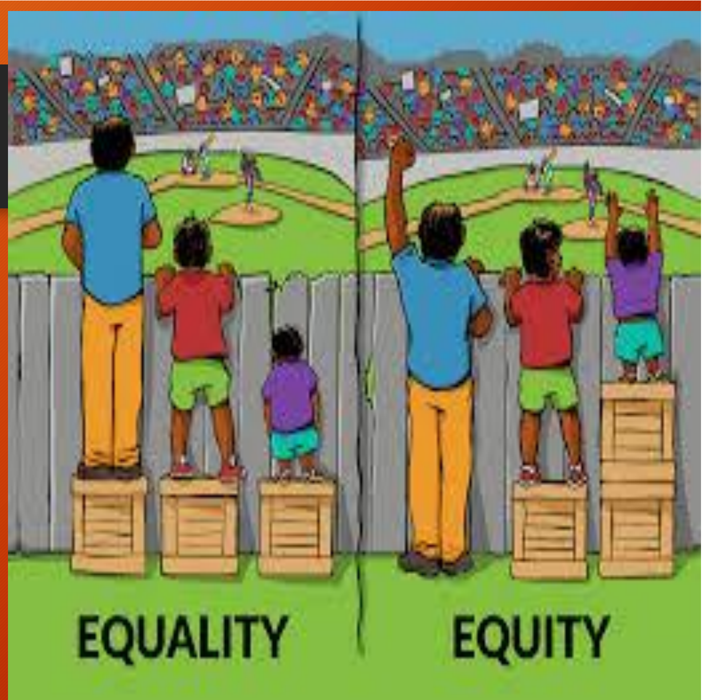
What's required to eliminate VH in Aboriginal and Torres Strait Islander communities?

Acknowledgements

- Uncle Chicka Madden MLALC
- Erin Flynn, Clare Bradley SAHMRI
- Gerard Estivill, Marianne Martinello, Pip Marks, Greg Dore, Jason Grebeley – Kirby Institute
- Kelly Hoskins, Jane Davies et al NT
- Jennifer MacLachlan, Ben Cowie (Vortex), Nicole Allard, et al– Doherty
- Participating sites SCALE-C

If we continue to do the same we will never achieve equity



How to achieve elimination

- What do we need to get there - HBV and HCV
- SCALE-C trial to eliminate Hep C in four Aboriginal communities

HBV and Aboriginal and Torres Strait Islander communities

- Achieving very high vaccination rates
- Number of linkage studies describing prevalence especially among mothers and children pre- post vaccination introduction (Deng Reekie Liu)
- Great work happening across the country that requires further support to scale up.

CHB prevalence well described as are monitoring and treatment data by local areas

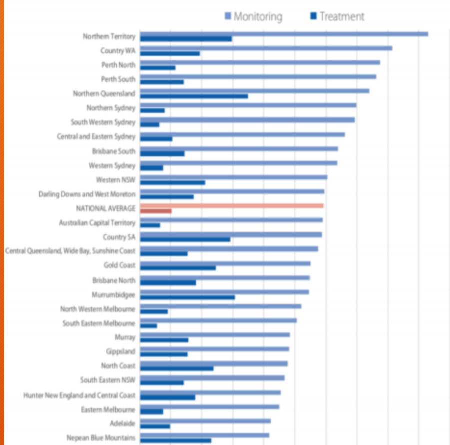


Figure A.9: Proportion of CHB treatment and monitoring provided by GPs*, by PHN, 2017

Table A.4 CHB prevalence estimates in Aboriginal and Torres Strait Islander Australians, by state and by remoteness region of Australia, 2017

State/Territory	Major cities	Inner regional	Outer regional	Remote	Very remote	TOTAL
ACT	0.7%	N/A	N/A	N/A	N/A	0.7%
NSW	0.7%	1.6%	2.9%	3.8%	5.3%	1.5%
NT	N/A	N/A	2.2%	5.1%	5.3%	4.6%
QLD	1.5%	0.8%	2.9%	1.4%	4.5%	2.1%
SA	1.7%	1.3%	2.2%	2.0%	1.7%	1.8%
TAS	N/A	0.7%	0.7%	N/A	N/A	1.4%
VIC	0.8%	0.7%	0.9%	N/A	N/A	1.5%
WA	1.2%	1.4%	3.9%	6.5%	8.4%	4.1%
AUSTRALIA	**1.1%**	**1.4%**	**3.8%**	**5.3%**	**5.5%**	**2.5%**

Data source: CHB prevalence estimates in Aboriginal and Torres Strait Islander people based on established population prevalence from published studies, adjusted according to region using notifications data and ABS population distribution information. N/A = not applicable (no regions with this level of remoteness exist in the jurisdiction).

