EC Australia

Partnering to eliminate hepatitis C

Annual Report Year 4, 2022

September 2023

Name of Organisation	Burnet Institute
Program Title	Eliminate Hepatitis C Australia Partnership (EC Australia)
Program Summary	EC Australia's goal is to catalyse efforts to eliminate hepatitis C as a public health threat by 2030. The Australian public will benefit from the health system savings that will occur through a targeted and cohesive approach to hepatitis C testing and treatment and from the consequent reduction of hepatitis C incidence and prevalence. Bringing together researchers and implementation scientists, government, health services and community organisations, EC Australia is supporting services to increase hepatitis C testing and treatment among priority populations, including people who inject drugs, Aboriginal and Torres Strait Islanders and prisoners. The EC Australia Partnership uses a health-system strengthening approach, which is structured around five key components: 1. Health promotion and awareness raising; 2. Workforce development and health service delivery; 3. Implementation research; 4. Evaluation and surveillance, and 5. Aboriginal Health Strategy.
Program objectives	1. Ensure that approximately 15,000 Australians with chronic hepatitis C are treated and cured of their infection annually. 2. Ensure that people identified with cirrhosis related to hepatitis C infection are treated and cured, and regularly monitored for liver cancer. 3. Establish a national collaborative framework to facilitate a coordinated response to the elimination of hepatitis C as a public health threat from Australia by 2030.
Reporting period	Year 4 Annual Report: December 2021 - December 2022

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Abbreviations and acronyms

ACCESS	Australian Collaboration for Coordinated Enhanced Sentinel Surveillance of Blood Borne Viruses and Sexually Transmitted Infections
ACCHO	Aboriginal Community Controlled Health Organisation
AHCWA	Aboriginal Health Council of Western Australia
AIVL	Australian Injecting & Illicit Drug Users League
AOD	Alcohol and Other Drugs
ASHM	Australasian Society of HIV, Viral Hepatitis and Sexual Health Medicine
BBV	Blood-borne virus
DAA	Direct-acting antiviral
EC Australia	Eliminate hepatitis C Australia National Partnership program
GP	General Practitioner
HCC	Hepatocellular carcinoma
LHD	Local Health District
MBS	Medicare Benefits Scheme
M&E	Monitoring and evaluation
NACCHO	National Aboriginal Community Controlled Health Organisation
NHMRC	National Health and Medical Research Council
NSP	Needle and syringe program
NTAHC	Northern Territory AIDS and Hepatitis Council Inc
Out of Home	Refers to any visual advertising experienced outside of the home (billboards, bus shelters or street furniture)
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PHRE	Peer-based Harm Reduction Education
PWID	People who inject drugs
QI	Quality improvement
QuIHN	Queensland Injectors Health Network
RNA	Ribonucleic acid
SAHMRI	South Australian Health and Medical Research Institute
SiREN	Sexual Health and Blood-borne Virus Applied Research and Evaluation Network
STI	Sexually Transmissible Infection
SVR	Sustained Virological Response
ToC	Theory of Change
UQ	University of Queensland
VHHITAL	Victorian HIV and Hepatitis Integrated Training and Learning
WANADA	Western Australian Network of Alcohol and other Drug Agencies
WDHSD	Workforce Development and Health Service Delivery

Thank you and Acknowledgements

Acknowledgement of Country

EC Australia as a flagship program of the Burnet Institute, recognise the Traditional Custodians of the land on which we live and work.

We are proud to acknowledge the Bunurong people of the Kulin Nations as the Traditional Owners and Custodians of the land on which our head office is located and recognise their strong and ongoing connection to Country. Recognising the ongoing impact of colonisation and intergenerational trauma on Aboriginal and Torres Strait Islander peoples, our position as a leading medical research institute demands that we strengthen our commitment to close the gap in health outcomes.

To do this, we are working to develop and maintain strong relationships with Aboriginal and Torres Strait Islander communities both locally and nationwide. Unequivocally, we need to ensure that EC Australia and Burnet Institute becomes a safe, respectful and inclusive workplace for First Nations people and that research initiatives pertaining to Aboriginal and Torres Strait Islander matters rest in the hands of Aboriginal and Torres Strait Islander peoples.

Acknowledgement of Peers

We acknowledge all the people who have lost their lives to hepatitis C and liver disease over the years. We acknowledge and thank the people with living and lived experience of injecting drug use, and hepatitis C, who have generously participated in the EC Australia National Partnership and specific research and implementation projects outlined in this report. Real people and real lives that give meaning to the work of the EC Australia National Partnership and contribution to progress towards hepatitis C elimination.

Acknowledgement of Jude Byrne

We would like to acknowledge Jude Byrne, who sadly passed in March 2021. Jude played a significant role in developing the EC Australia program, ensuring peer-led approaches were a key strategy throughout. Jude co-chaired the National Reference Group with EC Australia for the Health Promotion Campaign and coordinated the National AIVL Peer Network through the codesign period.

Thank you to Paul Ramsay Foundation

As the first four years of the Eliminate Hepatitis C Australia Partnership come to a close, we would like to acknowledge and thank the Paul Ramsay Foundation for its support.

It has been an incredible journey, and the team at Paul Ramsay Foundation have been supportive, flexible, and understanding, and always focused on outcomes and what was being learnt through the process.

Extra funds were granted in 2020, so we could continue for a fourth year through to 2022, ensuring our programs could respond to the COVID-19 pandemic.

We thank you for this opportunity and for your support.

paulramsay FOUNDATION

Thank you to the EC Australia Executive Committee

The EC Australia team would like to especially thank the members of its Executive Committee, many of whom have served for the last four years. This group has come together regularly to review EC Australia's progress, provide advice and counsel at critical time points, and support the coordination and integration of other national programs and key priorities.

Margaret Hellard	Burnet Institute / Alfred Hospital, VIC
Mark Stoové	Burnet Institute / Monash, VIC
Alisa Pedrana	Burnet Institute / Monash, VIC
Joseph Doyle	Burnet Institute / Alfred Hospital / Monash, VIC
Linda Selvey	University of Queensland, QLD
Jessica Michaels	Australasian Society of HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), NSW
Sione Crawford	Harm Reduction Victoria, VIC
Carrie Fowlie	Hepatitis Australia
Shweta Singhal	Department of Health, Australian Government, ACT
Louise Owen	Tasmania Statewide Sexual Health Service, TAS
Jane Davies	Menzies / Royal Darwin Hospital, NT
Geoff Manu	Australian Injecting and Illicit Drug Users League (AIVL), ACT
James Ward	University of Queensland, QLD
Geoff Drenkhahn	Burnet Institute, VIC
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Mellissa Bryant	Burnet Institute, VIC
Catherine Marshall	Menzies / Royal Darwin Hospital, NT
Andrew Llyod	Kirby Institute / University of NSW, NSW
Maria McMahon	Hepatitis NSW, NSW
Garry Sattell	Ramahyuck District Aboriginal Corporation, VIC
Dawn Casey	National Aboriginal Community Controlled Health Organisation, ACT
David Shaw	Royal Adelaide Hospital, SA
Tom Rees	SA Health, SA
Alex Thompson	St Vincent's Hospital Melbourne / Melbourne University, VIC

Thank you to our partners

The EC Australia team would like to thank all our partners for their incredible work, enthusiasm, and contributions to the EC Australia Partnership.

These last four years have been filled with many successes, and challenges, but overwhelmingly we have continued to work together, and to adapt and remain focused, on the important work to eliminate hepatitis C as a public health threat in Australia.

We look forward to continuing work with our partners in 2023 and beyond!

Executive Summary

2022 was the fourth year of EC Australia, and the last funded by the Paul Ramsay Foundation. We completed several key activities and saw some critical impacts from our work. Highlights include delivering the first peer-led National Health Promotion Campaign *It's Your Right*, concluding 21 Partnership Projects around Workforce Development and Health Service Delivery, delivering the fourth annual *Australia's progress towards hepatitis C elimination* report, and developing the first National Hepatitis C Health Promotion Campaign for Aboriginal and Torres Strait Islanders. We also coordinated a National Advocacy Committee to prioritise key policy and advocacy issues for the hepatitis C sector and secured an additional ~$20 million in funding across the partnership to continue key activities and begin new projects focused on hepatitis C elimination. The work in monitoring cirrhosis and hepatocellular carcinoma (HCC) has made significant progress in demonstrating that hepatitis C treatment (DAAs) reduces the impact of liver disease in people with hepatitis C across Australia.

Key achievements

EC Australia Showcase event: 9 – 10 November 2022

Over the 9 – 10 November, almost 100 EC Australia stakeholders came together in Melbourne and online, to look back across the last four years and celebrate the achievements and successes of our National Partnership.

The event commenced with a heartfelt Welcome to Country from Wurundjeri Elder, Uncle Ringo Terrick, of the Wurundjeri Woi-wurung Cultural Heritage Aboriginal Corporation, who shared a personal story and his wisdom about healing circles.

The two-day agenda included:

- An overview of the creation and national roll-out of the ***It's Your Right*** **Health Promotion campaign**, developed in partnership with the AIVL peer network. Attendees heard from Esha Leyden (QuIHN), Rochelle Aylmer (NUAA) and Sal Endemann (NTAHC), who shared their organisations' experience of the roll-out,
- A **Workforce Development session**, where we heard from 15 of the 21 funded partners about outcomes and key learnings from their projects. All 21 projects developed a Workforce Development Infographic that was on display,
- An **Implementation Research** session, where we heard from three projects about optimising existing surveillance systems (VIC) and actively following-up past hepatitis C notifications (QLD and TAS). We also heard about the upcoming NHMRC-funded Partnership Grant: *Optimising public health notifications systems to achieve hepatitis C elimination in Australia*,
- An **Aboriginal Health Strategy** session, which highlighted the *It's Your Right* Aboriginal burst co-design process, and the Bulgarr Ngaru integrated BBV/STI project, and also included a panel discussion with partners from ASHM and IUIH,
- A **Policy and Advocacy** session, which highlighted a range of work done with partners, including the prioritisation of policy issues that the partnership wants to take forward. We heard from partners at ASHM about removing barriers to testing, from the National Prisons Hepatitis Network on development of the Consensus Statement on the Management of Hepatitis C in Australia's Prisons, and from the Burnet Institute on the National Roundtable on Enhancing Hepatitis C Care in Community Pharmacies (convened in partnership with Hepatitis Australia and the Monash Addiction Research Centre), and

- **An Evaluation and Surveillance session,** which had presentations from the National Prisons Hepatitis Network's National Prisons Hepatitis Education Project: HepPEd, an overview of the national hepatitis C progress reports from 2019-2022, and a sneak peak of the (now released) *Australia's progress towards hepatitis C elimination*: annual report 2022. Dr Jessica Howell presented on the positive impact hepatitis C treatment is having on advanced liver disease; and Dr Nick Scott presented on an allocative efficiency modelling study which identifies key care cascade interventions to help ensure progress toward our 2030 targets.

More information and resources from the showcase can be found on the EC Australia website page.

Progress towards EC Australia goals

EC Australia was established with the goal of catalysing efforts to eliminate hepatitis C as a public health threat by 2030.

We set out to bring together key stakeholders and facilitate a strategic, cohesive, and multipronged approach to increase hepatitis C testing and treatment among priority populations, including people who inject drugs, Aboriginal and Torres Strait Islanders and people in prison. Guided by three key objectives, we provided catalytic funding to each jurisdiction to support this work.

1. **Ensure that approximately 15,000 Australians with chronic hepatitis C are treated and cured of their infection annually.**

Data from our 2022 Report on *Australia's progress towards hepatitis C elimination* showed that while Australia has **treated more than 95,000 people with DAAs between 2016 and 2021,** progress has stalled and levels of hepatitis C testing, diagnosis and treatment have declined. Only 11,314 people were treated in 2019, 8,228 in 2020, and 6,474 in 2021. Similar declines in annual hepatitis C RNA testing were reported with 17,357 people tested in 2019, 14,288 in 2020 and 13,130 in 2021. These falling treatment and testing rates highlight the considerable challenge that remains if we are to eliminate hepatitis C in Australia. While the COVID-19 pandemic was a contributory factor in this decline, other factors were (and continue to be) influential.

Yet, we have learnt from EC Australia's health promotion campaign that when we provide tailored support strategies (including outreach peer support, incentives, point-of-care testing, merchandise and events), we can reach significant numbers of people not connected to health services and successfully engage them in testing and link them into treatment. Through our workforce development and health service delivery projects, we know that when jurisdictions are supported to deliver hepatitis C care (e.g., through person-centred, nurse-led models involving peers and incentives in non-health related settings), we can reach people who have not been tested or treated. We also know that through the National Australian Hepatitis C Point-of-Care Testing Program that more than 9,000 people have been tested resulting in 1,297 diagnosed and 930 initiating treatment. We hope that these national activities, along with continued efforts within primary care, Aboriginal health services and prison settings, will reverse the trends in hepatitis C testing and treatment initiations over the next few years.

Moving forward, we know that flexible outreach models that provide a package of interventions to support priority populations to access testing, initiate treatment, and maintain engagement in care and prevention are critical. Importantly, partnerships models that involve integrated hepatitis nurses and peer workers (people with living and lived experience of injecting drug use and hepatitis C), and partnerships between health services and community organisations, are key to implementing high quality and patient-centred care.

To support populations affected by hepatitis C, it will be critical to look more broadly at the social determinants of health, and the social and structural barriers experienced by priority populations when engaging with the health and social systems. The work of community organisations,

especially those run by or involving peers, will be vital in providing social connection, offering positive and respectful engagement, and enabling ongoing support and pathways to other services (i.e., education and employment, legal services, food and housing, income and social protection, and family services).

2. **Ensure that people identified with cirrhosis related to hepatitis C infection are treated and cured, and regularly monitored for liver cancer.**

Encouragingly, DAAs have reduced the impact of liver disease in people with hepatitis C across Australia. We have seen a decline in hepatitis C-related liver transplants nationally since 2016 – including a decline in the annual number and the proportion of liver transplants for people with (or cured from) hepatitis C.

While availability of national monitoring data in this area remains challenging, the jurisdictional data we have been able to gather offers important insights.

In Victoria, DAA treatments are having a direct impact on the decline in hepatitis C-related cirrhosis and are contributing towards the decline in hepatitis C-related liver cancer, with hepatitis C no longer the leading cause of HCC liver cancer in Victoria – ranking third after alcohol and metabolic associated fatty liver disease.

However, we still have work to do to ensure people living with hepatitis C-related cirrhosis remain engaged in care and are routinely monitored.

Victorian and global data also indicate that people with hepatitis C-related cirrhosis remain at risk of HCC, even after achieving cure. Also, diagnosis of cirrhosis often happens too late for DAAs to prevent hepatitis C-related morbidity and/or mortality. In 2021-22, almost one third (30%) of people diagnosed with hepatitis C-related HCC in Victoria had not been treated for their hepatitis C at the time of cancer diagnosis. This suggests there is a group of people living with hepatitis C who are not currently accessing DAA treatment and are at high-risk of liver disease/liver cancer. This group should be prioritised for access to testing and treatment.

Furthermore, while people who inject drugs are a priority population for hepatitis C, only 31% of people diagnosed with hepatitis C-related liver cancer in 2021-2022 identified as someone who currently injects or has injected drugs in the past. This suggests that a proportion of people with hepatitis C do not identify as a person who injects drugs and therefore may not be reached by current public health messaging. This may be due to experienced stigma, or lack of memory of a past exposure, or exposure occurring through other risk situations such as iatrogenic exposure overseas. Further research is underway to explore this further. There may be a group of people with liver cancer and hepatitis C who have not been reached by current hepatitis C programs and may not know about their higher risk of developing liver cancer or how to address it. To improve health outcomes around liver cirrhosis and liver cancer for people with (or cured of) hepatitis C, there needs to be an increase in earlier diagnosis of cirrhosis, greater linkage to specialist care, and greater uptake in liver cancer surveillance. Encouragingly, the Roadmap to Liver Cancer Control in Australia, developed by Cancer Council Australia & The Daffodil Centre, identifies 26 priority action areas to address these issues.

3. Establish a national collaborative framework to facilitate a coordinated response to the elimination of hepatitis C as a public health threat from Australia by 2030.

This has been a cornerstone of our work over the past four years. EC Australia currently has a network of over 75 partner organisations, enabling us to rapidly share knowledge across the partnership, support better coordination on the ground, and foster new strategic partnerships (which in some instances has enabled partners to attract ongoing funding).

A major focus of EC Australia's work is building enduring partnerships with community organisations that represent people living with hepatitis C, people who inject drugs, and Aboriginal and Torres Strait Islander communities. We see these partnerships as central to an effective elimination response. They amplify the voices of people in priority populations, and enable their diverse experiences and perspectives to shape programs and approaches and make them more effective.

Another outcome of the national collaborative approach is learning and sharing new skills, and experiences and reflections about project implementation. Sharing this vital knowledge across the network can drive research agendas, facilitate rapid knowledge translation, and achieve policy change. This national network has become a valuable resource in Australia's elimination effort. We welcome the opportunity to continue this partnership over 2023-2027 with support from Burnet Institute to consolidate our existing partnerships, and grow the national hepatitis C network further to include stakeholders from the cancer sector and the wider social sector that will benefit the hepatitis C elimination response.

EC Australia Component Updates

HEALTH PROMOTION

Progress on the milestones 2022
1. National Health Campaign Implementation: Completed 2. National Health Campaign Evaluation: Completed

UPDATES AND PROGRESS IN 2022

Aims and objectives of the *It's Your Right* campaign:

- *It's Your Right* used a peer-led approach from design to delivery, by working in partnership with peers and AIVL's member organisations
- *It's Your Right* aimed to reach people who inject drugs, and not accessing hepatitis C testing and treatment services, to *shift* perceptions about treatment and to *support* people to be tested and treated
- *It's Your Right* linked people who inject drugs to peer workers and trusted services.

