to be understood e.g. poverty, exclusion.
- **Watch the video** of Zoe Dodd's presentation on [Conference Connect TV](#).

Case Study: Recruitment and Follow-up of PWID into a Nurse-Led HCV Treatment Trial

A flexible, nurse-led model of care may help overcome some of the barriers associated with engaging PWID in care and treatment. Since HCV transmission is driven by PWID who are frequently not engaged in care, nurse-led care may be important in eliminating HCV transmission.

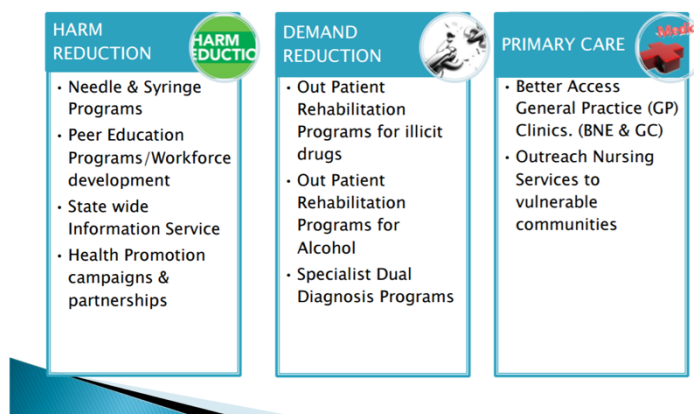
Read the [abstract](#) or view the [slides](#) of this study presented by Dr Joseph Doyle, Co-Head, Hepatitis Research, Burnet Institute, Australia.

Case Study: Quinh Treatment Management Program

- In 2014, QuIHN set up a Treatment Management Program which includes the Treatment in Injecting Drug Environment (TIDE) Project.
- Two-way communication system developed with tertiary settings for the most appropriate, timely treatment access for clients, a suite of screening and assessment procedures for community based prescribing, and an opportunity to increase testing and treatment options for clients who may not access current treatment facilities.

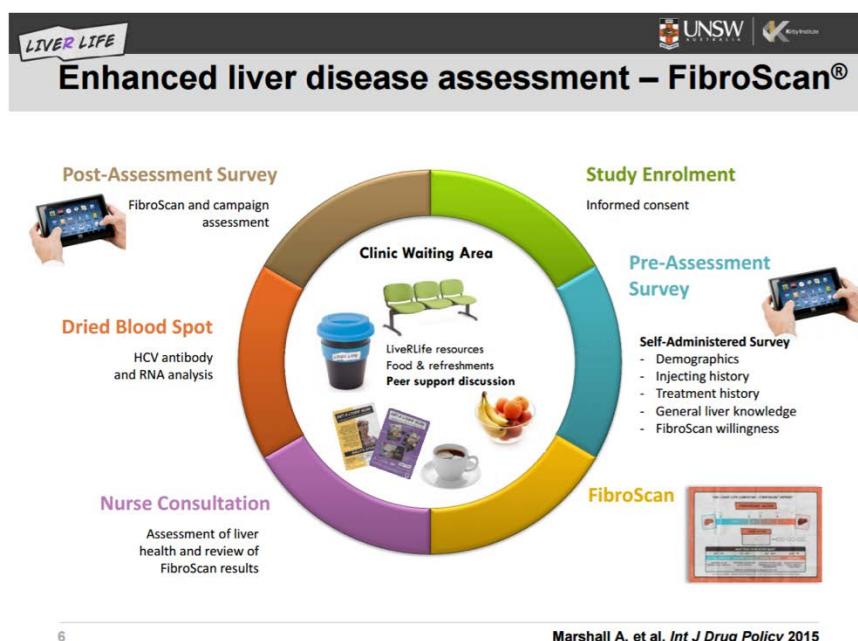
- Key learnings: need for flexibility, creativity, collaboration and spontaneity, whilst supporting the client through treatment as the centre focus of the project.
- **Read the [abstract](#) and view the [slides](#)** presented by Nik Alexander, Senior Program Manager - Harm Reduction Services, Queensland Injectors Health Network (QulHN).
- **Watch the video** of Zoe Dodd's presentation on [Conference Connect TV](#).