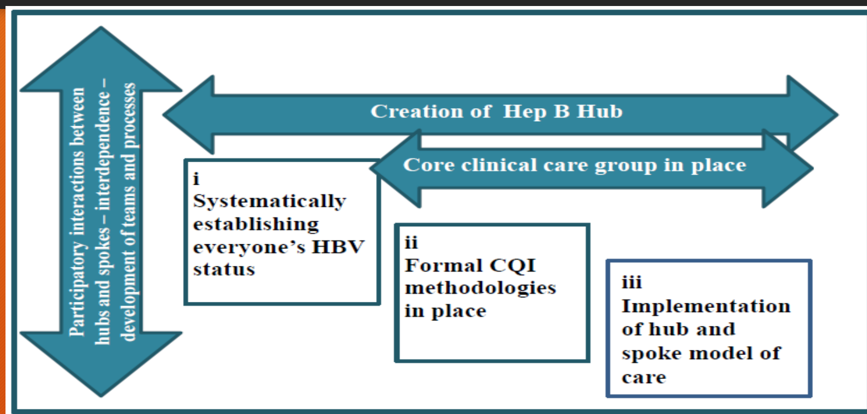
VIRAL HEPATITIS MAPPING PROJECT

NATIONAL REPORT 2017

Remoteness Area	Number of people with CHB	Proportion Aboriginal and Torres Strait Islander (%)	Treatment uptake for all people with CHB (%)
Major cities	188,971	1.5%	9.4%
Inner regional	23,412	10.5%	3.1%
Outer regional	13,771	25.5%	3.4%
Remote	3,273	65.4%	2.2%
Very Remote	4,520	86.8%	2.7%
AUSTRALIA TOTAL	233,947	6.30%	8.3%

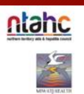
Nevertheless we still have a long way to achieving national and global targets

Summary of complex interventions to improve the cascade of care



Partnership Approach to Sustainably eliminating Chronic Hepatitis B in the Northern Territory

Hep B PAST



AIM: Improve the cascade of care for individuals living with CHB in the NT

	NT overall	TEHS	National Target
Aware of Infection	61%	94%	80%
Engaged in Care	15%	83%	50%
On Treatment	3.1%	18%	20%

THIRD National Hepatitis B Strategy

(Australian Government Department of Health 2018)

Partnership Approach to Sustainably eliminating Chronic Hepatitis B in the Northern Territory

Hep B PAST

Aim: To improve health literacy about HBV

Language	No. of speakers	Region	Progress
Kriol	20,000	Katherine	Consultation commenced
Yolnu Matha	6806	East Arnhem	Complete
Arrernte	5475	Alice Springs	Consultation complete
Murrinh-Patha	3100	Wadeye	Waiting
Pitjantjatjara	3000	Western Desert	Consultation commenced
Warlpiri	2509	Central	Consultation commenced
Tiwi	2102	Tiwi Islands	Consultation complete
Kunwinjku	2000	West Arnhem	Evaluating back translation
Anindilyakwa	1600	Groote Eylandt	Consultation commenced
Burarra	1000	Maningrida	Consultation commenced
Gurindji	900	Katherine West	Consultation commenced

What about HCV have we got the right denominator?