The *It's Your Right* national health promotion campaign was designed to increase hepatitis C testing and treatment uptake by non-Indigenous and Aboriginal and Torres Strait Islander people who inject drugs. This update focuses on what was delivered in 2022 for the roll out of *It's Your Right*, and key results from the evaluation findings and highlights.

It's Your Right rolled out in each state and territory of Australia from April to December 2022. The campaign period was implemented in three-month bursts. EC Australia worked in partnership with AIVL, Enigma, state-based drug user and hepatitis organisations, and local needle and syringe programs, to implement the campaign as shown in Table 1.

Table 1. Implementing partner organisations and campaign period by state.

Implementing Partner Organisations	State/Territory	Campaign period
Northern Territory AIDS and Hepatitis Council	NT	April 11th – July 11th
Queensland Injectors Health Network	QLD	April 11th – July 11th
Hepatitis SA	SA	April 11th – July 11th
Peer Based Harm Reduction WA	WA	June 13th – September 13th
Hepatitis ACT and Canberra Alliance for Harm Minimisation and Advocacy	ACT	June 13th – September 13th
Anglicare Tasmania and Tasmanian Department of Health	TAS	August 1st – November 1st
NSW Users and Aids Association	NSW	August 15th – November 15th
Harm Reduction Victoria	VIC	September 1st – December 1st

Funding Context

It's Your Right was funded by the Paul Ramsay Foundation and the Commonwealth Department of Health (via the *National Hepatitis C 50,000* Project). The Paul Ramsay Foundation funding covered the costs of co-design, funded peer activities and incentives, 40% of the media buy, all merchandise/wearables, and personal story videos. The Department of Health funding was for the out of home media buy (60% of the media buy), including the Aboriginal design and burst of advertising, and the evaluation.

Campaign Strategies

The campaign combined the following strategies to reach and engage people who inject drugs, in a range of different settings, and to link them to their local peer-led service:

- **Empowering, rights-based, health promotion messaging –** to prompt people who inject drugs to think about hepatitis C treatment, to shift their perceptions, and link them to their local peer drug user organisation. Messaging and artwork were also tailored to Aboriginal and Torres Strait Islander people who inject drugs,
- **Peer outreach/engagement activities and local linkage to care –** to increase peer-led conversations with people who are not engaging with health services. Peer conversations are the cornerstone of the campaign as peers with living experience are trusted sources of support. Peer workers used their local networks to start conversations about hepatitis C, provide hepatitis C point of care testing, or link people into their local, trusted, nurse-led, community-based testing and treatment service,
- **Financial incentives –** to support people to get tested, and to start and complete treatment, and
- **Localised social marketing (media assets)** – to build awareness and campaign recognition and promote peer-led organisations. These activities included: a paid media buy for street advertising, posters for peer-led and support services; merchandise (wearables and giveaways) for peers and staff to promote campaign messages and start conversations; a campaign landing webpage to promote easy--to--read information and referral contacts;

and an online video series to share personal stories about treatment through social media.

It's Your Right messages

It's Your Right was chosen as the overarching theme for the campaign. *It's Your Right* is bold and assertive, using a rights-based approach to communicate taking control, 'getting one over 'The Man'', and that it is possible to find simple, judgement-free treatment from people who are on your side. Vibrant colouring was used to support these empowering and confident messages.

The *It's Your Right* theme was selected following focus testing with people who inject drugs, health and community workers, and peer workers (N=86). The focus testing assessed the three concepts listed below, and *It's Your Right* was the strongest in terms of appeal, trust, and motivation.

- 'It's Your Right' – themed around taking control and 'getting one over 'The Man''.
- 'Get Sorted' – themed around hepatitis C treatment being achievable.
- 'One Less Thing' – themed around not letting hepatitis C 'hold you back'.

Rights-based messages were used across all the campaign products. The messages were designed to let people know that the new hepatitis C treatments are easier, have less side effects, and can be taken while using drugs, also that people can be treated again if they are reinfected. The call to action (on products) either: linked the audience to the *It's Your Right* website, or linked them to their local peer drug user organisation.

Image 1. Examples of poster messaging

Tailored messaging and products for Aboriginal and Torres Strait Islander people who inject drugs

The campaign's focus testing showed that while Aboriginal and Torres Strait Islander people, who inject drugs, responded positively to the *It's Your Right* theme, that appeal would have been stronger if the campaign included Indigenous artwork and language. During 2022, further co-design work was undertaken with Aboriginal peer workers, Enigma and We Are 27 (Indigenous design agency), to produce tailored messaging and products for an Aboriginal audience. The new designs and messages were used in the national advertising buy, and in posters and merchandise (tote bags, postcards, t-shirts and fitpack stickers) created for implementing partners.

This Aboriginal extension of *It's Your Right* was made possible by the funding provided by the Department of Health via the *National Hepatitis C 50,000* Project. Refer to the Aboriginal and Torres Strait Islander Health Program Section for more information.

IMPLEMENTATION

Social marketing campaign

The *It's Your Right* social marketing campaign consisted of:

- The national advertising buy
- Posters for services
- Merchandise (wearables and giveaways) for implementing partners
- Campaign website
- Peer story videos
- Social media assets
- Aboriginal extension assets.

Media buy

The national advertising was used to reach people who inject drugs. It was located 'out and about' in public spaces, and in place-based settings, such as convenience stores and medical clinics. The media buy was localised to areas surrounding where implementing organisations provided harm reduction and hepatitis C testing and treatment services.

EC Australia contracted an advertising and marketing agency, Enigma, to broker the media buy. Different types of advertising channels were purchased, with the mix of advertising types varying between jurisdictions. The mix of channels and the locations of the advertising were chosen by the implementing partners, based on their knowledge of local communities and recommendations from Enigma around advertising reach and dollar value. The timing of the media buy was weighted more heavily at the start of the three-month campaign to maximise the audience viewing opportunities across all the channels. The national spend on advertising was $678,362.06.

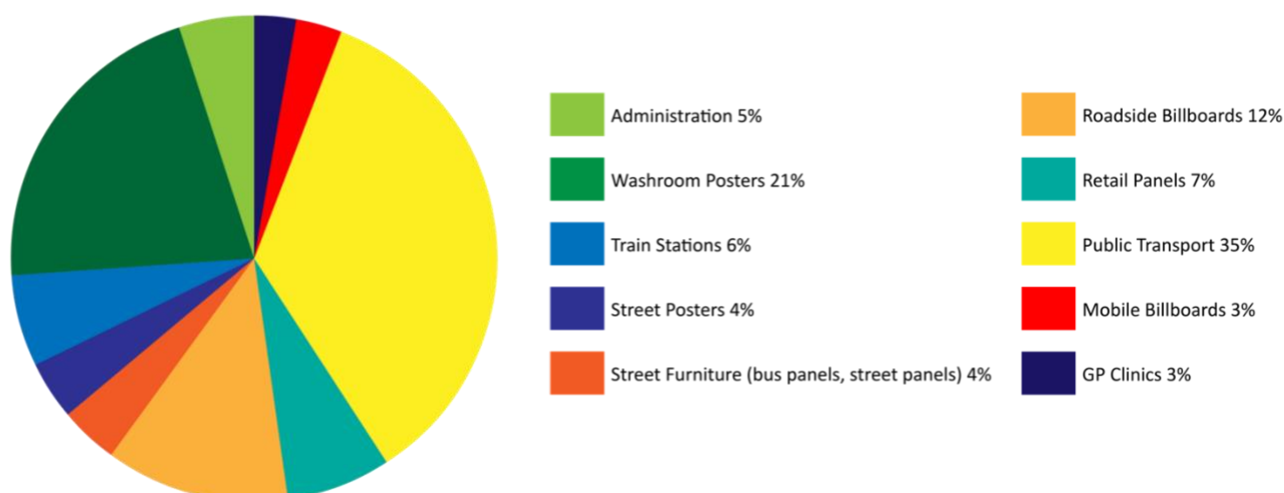

Figure 1. Breakdown of media buy by channel.

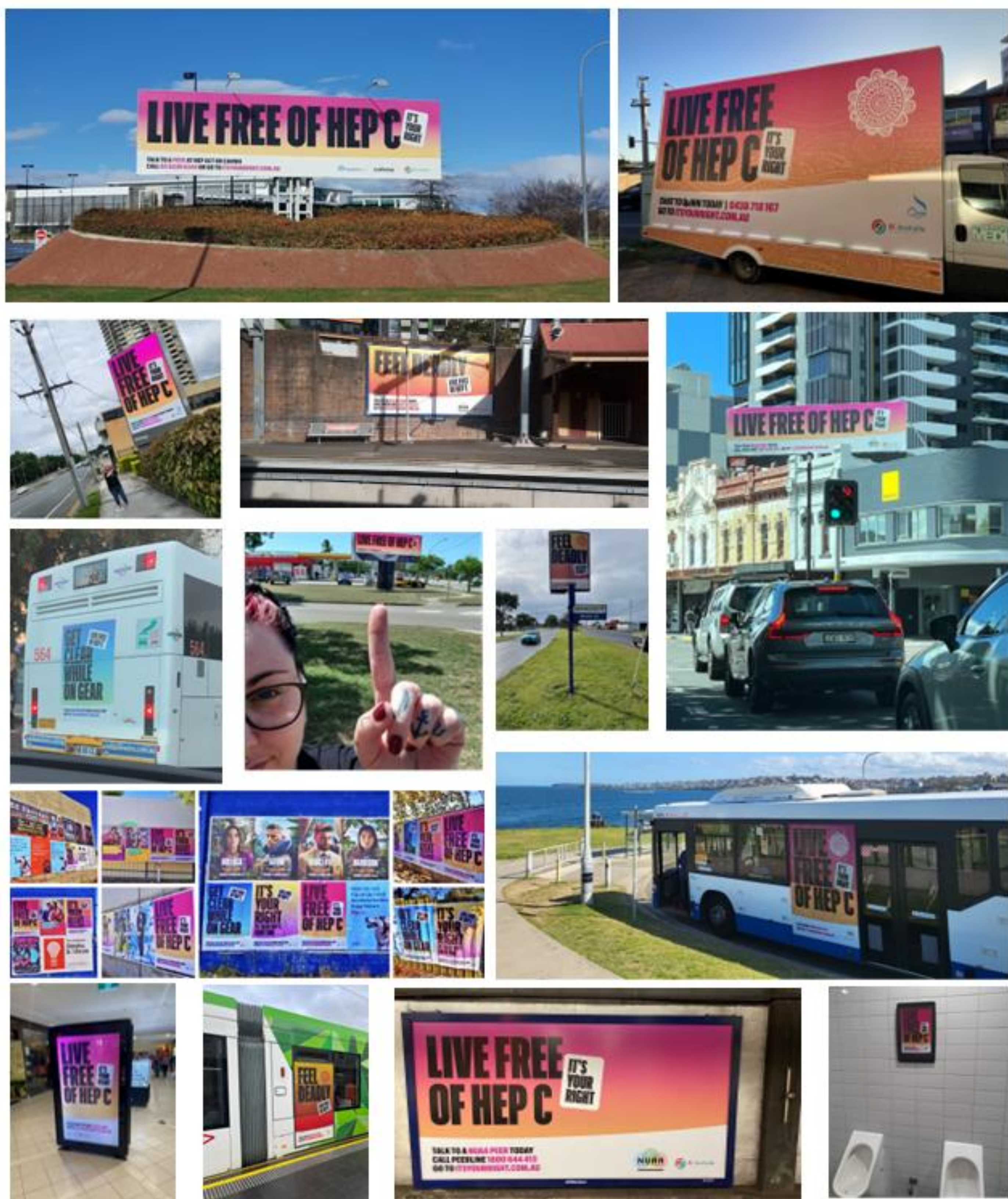

Image 2. Examples of purchased advertising placements

Posters and merchandise

Campaign posters and merchandise (including *It's Your Right*-branded event banners, t-shirts, tote bags, hats, water bottles, toiletry bags, torniquets, shower gel and sunscreen) were provided to each implementing partner organisation. Merchandise wearables were intended for peers and staff, to help make them visible to the community. They were used to start, and engage people in, conversations about hepatitis C testing and treatment.

Campaign Website

The campaign website provided information about testing and treatment, access to the peer story video series, and contact details and links to the implementing partners. Visit the campaign website at www.itsyourright.com.au.

Peer Stories

An online peer story video series was created, featuring three peers sharing personal stories about hepatitis C treatment. The series comprised seven videos: two in long-form, and five short videos for sharing on social media. These videos were shared through the campaign website, used to create social media clips shared by implementing partners, and played in health clinics in one jurisdiction. The videos on YouTube were intentionally not searchable, so that EC Australia and implementing partners could better control their dissemination.

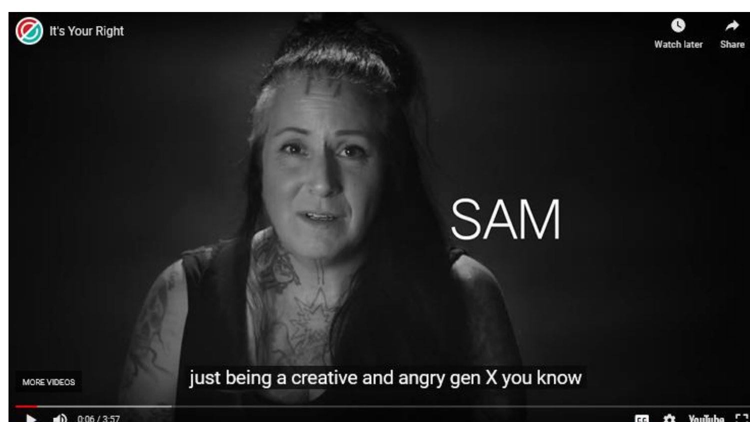

Image 3. Example of a peer video on the EC Australia YouTube page.

Social Media

Digital assets for social media (including, short animations of the *It's Your Right* messages and colours, and clips from the peer story videos) were provided for implementing partners to share through their own social media platforms. Each implementing partner was provided with a social media guide with advice about social sharing as part of the campaign.

Peer-led conversations, outreach, and linkage to testing and treatment

A key component of the campaign was maximising opportunities for peer-led hepatitis C conversations with people who inject drugs. To do this, during the campaign period, partner organisations adapted or expanded their peer-led hepatitis C engagement activities, and testing and treatment services.

Eight organisations received funding from EC Australia to implement peer-led activities during the campaign. They implemented a wide range of activities, based on what they determined would best meet the needs of their clients and local communities.

Most states and territories either engaged new peer workers, or increased existing peer worker hours, during the campaign period, to increase engagement between peer workers and people who inject drugs in their local community. With more staff and hours, some partners implemented new hepatitis C models of care in their services featuring things like:

- peers providing point of care testing,
- street-based, or van-based, outreach to engage new communities of people (including Aboriginal and Torres Strait Islander people, people experiencing homelessness, and people in regional areas),
- establishing new, or expanding existing, partnerships with community-based medical and nursing staff, who could provide hepatitis C testing and/or linkage to treatment.

Partner organisations with established hepatitis C models of care used campaign funding to expand these services into new regions or locations, increase service hours at existing locations, or re-launch services after COVID-19.

Incentives

Incentives for people engaging in hepatitis C testing and treatment were provided in all states and territories using *It's Your Right* funding. Incentive amounts ranged from $20 to $100. Different organisations paid incentives at different stages of the care cascade, to best engage people in hepatitis C care. Funding for incentives was provided to the partner organisations and administered by peer workers.

EVALUATION OF *IT'S YOUR RIGHT*

Another significant focus in 2022 was the evaluation of *It's Your Right*. This included finalising the evaluation plan and ethics application, setting up tools for data collection during the campaign period, and conducting surveys, interviews and focus groups after the campaign had ended.

The evaluation of *It's Your Right* sought to understand the national experience and the outcomes of the campaign. It included an analysis of organisational service delivery data, surveys of people who inject drugs (n=165, also referred to as clients in the results), interviews (n=18), and focus groups (n=23) with campaign designers and implementers.

The following section provides a snapshot of our evaluation findings. We will release a comprehensive evaluation report in the second half of 2023 - with recommendations for future iterations of the campaign, and learnings that may be useful for other organisations developing their own co-designed, peer-led, health promotion campaigns.

Key evaluation findings

It's Your Right met its objectives of engaging people who inject drugs in hepatitis C testing and treatment, including priority populations of Aboriginal people, people with unstable housing, and people who had not previously been linked to peer-led services.

- Reach: >8.9 million people across Australia were estimated to have seen at least one *It's Your Right* campaign asset.
- Conversations: 2,595 conversations about hepatitis C between clients and peer workers, or other harm reduction staff, during the campaign period.
- Testing: 1,343 people were tested for hepatitis C by implementing partners during the campaign period, including 194 Aboriginal and Torres Strait Islander people.[1]
- Treatment: 151 people were referred for hepatitis C treatment during the campaign period, including 16 Aboriginal people and Torres Strait Islander people.
- Incentives: 1,254 financial incentives were provided to clients engaging in testing and/or treatment during the campaign:
    - 880 incentives for getting tested,
    - 190 incentives for bringing a friend to get tested,
    - 88 incentives for getting test results,
    - 73 incentives for treatment referral and/or initiation.
- Campaign recall: this was strong, with more than 50% of clients surveyed able to recall the campaign spontaneously, and nearly three-quarters able to recall the campaign after being prompted by campaign images.
- Call to action: of the clients who recalled seeing the campaign, over a third (38%) said they spoke to a peer worker, and 31% said they got tested, because of the campaign.

Peer workers were critical to the success of the campaign. This was because of their delivery of peer-led engagement activities, such as financial incentives, new models of care, and enhanced outreach activities.

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[1] Data on Indigenous identity was not able to be collected by every partner organisation, so the number of Aboriginal and Torres Strait Islander people who were tested for hepatitis C or referred for treatment is likely an under-reporting.

