CONFERENCE RAPPORTEUR PRESENTATION

Epidemiology & Public Health Rapporteur

[AVHC 2026] · [12-14 August]

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ACKNOWLEDGEMENT OF COUNTRY

WHAT THIS SESSION COVERS

Reflecting on the session and where it points us next

01 Session overview – what was presented

02 Four key themes and take-home messages

03 Where future efforts are needed

26

Presentations in this area

14

15-minute and 5-minute oral talks

12

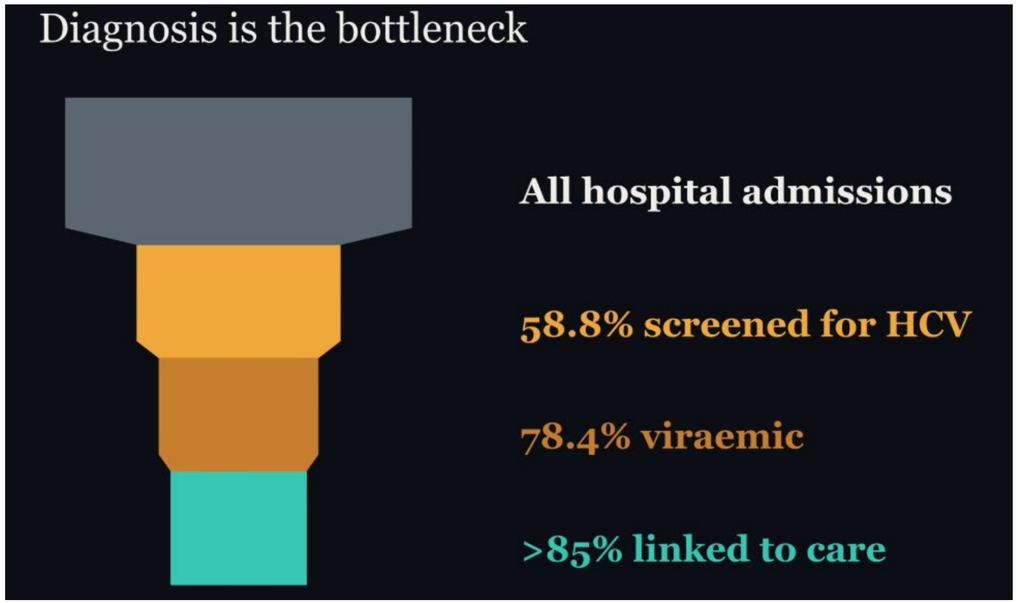
Poster presentations

TOPIC SPREAD ACROSS PRESENTATIONS

- Testing & case-finding
- Treatment retention
- Surveillance & prevalence
- Hepatitis D(elta)
- Priority populations & access

THEME 1 OF 4

Repositioning the systems and contact points we already have



1. **Kwon:** needle and syringe programs return around $2 per $1 spent, down from around $4 in 2009
2. **Doyle:** emergency department opt-out testing, $3,273 per QALY gained
3. **Miller:** reflex RNA testing added to the existing antibody pathway, SA
4. **Howell:** proposes the same for hepatitis D – reflex PCR after a positive antibody
5. **Carrington:** dried blood spot testing from research into routine practice, NSW first jurisdiction
6. **Michie:** whole genome sequencing pilot built on existing diagnostic labs and QAPs
7. **Matthews:** notification data used actively for care linkage, not only reporting
8. **Parker:** existing staff effort redirected into notification follow-up
9. **Fraz:** addiction medicine involvement ~4x higher odds of BBV screening; $3.24m (30%) lower inpatient costs

