EC Australia

Partnering to eliminate hepatitis C

Annual Report

Year 2 | 2020

Burnet Institute

Medical Research. Practical Action.

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EC Australia
Partnering to eliminate hepatitis C

Name of Organisation	Burnet Institute
Program Title	Eliminate Hepatitis C Australia Partnership
Program Summary	The long-term goal of EC Australia is to eliminate hepatitis C as a public health threat by 2030. The Australian public will benefit more broadly 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 will support services to increase hepatitis C testing and treatment among key affected 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	• Ensure that at approximately 15,000 Australians with chronic hepatitis C are treated and cured of their infection annually. • Ensure that people identified with cirrhosis related to hepatitis C infection are treated and cured, and regularly monitored for liver cancer. • Establish a national collaborate framework to facilitate a coordinated response to the elimination of hepatitis C as a public health threat from Australia by 2030.
Reporting period	Year 2 Report: April 2020 – November 2020
Report submitted to	Paul Ramsay Foundation, Grants Administrator
Date submitted	Tuesday 1 December 2020

EC Australia
Partnering to eliminate hepatitis C

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Abbreviations and acronyms

ACCESS	Australia Collaboration for Enhanced Sentinel Surveillance
ACCHS	Aboriginal Community Controlled Health Service
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
ECA	EC Australia program
GP	General Practitioner
HCC	Hepatocellular carcinoma
HCV	Hepatitis C virus
MBS	Medicare Benefits Scheme
M&E	Monitoring and evaluation
NACCHO	National Aboriginal Community Controlled Health Organisation
NHMRC	National Health and Medical Research Council
NSPs	Needle and syringe programs
NTAHC	Northern Territory AIDS and Hepatitis Council Inc
PATH	Peers supporting Access to Hepatitis C treatment
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
SAHMRI	South Australian Health and Medical Research Institute
SiREN	Sexual Health and Blood-borne Virus Applied Research and Evaluation Network
STI	Sexually Transmissible Infection
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

Executive Summary

Despite the challenges presented by COVID-19 and the transition to online working, EC Australia has made substantial progress over the last reporting period.

Following a soft pause, the Health Promotion Campaign had defined its key campaign audience as *people who inject and who may not be accessing services for hepatitis C testing and treatment* and has completed four out of six co-design workshops. The National Reference Group have moved through the 'Discovery Phase' into the 'Ideation Phase' workshops; which have identified key elements of the campaign implementation plan.

Most of the projects funded under the Workforce Development and Health Service Delivery (WDHSD) component have recommenced after being on-hold due to COVID-19. The pandemic has presented opportunities for projects to pivot to online modes of delivery and in some cases increase participant attendance compared to face-to-face delivery. Two of the model of care projects have demonstrated the importance of targeted clinical outreach to settings with known or suspected high prevalence of hepatitis C. Despite constraints presented in virtual delivery of care, peer-led models have continued to test and treat people who inject drugs (PWID), with peers in one model being able to reach a new cohort of people who had never been tested.

Through the Implementation Research component, EC Australia finalised and launched the report entitled, "Using notification data to increase access to the hepatitis C cure". This report has informed the development of a larger NHMRC Partnerships Grant due to be submitted in April 2021, with every state and territory health department joining as implementation partners.

Through the Evaluation and Surveillance component, the 2020 *Progress towards hepatitis C elimination* report was launched in November. This report includes new data relating to prison settings and hepatitis C among Aboriginal and Torres Strait Islander people. The team is continuing to provide ongoing support to the projects funded under the WDHSD component and seeking opportunities to identify potential sentinel sites to participate in the Australia Collaboration for Enhanced Sentinel Surveillance system.

The Aboriginal Health Strategy has convened a National Reference Group due to hold their first meeting in December 2020. The National Reference Group will inform, guide and provide cultural governance to the work of the Aboriginal Health Strategy. Work is underway to co-design an Aboriginal and Torres Strait Islander health promotion campaign. To address the gap in knowledge among Aboriginal Health Workers/Practitioners, the Aboriginal Program Manager delivered hepatitis C training in September to 30 Aboriginal Health Workers and provided practical examples of what workers could be doing in their services to increase testing and treatment.

To showcase the work occurring across the five components of EC Australia in November 2020 the team held a webinar series. The series was well-attended with positive feedback highlighting the usefulness of the content to attendees' work and providing an opportunity to share lessons and collaborate on important issues.