QulHN Services: At A Glance



Case Study: The LiveRLife Campaign - Associate Professor Jason Grebely, The Kirby Institute

Liver disease burden among people who inject drugs (PWID) is high, yet few strategies to enhance liver disease screening have been evaluated. The aim of this study was to assess factors associated with severe fibrosis/cirrhosis and follow-up among PWID participating in a liver health promotion campaign.



Conclusions

- Demonstrated considerable liver disease burden in this population
- A high proportion attended post-LiveRLife clinical follow-up
- Provided an opportunity to address other health issues (e.g. HAV/HBV vaccinations)
- Developed key partnerships between services, clinical providers, and researchers
- Demonstrated the feasibility of interventions to enhance health outcomes among people in drug and alcohol settings.
- **View the [slides](#).**
- **Watch Jason Grebely's presentation** on [Conference Connect TV](#).

PRIORITY POPULATION: ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Presentation: HCV Prevalence among Aboriginal and Torres Strait Islander Australians: A Meta Analysis - Dr Mary Ellen Harrod, Chief Executive Officer, NSW Users and AIDS Association

- HCV rates in Aboriginal and Torres Strait Islander population are **4 times** greater than non-Indigenous population and have **increased by 43%** in the five past years.
- **70%** of Aboriginal and Torres Strait Islander PWID in an NSP program had HCV.
- Despite higher notifications, only **four of the eight jurisdictions** of Australia are included in anti-HCV reporting.
- Highest anti-HCV prevalence is in Aboriginal people who inject drugs followed by Aboriginal people in prison.

Presentation: Experiences of Diagnosis, Care and Treatment among Aboriginal people with HCV - Loren Brener, Senior Research Fellow, Centre for Social Research in Health

- This CSRH study of 203 Aboriginal people living with HCV confirmed the importance of providing a HCV diagnosis in a culturally appropriate way.
- [View the presentation slides and listen to the audio recording.](#)

Case Study: Deadly Liver Mob - Kerri-Anne Smith, Aboriginal Hepatitis C Health Promotion Officer

Deadly Liver Mob Project (DLMP) operates out of the Needle and Syringe Program (NSP) in partnership with the co-located Sexual Health Clinic Mt Druitt Community Health Centre, New South Wales. It is dedicated to improving Aboriginal and Torres Strait Islander peoples access into hepatitis C treatment and aims to create a more meaningful encounter with clients accessing the NSP as well as their family, community and injecting network.

- Storytelling approach used.
- Aboriginal staff front and centre.
- Further incentive offered to encourage participants to go into Sexual Health Clinic for hepatitis testing, hep B vaccinations and /or sexual health screening.
- NSP and sexual health services co located. DAAs could be rolled in to this.
- Note: Different priorities across SH, NSP and community leadership need to be acknowledged. e.g. you might not want to screen a 91 yr old for STIs, but engaging him/her could be vital to engaging the community.
- **Find out more** on [HealthInfoNet](#) or **watch the presentation** on [Conference Connect TV](#).

PRIORITY POPULATIONS: REMOTE/RURAL

Presentation: Community Assessment of Fibrosis in Primary Care and Rural Settings

- Annie Balcomb, General Practitioner, Prince St Medical Practice

Challenges of rural care setting include:

- Limited Fibroscan and imaging access
- Travel distances and poor public transport
- Specialist and investigation costs - few public gastroenterology clinics
- Lack of gastroenterologists and long waiting lists >6 mths
- Stigma living with HCV
- Shortage/high turnover of GP's in some settings

Rural advantages include:

- Specialists known and readily available for advice
- Clients well known and trust GP's
- Outreach Fibroscan clinics
- Used to dealing with complex chronic conditions
- Keen to upskill and take on challenges
- [View the presentation](#), which provides guidance on diagnosing advanced liver disease/cirrhosis.