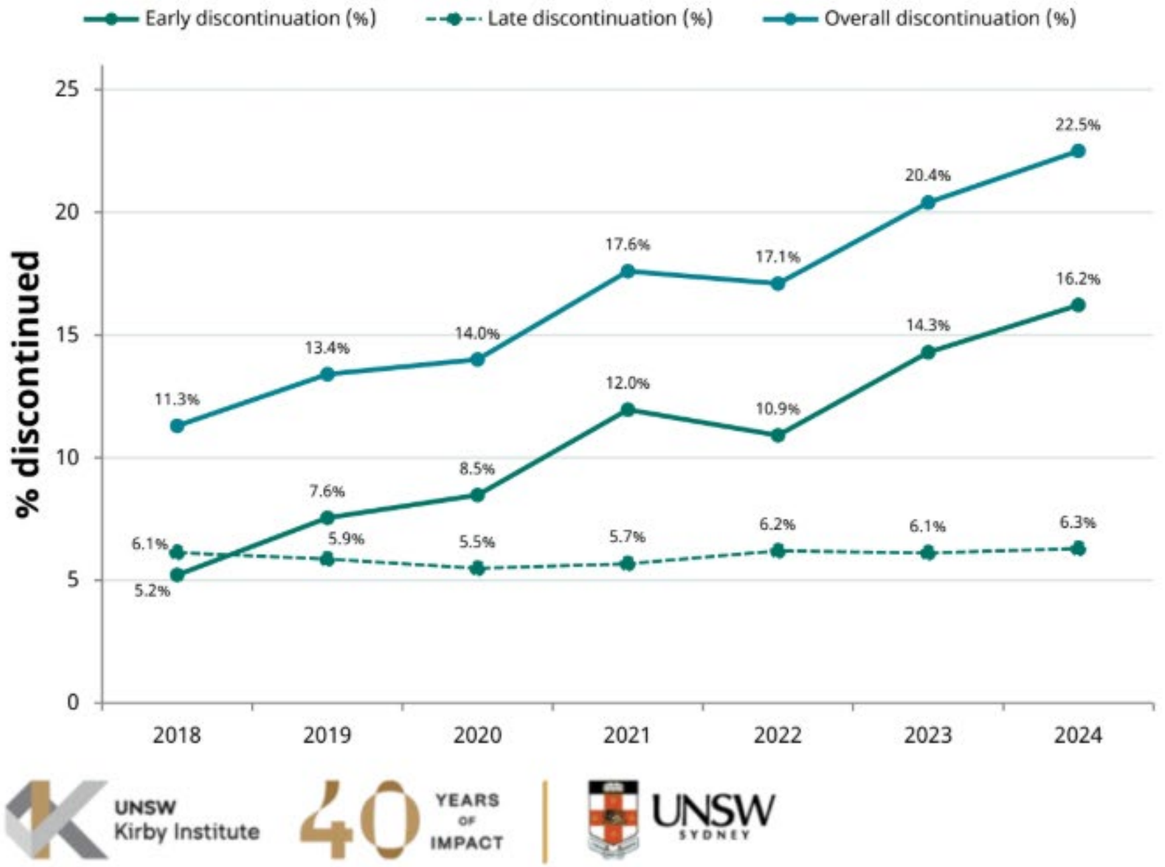
Ezaam Fraz et al. Addiction medicine involvement is associated with improved hepatitis C and blood-borne virus screening and reduced health care utilisation among hospitalised incarcerated people who inject drugs

THEME 2 OF 4

Attention is shifting to what happens between the steps

1. **Winter:** 79% treatment initiation, 52% confirmed cure (12 studies, pooled)
2. **Howell:** fewer than half of anti-HDV positives receive a follow-up PCR
3. **Polkinghorne:** only 14% of people living with hepatitis B were ever tested for hepatitis D of those testing antibody positive, 19% received a PCR; 34% of tests came 6+ months after diagnosis
4. **Tillakeratne:** discontinuation 11.3% (2018) to 22.5% (2024), driven by early dropout
5. **Tillakeratne:** retreatment among early discontinuers 14.7% to 3.9%; 11.2% ever retreated
6. **Tillakeratne:** gastroenterology-initiated courses less likely to discontinue than GP-initiated, aOR 0.72
7. **Miller:** reflex testing removes the second appointment
8. **Parker:** the unit as “a bridge” – 97% of notifications RNA tested, 81% of eligible cases treated
9. **Valerio:** median age at diagnosis 17; 42% of children diagnosed before age 13
10. **Winter:** confirming cure requires a return visit – 93% initiated, 56% returned and cured in her own mobile model

Discontinuation nearly doubled, driven by early dropout



% of discontinuations that were EARLY

46% → **72%**

2018 2024

Recent discontinuation increasingly means only the first 28-day dispensation was ever filled.