Highlights

It's Your Right enabled community organisations to engage people who inject drugs within an empowering health promotion framework.

"I like how it says 'It's Your Right' - reminds me that I'm not a bad person for needing treatment/getting hep C" (Survey participant)

"It is good to see it out in the open not hidden away. Like on the bus, everyone can see it" (Survey participant)

***It's Your Right* engaged people who inject drugs.** The evaluation findings indicate that *It's Your Right* reached people who inject drugs, including Aboriginal and Torres Strait Islander people, people who have unstable housing, and people who had not attended the implementing organisations before. Engagement through peer workers, and exposure to the colourful and vibrant campaign products (within partner organisations and other local health and community services) were critical points of client exposure to the campaign. The national advertising campaign was localised around relevant services. Buses and street-based advertising (billboards, paste-up posters) were where most people saw the campaign.

Campaign recall was strong, with over half (53%) of clients surveyed being able to recall the campaign spontaneously. Nearly three-quarters (72%) were able to recall it after being prompted by campaign images. More specifically, participants could recall the campaign in an NSP (53%), on merchandise (34%), on a bus (30%), and on street advertising (including billboards and posters – 27%). Survey participants said the campaign messages were easy to understand, attractive and appealing, and made people who inject drugs feel valued in a public space.

Incentives were critical to engaging people who inject drugs in the campaign. A total of 1,254 incentives were paid to clients for engaging in hepatitis C testing and/or treatment.

"Because we [provided] incentives [for testing] and incentives to bring a friend, we actually engaged with a lot of people who we hadn't before, who were really new to our service. Homeless people, Aboriginal people, that hadn't actually used our services before."

(Staff member of implementing partner)

It's Your Right stimulated peer-led conversations and linked people to testing and treatment

Peer-led engagement activities were essential to the successful delivery of *It's Your Right.* People who inject drugs took action as a result of their engagement with the campaign. Over a third (38%) of clients surveyed, who recalled seeing the campaign, said they spoke to a peer worker, and 31% said they got tested, because of the campaign. As a result, during the campaign, there were 2,595 conversations between peer workers and people who inject drugs about hepatitis C, 1,343 hepatitis C tests, and 151 people referred for hepatitis C treatment.

"Knowing that you can proceed with testing and potential treatment with an advocate who has similar life experience is an invaluable incentive"

(Client survey participant)

Merchandise was also considered integral to initiating hepatitis C conversations with community members, both within services and at events.

The success of the peer-led engagement activities demonstrates their importance as a cornerstone of the campaign strategy.

The opportunity to get involved in [It's Your Right] meant we had … additional funding that could support not only newer peer workers who were [city] based, but [could] even … pay for peer workers in [regional location] … we could hire extra peer workers … to help out with the campaign roll out … it really neatly coincided with the launch of [project] … and our point-of-care testing, so it was a really nice complete package, where we could add the It's Your Right merchandise and funding and incentives as well … It gave us the opportunity to expand … into a different jurisdiction … It was really nice to be able to expand what we would do at our own NSP, and … take that on the road ….”

(Peer worker involved in implementation)

It's Your Right elevated peer-led approaches

It's Your Right was the first Australia-wide hepatitis C campaign co-designed and delivered by peer workers with living and lived experience of injecting drug use. This peer-led approach from design to delivery highlighted several strengths:

- The co-design process genuinely placed the knowledge and ideas of people with lived and living experience of injecting drug use and hepatitis C at the centre,
- It led to a campaign that was more positive, vibrant, and engaging for people who inject drugs,
- It demonstrated how critical peers are to hepatitis C elimination efforts. Peers are highly skilled in building trust with affected community members, and by prioritising and funding peer engagement activities, the campaign was able to boost peer-conversations and provide a link to testing and treatment through a trusted health service (usually a peer drug user organisation, or a peer drug user organisation collaborating with a nurse-led program),
- It supported and enabled the changing scope of practice of peer workers, which now includes point-of-care testing, partnering with nurses in delivering care, conducting follow-up of clients post-testing, and providing treatment support. This wider scope of practice means clients can access hepatitis C services that are more flexible, responsive, and delivered by peers with a deep understanding of how to manage and overcome barriers that clients face when engaging with traditional models of hepatitis C care.

“When clients would come in to get their fitpacks … I would just say … “have you heard about this campaign?” And then I'd say “we've got … this bag and we've got … these little pouches or a drink bottle” and … they'd actually get their friends to come in the next day and say “oh I've heard that you've got stuff to give away”. Everyone likes free stuff. And that's how I did it.”

(Staff member of implementing partner organisation)

“Thank you guys! I wouldn't have got this testing / treatment if not for your bright bus, happy smiles and good personalities! Yay😃”

(Client survey participant)

Lessons and Insights from implementation

The evaluation of *It's Your Right* included focus groups with staff from the implementing organisations. Twenty-three staff members provided insights into the benefits and challenges of the campaign.

It's Your Right galvanised a positive response

Staff at partner organisations felt that being part of a campaign (which was prominent in the community, and advertised through mainstream channels, like public transport and billboards), added legitimacy, and built excitement and enthusiasm for implementation.

The campaign, and the flexible funding provided by EC Australia for implementation, allowed partners to recruit new peer workers, implement new models of hepatitis C care, trial incentives for clients, and create new connections and partnerships with health and community services in their local areas.

A key challenge was the additional workload created for peer workers. This can be particularly challenging for peers and organisations, where peer worker time is already stretched and recruiting new peers can be difficult. Some peer workers and organisations found parts of the campaign administration challenging, such as the management and distribution of posters and merchandise, and the administration of incentives.

It's Your Right incentives facilitated testing and treatment

Most states and territories offered incentives for getting tested for hepatitis C, and for starting treatment. Half of the implementing organisations offered incentives for bringing a friend to be tested for hepatitis C. Also, for a person getting their final sustained virological response (SVR) test post-treatment. Some states paid cash incentives, while others offered supermarket vouchers, depending on the preferred approach of the partner organisation.

Staff at implementing organisations identified incentives as critical for engaging new and existing clients in hepatitis C testing and treatment. They were a good conversation starter and helped clients to overcome some financial barriers to treatment. In some jurisdictions, the costs of medication co-payments were covered (in addition to the incentive payment) if the client was unable to afford medication costs.

However, administering incentives could be challenging for partner organisations. Some organisations used supermarket vouchers, but needed to ensure they were for the supermarket chain preferred by most clients. Organisations using cash incentives needed to ensure money was secured, and sometimes ran out of cash during high-demand testing clinics.

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Harm Reduction Victoria (HRVIC)
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NSW User and AIDS Organisation (NUAA)
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Tasmanian Department of Health

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WORKFORCE DEVELOPMENT AND HEALTH SERVICE DELIVERY

Progress on the milestones 2022
1. Project implementation and evaluation: completed

Updates and Progress in 2022

The Workforce Development and Health Service Delivery (WDHSD) component aimed to identify, develop, and implement priority activities that increase access to and uptake of, hepatitis C testing and treatment (through the reduction of structural barriers and enhancing enablers). Priority activities were informed by Jurisdictional Implementation Working Groups under the following guiding principles:

- Scale up existing programs shown to increase testing and treatment;
- Support health services to prioritise hepatitis C care;
- Use evidence-based approaches;
- Avoid duplication;
- Ensure equity addressing gaps in response to local data; and
- Demonstrate impact and enhance sustainability.

The WDHSD component funded 21 priority activities (projects) across eight jurisdictions in Australia, and one evaluation contract which supported six projects in Queensland (QLD). Funding totalled $4.1 million and commenced in September 2019.

All projects were encouraged to measure and reflect on their success against the overall objectives of EC Australia. Projects were encouraged to design and implement monitoring and evaluation activities (i.e., evaluation plan, log frame, data collection, reporting). The focus of these monitoring and evaluation activities was to build capacity within organisations, give projects insights into the benefits of evaluation and the use of data for continuous improvement, and for EC Australia to collate and summarise data across all projects to assess the effectiveness of respective activities.

The COVID-19 pandemic had a significant impact on all 21 projects. Some projects employed staff and commenced implementation by March 2020. Whereas other projects delayed the start date or were placed on hold during 2020 and part of 2021. EC Australia worked closely and adaptively with projects to adjust implementation timeframes and delivery of project activities.

Outputs and outcomes

Reporting

All projects provided routine reporting to EC Australia, using a template, every six months, during implementation. Reporting was supported by regular six-monthly meetings to discuss implementation learnings. All projects delivered a final report.

Project reporting focused on barriers and enablers to implementation; quantitative and qualitative measurement of specified outcomes; and future opportunities. This section has been collated by the EC Australia project team, condensing findings provided by the projects, summarising outcomes within themes, and pooling data where possible (i.e., data measured in the same way)

Using information provided to EC Australia by each project in the final report, the following section provides a a short description of each project, the key findings, and the lessons learnt.

The projects have been grouped under four main themes: Theme 1: Models of Care (five projects), Theme 2: Client Engagement (six projects), Theme 3: Workforce Development (seven projects), and Theme 4: Surveillance (three projects). Where projects used consistent methods of data collection and reporting of quantitative outcomes, we pooled the results to provide outcomes across projects, within a theme.

Infographics

To make use of monitoring and evaluation activities, and support dissemination of the project findings to partner organisations' stakeholders, EC Australia supported the development of an infographic for each project (which reports the project's significant learnings and results). The infographics can be found here.

There are discrepancies between the data presented in this report and some of the infographics. Several projects were active before and after the EC Australia funding, so partners decided to include data for the duration of the project (whereas this report focuses on the EC Australia funded component).

Theme 1: Models of care

Overall impact

Between June 2020 and December 2022, EC Australia funded and supported five innovative projects offering person-centred, flexible, hepatitis C testing and treatment models of care across different settings, including Needle Syringe Programs (NSP), mental health services, community corrections, prisons, Alcohol and Other Drugs (AOD) services, and primary care. The models of care ranged from standard care in community settings to simplified testing and treatment pathways (using a nurse-led approach with a mixture of testing options, including laboratory-based testing and point-of-care hepatitis C antibody and RNA testing).

All five projects reported the total number of people tested for hepatitis C, though not all projects reported hepatitis C antibody testing and RNA testing separately. Across all five projects, **2,402 people were tested for hepatitis C** (antibody, RNA, or both, and venipuncture or point-of-care).
A total 265 **people were hepatitis C RNA positive**, and **178 people were prescribed treatment** for hepatitis C.

Nurse-led models that operated in partnership with peers (people with living experience of injecting drug use and/or hepatitis C), emerged as a novel approach to engaging people who were socially marginalised.

Point-of-care testing, both hepatitis C antibody and RNA, enabled high numbers of people to be tested in priority settings and was highly acceptable to consumers.

Community corrections emerged as a new priority setting for hepatitis C testing and treatment. There was significant interest from and engagement with community corrections officers who conducted supportive referrals to the clinic and a high number of people at risk of hepatitis C were identified.

Hepatitis ACT - Nurse Practitioner-led Hep C Outreach Clinic

Key findings

In the Australian Capital Territory (ACT), this new model focused on engaging people at risk of hepatitis C through the Hepatitis ACT NSP and linking them to nurse practitioner-led testing (venipuncture) and treatment services. The EC Australia funded project was delivered alongside a one-year Reach, Teach, Test (RTT) pilot, funded by an ACT Health grant. The RTT pilot was delivered by Hepatitis ACT in partnership with peer workers employed by the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA). Peer support workers from both organisations assisted clients to access testing at a weekly nurse practitioner -led clinic (funded by EC Australia), as well as providing ongoing support and education for those engaging in hepatitis C treatment and care. Through alignment of the project and the RTT pilot, people accessing the nurse practitioner-led hepatitis C outreach clinic were provided with cash incentives to support them through their treatment journey:

Milestone	Who	Incentive
Hepatitis C antibody and RNA test	Clients at risk of hepatitis C	$40
DAA treatment commencement	Clients with positive hepatitis C RNA result	$40
SVR 12 completion	Clients who completed treatment	$60
Peer education workshop 1	Clients living with hepatitis C or at risk of hepatitis C	$40
Peer education workshop 2	Clients living with hepatitis C or at risk of hepatitis C	$40
Peer education workshop 3	Clients living with hepatitis C or at risk of hepatitis C	$40
	Total incentives available per client	**$260**

Between April 2021 and February 2022, a total of 994 people were approached for testing with **95/994 (9%) tested for hepatitis C** (type of test not reported). Of those tested, **24/95 (25%) were hepatitis C RNA positive**. **Ten people commenced treatment** prescribed by the nurse practitioner.

Lessons and reflections

This model aimed to differentiate itself from other primary care models by adopting a harm reduction framework. The nurse practitioner developed a reputation for providing safe, non-judgmental, and person-centred care.

The project identified the need to refine its strategy for follow-up as 10/24 (41%) of people diagnosed with hepatitis C initiated treatment, indicating a need for novel interventions to reduce loss-to-follow-up after diagnoses. There was a need to develop a wraparound client communication strategy, to support patient follow-up, instead of relying on text messaging. The project secured ongoing funding until June 2024, with point-of-care testing added to the suite of services.

Northern Territory Nurse-Peer Partnership

Key findings

In the Northern Territory (NT), a clinical nurse consultant worked in partnership with a peer support worker from the NT AIDS and Hepatitis Council (NTAHC), in Darwin, to provide hepatitis C testing, treatment, and supported follow up through community-based settings, such as NSPs. The project offered financial incentives (gift vouchers) when people were tested, commenced treatment, and when attending for an end of treatment blood test (to assess for SVR). The value of the vouchers ranged from $25 to $30.

Between May 2021 and October 2022, the project held 65 community-based clinics and **111 people were tested** for hepatitis C antibodies, **60/111 (54%)** tested hepatitis C **antibody positive** and **20 people were hepatitis C RNA positive,** although the total number of people tested for hepatitis C RNA was not reported**. A total of 13 people commenced treatment**. A total of 113 people received a voucher.

Lessons and reflections

The project identified that the respectful nurse-peer working relationship was crucial to the success of removing barriers to care and providing a holistic and safe health care environment for people with, and at risk of, hepatitis C.

The project staff reported difficulty quantifying the role of the peer. They experienced challenges collecting insightful data, therefore, the impact of the peer was not clearly described quantitatively. Anecdotally, the role was invaluable and a critical element to the implementation of the project.

Tasmanian Eliminate Hepatitis C Australian Outreach Project

Key findings

In Tasmania, this project delivered a nurse-led outreach model of care servicing hepatitis C priority populations and community settings through the government-funded Tasmanian Statewide Sexual Health Service. This project was designed to address gaps in community-based

DAA prescribing, by establishing nurse-led hepatitis C care pathways in priority settings across the state. Settings included AOD services, NSPs, and mental health services. Services provided by the project included hepatitis C education for staff and clients, and clinical care across the hepatitis C cascade of care, including testing, treatment, and post-treatment support.

Between June 2020 and September 2022, 47 sites were visited by one Clinical Nurse Consultant. There were 731 interactions with people at risk of hepatitis C by the nurse consultant. From data provided in the infographic, **448 people** had venipuncture performed and **were tested for hepatitis C** (antibody, RNA, or both). A total of **80 people were hepatitis C RNA positive**, and **74 people commenced treatment**.

Lessons and reflections

Providing outreach, drop-in hepatitis C services in community-based clinics was effective in engaging people living with, and at-risk of, hepatitis C. Nurse-led, person-centered care was critical to the success of the project.

The project identified the potential for a different approach to workforce education in the future. For example, fostering and encouraging 'champions' among mental health service staff, rather than delivering broad education to all staff.

This project received ongoing and expansion funding from the Tasmanian Health Service, for seven years, to create a comprehensive statewide hepatitis C service with two clinical nurse consultant positions and medical and administration support.

Hepatitis Queensland: Community Corrections Project

Key findings

In QLD, Hepatitis QLD held a monthly onsite hepatitis C testing and treatment clinic at three Community Corrections locations across Brisbane. The model provided a "one-stop shop", with a General Practitioner (GP)-led model of care, a community outreach nurse providing Fibroscans, and point-of-care testing and phlebotomy services.

Between August 2020 and June 2022, 36 clinics were conducted, **199 people were tested for hepatitis C** (note that, 16 of the 199 people were not on community corrections orders). Of the 199 people tested, **86/199 (43%) were hepatitis C antibody positive and were RNA tested**, of which **45/86 (52%) were hepatitis C RNA positive.** A total of 34 **people started treatment**. Six people were referred to a tertiary liver clinic.

Lessons and reflections

This new model of care provided hepatitis C testing and treatment to people not engaged in mainstream healthcare or other prison or community programs.

Community corrections needs to be considered a key setting (within Corrections) for hepatitis C activity given the observed hepatitis C RNA positivity. Many people move through the justice system so this setting should be included and prioritised in national and state strategies.

There is a need to improve the linkage to specialist care, as some people needed support in navigating the specialist health care system and covering the costs of attending specialist care appointments.

This project received further funding for the period from July 2022 to June 2023.

Point of Care Testing for Hepatitis C in Mental Health, Prison and AOD Settings (PrOMPt) – South Australia

Key findings

In South Australia (SA), this model implemented point-of-care hepatitis C antibody testing and reflexive point-of-care hepatitis C RNA testing in an inpatient mental health service, a remand prison, and an AOD withdrawal inpatient unit.

Between October 2020 and December 2021, **1,549 people received a point-of-care hepatitis C antibody test** of which **264 (17%) were positive.** All people with a positive hepatitis C antibody test were tested for hepatitis C RNA (using a point-of care test) and **55/264 (21%) were hepatitis C RNA positive**. Of these people, 50/55 (91%) were linked to care and **47/55 (85%) commenced treatment for hepatitis C.** By setting, the number tested and hepatitis C RNA positive was 5% (39/877) in the remand prison, and 2% (10/496) in the AOD unit and 3% (6/176) in the mental health unit).