PRIORITY POPULATION: PRISONS

- Prisoners have been identified in the [Third National Hepatitis C Strategy 2010–2013](#) as a priority population for assessment and treatment.
- Around 30,000 individuals are in Australian prisons at any one time with around one fifth testing positive for hepatitis C antibodies.
- Incidence is associated with older age, injecting methamphetamine and injecting heroin, with no protective effect of OST.
- Despite this high prevalence, treatment coverage is low.
- Australian prisons are the responsibility of individual state and territory governments and key evidence-based strategies remain controversial to some.
- There is no formal NSP yet modelling suggests this would have the greatest impact on HCV.
- In 2015, a Parliamentary Inquiry into Hepatitis C in Australia highlighted the need to establish a framework for a national approach to BBVs in prisons.
- Conclusion: [Australia's response to BBVs in prisons has been slow, disjointed and in most cases does not address BBVs through effective strategies.](#)
- [View the slides and audio recording from Kevin Marriott's presentation.](#)
- [SToP-C](#) - is the first treatment-as-prevention study for HCV worldwide and will establish this intervention in public health policy internationally.

Priorities

- Improved harm reduction strategies
- Evaluation of interferon-free HCV treatment as prevention strategies in prisons

Related Studies

[Stable Incidence of Hepatitis C Virus Infection among People with a History of Injecting Drug Use in an Australian Prison Setting, 2005-2014: The HITS-P Study - by Evan Cunningham, PhD Candidate, Kirby Institute](#)

- Syringe sharing was associated with HCV infection among continually imprisoned participants, irrespective of frequency of injecting or the type of drug injected.
- Each individual injecting event carries with it a higher chance of HCV infection due to the scarcity of clean injecting equipment.
- Even people with a lower frequency of injecting drug use in the prison environment have a high risk of infection.
- **View the [slides](#).**
- **Watch on [Conference Connect TV](#).**

The Prison Economy of Needles and Syringes: What Opportunities Exist for BBV Risk Reduction When Prices are so High? - Carla Treloar, Professor, Centre for Social Research in Health, UNSW

- [View the presentation slides and listen to the audio recording.](#)
- **Watch on** [Conference Connect TV.](#)

Hepatitis C Virus Exposure, Infection and Associated Risk Behaviours in Two Maximum-Security Prisons in New South Wales, Australia - Behzad Hajari, Associate Lecturer, UNSW

Among prisoners at risk of HCV, those with previous HCV exposure and clearance were more likely to report high risk injecting than those with no previous exposure, suggesting the risk for re-infection and the need for increased prevention activities. (SToP-C Study)

- Watch on [Conference Connect TV.](#)