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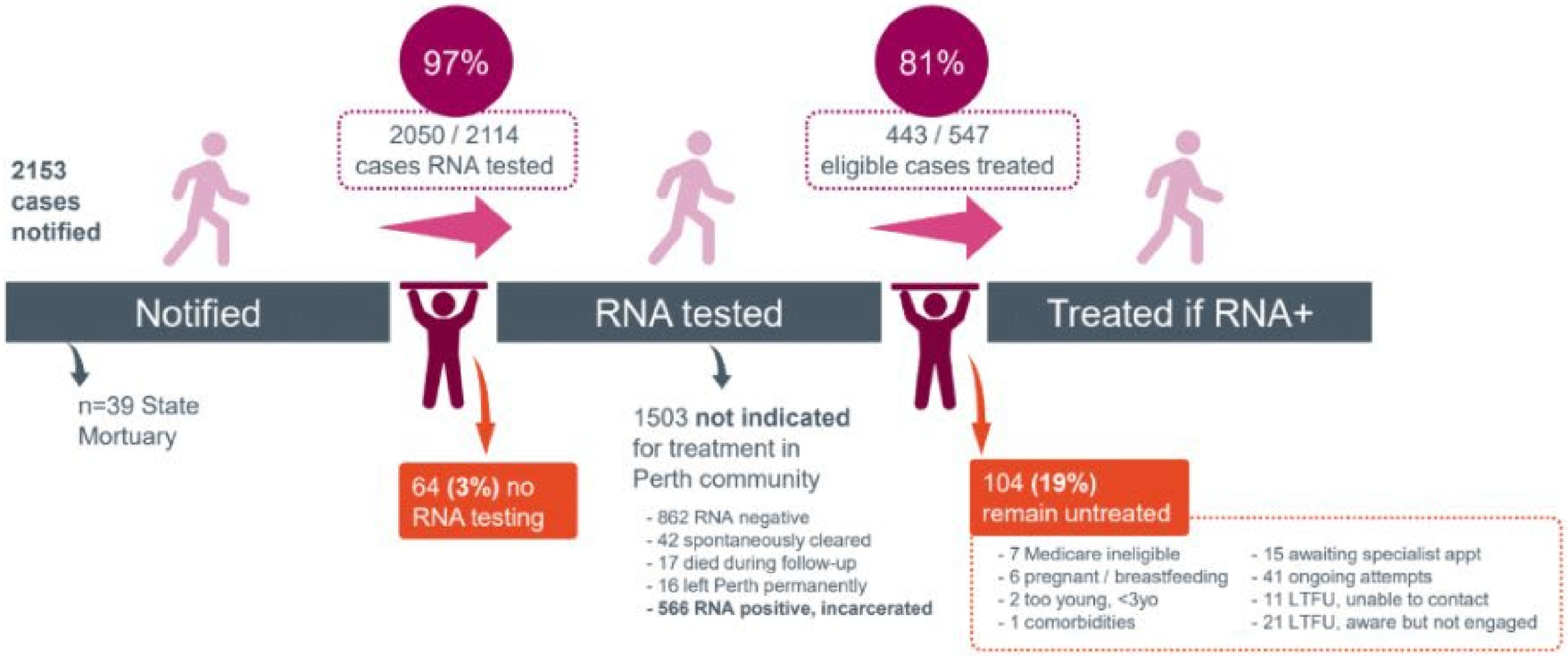
Shane Tillakeratne et al. A Decade of Direct Acting Antiviral therapy: Trends in hepatitis C Treatment Completion, Discontinuation, and Retreatment in Australia, 2018–2024

How is it going? 3 years of data.