- Modelling in 2007 suggested between 13,000-22,000 people living with Hep C
- Suggestion that 7,600 Indigenous people requiring treatment
- Overlapping populations – prisoners, current PWID and former PWID, others in community non IDU related HCV

Notification data- Aboriginal and Torres Strait Islander people

	Year of hepatitis C notification					
	2013	2014	2015	2016	2017	2013–2017[a]
Characteristic						
Total cases	594	659	731	780	744	3508
Sex						
Male	360	430	497	500	504	2291
Female	234	229	234	280	240	1217
Median age in years	30	30	30	30	31	151

- NSW Victoria and ACT data not included here……….40% pf population
- In 2017, of the 610 newly acquired hepatitis C infections notified, 192 (31%) were notified in the Aboriginal population

Reducing new infections

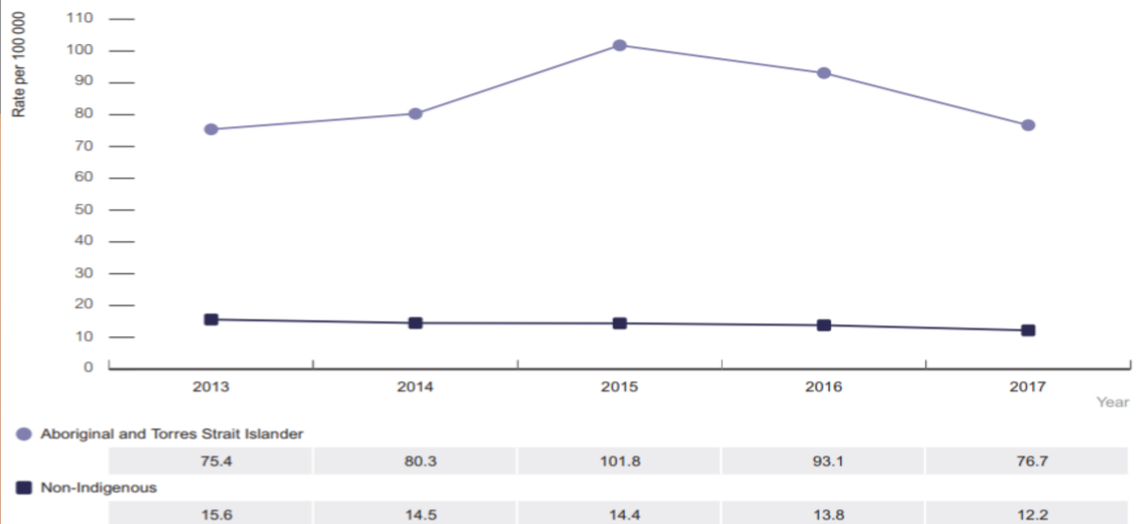
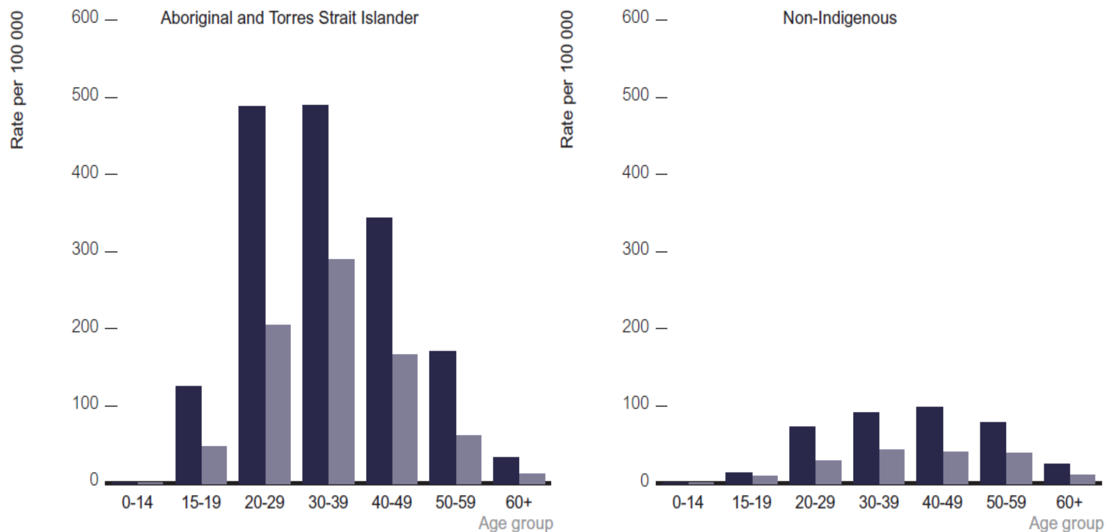


Figure 2.1.6 Hepatitis C notification rate per 100 000 in people aged 25 years and younger, 2013–2017, by Indigenous status

	2013	2014	2015	2016	2017
Aboriginal and Torres Strait Islander	75.4	80.3	101.8	93.1	76.7
Non-Indigenous	15.6	14.5	14.4	13.8	12.2

Source: Australian National Notifiable Disease Surveillance System; includes jurisdictions with Indigenous status completeness ≥50% (Northern Territory, South Australia, Tasmania, Queensland and Western Australia) for each of the five years 2013–2017.