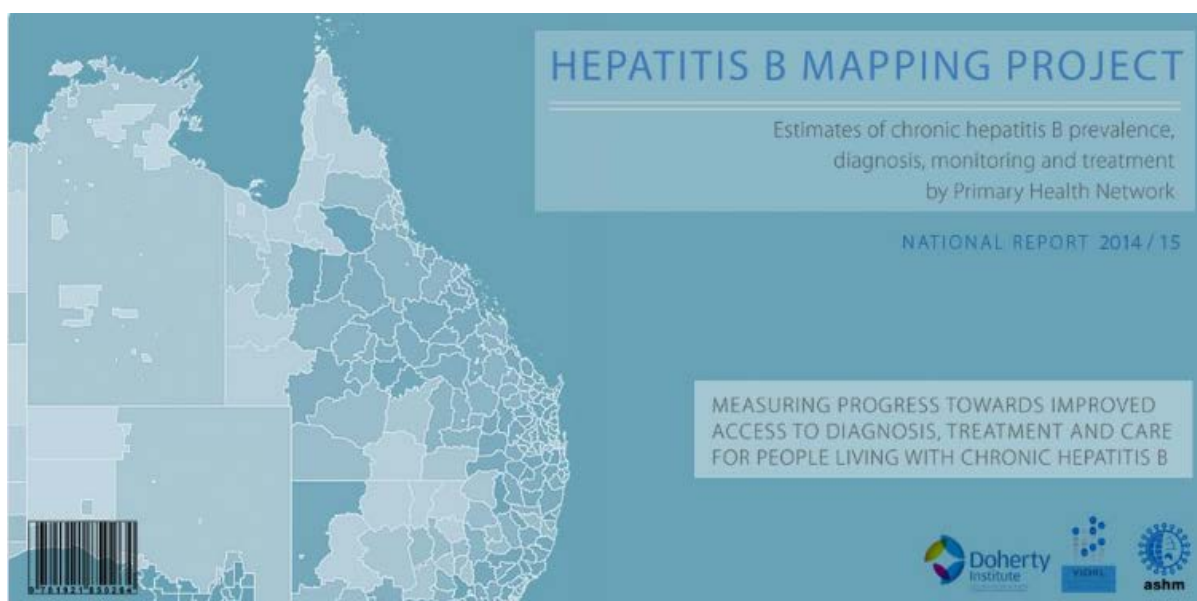
In Focus – HBV

- **232 600** with **HBV** in Australia in 2015
- 38% were born in Asia Pacific / 9.3% were Aboriginal and Torres Strait Islander people
- Rates in Indigenous Australians are **3 times higher** than non-Indigenous Australians.
- **38%** of people with HBV remain **undiagnosed**.
- **15%** would benefit from treatment but only **6%** have received it.
- An estimated 21, 239 people are currently not receiving the treatment they need.
- Rates of notification have declined thanks to infant and adolescent vaccination programs.
- There is limited information on uptake of testing.
- In the Northern Territory, HBV prevalence is 3.4%.

In NSW

- 77 000 people with HBV but only half are diagnosed.
- Approximately 60% were born overseas.

LAUNCH OF 3RD HEPATITIS B MAPPING PROJECT



What's new?

- Updated estimates of prevalence, diagnosis, treatment and monitoring for 2015.
- Data reported for each newly generated Primary Health Network.
- Information of treatment provider type and drug prescribing patterns.
- Measurement of trends over time according to Primary Health Network.

Key findings

- Treatment uptake increased 16% nationally in 2013-2014, most significantly in NSW.
- No PHNs reached the target of 15% treatment uptake.
- 15% engaged in care.
- **View** the [presentation slides](#) by Benjamin Cowie or to download, see previous reports and additional information **visit** the [ASHM website](#).
- **View/hear Benjamin Cowie's presentation** [Hepatitis B vaccination in the era of elimination](#).
- **Watch the launch of the Third National Hepatitis B Mapping Report** on [Conference Connect TV](#).

CASCADE OF CARE

Barriers to testing and treatment:

- Poor awareness in both health workers and patients.
- GP education essential.
- Perception (unproven) that there's too much testing for HBV going on.
- Translating a brochure into a language someone speaks isn't sufficient.
- People's primary source of HBV information is their GP. If the GP doesn't promote testing or initiate a conversation then person likely to fall through the gap.

Presentation: The Cascade of Care for Chronic Hepatitis B in Australia, 2013-2014

- Jennifer MacLachlan, WHO Collaborating Centre for Viral Hepatitis, the Doherty Institute

- The largest gap in the cascade of care is between diagnosis and engagement in ongoing care
Treatment uptake is increasing more rapidly than other indicators
- Large gap between current levels and National Strategy targets
- Further work
 - Improving data sources and estimates
 - Linkage of data to identify individual trajectories of care, validate assumptions
 - Continuing to measure progress, impact of initiatives and policy changes
- **View** the [presentation slides](#)
- **Watch** on [Conference Connect TV](#)

Presentation: Interventions to enhance the hepatitis B cascade of care - Jennifer MacLachlan, WHO Collaborating Centre for Viral Hepatitis, the Doherty Institute

- Major gaps in cascade are in diagnosis and engagement in care.
- Further information needed on those lost to engagement in care, successful interventions.
- Key aspects include prior assessment of needs, systematic processes, tailoring to affected communities.
- **Watch on Conference Connect TV**

Presentation: HBV Treatment: Past, Present, Future - Scott Bowden, Senior Medical Scientist, Victorian Infectious Diseases Reference Laboratory

- **View** the [presentations slides](#).

IN THE COMMUNITY

Case Study: Two hepatitis B outreach testing models - Marina Suarez Multicultural HIV and Hepatitis Service MHAHS

- Indonesian community targeted through community planning project.
- Chinese community targeted through private English-language college.
- Both models equally successful.
- Conclusion: No one size fits all. Outreach models need to be adapted to community, settings and resources available.
- **View/hear** Marina Suarez' presentation [Engaging Diverse Communities in the Response to Hepatitis B: The Hepatitis B Community Alliance NSW](#)
- **Watch** on [Conference Connect TV](#)