Lessons and reflections

The project demonstrated the feasibility of implementing hepatitis C point-of-care testing in mental health, prison, and AOD settings. Using point-of-care antibody testing with all positive tests then being progressed to point-of-care hepatitis C RNA testing was effective and efficient. The project is an example of how to implement an integrated and streamlined model of care in priority settings.

As a result of this project and the finding that over half the participants with a current hepatitis C infection reported a recent history of homelessness, SA Health funded the scale up of point-of-care testing in priority settings across the State.

Theme 2: Client Engagement

Overall impact

Six projects were focused on enhancing engagement with clients living with, or at risk of, hepatitis C. The projects were grouped into three types:

- **Incentives projects** which involved providing financial payments to people at various points throughout the care cascade to support their engagement in hepatitis C testing and treatment.
- **Peer worker projects** *which* employed people with living experience of hepatitis C and/or injecting drug use to identify and engage people living with, or at risk of, hepatitis C, and support them to have hepatitis C discussions and education, and access testing and treatment.
- **Transition from prison to the community** project which involved a project officer supporting people to maintain their engagement with hepatitis C care when released from prison through supported referrals and ensuring hepatitis C medication was provided upon release.

Incentives projects: Between January 2020 and December 2022, three incentive projects were implemented in QLD (two projects) and New South Wales (NSW). The two QLD projects reported the same metric (i.e., the number of people who received an incentive as part of engagement in hepatitis C care). A total of **419 people received an incentive** (financial payment) for hepatitis C testing, treatment, and/or treatment follow-up.

In NSW, the number of people who received an incentive was not reported, but **1,033 people were tested for hepatitis C** (any type of test), and **113 were hepatitis C RNA positive**. A total of **30 people started treatment.**

Peer worker projects: Between October 2019 and December 2021, two peer worker projects were implemented across QLD and Western Australia (WA). The two projects reported the same metric (i.e., the number of people who had any sort of interaction with a peer). In total, **727 people had an interaction with a peer worker.** The QLD project added hepatitis C testing for a short time, and **117 people received a point-of-care test for hepatitis C RNA** conducted by a peer worker.

Transition from prison project: One prison transition project was implemented in QLD between January 2020 and June 2021. A total of **376 people transitioning from prison to the community received hepatitis C support,** which included **287 cases referred** on for hepatitis C treatment or management across both community and correctional settings.

Cairns Hep C Free: Increasing Testing and Treatment Through Incentives and Support

Key findings

In Cairns (QLD), the sexual health service team provided incentives to people who inject drugs to support meaningful engagement in hepatitis C testing and treatment. Cash payments of $10 to $20 (the amount was increased in response to the COVID-19 pandemic and subsequent increases in social support payments) were provided when an individual was tested, commenced treatment, completed treatment, and underwent SVR testing.

Between January 2020 and May 2021, **122 people** received an incentive. Of these, 27/122 (22%) were hepatitis C RNA positive, and 24/27 (89%) initiated treatment. Of those who started treatment, 21/24 (87%) completed it. Of the incentive payments, $1,370 were for hepatitis C

antibody testing, $1,900 for hepatitis C RNA testing, $1,366 for treatment completion, and $1,366 for SVR testing.

Lessons and reflections

Incentives supported people with transport costs to access hepatitis C testing and care. People engaged through this project had limited prior involvement with health services. The project focused on building relationships with colleagues in other services, as well as with people from priority populations, to achieve these outcomes.

University of Queensland (UQ) Hepatitis C Testing Incentives

Key findings

In QLD, six organisations were funded to provide $20 incentives to support individuals to engage in hepatitis C testing and treatment. The six organisations also collected and reported evaluation data. The organisations were Aboriginal and Torres Strait Islander Community Health Service Mackay, Sunshine Coast University Hospital Hepatology Partnership, Inala Indigenous Health, Kombi Clinic, Pharmaceutical Rehabilitation Services, and Inclusive Health and Wellbeing Hub.

Between January and November 2021, **297 people** received an incentive for hepatitis C testing, treatment, and/or treatment follow-up.

Only one service (the Pharmaceutical Rehabilitation Service), could dispense DAA treatment directly to clients. They issued cash incentives for testing and treatment and offered people the option to use it to pay the out-of-pocket prescription expenses of $19.80 for their course of DAAs.

Lessons and reflections

The project observed that incentives created an administrative burden for funders and implementers. Flexibility in the incentives model was needed to allow services to meet the needs of people in their local communities and their testing and treatment models.

New South Wales: Service Optimisation in Needle and Syringe Programs with Incentives and Clinical Pathways (Project SONIC)

Key findings

In NSW, 11 Local Health Districts (LHDs) participated in this project.

One LHD, South-Eastern Sydney, developed two online workforce development modules for NSP workers to build their hepatitis C testing and treatment capacity and confidence.

Ten LHDs including, Western Sydney, Sydney, South Western Sydney, Northern Sydney, Nepean Blue Mountains, Northern NSW and Mid North Coast, Illawarra Shoalhaven, Hunter New England, Central Coast, and Southern NSW, offered an incentive hepatitis C test and treat model in NSPs

that were co-located with, or had onsite access to, primary care clinics for onward referral when necessary.

The testing modality varied between sites, either using Dried Blood Spot (DBS) testing or venipuncture, conducted by nurses, health education officers, or NSP workers. The incentive amount, and the point at which the incentive was used, varied across sites. For example, participating in an education session or in overdose prevention (naloxone) ($10–$40), testing ($10–$40), returning to receive results ($10–$20), a peer referral ($10 per referral), starting treatment ($20–$30), collecting medication ($20/each month for three months), treatment completion ($20–$30), and travel reimbursement to NSPs ($20).

Between May 2021 and June 2022, **1,033 people** were tested for hepatitis C, of which **113/1033 (11%) were hepatitis C RNA positive.** A total of **30 people started treatment**. The project was unable to report the number of people who received an incentive.

Lessons and reflections

Peer workers were a crucial component of the project because of their ability to connect with people and establish a trusted relationship. Peer workers connected with people who were not accessing the NSP and encouraged them to come into the NSP and receive incentivised hepatitis C testing. The peer workforce was particularly useful when accessing homelessness services or other outreach activities.

While NSPs were a good location to reach and engage people who inject drugs, in peer-led hepatitis C discussions, increasing the reach of the program to other settings (e.g., pharmacies, housing services) would have been beneficial. Expanding the breadth of testing models, to include peer-led point-of-care would have been useful to overcome challenges in linking people to confirmatory (laboratory-based) testing and/or treatment because of a lack of onsite clinical services. Ideally, future models would operate from NSP sites with co-located or onsite prescribers.

The project has prompted further work to improve treatment pathways within/from NSPs.

Peer Based Harm Reduction Western Australia (PBHRWA): Hep C Peer Harm Reduction Education Project – Hep C PHRE

Key findings

In WA, this project recruited and trained peer educators to disseminate accurate information, and normalise conversations, about hepatitis C within their peer networks. Peer workers recorded their 'peer-to-peer education sessions' in a diary that was submitted monthly to the PBHRWA project officer.

Between October 2020 and December 2021, **21 peers were recruited and trained**. A total of **669 people received 'peer-to-peer' hepatitis C education**, of whom 106 were followed up by the project officer to link them to PBHRWA's hepatitis C testing service. Of those referred, **63 people attended clinic appointments for hepatitis C testing and treatment**.

Lessons and reflections

Through this project, peer educators reached people with no previous experience of a hepatitis C discussion and/or who were unaware of the services offered by PBHRWA. The project revealed gaps in knowledge among people who inject drugs, specifically, many did not know that hepatitis C is curable.

Increasing hepatitis C testing could be achieved by simplifying the clinical pathway and enabling peer-led point-of-care testing and venipuncture. The project also identified the need to simplify the data collected by peers about their engagements and discussions.

QuIHN Hepatitis C Community Peer Support Project

Key findings

In Southeast QLD, five peer workers were employed part-time over various periods between 2020 and 2022, to engage people at risk of hepatitis C and link them to community-based testing and treatment. Two of the peer workers, identified as First Nations people, focused on engaging Aboriginal and Torres Strait Islander people at risk of hepatitis C. Due to recruitment and retention challenges, there were two phases of this project involving different peers.

Between September 2020 and September 2021, **58 people** were referred to peer workers. Between March and December 2021, peer workers offered POC testing and **117 people received hepatitis C RNA point of care testing,** of which 81 tests were valid, with a hepatitis C RNA positivity of 10/81 test **(12%)**. Between September 2020 and December 2021, **peers supported 18 people to commence hepatitis C treatment**.

Over the two years of the project, 108 different services were targeted. Services were contacted by phone, or visited face to face, by peer workers to promote the peer support project. Project materials, promoting the role of the QuIHN peers, included posters, flyers and NSP labels. The project did not provide details about the types of services targeted.

Lessons and reflections

The project worked in partnership with Queensland Injectors Voice for Advocacy and Action, to create a mentoring and support network for peers that extended the reach of their hepatitis C care model to new services. It emphasised the importance of offering a professional supervision program for peers to ensure that QuIHN continues to offer a safe environment, and employment opportunities, for people with lived experience.

This model elevated the role of peer workers by promoting their services to existing partners and building new relationships with a broad range of services.

A comprehensive marketing and engagement plan, executed consistently, may have amplified the project's reach and impact. The project also identified the additional value of peers offering POC tests to people.

QuIHN Prison Transition Service

Key findings

In QLD, the Prison Transition Service created a vital link between Queensland Prison Health and community-based services, ensuring that people with hepatitis C moving in and out of prison, remained engaged in hepatitis C care. The prison transition worker engaged with potential clients by offering hepatitis C education sessions at their induction (upon entry to prison), attended health clinics to facilitate face-to-face contact with clients, and responded quickly to referrals from clinical staff.

Between January 2020 and June 2021, **376 people were referred** to the prison transition service from 13 Correctional Centres. Of these referrals, the highest need was for initial testing, with 123/376 (32%) of people tested. In total, 287 people were referred for further hepatitis C testing, delivery of results, treatment, or management. Of the people referred, 77 were referred to the QuIHN hepatitis C treatment and management service. 27 people were provided with hepatitis C treatment prescribed by a correctional health service.

Lessons and reflections

The project demonstrated that a dedicated prison transition worker, who had a presence both inside prisons and in the community, enabled strong relationships with prisoners prior to release and increased trust and consistency in support following release into the community. Strong partnerships between Queensland Prison Health, and community services, enabled streamlined pathways for care.

There is a future opportunity to expand the intervention and connect people via in-reach prison services, transition services, and community corrections services. This would establish an enduring option for people at high risk of hepatitis C to access hepatitis C testing and treatment services.

This project received additional funding to continue during 2022–23.

Theme 3: Workforce Development

Overall impact

Seven projects, focused on building the hepatitis C capacity of the health workforce, were implemented across WA, SA, Tasmania, Victoria, and nationally between January 2020 and December 2022. Three main approaches were implemented, including delivery of education and training, support to conduct clinical audits, and facilitating a continuous quality improvement (CQI) cycle.

- Four projects delivered hepatitis C education and training programs, including ASHM, the SA GP Education Project, TasCHARD, and the Aboriginal Health Council of Western Australia (AHCWA).

- Victorian HIV and Hepatitis Integrated Training and Learning (VHHITAL) and Hepatitis WA supported primary care clinics to audit their patient management systems to identify: people at risk of hepatitis C; people who had incomplete testing (i.e. antibody, but not RNA); or, people who were eligible, but had not received treatment.
- The Western Australian Network of Alcohol and other Drug Agency (WANADA) developed a CQI cycle and supported organisations to perform self-reflection and assessment.

All seven projects reported the same metric (i.e., the total number and type of services that were engaged as part of the project). In total, **82 primary care practices, 12 alcohol and other drug services, and 14 Aboriginal Community Controlled Health Services** participated, reaching over 700 staff, including clinical staff (GPs, nurses, nurse practitioners), alcohol and other drug workers, Aboriginal Community Controlled Organistion staff, community workers, medical students, practice managers, and reception staff.

The seven projects focused on different settings and workforces and not all projects stratified the data by the role of participants. Of the seven projects, three (Victoria, SA, national) reported the same metric (i.e., the number of GPs, nurses, and nurse practitioners reached). Across these three projects, **122 General Practitioners (GPs), 122 nurses, and 48 nurse practitioners** participated in education and training workshops on hepatitis C testing, treatment, and care.

One project focused on **Aboriginal Community Controlled Health Services** in WA, **125 staff,** clinical and non-clinical, were trained on hepatitis C. Evaluation data showed there was an increase in participant knowledge after attending the Birds and BBVs program. Of note, 96% of people would recommend the course to others, and 93% agreed that “at the end of this training I am confident that I could provide information on testing for hepatitis C”.

One project focused on **AOD services** in WA**, with 88 staff** participating in hepatitis C-related education, which subsequently enabled them to identify areas for improvement. Pre- and post-training knowledge surveys were completed by 80 participants. Post-training survey results revealed there were increases in knowledge by 30% or more around hepatitis C testing, treatment, and the health impacts of hepatitis C.
One project had a broad, community-focus. **130 community service workers** and **45 medical students** in Tasmania received hepatitis C-related health promotion resources and information. No specific outcomes were reported.

Two projects, in Victoria and WA, focused on using patient management software for CQI activities. The projects reported the same metrics (i.e., total number of practices engaged in the projects). A total of 23 primary care practices were reached. The Victorian project reported the number of specific staff engaged which was **seven GPs, four practice nurses**, **three practice managers**, and **three reception staff** across eight practices. Practice staff were trained in CQI activities with a hepatitis C focus and conducted systematic searches of patient management software. A total of **1,837 people were identified as needing follow-up** for hepatitis C care.

In WA, **ten ‘hepatitis C champions’** (specific role not described) in primary care practices were trained to lead hepatitis C activities, specifically clinical auditing. A total of **1,884 people were identified as needing follow-up** for hepatitis C care.

Victoria: Hepatitis C Quality Improvement Project in North Western and South Eastern Melbourne Primary Health Networks

Key findings

In Victoria, the VHHITAL program implemented two structured data driven quality improvement (QI) projects – through the North Western Melbourne Primary Health Network (NWMPHN) in 2020, and South Eastern Melbourne (SEMPHN) in 2022. Both projects aimed to increase hepatitis C management in primary care practices through a supported QI activity. This involved facilitated learning workshops, peer learning, in-practice clinical mentoring, QI coaching, and discussing data measures and analysis, and supported implementation of the EC Australia Practice Support Toolkit. The clinical audits were conducted to identify people at risk of hepatitis C who had not been offered a test, and people with hepatitis C who had not been linked to treatment.

In 2020, NWMPHN engaged five GPs, three Practice Managers, and two practice nurses, across four primary care practices. They were trained and supported to audit their patient clinical information systems, finding 110 people at risk of hepatitis C or a current diagnosis or history of hepatitis C, or who had been treated and required post-treatment follow up. Additional data, beyond the project's end date, is presented in the infographic.

In 2022, SEMPHN engaged two GPs, two practice nurses, and three reception staff, across eight primary care practices. They audited their patient management systems, finding 1,727 people at risk of hepatitis C. The project was unable to report the number of patients who were recalled and/or tested.

CQI methodology increased awareness about hepatitis C in primary care clinics and led to the development of transferrable skills, as it enables practice staff to conduct audits in other disease areas.

Lessons and reflections

To increase the profile of hepatitis C in general practice, future projects could focus on engaging people at risk of hepatitis C and people at risk of hepatitis C-related liver disease (such as, people with cirrhosis or abnormal liver function tests, or non-communicable diseases, like fatty-liver disease). Improvements in data quality (including ensuring hepatitis C risk factors, specifically injecting drug use, are captured in patient clinical information systems) would facilitate the identification of people at risk of hepatitis C. Collecting data on the number of people who are recalled, tested and linked to treatment would improve our understanding of the effectiveness of CQI activities in primary care.

A reflection from the NWMPHN project was that a six-month QI project in general practice, that relied on patients visiting the practice, may not see a measurable impact during a short implementation period. Therefore, it is important to monitor data beyond the implementation period including measurable sustainable improvements and QI in practice.

Clinical partners, including the Integrated Hepatitis Nurses, were integral to delivering education to general practice staff. Their role could be expanded to provide ongoing support to GPs and practice nurses.

Hepatitis WA: Regional Clinical Development Project

Key findings

In WA, an experienced practice manager was employed by Hepatitis WA to train and upskill clinical staff in primary care clinics in the Pilbara, Goldfields, and the Wheatbelt. They were trained to conduct audits of their patient management systems to identify people living with, and at-risk of, hepatitis C and link them to testing and treatment.

Between May 2020 and March 2021, the project reached out to 32 primary care practices. **Eleven practices participated in the clinical audit component of the project from which 10 'hepatitis C practice champions'** were identified and trained. Through patient management system audits, **47 people were identified as needing further hepatitis C testing and care**. Fourteen people were recalled, with one person starting hepatitis C treatment.

Lessons and reflections

Whilst 'hepatitis C champions' were identified and trained, they lacked the time and autonomy to focus on hepatitis C alongside their regular duties, particularly during the COVID-19 pandemic. Interestingly, the project noted that in practices where the practice manager or nurse could autonomously recall a patient, the effectiveness of using patient management systems to identify and recall patients increased.

The project needed to be implemented remotely (due to the COVID-19 pandemic) which may have limited its ability to support practices effectively. However, the remote implementation did increase the geographical reach of the project.

Western Australian Network of Alcohol and other Drug Agencies (WANADA): Increasing Alcohol and Other Drug Service Users' Access to Hepatitis C Testing and Treatment

Key findings

In WA, **twelve alcohol and other drug (AOD) services** participated in the project to develop their capability to deliver hepatitis C care to service users at-risk of hepatitis C and contribute to the uptake of treatment. WANADA developed the Hepatitis C Virus Capability Assessment Tool (HCVCAT) to assist specialist AOD organisations to review their service capability to provide hepatitis C care.