Kirby Institute: BBV and STI in Aboriginal and Torres Strait Islander people: annual surveillance report 2018.



HCV treatment uptake

People living in remote areas taking treatment up half the rate of others living in urban and regional Australia

22% of population live here compared to 2% of non Indigenous Australians

Table B.4: CHC treatment by remoteness category, end of 2017

Remoteness	Total population	People living with CHC	CHC prevalence (%)	Number received treatment, Mar 2016 – Dec 2017	Treatment uptake, end of 2017 (%)	Area (km²)
Major cities	17,572,357	150,697	0.86%	35,764	23.7%	43,074
Inner regional	4,369,426	46,524	1.06%	11,790	25.3%	656,785
Outer regional	1,929,059	24,777	1.28%	5,001	20.2%	2,145,265
Remote	233,231	3,373	1.45%	431	12.8%	1,554,140
Very remote	149,363	1,936	1.30%	209	10.8%	1,135,970
AUSTRALIA	**24,253,435**	**227,306**	**0.94%**	**53,597**	**23.6%**	**5,536,963**

Data source: Treatment data sourced from Department of Human Services Medicare statistics. Estimates of CHC prevalence based on published national estimates and notifications distribution. Totals may not add up due to inclusion of people without a region of residence recorded in source data.

Health care access

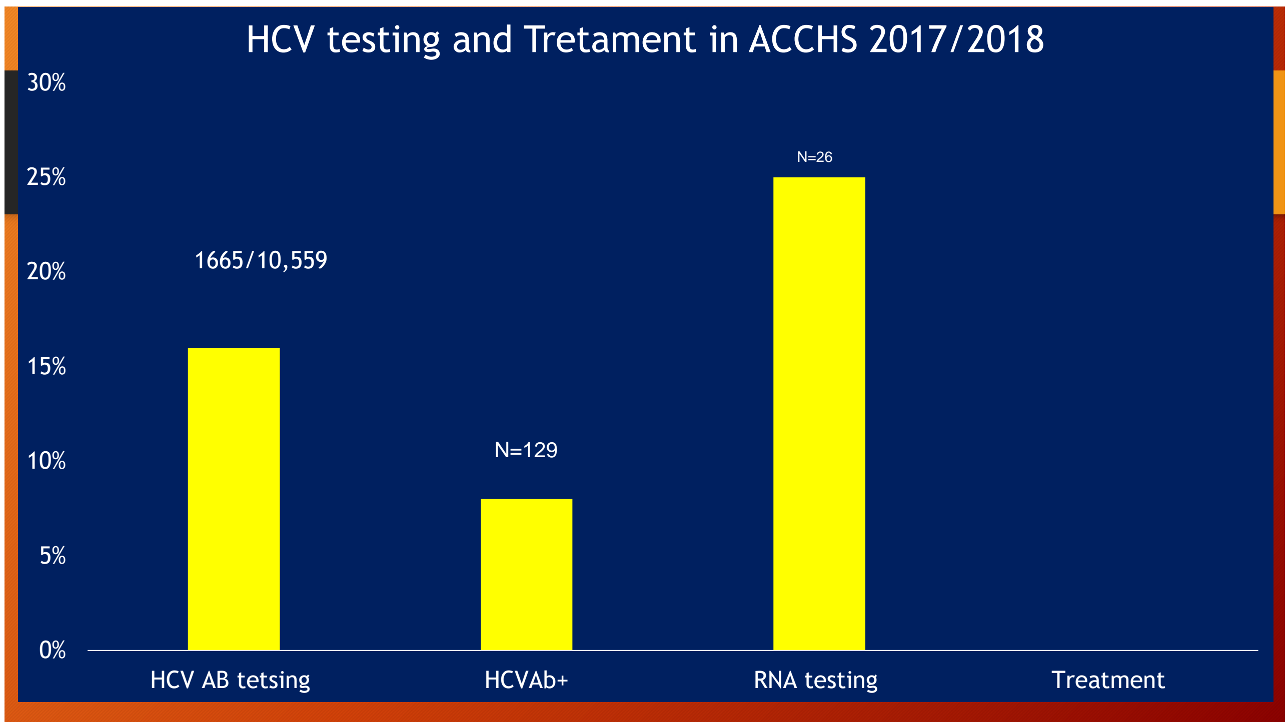
ATLAS: national STI and BBV surveillance network