Case study: Linh Nguyen

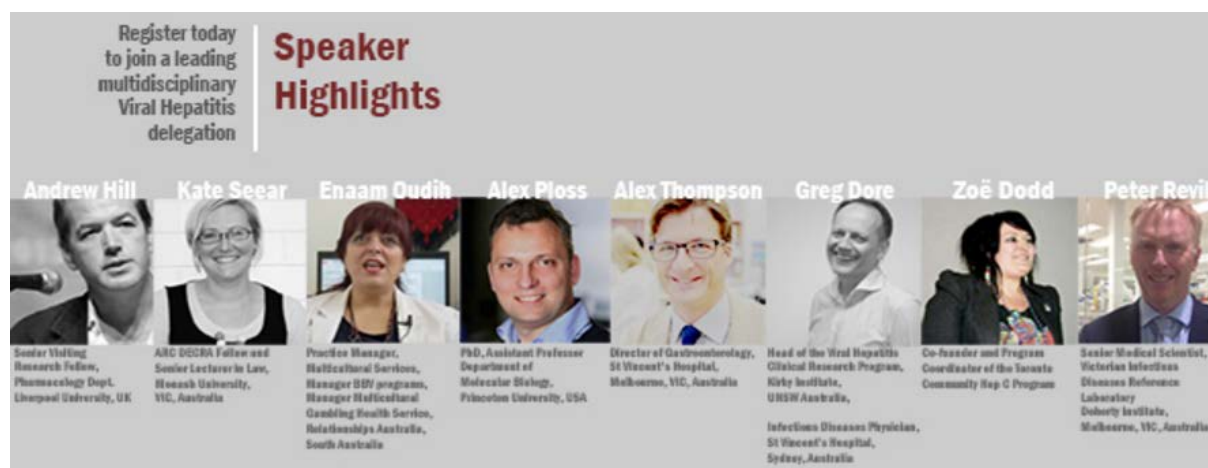
Personal story of Linh, a Vietnamese mother of 2, one of whom is living with Hepatitis B

- Adult diagnosis of HBV in Australia.
- Provided with very limited information that was inaccessible to her: technical language she couldn't comprehend and pamphlets she couldn't understand.
- Was offered no support at time.
- Profound stigma and discrimination from her own community.
- Enormous guilt at passing HBV to her child.
- Strong call for doctors to appreciate how overwhelming this can be for patients, the cultural and social elements involved, the fear they might have every time they come for an appointment, and how this may impact their ability to assimilate information.
- **Watch** on [Conference Connect TV](#)

Highlight – Keynote Speakers

Watch video recordings of our keynote speakers and other presentations from VH16:

[Conference Connect](#)



Dr Andrew Hill

Senior Visiting Research Fellow Pharmacology and Therapeutics, University of Liverpool, UK

Treating epidemics with low cost medications

If pharmaceutical companies refuse to lower prices, we need back-up mechanisms to ensure access:

- Compulsory licenses
- Buyers' Clubs

Kate Seear

ARC DECRA Fellow and Senior Lecturer in Law, Monash University, Victoria, Australia

Hepatitis transmission and prevention

Although they might not always view it as part of their job, lawyers have ethical and professional obligations to consider the potential for their work to shape, reinforce and entrench stigma, to produce harms and to shape BBV epidemics.

- View the [presentation slides](#).

Enaam Oudih

Manager, BBV programs, Practice Manager, Multicultural Services

Cross Cultural Community Engagement Matters

Work must be:

- Directed at individual and social environments
- Participatory and transformative

From individual to family/group to community back to individual

Alex Plos

PhD, Assistant Professor, Princeton University, USA

Deciphering Host Range Restrictions of Human Hepatitis Viruses

A focus on the construction of animal models suitable for studying human hepatitis virus infections at the organismal levels as well as for preclinical testing of novel intervention approaches.

Alex Thompson

Director of Gastroenterology, St Vincent's Hospital

Recommendations for the Management of Hepatitis C Virus Infection: Australian and International Guide

- View/listen to the [presentation slides](#).
-

Zoe Dodd

Co-founder and Program Coordinator, Toronto Community Hep C Program, Toronto, Canada

The Future of Hep C Care for People Who Use Drugs: Lessons from a Community-Based, Harm Reduction, Client-Driven Program in Toronto, Canada

- View the [presentation slides](#).
-

Greg Dore

Head, Kirby Institute, UNSW

The New HCV Treatment Era in Australia: Early Lessons

Peter Revill

Senior Medical Scientist, Victorian Infectious Diseases Reference Laboratory (VIDRL), Doherty Institute, Victoria, Australia

Global Strategies are Required to Cure and Eliminate HBV

Differences in the HBV and HCV lifecycles mean that curative approaches for HCV will not cure HBV infection. There are a number of major challenges that must be overcome before HBV cure can be realised.