Erica Parker et al. Hepatitis C elimination progress in Perth

THEME 3 OF 4

What we can now see

We can see more than we could before, which also tells us what we still don’t know

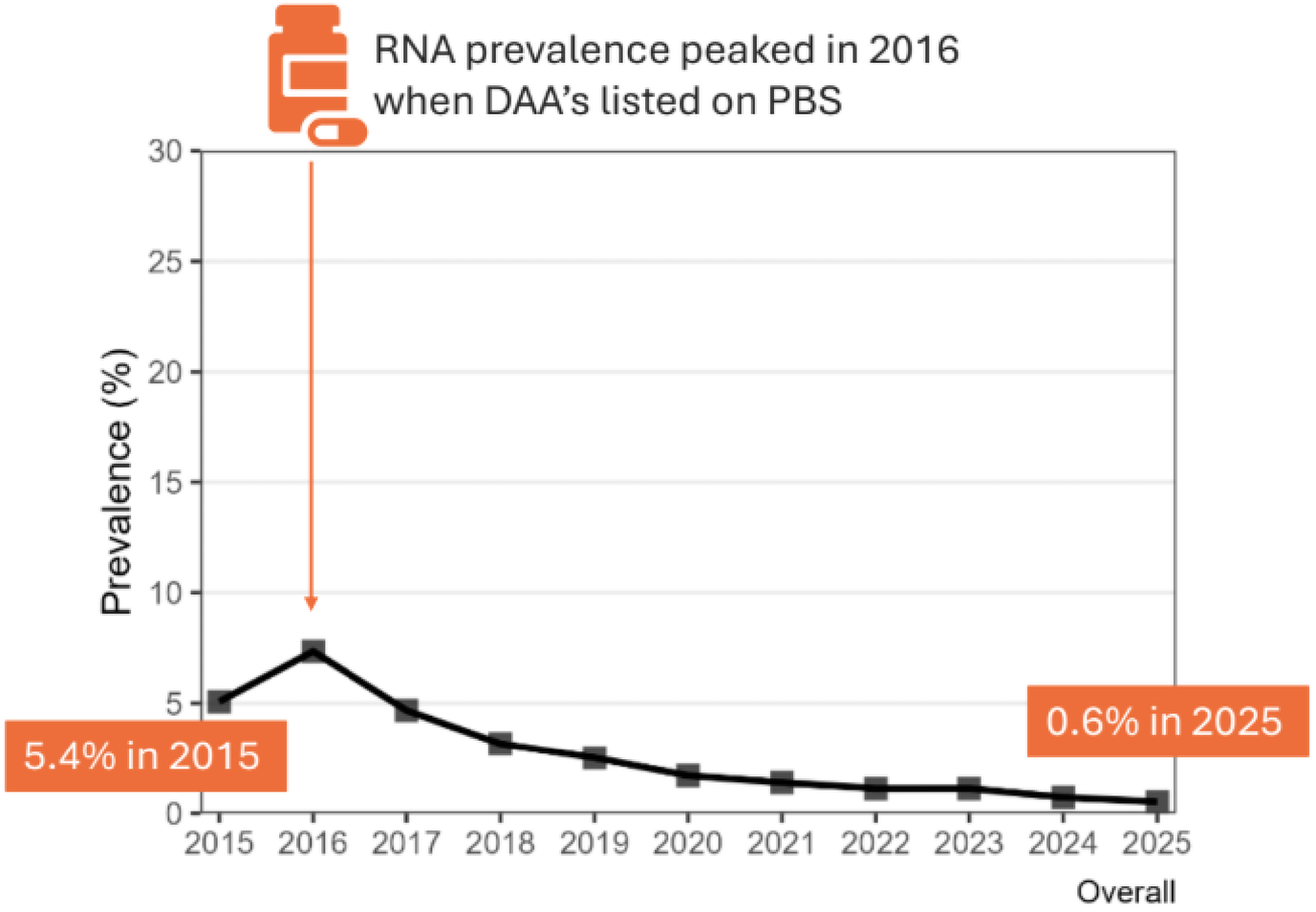
1. **Asselin:** HCV RNA positivity 5.4% to 0.6%, 2015–2025, ACCESS network
2. **Valerio:** ETHOS Engage prevalence 24% to 9%; advanced fibrosis 14% → 8% across waves; 20% → 4% among those cured between visits
3. **Stevens:** prevalence roughly halved among people accessing DBS testing, NSW
4. **Parker:** Perth prevalence estimated for the first time, 21.9 per 100,000 in 2026
5. **Wilshin:** WA dashboard – testing, treatment, vaccination and notifications in one view
6. **Hawkes:** 2,360 liver cancer cases (2018–22); First Nations incidence 18.0 vs 7.2 per 100,000, survival 14.3% vs 24.0%
7. **Valerio:** 15,996 mothers and 36,332 children described across 1994–2021
8. **Michie:** H2Seq aiming at real-time detection of transmission clusters