ATLAS

- First national surveillance network of 40-50 Aboriginal Medical Services contributing STI and BBV testing and diagnosis data, supplemented with behavioural data

Why?

- Enhance current surveillance systems that predominantly collect only notification data
- Provide evidence to guide policy and program responses
- Enable health services to access data in formats that will enhance CQI and reporting



What else is required – Health Care Settings

- Need to be mindful just over half of population use ACCHS
  - initiatives for ACCHS and mainstream services are required
- Develop diagnosis and treatment cascades, identify gaps and act – client or clinician
- CQI programs
- Incentives

What else is required - Health Promotion

- Far reaching but targeted national campaign to promote testing and treatment for HCV is required
- Local initiatives can hang off the broader campaign
- Aboriginal people will be critical to development of campaign to ensure it has meaning, resonates and framed correctly
- Without this Aboriginal people will be left behind (PrEP is a good case study)

Snapshot of results of health promotion

- **Website: youngdeadlyfree.org.au**
- 1 Jan – 31 Dec 2018 = 66,282 pageviews
- 1 Jan-31 July 2019 = 44,309

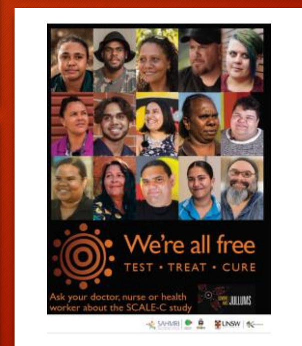
- **FB: youngdeadlyfree**
- 1 April 2018-30 June 2019 reached: 223,872 feeds
- 1 July 2017-31 March 2018 reached: 139,870 feeds

Strategies for hepatitis C testing and treatment in Aboriginal communities that Lead to Elimination

- *Funding*: NHMRC Project grant (2018-2022)
- *Collaborators*: SAHMRI, Flinders University, Kirby Institute
- Partners: Jullums Lismore AMS, Port Lincoln Aboriginal Health Service, Walhallow Aboriginal Corporation and Pangula Mannamurna
- *Ethics approval*: St Vincent's Hospital Sydney, Aboriginal Health & Medical Research Council (NSW) and Aboriginal Health Research Ethics Committee (SA)

SCALE-C Design

- *Design*: Prospective cohort study
- *Setting*: Aboriginal health services, NSW (n=2) + SA (n=2)
- *Population*: People with or at risk of HCV (n=286)
- *Intervention*: Community-based “test and treat”
- *Endpoint*: Change in HCV prevalence (>50% reduction) and incidence
- *Secondary objectives:* treatment uptake, phylogenetics; barriers & enablers to HCV care



Where to from here- to achieving elimination

Health Care Setting

- Health promotion campaign nationally & reinforced with local initiatives
- Reduce siloed approach finding and documenting models of care
  - in and out of clinic with leaders in communities
- Assessment of gaps in cascades where they are available and acting on them (CQI)
- Are incentives required to reach our peoples - if so for who, and how should they be administered?

Community

- A combination of biomedical, behavioural, structural and cultural strategies will be required to impact VH
- Need to have the right people designing and delivering the programs
- Reframing the approach in communities away from only individuals to thinking more about families and communities and embedding Indigenous ways of knowing
- Reframing elimination into a wellness perspective

More broadly

- Denominators
- Cascades for population groups + monitoring and evaluation
- Need to look at other opportunities in communities to achieve wellness/elimination
- Central repository of all the models of care that work - (PAST- KRC- NT Remote- DLM- NSW Ministry of Health- DBS Prisons)
- Registries- jurisdictional

The two big R's