- View/listen to the [presentation slides](#).
-

Highlight – Associated Events

BMS Breakfast Satellite Meeting

- HCV Elimination by 2026: Australia leads the world
- Dr Norman Swan led a panel of national experts in a Q&A style discussion to determine how Australia will lead the world in the elimination of HCV. Attended by 176 delegates.

Abbvie Breakfast Satellite Meeting

- Curing HCV - Leave No Patient Behind
- Whilst the new all-oral direct acting antivirals have revolutionised the treatment of hepatitis C in Australia, challenges exist with certain patient types and non-traditional treatment settings. The Symposium addressed these challenges through real world case studies. Attended by 143 delegates.



Curing Hepatitis C with new treatments course for GPs and other medical professionals.

This course covered the patient and prescriber eligibility for the new interferon-free treatment regimens listed on the PBS S85 (General Schedule) from 1 March 2016. Completion of this course assists primary care medical practitioners to confidently prescribe these new hepatitis C treatment regimens in consultation with a specialist.

ASHM Highlight:

- Viral Hepatitis 101 Workshop
- Workshop for non-clinical professionals working in the sector.

Introduction to the Nursing Care and Management of Patients with Advanced Liver Disease

- The AHA aims to educate registered nurses across primary and tertiary care about the specialised management of patients with cirrhosis of the liver.

Spotlight – Towards Elimination

NEW PARTNERSHIP AIMS TO ELIMINATE HEPATITIS C IN A DECADE

The quest to eliminate the burden of hepatitis C in Australia within a decade was boosted by a new, exciting collaborative project between Burnet Institute and The Kirby Institute, formally launched at the Australasian Viral Hepatitis Conference.

Known as the ‘Australian Hepatitis C Elimination Program’ the event was welcomed by delegates with t-shirts featuring a specially designed [Reg Mombassa](#) t-shirt. The event was accompanied by a [twitter campaign](#) that involved high profile individuals such as Tanya Plibersek, and a new video in the [Change Project hepatitis C series](#). Find out more about [‘Elimination is the goal’](#).



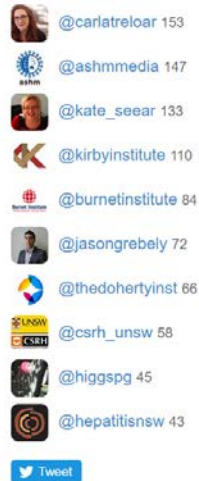
PROJECT OF THE BURNET AND KIRBY INSTITUTES



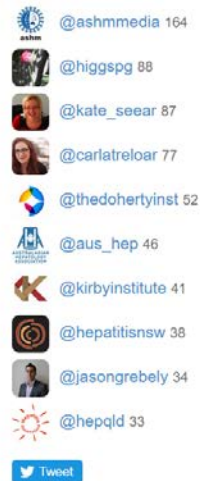
Spotlight – Engagement

The #VH16 Influencers

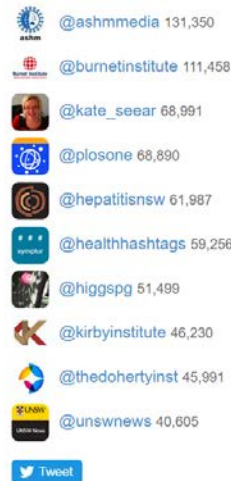
Top 10 by Mentions



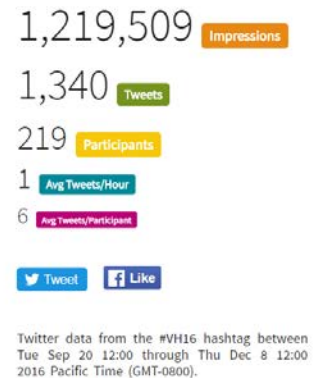
Top 10 by Tweets



Top 10 by Impressions



The Numbers



#VH16 Participants



Don't miss out on 2017!