Results

In the overall sample, between 2015 and 2025

HCV RNA prevalence declined from 5.4% to 0.6%

A reduction of 88.9% from 2015



Jason Asselin et al. Estimating changes in HCV RNA positivity after broad access to HCV treatment using routinely collected clinical data from a national clinical surveillance network

THEME 3 OF 4

What we still can't

We can see more than we could before, which also tells us what we still don’t know

1. **Polkinghorne:** why hepatitis D screening rates remain low is not understood
2. **Tillakeratne:** dispensing data alone can't separate an abbreviated cure from a failure
3. **Tillakeratne:** concurrent HIV treatment carried higher odds of discontinuation, aOR 1.50, reason unknown
4. **Asselin:** RNA prevalence persists among people with recent opioid agonist treatment
5. **Leiwia Dick:** 44% of HBsAg-positive pregnant women in Vanuatu had high viral load, vs 21% globally (n=32)

THEME 4 OF 4

Who’s being missed follows a pattern

1. **Castellano:** “We've swept out the centre of the room and now we need to get to the corners”
2. **Winter:** mobile care adjacent to the community corrections setting
3. **Myers:** mobile nurse and peer-led van, people with historical risk factors
4. **Fraz:** hospitalised and incarcerated patients
5. **Nguyen:** Hep B PAST – primary care contacts +53%, antiviral treatment +73%, inpatient stays 4.2 → 2.8 days
6. **Tillakeratne:** remote residence aOR 1.38; discontinuation higher under 45
7. **Asselin:** people receiving opioid agonist treatment
8. **Stevens:** NSW priority settings – NSPs, AOD services, custodial, Aboriginal health services
9. **Valerio:** 45% of children with hepatitis C treated; 52% of males, 35% of females
10. **Castellano:** cure needs to be accessible, not only available

LOOKING AHEAD

Where future efforts are needed

1. Shared national approaches to the testing innovations built separately in each state
2. Reflex hepatitis D PCR after a positive antibody result (Howell)
3. Legislative and data handling reform to allow notification follow-up (Matthews, Parker)
4. Linking dispensing data to virological testing (Tillakeratne)
5. Same-day and embedded treatment initiation where engagement already exists (Tillakeratne)
6. Shorter-duration regimens, and long-acting formulations (Tillakeratne)
7. Continued investment in prevention infrastructure (Kwon)
8. Sustained effort where prevalence persists – OAT, custodial, remote, Pacific, women and mothers

Thank you

Thomas Rudge, Kirby Institute, University of New South Wales
Dr Annabelle Stevens, NSW Health

Acknowledgements

[Presenters and session chairs to thank] [Co-authors, collaborators, or funding bodies] [Conference organisers]

THEME 5 OF 5

Co-design featured in how reform is being developed

1. **Matthews:** Connect C co-design workshops, NT and Queensland, 2024–2026
2. **Matthews:** lived experience, providers, policymakers and community organisations
3. **Matthews:** clarified roles, streamlined referrals, embedded peer support
4. **Matthews:** consensus statements to guide regulatory and data recording reform
5. **Castellano:** NSW Aboriginal Blood-Borne Virus and STI Framework, community leadership
6. **Castellano:** consultation for the 2026–28 NSW Hepatitis C Strategy