Before the project, services were aware of risk factors for hepatitis C, but had limited and variable pathways to testing and treatment. At the 12 participating services, **88 AOD staff** completed pre-post-training evaluation to identify changes in hepatitis C care within their practice. There were significant improvements in knowledge because of the training. The post-training knowledge survey indicated nearly all workers were aware of hepatitis C transmission risks, the function of the liver, and the risk factors for developing chronic liver disease. There was at least 30% increase in knowledge around hepatitis C testing, treatment, and health impacts.

At completion of the project, services had developed referral pathways and relationships with hepatitis C treatment providers. They reported placing greater importance on hepatitis C care at their services.

Lessons and reflections

Use of the HCVCAT allowed services to reflect on, and change, their response to hepatitis C. Peer-led training helped address the stigma associated with hepatitis C within AOD services, and increased health workers' confidence in raising awareness of treatment and linking service users to care.

This project received a further 12 months of funding from WA Health to support further implementation of the HCVCAT to additional AOD services in 2022–2023.

Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM): Creating Champions of Change

Key findings

This project delivered a series of national educational activities, and evaluated 'Beyond the C' (a clinical audit and case-finding project to enhance hepatitis C testing, treatment, and care).

Nationally, between 2020 and 2021, **99 nurses and 48 nurse practitioners** participated in online hepatitis C training courses. They were from public and private hospitals, general practice, corrections, metropolitan and regional locations, AOD services, community health, Aboriginal Health Services, Sexual Health Centres, mental health and homeless health services.

The Beyond the C project recruited 27 sites across nine Primary Health Networks, including three sites in regional centres, nine in rural settings, one remote site, and one very remote locality. The virtual design provided the ideal environment for supporting enrolled practices with their case-finding and clinical auditing CQI activities. Participants indicated the project made tangible improvements to practices' ability to identify, recall, test, and treat patients with hepatitis C.

Lessons and reflections

Moving to online delivery for the educational activities provided increased accessibility, and flexibility of learning and development opportunities, particularly at a time when the health workforce had reduced capacity and experienced competing demands due to the COVID-19 pandemic.

Evaluation of the Beyond the C program identified strong interest in delivering hepatitis C care and identifying people who are at risk, previously tested and/or not treated. ASHM reflected on the importance of establishing relationships with local networks, such as Primary Health Networks and Local Health Districts, to support practices in a sustainable model of CQI.

This project received a further funding from Commonwealth Department of Health as part of the National Hepatitis C 50,000 Project continue the Beyond the C project over 2022–2023.

South Australia: GP Peer Education Project

Key findings

In SA, the GP Peer Education Project provided in-house GP-to-GP education and support for testing and treatment of hepatitis C to high caseload clinics located in the northern suburbs of Adelaide.

Between 2020 and 2021, **115 GPs** and **23 nurses** across **38 primary care practices** received education and support from a GP (peer). Of these practices, 14 agreed to audit their patient management systems to identify people (at high-risk of hepatitis C) for further clinical care.

The project provided tools, resources, and support to allow GPs to treat patients in primary care instead of referring them to specialist care. It reported increased GP awareness of the key changes to hepatitis C treatment options.

Lessons and reflections

The project found that the administrative burden exceeded their expectations. Future iterations of the project would benefit from administrative support. Further, the resourcing of a second GP educator would have been useful.

Aboriginal Health Council of Western Australia (AHCWA): Hepatitis C Project

Key findings

In WA, this project worked with Aboriginal Community Controlled Health Organisations to increase awareness of, and enthusiasm around, hepatitis C testing, diagnosis, and management. This involved delivery of the 'Birds and BBVs' education program, and the provision of resources and support to conduct clinical audits.

Between September 2020 and October 2021, **105 staff** received hepatitis C specific education sessions across **13 Aboriginal Community Controlled Health Services (ACCHS)**. Due to the COVID-19 pandemic, face to face education was put on hold and online information sessions were developed. Thirteen online sexual health sessions were delivered to 140 staff from ACCHS, WA Department of Health and other services who work with Aboriginal people between February and June 2022, of these sessions, three focused on hepatitis C and harm reduction.

It was not reported how many participants completed post-course evaluation. However, the project reported that evaluation data showed there was an increase in participant knowledge in all training objectives of the Birds and BBVs program. Of note, 96% of people would recommend the course to others, and 93% agreed that "at the end of this training I am confident that I could provide information on testing for hepatitis C".

Six ACCHs participated in audits of their patient management system. Sixteen people who were hepatitis C antibody positive were identified. One person was recalled. No other outcome data was provided.

Lessons and reflections

The project raised awareness about hepatitis C among ACCH staff and highlighted the need to embed hepatitis C management into regular service delivery. To ensure hepatitis C prevention is prioritised, AHCWA increased their advocacy for point-of-care hepatitis C testing, and NSPs in ACCHs. Continuity of staff was a challenge for this project.

A valuable insight was that in the future, a focus on addressing stigma, and perceptions of hepatitis C, would be important to increase engagement with hepatitis C care in Aboriginal Health Services.

Tasmanian Council on AIDS, Hepatitis & Related Diseases (TasCHARD): Tasmanian EC Australia Community Education Project

Key findings

In Tasmania, this project delivered a multipronged health promotion campaign for people at-risk of hepatitis C, and the health and social workforce in Hobart, to increase access to hepatitis C testing, treatment, and harm reduction strategies.

Between October 2019 and September 2020, the project provided health promotion sessions to **130 community service workers** and **45 medical students.** A total of **47 organisations** were engaged during the project and 19 resources were created to increase awareness of hepatitis C. A total of 12 sessions were delivered to prison residents and 2,500 hepatitis C treatment information cards were distributed to NSPs.

AOD support services welcomed hepatitis C education and professional development opportunities and identified that further support is needed to increase awareness of hepatitis C treatment and referral to hepatitis C testing services.

Lessons and reflections

The project observed that through increasing its presence in the community, and producing a breadth of hepatitis C resources, it strengthened the organisation's capacity to deliver hepatitis C-related health promotion.

This project received further funding from Primary Health Tasmania to expand service delivery in rural and remote Tasmania between July 2021 and June 2022.

Theme 4: Surveillance

Overall impact

Three projects aimed to maximise opportunities to increase linkage to care among people testing hepatitis C antibody positive. Two projects, conducted in QLD and Victoria, were based in their Departments of Health. They used passive surveillance systems (notifications of hepatitis C) to

contact diagnosing clinicians, obtain information on any further care provided to the people identified, encourage clinicians to follow patients up and provide further care when needed.

The third project was based in a tertiary outer metropolitan hospital. It undertook opt-out hepatitis C antibody testing on pathology collected during emergency department (ED) visits and followed-up people identified as hepatitis C antibody positive.

The NSW and QLD notifications projects reported similar outcomes (i.e., number of people eligible that received a follow up hepatitis C RNA test). In NSW, **33/42 (79%) of people** who were hepatitis C antibody positive and unknown hepatitis C RNA, **were followed up with hepatitis C RNA testing**. In QLD, **36/62 (58%) of people** who were hepatitis C antibody positive and unknown hepatitis C RNA, **were followed up with hepatitis C RNA testing** but did not advance to treatment (number of people HCV RNA positive after follow-up not reported).

Both projects also reported the number of people prescribed treatment for hepatitis C (following positive hepatitis C tests and follow-up by the project). In NSW, **four out of five (80%) people who were hepatitis C RNA positive were linked to care and treated**. In QLD **26/62 (42%) of people who were eligible for follow-up by the project (i.e., HCV RNA test not found) were prescribed treatment after follow-up**.

Across both QLD and NSW projects, following up hepatitis C notifications resulted in **246/356 (70%)** eligible people **receiving a follow up hepatitis C RNA test** and **41/117 (35%)** people being **prescribed treatment**.

NSW: SEARCH 2

Key findings

In NSW, this project developed an automatic computer algorithm to screen and test eligible adult patients, admitted to the emergency department for hepatitis C antibody (hepatitis C Ab) using blood already collected during the emergency visit. The project also conducted a patient survey to evaluate patient perspectives on this model of testing.

For a three-week period in July 2021, **2,028 people had hepatitis C testing** 'added on' to any pathology taken during an ED visit. Of those tested, 69/2,028 (3%) were hepatitis C antibody positive, of whom 12/69 (17%) were 'new' hepatitis C antibody positive diagnoses.

Of the 69 people who were hepatitis C antibody positive, 42/69 (61%) required hepatitis C RNA testing (i.e., not currently on treatment). Of those 42, 33/42 (79%) received hepatitis C RNA testing, and 5/33 (**15%) were hepatitis C RNA positive**. Of these five people, 4 (**80%) were linked to care and initiated treatment**.

A key finding (reported in the infographic) was that 69% of patients supported this model of testing, preferring opt-out consent rather than not being tested. However, importantly, 31% disagreed with this method of testing.

Lessons and reflections

By automating the 'adding on' of hepatitis C testing to standard pathology tests conducted during an emergency department visit, this project trialed 'opt-out' testing. It demonstrated the ability to detect new hepatitis C cases and link them to care.

This project is currently being scaled up across five hospital EDs in NSW. Ongoing funding has been received from the Ministry of Health, NSW.

Victoria: Coordinated Hepatitis Responses to Enhance the Cascade of Care by Optimising Existing Surveillance Systems (CHECCS)

Key findings

In Victoria, this project established innovative surveillance system-based follow up of people who were the subject of a hepatitis C notification. Support was provided to diagnosing clinicians and cascade of care measurements were generated.

Between September 2021 and March 2022, further information was sought for 513 notifications, of which 356 (69%) had further information obtained. Of these, 328/356 (92%) of the diagnosing clinicians had provided or attempted to provide follow-up care, such as RNA testing or referral. Of these 328 notifications where care was offered or provided, 246 (75%) clinicians reported they had ordered a hepatitis C RNA test. Of the 117 people who tested hepatitis C RNA positive, 45 were offered treatment, while another 64 were referred for further care or the clinician reported they intended to provide further care in the future. For eight notifications, the clinician reported no reason for not offering treatment, or the patient was lost-to-follow-up.

Of the 286 clinicians contacted directly, 100 (35%) requested further resources to assist with management, and 28 (10%) reported that CHECCS led to engagement or re-engagement of the case. For those that were identified as requiring a second follow-up call due to the case being considered high risk of loss to follow up (47 cases), 28 (59%) reported that CHECCS follow-up led to improved engagement.

Lessons and reflections

The project demonstrated benefits of enhanced follow up for people at risk of loss to follow up, and many diagnosing clinicians were provided with resources and support. Strong links were established for diagnosing clinicians with Victoria's Integrated Hepatitis C Nurses, helping bridge care gaps for marginalised people. Lack of contact with diagnosing clinicians was a key gap, particularly for cases diagnosed in hospital settings.

This approach has been best practice for use and scale up by Victoria's Local Public Health Units, embedding cascade of care data points into the Victorian Surveillance System, providing real time data about care uptake and treatment.

Queensland Health Notifiable Conditions System Follow Up of New Hepatitis C Cases

Key findings

In QLD, this project aimed to use notifications data to identify people who were diagnosed for the first time with a positive hepatitis C antibody test. Queensland Health contacted clinicians about patients who had not received a hepatitis C RNA test and encouraged further testing.

Between November 2020 and June 2021, **769 notifications of people who tested hepatitis C antibody and/or RNA positive,** and not been notified in Queensland previously, were received by the Queensland Health from community-based clinicians. Of those, 244/769 (**32%) people had no hepatitis C RNA test recorded and required clinical follow-up**. Of the 244 notifications for which diagnosing clinicians were contacted, 134/244 (55%) of people were lost to clinic/clinician-led follow-up, 48/244 (20%) people had already been treated or were being case-managed, and 62/244 (25%) people were recalled by their clinician and had hepatitis C RNA testing. Of these 62 people 33 tested negative, three tested positive but were not treated, and 26 (42%) were treated ***after follow-up by the project***.

The project found that 34% (83/244) of notifications, with no evidence of a hepatitis C RNA test, were from hospital-based clinicians (hospital or emergency department).

Lessons and reflections

The project concluded that providing clinicians with direct support and information, after a notification, can increase testing and treatment.

The project highlighted that hospitals do not have a consistent and coherent approach to following-up people tested for hepatitis C.

Ongoing funding

The following nine projects received ongoing funding enabling their continuation (see section 'EC Australia funding secured as a result of the partnership' for details):

- ASHM: Beyond the C,
- Hepatitis ACT: Hepatitis C Outreach Clinic,
- Hepatitis Queensland: Community Corrections Project,
- Liverpool Hospital: SEARCH 3,
- QuIHN: Prison Transition Service,
- Tasmanian Council on AIDS, Hepatitis and Related Diseases: Education,
- South Australia (SA) Health: Point of Care Testing Scale-up,
- Tasmania Statewide Sexual Health Service: Tasmanian Eliminate Hepatitis C Australian Outreach Project,
- Western Australian Network of Alcohol and Other Drug Agencies: Increasing Alcohol and Other Drug Service Users' Access to Hepatitis C Testing and Treatment.

IMPLEMENTATION RESEARCH

Progress on the milestones 2022
1. Preparation for NHMRC Partnership Grant resubmission: completed

CONNECT C

Updates and progress 2022

The National Health and Medical Research Council (NHMRC) partnership grant proposal, now known as CONNECT C, was successful in the 2022-2023 funding round. CONNECT C has partner commitments from all mainland jurisdictional Departments of Health, National Peak Bodies, and community and clinical partners. Along with commitments from local health agencies and public health units in New South Wales, Queensland, and Victoria.

CONNECT C's goal is to identify effective strategies for using hepatitis C notification data to identify and link people diagnosed with hepatitis C to appropriate care pathways, offering timely access to treatment and hepatitis C cure.

It will be delivered over a four-year period with three key phases:

Phase 1 Enabling Environment: participatory workshops with government departments, affected communities and primary care providers,
Phase 2 Implementation and evaluation of interventions: implement and evaluate interventions to identify the most effective strategies, and
Phase 3 Modelling and research translation: effectiveness/cost-effectiveness modelling to identify optimal approaches, and share learnings and inform standards of practice that can be sustained within government public health units.

Work in 2023 and beyond

CONNECT C is currently in the project initialisation phase, establishing governance, frameworks and undertaking a comprehensive environment scan of hepatitis C notifications' operational and regulatory systems in Australia.
Once established, work for 2023 will focus on **Phase 1**, which includes:

- Development and delivery of participatory workshops, and
- Co-design of Aboriginal and Torres Strait Islander programs.

EVALUATION AND SURVEILLANCE

Progress on the milestones 2022
1. Delivery of the fourth annual *Australia's progress towards hepatitis C elimination* national report: completed 2. Cirrhosis and Hepatocellular Carcinoma monitoring: completed 3. Cost effectiveness and resource mapping models for hepatitis C elimination: completed

Progress toward hepatitis C elimination national report

Updates and progress 2022

To understand progress towards hepatitis C elimination, gaining insights from data is essential. This can range from measurement of new infections, counts of people tested and treated, and people receiving hepatitis C-related liver transplants, through to projections based on mathematical modelling. The fourth annual *Australia's progress towards hepatitis C elimination* (the report) was released on Friday, 18 November 2022. It was launched at a public webinar, with guest speakers from the Burnet Institute, Kirby Institute, Hepatitis Australia, University of Queensland Poche Centre for Indigenous Health, Harm Reduction Victoria, Royal Prince Alfred Hospital, and St Vincent's Hospital.

The report brings together national data from across the sector (over 20 different sources of data) to give an overview on progress towards eliminating hepatitis C in Australia by 2030. The development of the 2022 report included a process of community consultation; organisations generously gave their time for consultation including (alphabetical order): Australian Federation of AIDS Organisations (AFAO); Australian Injecting and Illicit Drug Users League (AIVL); Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM); Hepatitis Australia; National Aboriginal Community Controlled Health Organisation (NACCHO); National Association of People with HIV Australia (NAPWHA); and NSW Community Restorative Centre (CRC).

The report highlights the urgent need to improve the rates of testing and treatment if Australia is to stay on track and meet its elimination goals. It highlights the crucial role of prison-based hepatitis C care in delivering treatment in Australia, but also the declines in testing and treatment in community services that need to be addressed. The report highlights gaps in our knowledge and informs future directions in Australia's hepatitis C elimination response. Future reports will aim to fill gaps identified and collate data for all priority populations and settings.

The report was recently used by the Victorian Department of Health to inform the government's strategic plan to eliminate hepatitis C (Victorian Hepatitis C Plan 2022–2030).

Work in 2023 and beyond

The fifth *Australia's Progress towards hepatitis C elimination* report will be produced in 2023.

Image 4. Key findings captured in the report.

Eliminating hepatitis C in Australia

Where are we now 2022

KEY FINDINGS

The rate of **new infections** has **declined** since 2016. This positive trend demonstrates Australia's progress towards reducing transmission.

95,395 people received direct-acting antiviral (DAA) treatment between March 2016 and the end of 2021.

Between the start of 2016 and the end of 2020, **43%** of people living with hepatitis C had been **treated.**

Medicare data shows **declines in testing** since **2016.**

At the end of 2020, an estimated **117,800** people were still living with hepatitis C, highlighting the challenge remaining to eliminate hepatitis C in Australia.

Challenges remain in ensuring **equitable access to treatment** across **metropolitan, rural,** and **remote** locations.

The **number treated** each year continues to **decline.**

More investment is needed to tackle experiences of **stigma,** which have not improved between 2018 and 2021.

The **COVID-19** pandemic **increased challenges** to accessing health care for people affected by hepatitis C.