Australasian Viral Hepatitis Elimination Conference 2017

10 – 11 August 2017, Pullman Cairns International, Cairns, Queensland

There is an urgent need to increase the number of clinicians able to treat hepatitis B and hepatitis C. Until March 2016, therapy uptake for HCV was slow, due to both hard to reach priority populations and the difficulty and length of the treatment itself. In hepatitis B, many people remain undiagnosed and confusion still exists around the idea of a 'healthy carrier', masking the need for monitoring and, in some cases, the prescription of effective therapy.

This is the first time that the Australasian Viral Hepatitis Elimination Conference will be held. It is to be held in the off-year of the Australasian Viral Hepatitis Conference to cater for the educational needs of those working in the viral hepatitis sector.

The Committee look forward to welcoming you to Cairns in 2017

Find out more at www.avhec.com.au or follow @ASHMmedia on twitter.

A banner for the Australasian Viral Hepatitis Elimination Conference 2017. The left side features a teal background with a white target symbol overlaid on a cluster of virus particles. The right side has a white background with the AVHEC logo in red and teal, followed by the text 'Australasian Viral Hepatitis Elimination Conference 2017'. A red bar at the bottom contains the dates, location, and website.

AVHEC
Australasian Viral Hepatitis
Elimination Conference 2017

Thursday 10 - Friday 11 August 2017 • Pullman Cairns International • www.avhec.com.au

With thanks

Conference organising committee

Tanya Applegate	The Australian Centre for HIV and Hepatitis Virology Research (ACH2)
Scott Bowden	Victorian Infectious Diseases Reference Laboratory/Doherty Institute
Ben Cowie	ASHM Viral Hepatitis & The Coalition for the Eradication of Viral Hepatitis in Asia Pacific (CEVHAP)
Krispin Hajkowicz	Australasian Society for Infectious Diseases (VH-SIG)
Greg Dore	The Kirby Institute
Jeffrey Wong	New Zealand Society of Gastroenterology
Kelly Barclay	Hepatitis Foundation of New Zealand
Angella Duvnjak	Australian Injecting & Illicit Drug Users League (AIVL)
Joanne Morgan	Australian Hepatology Association
Mark Stooze	Burnet Institute
Emma Day	ASHM NPED
Carla Treloar	Centre for Social Research in Health (CSRH)
Helen Tyrrell	Hepatitis Australia

Basic Science Committee

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Tanya Applegate	Australian Centre for HIV and Hepatitis Virology Research (ACH2) / Kirby Institute
Karla Helbig	Adelaide University
Heidi Drummer	The Burnet Institute
Mark Douglas	University of Sydney
Silvana Gaudieri	University of WA
Nick Eyre	Adelaide University
Nicole Robertson	ASHM Representative

Clinical Care Committee

Krispin Hajkowicz	ASID - Australasian Society for Infectious Diseases
Joanne Morgan	AHA
Greg Dore	Kirby Institute
Jeffrey Wong	New Zealand Society of Gastroenterology
Stephen Pianko	GESA/ALA
Paul Clark	Local QLD Gastroenterologist and ALA member
Olivia Cullen	Local QLD Gastroenterologist and ALA member
Graeme Macdonald	Qld Hepatologist and Liver Transplant Physician
Sonja Hill	ASHM NPED Representative

Community & Social Research Committee

Helen Tyrrell	Hepatitis Australia
Carla Treloar	Centre for Social Research in Health
Angella Duvnjak	Australian Injecting and Illicit Drug Users League
Kathryn Leafe	NZ Needle Exchange Program
Jack Wallace	Australian Research Centre in Sex, Health and Society
Elena Cama	Centre for Social Research in Health
Kristen Stone	Cancer Council NSW
Ursula Swan	Mental Health Commission WA & Hepatitis WA
Jodie Walton	Hepatitis Queensland
Suzanne Fraser	National Drug Research Institute
Nik Alexander	QUIHN, Queensland
Jenny Kelsall	Harm Reduction Victoria
Beni Falemaka	ASHM NPED representative

Epidemiology, Public Health & Prevention

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Lisa Maher	The Kirby Institute
Emma Day	ASHM – Viral Hepatitis Program
Kelly Barclay	Hepatitis Foundation of New Zealand
Mark Stooze	The Burnet Institute
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