Burnet reach for the many

UNSW Kirby Institute

Source: Burnet Institute and Kirby Institute. Australia's progress towards hepatitis C elimination: annual report 2022. Melbourne: Burnet Institute; 2022.

Cirrhosis and Hepatocellular Carcinoma (HCC) monitoring

Updates and progress in 2022

Our aims

Our work in monitoring liver cirrhosis and HCC liver cancer, focuses on two aims, to:

1. Determine the impact of hepatitis C treatment (direct acting antivirals, or DAAs) on hepatitis C-related morbidity and mortality due to liver cirrhosis and liver cancer, and
2. Improve the linkage of people with hepatitis C-related cirrhosis into liver cancer surveillance programs and specialist care and keep them engaged with care and monitoring for liver cancer.

In 2022, our work focused on the first of these aims, including to identify challenges facing the population of people with hepatitis C-related liver disease. All 2022 milestones were achieved.

Our work on the second aim (improving linkage to care and monitoring) has begun and continues through 2023 and beyond.

Lessons and insights in 2022

DAAs have reduced the impact of liver disease in people with hepatitis C across Australia. This is reflected in the decline in hepatitis C-related liver transplants, nationally, since 2016 – including a decline in the annual number, and the proportion, of liver transplants for people with (or cured from) hepatitis C (*based on data from ANZLITR, the Australia & New Zealand registry of adult liver transplant recipients since 1985*).

Decline in liver transplants for hepatitis C since introduction of hepatitis C cure in Australia

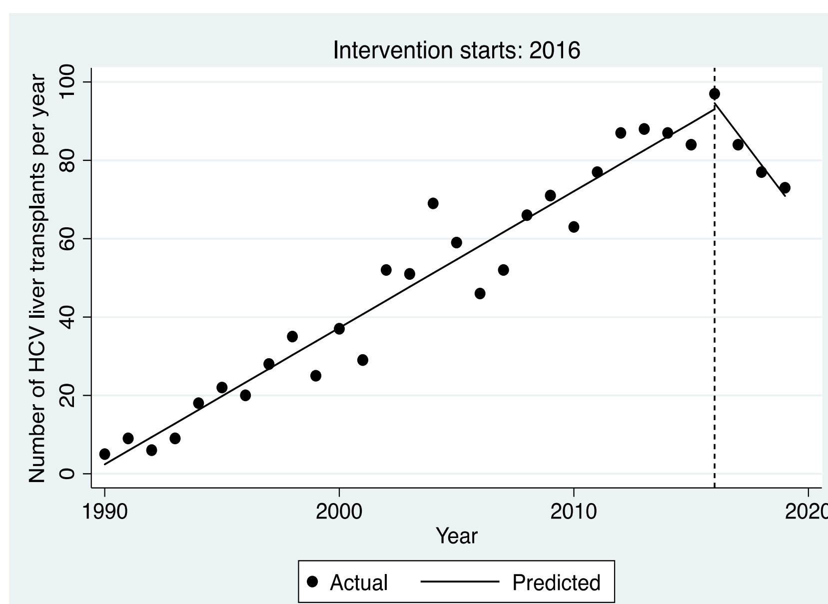

Figure 2. Regression analysis reflecting the decline in liver transplants following the introduction of DAAs since 2016.[2]

[2] Australia & New Zealand Liver & Intestinal Transplant Registry (ANZLITR)

DAA treatments are having a direct impact on the decline in hepatitis C-related cirrhosis in Victoria (*based on data from the PRECISE study of cirrhosis cases in Victoria since 2010*).

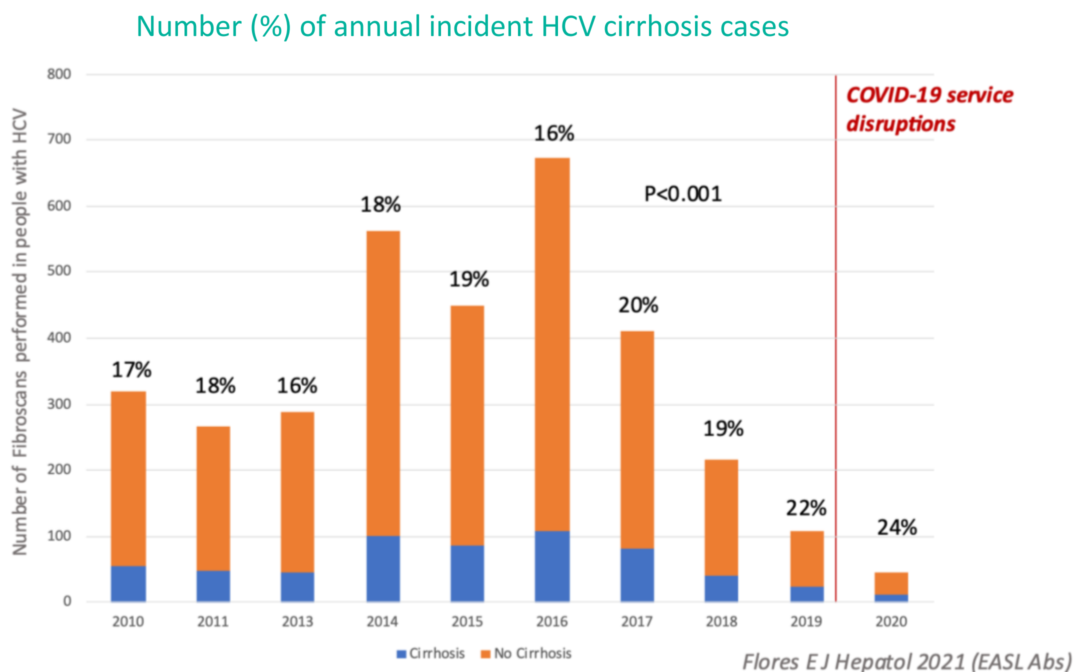

Figure 3. Number (%) of Fibroscans performed on people with and without hepatitis C-related cirrhosis between 2010 to 2020.[3]

DAAs are also contributing towards the decline in hepatitis C-related liver cancer (*based on data from the HOMER 1 & 2 studies of HCC cases in Greater Melbourne since 2012*).

Encouragingly, the HOMER studies also shows that hepatitis C is no longer the leading cause of HCC liver cancer in Victoria – it now ranks third after alcohol and metabolic associated fatty liver disease (MAFLD).

Things are less positive for people living with hepatitis C-related cirrhosis. Data indicates that a diagnosis of cirrhosis often happens too late, there is poor linkage of people to specialist care, and there is a decline in monitoring of people's risk of developing liver cancer (through liver cancer surveillance), all of which indicates an increasing risk of morbidity and/or mortality for this population.

On cirrhosis, data from the HOMER study indicates that one in three people get their first cirrhosis diagnosis when they are also diagnosed with liver cancer, which is too late. While the COVID-19 pandemic may have affected surveillance uptake of testing for cirrhosis in the 2021-22 data, there is likely to be a lack of assessment of cirrhosis in at-risk populations. Further research is needed to identify reasons underlying the lack cirrhosis assessment, and how this could be addressed.

[3] Flores JE, et al. *J Hepatology* 2021 (EASL Abs)

For 24% of people with a new diagnosis of cirrhosis by Fibroscan (as identified in the PRECISE study), there was no evidence of a referral to specialist care from a GP. A further 20% of people were diagnosed and referred but did not attend the specialist appointment. The data suggests a significant number of people who may need specialist care aren't seeing a liver specialist. Further work is underway to interrogate the data further to determine the extent and potential reasons for this issue.

On liver cancer, almost one third (30%) of people diagnosed with hepatitis C-related primary liver cancer, in Victoria, had not been treated for their hepatitis C (as shown through the HOMER studies). This suggests there is a group of people living with hepatitis C who are not currently accessing DAA treatment and face a high-risk of liver disease/liver cancer. This group should be prioritised for access to testing and treatment.

Only 31% of people diagnosed with hepatitis C-related liver cancer identified as someone currently injects, or has injected, drugs (based on data from the HOMER studies). People who inject drugs are a priority population for hepatitis C health promotion and screening. However, it seems there is a group of people with liver cancer and hepatitis C who have not been reached by these activities, and who may not know about their higher risk of developing liver cancer or how to address it. Among this group, further research is needed to better understand how to ensure all people who might be at risk of hepatitis C are offered testing and appropriate linkage to care.

On liver cancer surveillance, there has been a decline in regular monitoring for liver cancer in people with hepatitis C-related cirrhosis since 2016 (based on data from the HOMER studies) – with only 41% of hepatitis C-related liver cancer cases diagnosed through a surveillance program, compared to more than 50% in 2012-13.

Further, more than two-thirds (70%) of people with hepatitis C-related cirrhosis and liver cancer had been treated for hepatitis C, but not enrolled in liver cancer surveillance, despite being at increased risk for developing liver cancer. This highlights missed opportunities to monitor for liver cancer and identify it earlier and/or poor linkages to specialist care.

To improve health outcomes around liver cirrhosis and liver cancer for people with (or cured of) hepatitis C, there needs to be an increase in earlier diagnosis of cirrhosis, greater linkage to specialist care, and greater uptake in liver cancer surveillance. These issues are a crucial part of our work in Aim 2 of this project.

Work in 2023 and beyond

The PRECISE cohort study (of cirrhosis cases in Victoria) will conclude in December 2023. As will the CAPRISE cohort study (of liver health blood markers in the general population in Victoria through pathology), and the HOMER 2 cohort studies (of liver cancer cases in Greater Melbourne). However, prospective follow up of the cohorts of people in the PRECISE and HOMER 2 studies will continue into 2024.

The HCC Optimal Care Pathway working group will meet in late-2023 and early 2024 to discuss issues such as, benchmark achievements and discrepancies in case definitions and mortality outcomes.

We are providing data on HCC case ascertainment, from the HOMER studies (via the Victorian Cancer Registry) to the Australian Institute of Health and Welfare, to assist in its work on the national HCC case definition in late-2023.

There will be further discussions in 2023 about the potential to link Victorian prospective case ascertainment and data collection systems with plans for a national liver cancer database (e.g., through Monash University) to enable long-term data surveillance and monitoring of liver cancer.

Cost effectiveness and resource mapping models for hepatitis C elimination

Allocative efficiency modelling

Updates and progress in 2022

Mathematical modelling was used to quantify the benefits of investing in interventions to improve diagnosis and treatment for hepatitis B, hepatitis C, HIV and sexually transmitted infections (BBVSTIs), over 2023-2030. The modelling was conducted for the Commonwealth Department of Health and involved consultations with a number of stakeholders from community, health and academic organizations.

The hepatitis C component aimed to identify care cascade interventions that should be prioritised to achieve 90% diagnosis and 80% treatment targets by 2030. There were 24 hepatitis C interventions modelled, which were parameterised through available literature of pilot studies or intervention trials designed to increase diagnosis, linkage to care, treatment uptake and workforce capacity to deliver services. Many of these interventions were based on evidence generated through EC Australia studies. Conducting sub-national analyses was explored, but insufficient data on risk populations was available to enable meaningful analysis.

The results were presented at the September 2022 Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS) meeting and are being used to inform budget submissions and decisions around intervention prioritisation. The final report was submitted to the Commonwealth Government in October 2022.

Work in 2023 and beyond

Ethics approval is currently being sought to allow results to be made publicly available outside of this government reporting framework, with the aim being to produce a peer-reviewed publication in 2023.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH STRATEGY

Progress on the milestones 2022
Update on Aboriginal Health Strategy: 1. Bulgarr Ngaru Quality Improvement Program for BBV/STIs: in process 2. Aboriginal burst of the *It's Your Right* campaign: completed 3. National hepatitis C Health Promotion Campaign for ACCHOs: in process

Bulgarr Ngaru Medical Aboriginal Corporation Quality Improvement Program for Bloodborne Viruses (BBVs) and Sexually Transmitted Infections (STIs)

Update on Progress in 2022

EC Australia has continued to work in partnership with Bulgarr Ngaru Medical Aboriginal Corporation (BNMAC) and the ASHM to increase testing and treatment of BBVs and STIs among Aboriginal communities. The project works towards achieving micro-elimination of hepatitis C across BNMAC services in Northern NSW with a focus on building capacity in the management of STIs and BBVs.

The project was delayed due to the impacts of COVID-19 outbreaks in 2021 and the 2022 floods across Northern NSW. A variation to the project contract was granted and the project has been extended until October 2024. Phase 1 of the project has been completed. EC Australia is working closely with BNMAC to deliver Phase 2 and Phase 3.

Phase 1: Workforce Development and Education

Phase 1 was delivered in late November 2022. Through the delivery of two training packages, this activity focused on building workforce capacity. Sessions on the 'Introduction to Sexually Transmitted Infections' and 'Hepatitis C for Aboriginal and Torres Strait Islander Health Workers and Practitioners' were delivered. These training packages aimed to build staff knowledge and awareness of culturally appropriate approaches to increasing testing and treatment coverage for STIs and BBVs.

Eleven staff attended the training including general practitioners, reception staff, Aboriginal and Torres Strait Islander health workers, managers and nursing staff. Seven participants completed a post-course survey indicating that the course provided participants with a good base knowledge of the BBV/STIs. Participants also reported a significant increase in confidence to discuss and encourage BBV/STI screening and treatment uptake with clients. Participants appreciated content that focused on how to start a conversation with clients, both sensitively and in a culturally appropriate way.

What's next and future work in 2023 & 2024?

Phase 2 (Implementing a Continuous Quality Improvement framework to improve surveillance and clinical indicators of STIs and BBVs) has commenced across all sites and is due to be completed by mid-2023.

Phase 3 (Community campaigns with rapid point-of-care testing, and a peer-referral incentives program for patients along the care cascade for hepatitis C) will be implemented from mid-late 2023.

BNMAC was successful in acquiring two GeneXpert Point of Care Testing Systems as part of the Kirby Institute's, National Australian hepatitis C Point-of-Care Testing Program. Nursing and Aboriginal Health Worker staff are currently undertaking operator training provided by the International Centre for Point of Care Testing (Flinders University). The machines will be integrated into current models of care and used at outreach clinics in discrete Aboriginal communities in Northern NSW.

Aboriginal and Torres Strait Islander burst of the *It's Your Right* campaign

Update on Progress in 2022

Findings from focus testing of *It's Your Right* campaign messages in 2022 indicated that campaign materials would be more meaningful and effective for Aboriginal audiences by incorporating Aboriginal artwork and language. Consequently, the project was expanded to include a separate burst that specifically targets Aboriginal people who inject drugs. This expansion included a separate burst of activities and resources featuring Aboriginal artwork, and messaging aimed to increase hepatitis C testing and treatment uptake in Aboriginal people who inject drugs.

An Aboriginal design agency (We Are 27 Creative) worked with a small group of Aboriginal peer workers, through five online workshops, to codesign artwork and culturally appropriate messages. Using an Aboriginal design agency ensured Aboriginal culture and custom were prioritised and incorporated into the design of artwork and messages. We Are 27 Creative used an online word-clouding platform to explore perceptions of family, health, (caring for) country and culture, which informed the theme *Bloodlines* and corresponding artwork, as outlined in the diagram below.

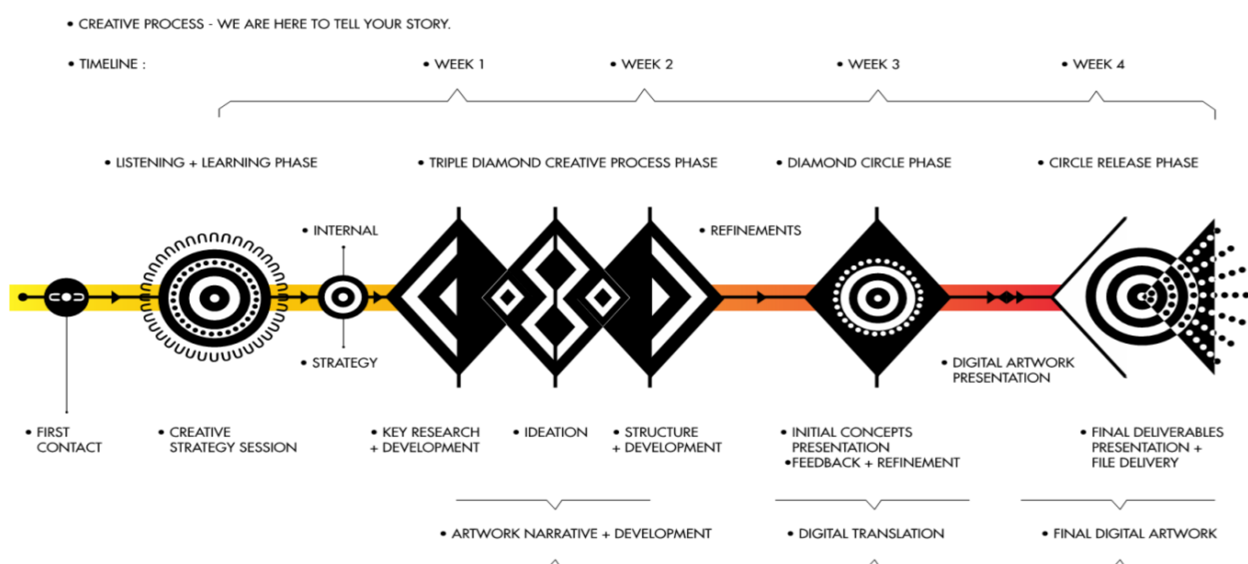

Figure 4. The cultural framework used for the creative process.

Bloodlines speaks to Aboriginal people and considers bloodlines as Mob (people) and connection to Country – 'all is one'. It recognises that all aspects of land, sea and sky are interconnected. The artwork also resembles a cross-section of the body, depicting blood vessels, blood cells and the healing and repairing of the body, relevant to bloodborne viruses and hepatitis C. Equally, *Bloodlines* represents celestial bodies and places of meeting. The central motifs represent Mob and people coming together. These messages are captured on the postcard pictured below.

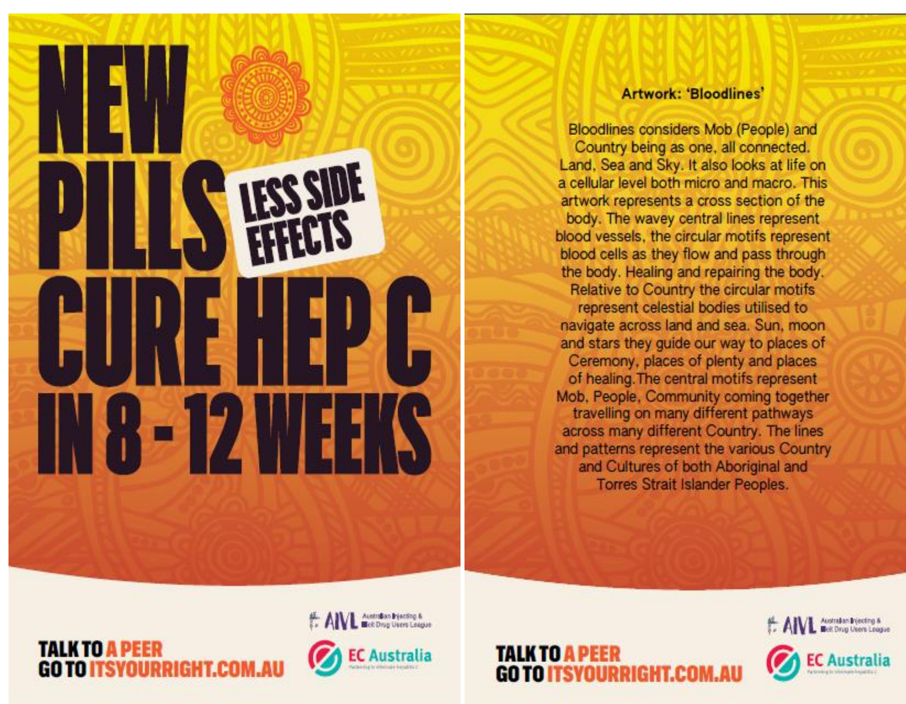

Image 5. The postcard resource describing the *Bloodlines* theme coupled with a selected message and call to action.

A suite of resources was developed, including seven tailored messages and colours representing the Aboriginal and Torres Strait Islander flags, and the rainbow to represent the LGBTQIA+ communities. Results from focus testing found that artwork and messaging appealed to Aboriginal audiences. Surveys were administered to Aboriginal clients and peer workers to focus test the messages and artwork developed by the codesign group. Of the 73 responses received, the majority of people viewed both messages and artworks positively, and agreed the messages and artwork were eye-catching, use more inclusive/familiar language, and are encouraging.

As part of the *It's Your Right* campaign, a mix of in- and out-of-house media advertising went into production, including posters, street advertising, mobile billboards, digital posters, social media tiles, shirts, tote bags, and t-shirts with Aboriginal artwork and messages.

Evaluation of the Aboriginal expansion of *It's Your Right*

Findings from the evaluation of the *It's Your Right* campaign found that the campaigns successfully engaged Aboriginal people who inject drugs in hepatitis C testing. 194 Aboriginal people were tested for hepatitis C (14% of all people tested during the campaign), and 16 were referred for treatment. When surveyed, Aboriginal respondents (n=54, 33% of total respondents) emphasised the importance of Aboriginal peer workers, Aboriginal artwork and language,

incentives, and non-judgemental attitudes towards injecting drug use in supporting engagement with hepatitis C care. Inclusiveness enhanced symbolic interactions helped to make peer conversations easier with Aboriginal people who inject drugs within mainstream organisations.

Staff from peer organisations involved in the implementation of the campaign agreed that *It's Your Right* engaged Aboriginal people who inject drugs in hepatitis C testing and treatment through advertising and other campaign activities. Aboriginal-specific assets were considered crucial to the success of the campaign.

Image 6. Posters developed as part of the Aboriginal campaign expansion of *It's Your Right*.

Aboriginal and Torres Strait Islander Hepatitis C Health Promotion Campaign

During 2022 and 2023, EC Australia is collaborating with a network of national partners from the ACCHO sector to design, implement and evaluate the National Hepatitis C Aboriginal and Torres Strait Islander Health Promotion Campaign. It is aligned with the Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018-2022, particularly the key action areas around education and prevention, and testing, treatment and management.

This campaign will work with a number of ACCHOs around Australia, to establish or build on existing local initiatives to improve the rates of hepatitis C testing and linkage to treatment, and reduce the number of Aboriginal people who are undiagnosed or receive late diagnosis of their hepatitis C. The campaign will support the ACCHO sector to provide culturally appropriate, safe, innovative, and effective models of hepatitis C care.

A National Reference Group was convened to co-design the campaign. The Reference Group has representation from 11 partner organisations (listed below) and is working closely with EC Australia, Enigma, and We are 27, to provide oversight of the development, implementation, and evaluation of the campaign.

- National Aboriginal Community Controlled Health Organisation (NACCHO)
- Queensland Aboriginal and Islander Health Council (QAIHC)
- Victorian Aboriginal Health Service (VAHS)

- Pangula Mannamurna Aboriginal Corporation
- Bulgarr Ngaru Medical Aboriginal Corporation
- Institute for Urban Indigenous Health (IUIH)
- Aboriginal Health Council of WA (AHCWA)
- Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
- Derbal Yerrigan Health Service
- Aboriginal Health & Medical Research Council of NSW (AH&MRC)
- Danila Dilba Health Service

Tasmanian Aboriginal Centre (TAC)

Update on Progress in 2022-2023

Workshop #1: Kick off workshop (December 2022):

The Reference Group convened for its first meeting to share learnings, and explore previous assets, messaging and channels, from the *It's Your Right* campaign. In this meeting, Reference Group members were encouraged to vote on preferred pathways. Pathway A proposed adapting existing resources from *It's Your Right* (*'Bloodlines'* theme and artwork), while Pathway B proposed developing an entirely new campaign. A consensus was reached to proceed with Pathway A (see figure 6) as it was a more streamlined and pragmatic approach.

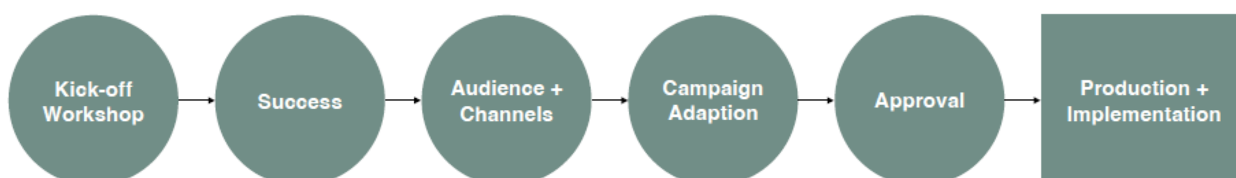

Figure 6. provides an overview of the process required for adapting existing campaign resources (Pathway A).

Workshop #2: Success

The second workshop reviewed the *It's Your Right* campaign and focused on determining markers of success.

Broad markers of success centred around: reducing stigma, shame and discrimination associated with hepatitis C; empowering mob to ask for tests; improving staff confidence to discuss hepatitis C; increasing the uptake of testing and treatment; and translating lessons from the campaign to the community.

Workshop #3: Audience and channels

In the third co-design workshop, the Reference Group explored who the campaign is trying to reach (audience), and how and where the campaign could connect with the audience (channels). From this exploration, the Reference Group identified a range of potential audiences, including Aboriginal Elders; people who have contact with custodial settings; people who inject drugs; the LGBTQIA+ community; and women.

Potential channels for reaching these audiences included health services with point-of-care testing machines; health service staff; or Community and significant events in the Aboriginal calendar.

Workshops #4 and 5: Campaign adaptation

The purpose of the Campaign Adaptation workshops was to revisit the *Its Your Right* Campaign Indigenous Artwork theme "*Bloodlines*" and explore campaign calls to action.

Workshop #4 – Creative adaptation of artwork

The Reference Group explored mediums for advertising, such as vehicles, shirts and other merchandise. They generated ideas around how the *Bloodlines* story could be shared with the audience as part of the campaign. Key ideas included having the artwork prominent in services implementing the campaign; creating ways to engage with the artwork digitally (through online storytelling and animation); using the artwork on merchandise; and using the artwork on vehicles in implementing services.

The Reference Group went on to explore the potential calls to action, with a focus on raising awareness of the campaign's key messages, and prompting people to take action to get tested for hepatitis C.

Workshop #5 – Refining messages, audience, and channel

Workshop #5 focused on reviewing previous discussions, and refining messages, audience, and channels in preparation for development of the first draft of the campaign assets and focus testing campaign messaging with community members. It was decided the suite of messages from the Aboriginal extension of *It's Your Right* will be retained, with additional messages centred around two concepts – the 715 Health Check and Protecting Your Mob – which will be focus tested with community members.

This workshop was also used to discuss site selection for the campaign. The Reference Group is developing an Expression of Interest (EOI) process for new sites, in addition to sites already participating in the campaign co-design process.

Upcoming workshops

In upcoming workshops, the Reference Group will:

- Approve draft campaign designs,
- Focus test the new messages with Aboriginal community members and services,
- Finalise the EOI process and share EOIs with ACCHOs and select sites,
- Finalise the campaign messaging, designs, channels and implementation strategies and activities, and
- Determine an evaluation strategy based on the evaluation of *It's Your Right.*

Work in 2023 and beyond

Production of media assets will commence following completion of all formal workshops. Implementation will take place from mid-2023, with the evaluation planned to commence from late-2023.

ADVOCACY STRATEGY

Progress on the milestones 2022
1. Advocacy engagement work update

Updates and Progress in 2022

Peer Workers

This year, we began exploring how EC Australia can support drug user organisations in the development and sustainability of the peer workforce. Through conversations with peer organisations and drawing on the experiences of several EC Australia projects that highlighted the value of peer worker interventions, we began discussing current workforce development activities and what more is needed, especially given the importance peers in the next phase of elimination. This work is developing collaboratively in 2023.

In June 2022, we co-authored a commentary piece with QuIHN about the role and value of peer workers. It drew on the evaluation of QuIHN's EC Australia peer project. You can read the commentary piece here.

Testing

Following an ASHM and Hepatitis Australia diagnostics roundtable in 2022, we worked with a group to progress actions on reflexive testing and point of care testing. In May 2022, we met with stakeholders at the Medical Services Advisory Committee (MSAC) to discuss processes for submitting applications to MSAC and/or the Pharmaceutical Benefits Advisory Committee (PBAC) to amend existing items or introduce new items. We continue to work on these and other hepatitis C testing issues as a member of the ASHM Hepatitis C Diagnostics, Policy, and Advocacy Steering Committee.

Prisons

On World Hepatitis Day, we published a piece in *The Conversation* with partners at St Vincent's Hospital Melbourne about the role of prisons in hepatitis C elimination efforts. You can read the full piece here.

Work in 2023 and beyond

Developments in hepatitis C testing and treatment (e.g., TGA approval of RNA POC testing, and nurse practitioner prescribing of DAAs) and greater recognition by governments of the value of peer workers (through funding and policy support in hepatitis C strategies and plans) reflect important progress in elimination efforts. However, there is much more to do. The next phase of elimination requires enabling a community-led response with ever-greater innovation, adaptability and flexibility, in interventions and program-level responses, to reach and engage a broader range of people where they are.

Social Impact Analysis

Progress on the milestones 2022
1. Outcome of Social Outcomes work to explore sustainable funding mechanisms and role of social impact bonds

Social Outcomes is a 'for purpose enterprise' established in 2014 to work with clients from across all sectors to maximise their desired social, cultural or environmental impact through an evidence-based design process. Social Outcomes was engaged by EC Australia in 2020 to 1) identify ways in which EC Australia might broaden its appeal to funders beyond the life of the current agreement with the Paul Ramsay Foundation, 2) develop an evidence-based theory of change (ToC) on how eliminating hepatitis C can potentially deliver additional social impacts and an impact measurement framework to strengthen future funding proposals 3) prepare a funding proposal to assist in exploring alternative financing models, including the potential role of social impact bonds.

1) Identify ways in which EC Australia might broaden its appeal to funders

Social outcomes prepared the '**Laying the Foundations Report: Preparing for the future funding of eliminate hepatitis C Australia',** which identified that EC Australia's broader appeal lies in the fact that populations carrying the greatest burden of hepatitis C are amongst Australia's most disadvantaged populations. By addressing specific social determinants along with eliminating hepatitis C, there is potential to deliver both health and social impacts for disadvantaged populations. This opens the door to attracting the interest of government and philanthropic funders, who are more generally concerned with addressing social and economic disadvantage in Australia.

The discussion paper considered the following key questions:

- Who are the populations most at risk of hepatitis C?
- What barriers do these populations face in accessing care?
- What can we learn from the social sector's approach to addressing the disadvantage and discrimination faced by these populations?
- How might people be better off if hepatitis C initiatives are delivered into more holistic care systems?
- How might these learnings be applicable beyond hepatitis C?
- How might EC Australia generate cost savings for governments?
- What are the next steps in this process?

The report's Executive Summary can be accessed here.

The biggest learning from this activity

The report revealed two broad pathways for increasing EC Australia's appeal to a broader set of funders, taking into account EC Australia's deep research expertise and partnership capabilities.

A. Expand the focus on health system interventions to demonstrate impact beyond direct hepatitis C elimination (to deepen the pockets of health funders)

The report outlined how EC Australia could continue to demonstrate the health and economic case for shifting hepatitis C treatment from the tertiary to the primary system. It could also integrate additional elements demonstrating the potential impact beyond hepatitis C. In particular, EC Australia could incorporate an analysis of how new models of care, being trialled within EC Australia (e.g., peer-based models, client-centred delivery, nurse-led care), help to address some of the structural barriers experienced by marginalised populations within the health system.

To attract a deeper pool of health funding, EC Australia could consider examining the impact of this approach on:

- the multiple non-hepatic comorbidities experienced by populations affected by hepatitis C (e.g., diabetes and cardio-vascular disease); and
- other diseases which disproportionately impact disadvantaged populations and have a similar treatment profile (e.g., other blood-borne viruses, vaccine preventable diseases).

B. Intentionally engage in service systems redesign to address the social determinants of hepatitis C (to broaden the potential funding base)

As populations most at risk of hepatitis C are amongst Australia's most marginalised and disadvantaged, the report outlines how applying a broader, social determinants of health approach to hepatitis C elimination efforts may increase their effectiveness. This includes ensuring hepatitis C treatment is delivered in a context that also tackles both the social determinants of the disease and the social and structural barriers experienced by people when engaging with the health and social systems. The report provides some elucidating case studies. It also suggests integrating hepatitis C care into services which provide social and housing services to test whether this increases the uptake of hepatitis C treatment for populations not currently engaged in care, as well as other quality of life and social outcomes. This type of partnership between innovative service delivery systems and first-class research partners, like those in EC Australia, could be of significant interest to a broader set of government and philanthropic funders.

These two strategies are not mutually exclusive. Indeed, the evidence reveals a strong common thread highlighting that, as with other diseases and health conditions that disproportionately affect people experiencing disadvantage, people with hepatitis C are less likely to seek help to prevent, test for, and treat such diseases. This is due partly to their experiences of stigma, discrimination, and other structural barriers within the healthcare system, and partly because of the impact of social exclusion and instability. If someone is struggling to find food, stable housing and a job, and has a mental illness to cope with, they are much less motivated to address 'tangential' health issues like hepatitis C.

The report asks whether engaging people (from priority populations) in a successful course of hepatitis C treatment, delivered in a holistic and supportive service system, might increase their confidence to engage with other supports, acting as a catalyst to improve their wellbeing overall. It is a big claim, but testing it could have broad reaching impacts and EC Australia is best placed to do so. This may appeal to funders.

Government funders in the social service delivery sector are increasingly interested in the cost savings generated by new approaches to social issues. They may be more likely to fund programs where those savings are substantial. This may be particularly important for new service approaches, which are more expensive initially, than business-as-usual activities. While the modelling of cost savings needs to be informed by the delivery model, approach and outcomes, a measurement framework could be useful to clearly identify the types of outcomes that could be achieved through this type of model, modelling of the current baseline costs could be useful to identify the current cost of 'doing nothing' and highlight the significant costs currently allocated to priority populations.

2. Develop an **evidence-based theory of change (ToC) and an impact measurement framework designed to strengthen funding transactions and identify potential social impacts**

Social Outcomes led a process to develop a theory of change (ToC), and accompanying measurement framework, to help broaden the funding base for hepatitis C elimination. The ToC identifies how EC Australia could deliver greater impact. That is, if we could implement, measure and demonstrate that embedding hepatitis C care within a more integrated, holistic care model, and/or through health system re-design, delivers improved health and social outcomes to socially excluded Australians.

The theory of change proposes testing two complementary approaches to improving health and social outcomes:

- 'Light Integration' approach – delivering hepatitis C care services in non-health care settings allied health and non-health care settings where socially excluded populations are already engaging and feel comfortable (e.g., mental health services, NSPs, AOD services), (take the service to where the people are).
- 'Deep Integration' approach – delivering hepatitis C care services within existing integrated service environments where multiple service providers offer co-ordinated and holistic services for socially excluded populations.
- 'Social Stability effect' – testing the impact of improved social stability on the uptake of hepatitis C care, and
- 'Health Gateway effect' – testing the impact of successful uptake of hepatitis C care on future help-seeking behaviours, social connections and wellbeing.

The ToC also includes complementary evaluation, research and advocacy activities to support longer-term outcomes of improved health (including hepatitis C), and social outcomes for socially excluded populations, along with improved service experiences, and a broader funding base.

The measurement framework describes the indicators that could be used to measure implementation progress across the ToC.

The ToC and Measurement framework

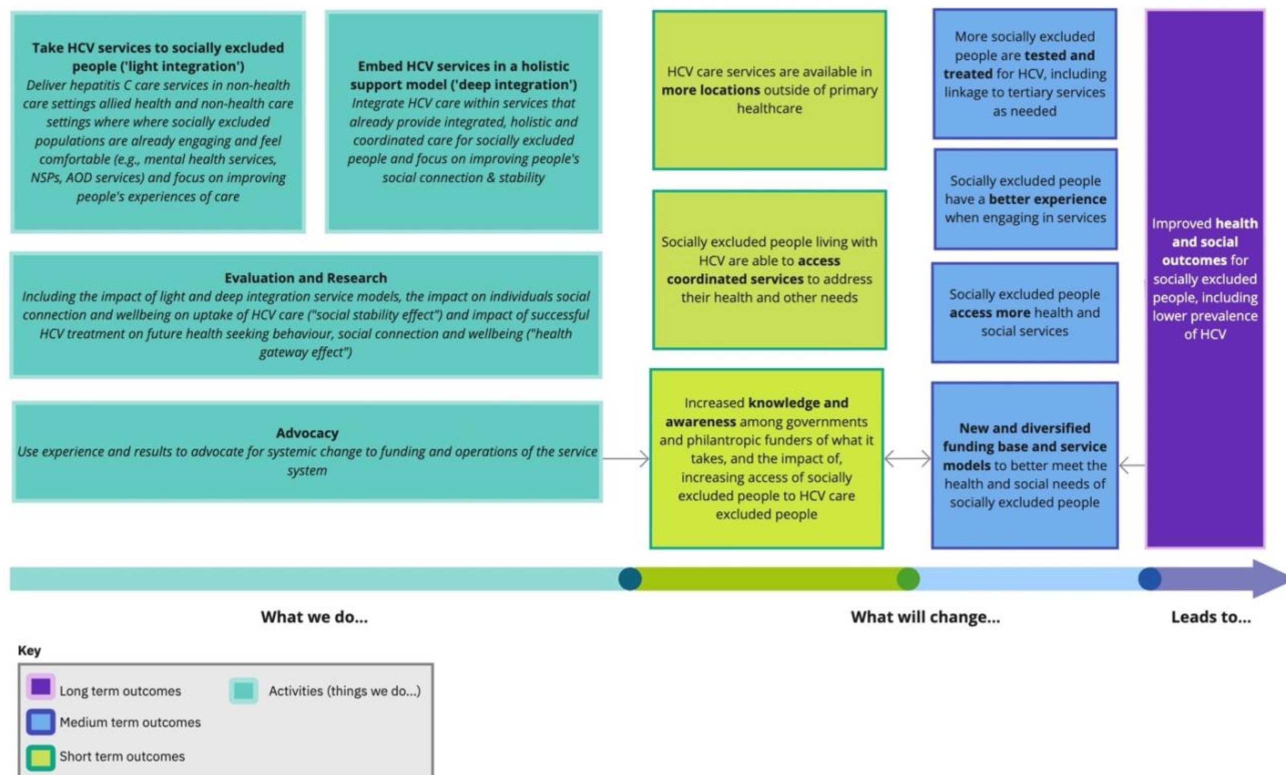

Figure 7. Simplified diagram of the EC Australia/Burnet Institute ToC.

By working to eliminate HCV, ECA/pilot project will demonstrate how the universal access service system can better deliver improved health and social outcomes to socially excluded Australians

If we do this... (Strategic Activities)

Deliver HCV prevention and treatments through existing allied health, primary health and social service delivery partners already engaging with socially excluded populations (eg NSP, mental health, AOD, homelessness, employment, food banks etc) (the light integration effect)

Identify, partner and co-design a pilot project with providers already engaged in delivering integrated social service delivery systems to test:
(a) the impact of delivering services in place-based, integrated, non-judgemental environments (the deep integration effect)
(b) the impact of a person's social connection and wellbeing on the uptake of HCV testing, treatment and reinfection (the social stability effect); and
(c) the impact of successful HCV treatment on future help-seeking behaviours, social connections and wellbeing (the health gateway effect).

Research and analysis: Conduct detailed health, social and economic measurement and analysis to support research and advocacy tools designed to inform improved health and social service delivery systems to socially excluded populations

Advocacy: Advocate for systemic change to the health and social service delivery system based on the research findings (note to expect different timing ie after pilot begins publishing results)

We will demonstrate this... (Outputs)

- Increased no. of locations where both social support and HCV information testing, treatment are available
- Increased no. staff at non-health services referring target population to HCV testing
- Increased no. of people in target population reporting less stigma
- Increased no. of people in target population reporting knowledge of HCV risks, testing and treatment options
- Number and types of support services accessed during and after HCV testing and treatment (eg mental health, NSP, OST, housing services, employment services, non-HCV related health care)

Pilot project publishes :
- shared measurement framework including; short, medium and long term health and social outcomes to be measured; and Indicators of help-seeking behaviours
- Design for the modelling of economic benefits
- Initial insights into the impact of:
  (a) The light integration effect
  (b) The deep integration effect
  (c) The social stability effect
  (d) The health gateway effect
  (e) The opportunities and challenges of delivering integrated health and social services to social excluded populations

Government policy documentation recognises link between social and health service delivery. Government tenders and philanthropic funding opportunities reflect new evidence base on effective social service delivery

We can observe these changes... (Short/medium term outcomes)

- Increased uptake of HCV testing and treatment
- Increased no. of people in target population reporting less stigma and greater client satisfaction when accessing health services
- Increased no. of people access increased number of other health and social support services during and after HCV testing and treatment

Pilot project publishes:
- Improvements in the health, social and wellbeing outcomes experienced by the target population
- Findings on the health, social and economic outcomes of:
  (a) The light integration effect
  (b) The deep integration effect
  (c) The social stability effect
  (d) The health gateway effect
- Insights on the opportunities and challenges of delivering integrated health and social services to socially excluded populations

Increased government and philanthropic funding base allocated to evidence-based, outcomes-focussed integrated health and social service delivery for diseases other than HCV

And ultimately people who are socially excluded will experience this... (Longer term outcomes)

HCV outcomes:
- Lower prevalence of HCV in Australia
- Lower HCV reinfection rates

General health outcomes and social outcomes: socially excluded populations experience improved health and social wellbeing as identified by the pilot project results

Delivery system outcomes beyond HCV:
Socially excluded populations routinely engage with multiple supports across the health and social services system and report:
- simplicity of accessing those integrated supports
- reduced stigma and discrimination when seeking health care and social supports

Integrated health and social services is accepted as 'standard/best practice'

Government and philanthropic funding addressing diseases disproportionately impacting socially excluded populations:
- broadens beyond traditional 'health' sources and
- grows in total size

Figure 8. Visualisation of the EC Australia/Burnet Institute Impact Measurement Framework.

2. Prepare a transaction proposal to assist in exploring alternative financing models, including the potential role of social impact bonds.

We are engaging with potential partners, to explore the development a draft funding proposal (with an evidence base, proposed model, measurement indicators, value proposition for funders and potential role of investors) for this work.

Originally conceived as a means to explore the potential role of social impact bonds in funding future EC Australia activity, this has not been the focus of this work to date. It is unclear if this will be part of future discussions.

Additional Work

National Prisons Hepatitis Education Project: HepPEd

Collaborators: National Prisons Hepatitis Network (NPHN), Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM).

EC Australia has supported the National Prisons Hepatitis Education Project: HepPEd by providing $50,000 of funding. The overall goal of HepPEd was to develop, deliver, and evaluate a prison-specific hepatitis C education program to improve hepatitis C public health literacy and facilitate enhanced hepatitis C testing and treatment uptake in the prison sector. The HepPEd project targets three key audience groups: healthcare providers working in the prison setting, correctional officers, and people in prison. It was delivered in three phases.

A final report for this project was submitted in March 2023, following delivery and evaluation in select prison sites across Australia in 2022.

There was consensus on the importance of developing *prison-specific* hepatitis C educational resources for the three target audiences. There was also impetus for the development of a *prison-focussed* hepatitis C education program, to scale-up hepatitis C testing and treatment.

The resources, key messages, learning objectives, key topics, characters, and storyline were all co-designed by the target audience's steering committee. Key stakeholders were involved at each stage, including members from justice health and corrections organisations (e.g., service deliverers, administrators, prison healthcare and correctional staff, executives), non-governmental hepatitis and drug-user organisations (including consumer advocates, education developers, and providers), research institutes, and members from the target audience groups.

The project responded to budgetary restrictions and logistical challenges by implementing in less prison sites than initially planned (e.g., ~6 sites instead of 20, nationally).

The evaluation is anticipated to commence in mid-2023, with study findings to be published in 2024. It aims to evaluate the impact of the HepPEd project on hepatitis C testing and treatment rates amongst people in prison, and the public health literacy of the sector.

With widespread enthusiasm and anticipation for the HepPEd program across Australian prisons (i.e., those not participating in the research evaluation), there are plans to make the HepPEd Program available to non-study jurisdictions as soon as possible, potentially in parallel to the research study. There is also interest internationally, leading to discussions with potential funders about the adaptation and implementation of the program for an international audience.

The National Prisons Hepatitis Education Project: HepPEd: Report of findings from the National Needs Assessment and Steering Committee Process: Public Health Literacy and Hepatitis C Education in the Australian Prisons can be found here.

To keep up with future information on this project, and for contacts see the National Prisons Hepatitis Network website.

The Queensland Injectors Health Network C Regional and Remote Outreach Project

Collaborators: Queensland Injectors Health Network (QuIHN) and the Queensland University of Technology (QUT).

This project aims to evaluate the fidelity and sustainability of a novel hybrid face-to-face/telehealth model that facilitates hepatitis C diagnosis, treatment, and management for people living in regional and remote Queensland, using Nurse Practitioner and Harm Reduction Worker partnership model.

QuIHN will provide monthly, face-to-face clinics, with telehealth support provided in between. The project will target Mt Isa, Townsville, Rockhampton & the Wide-bay area. QUT is collaborating on the evaluation of the care cascade delivered by this project.

This is a mixed method study using clinical audits, pre- and post-surveys, and semi-structured interviews.

The project is running for 12 months from October 2022 to October 2023.

EC Australia Beyond 2022

EC Australia has secured critical funding to continue over the next five years - from 2023 to 2027. This will allow EC Australia to maintain momentum towards the goal of eliminating hepatitis C as a public health threat in Australia by 2030.

In June 2022, EC Australia prepared an internal funding proposal to the Burnet Institute's Board for critical funding to retain staff and maintain program capacity over the next 5 years (2023-2027). The Board approved the proposal, agreeing to provide EC Australia with $1.3 million in funding per year. This will support the EC Australia project team to continue operations, and support select priority activities. However, there is an explicit focus for EC Australia to seek additional third-party funding to continue to support implementing partners and reinforce strong collaborations.

EC Australia recognises the need for enduring partnerships, especially given the work involved in growing a network of over 75 partner organisations. Our innovative interdisciplinary approach and governance structures have enabled us to rapidly share knowledge generated in one part of EC Australia across the network, to ensure coordinated implementation in other areas. It is important that this continues, and we are committed to the national collaborative framework. We will continue to bring the sector together for annual showcase events (highly valued by our EC Australia partners). In partnership with the Kirby Institute, we will also continue to produce the *Australia's progress towards hepatitis C elimination* annual reports.

Over the next 12 months, EC Australia's priorities will include working with our partners to secure additional program funding to support priority areas of service delivery and community engagement for people living with hepatitis C. We will also continue areas of work from EC Australia that were not completed within the 2019-2022 period, including support Aboriginal and Torres Strait Islander communities to access testing and treatment, and people living with cirrhosis (to ensure they get access to treatments early and are regularly monitored to reduce their risk of developing hepatitis C-related liver cancer and liver disease).

Thank you to the Burnet Institute Board and Executive for their support of EC Australia.

Next steps:

In 2022, EC Australia began consulting with its Executive Committee around the direction for partnership and how it should continue in coming years.

In the first half of 2023, we spoke with a broader range of partners to gain further input to the future directions of EC Australia. The EC Australia team is currently reflecting on this feedback and identifying key priorities through strategy workshops to inform a workplan for the initial stage of EC Australia phase 2. We plan to share the priorities and workplan with EC Australia partners in mid-late 2023.

EC Australia funding secured as a result of the partnership

As well as the funding from the Paul Ramsay Foundation, to date EC Australia has successfully secured an additional ~$20 million for hepatitis C elimination efforts from a mix of funder types, including: the Commonwealth Department of Health, State/Territory Governments, NHMRC & Medical Research Future Fund (MRFF) Grants, Pharmaceutical Grants, and Primary Health Networks funding.

Projects initiated through funding by EC Australia in Queensland, Tasmania, ACT and South Australia have (with support from the EC Australia team) already secured new and/or additional funding to continue their activity.

The following is a list of all the funding secured consequent to EC Australia's initial investment.

2019

- Hellard M, Doyle JS, Pedrana AE, Stoové M, Iser D, Owen L. A randomised controlled trial of active case management to link hepatitis C notifications to hepatitis C treatment. 2019-2021. Funding from AbbVie (Global/Australia), **$405,000**
- Doyle JS, Pedrana AE, Hellard M, Owen L, Richmond J, Draper B, Iser D. Hepatitis C micro-elimination program: enhancing hepatitis C testing and treatment in primary care settings through targeted education in Tasmania. 2019. Funding from AbbVie (Australia) **$140,000**

2020 - 2021

- Cairns Sexual Health Service, Burnet Institute & University of Queensland - Preparing for the final phase of elimination in Cairns: An implementation trial of a test-and-treat approach to reach the final 30%, Funding from Gilead Sciences, August 2020 - June 2023: **$480,114**
- TasCHARD - Funding from Tasmanian Primary Health Network, July 2021 - June 2022: **$138,000** (funding went from $16,000 in 2019, to $40,000 2020 - 21, up to $138,000 for 2021-22)
- Bulgarr Ngaru Medical Aboriginal Corporation (BNMAC), Burnet Institute & ASHM - Evaluation of an integrated BBVs and STIs health systems intervention in an NSW Aboriginal Community Controlled Health Organisation, Funding from Commonwealth Department of Health, STI/BBV section. 2021 - 2023. **$500,000**
- EC Australia - via the National Hepatitis C 50,000 Project to expand the **It's Your Right campaign** to reach Aboriginal and Torres Strait Islanders, and to design a hepatitis C campaign for Aboriginal Community Controlled services in partnership with NACCHO. Funding from Commonwealth Department of Health, December 2021 - December 2022. **$1.25 million.**
- Implementing hepatitis C testing and treatment in community pharmacies to accelerate elimination of hepatitis C: the PharmEC Project. GCK5G9V Commonwealth Government –

Activities to Support the National Response to Blood Borne Viruses and Sexually Transmissible Infections. **$236,861**

- EC Australia - Funding from Paul Ramsay Foundation for the extension of EC Australia for a fourth year. **$1 million.**
- Burnet Institute's BBVSTI contract. 'Investment case and allocative efficiency analysis of HIV, hepatitis B, hepatitis C and STIs'. Funded by Commonwealth Department of Health, 2021 - 2022. **$212,129**.
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) via the National Hepatitis C 50,000 Project - Funding for Beyond the C from the Commonwealth Department of Health. **$1 million**.

2022

- SA Health **-** Scale up HCV POC testing in South Australia sites and other settings, Funded by SA Health **$259,573**
- Hepatitis ACT - Funding from ACT Health for NSP testing and treatment, and incentives. Funding for 2 years. **$500,000** (transition from NSP to GP model, due to lack of NSP's in ACT)
- Hepatitis QLD - Funding from Brisbane South Primary Health Network for Community Corrections project in South QLD. July 2022 - June 2023. **$87,000**.
- WANADA - Funding from WA Health to support further roll out of the hepatitis C CAT to additional services, and follow-up. 12 months, 2022-2023. **$74,000.**
- Unitaid - Catalyse uptake of Under-utilised Tools & Treatment Simplification for HepC (CUTTS HepC) in Armenia, Georgia, Tanzania (2023-2027). **$9.4 million.**
- Burnet Institute & State Jurisdictions - NHMRC 2021 Partnership Project - Optimising public health notification systems to achieve hepatitis C elimination in Australia (2022-2026) **$1.4 million.**
- Howell, J. et al - Hepatitis B related cirrhosis and hepatocellular carcinoma – Funding from Gilead TREAT HBV (2021 – 2023) **$189,002.**

2023

- Tasmanian Health Service - A statewide nurse-led hepatitis C outreach program, Statewide Sexual Health Service (2023-2030) - **$2.5 million.**
- Gilead – QuiHN Prison Transition scaled up to deliver services in Brisbane and Townsville – *amount unknown*
- EC Australia, Harm Reduction Victoria, Royal Melbourne Hospital and Enigma – *It's Your Right 2023* – a Peer-led initiative to Increase Hepatitis C Testing and Treatment for People Who Inject Drugs in Victoria – additional Western suburbs roll out – funding from Victorian Government (2023) **$84,900**
- South Australia Health - PROMPt - Point of Care Testing for Hepatitis C in the Priority Settings of Mental Health, Prisons and Drug & Alcohol Facilities – follow on study using PROMPt model at a homeless services – Gilead Sciences. Inc (2023) **$50,000**
- **Total 'extra' funds associated with EC Australia 2019 - 2022 = $19,906,579**

About EC Australia

Eliminating hepatitis C as a public health threat in Australia by 2030 is the long-term goal of EC Australia.

By bringing together researchers and implementation scientists, government, health services and community organisations, EC Australia will support services to increase hepatitis C testing and treatment among priority affected populations.

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EC Australia

Partnering to eliminate hepatitis C

Burnet

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