Progress towards program goals

- *Ensure that at approximately 15,000 Australians with chronic hepatitis C are treated and cured of their infection annually.*
- *Ensure that people identified with cirrhosis related to hepatitis C infection are treated and cured, and regularly monitored for liver cancer.*

Despite the challenges presented by COVID-19 and the transition to online working, EC Australia has made substantial progress towards the program outcomes and the hepatitis C elimination targets. Efforts to eliminate hepatitis C as a public health threat by 2030 are progressing in Australia with around 82,000 people receiving DAA therapy by the end of 2019. This is equivalent to 44% of the estimated chronic hepatitis C population in 2016. An estimated 10,000 to 12,000 people were treated in 2019. Whilst this is below the 15,000 annual treatments that EC Australia is aiming to achieve, encouragingly, treatment uptake has been relatively high in some priority populations that drive new infections. Among people who inject drugs (PWID) and HIV-positive gay, bisexual, and other men who have sex with men (GBM), treatment uptake appears to be proportionately higher than for other people living with hepatitis C. An estimated 29% of people treated in 2019 were treated in prison (again suggesting a high proportion of people with a history of recent injecting drug use). Other evidence of Australia's progress toward hepatitis C elimination is a decline in hepatitis C incidence in PWID and GBM. In addition, there are reports of lower prevalence of infection among people reporting recent initiation of injecting drug use (IDU).

While there continues to be a lack of routinely collected data across Australia on progress towards reducing cirrhosis and liver cancer, the available data suggests progress is being made in this area, with a decline in liver transplants attributed to hepatitis C. This suggests that hepatitis C treatment is reducing both liver failure and liver cancer.

The ongoing decline in the number of Australians undergoing hepatitis C testing (in particular, having a complete test event as evidence by a hepatitis C RNA test) and commencing treatment is a concern. If the current levels of testing and treatment uptake continue to decline, Australia will struggle to meet its elimination targets. Work needs to be done to increase awareness and engagement with key risk populations to increase testing uptake. There is also a critical need to ensure that the drop off in the hepatitis C cascade of care is reduced; it is important that when a person is first diagnosed that every effort is made to ensure they are supported to start and complete treatment.

Another important issue is equitable access to testing and treatment. Mapping of treatment uptake suggests some areas of Australia are less successful at engaging people in hepatitis C care. This is particularly the case in rural and remote areas, including within the Aboriginal and Torres Strait Islander communities who are disproportionately impacted by hepatitis C.

There are a number of challenges ahead for hepatitis C elimination. Being on track in 2020 does not mean Australia will be on track in 2025 and 2030 and achieve the 2030 targets. Hepatitis C elimination will require considerable and sustained effort. It is important to recognise that the strategies that enabled the first 40-50% of people with hepatitis C to engage with testing and treatment may not be effective for the remaining 50–60%. This does not mean the initial strategies were ineffective (indeed, our evidence suggests the reverse), but that phases of elimination require different approaches; in which changing epidemiology requires modified testing, treatment and prevention strategies and adapted surveillance approaches. As the challenges shift between phases, so should the response.

'Adapting old strategies and adopting new ones to achieve HCV elimination'

EC Australia's workplan and response in 2021 will recognise that people living with hepatitis C have competing health and social priorities, often associated with social disadvantage, substance misuse, and mental illness. Some have experienced stigma and discrimination in healthcare settings; for other treating their hepatitis C is a low priority because they do not feel unwell; some lack the resources. The planned launch of the National Health Promotion Campaign in 2021 will be a shift from past approaches by focussing on engaging people who currently inject drugs who are not well connected to mainstream services and are delaying and/or avoiding treatment. The campaign will try to stimulate conversations about treatment and for peers and services to 'finish' conversations; while trying to shift perceptions about treatment, and increase motivation/confidence to take up treatment.

This national campaign will be delivered by a workforce of peers across Australia; and will benefit from linkages with the 21 Workforce Development projects that are being implemented across health services in each state/territory. Interim reporting across these 21 projects have identified a number of critical lessons and opportunities presented by the COVID-19 pandemic including; the significant pivot to online delivery enabling engagement with a larger, more geographically diverse audience and increase in participant attendance compared to face-to-face delivery. Peer-incentive programs that have demonstrated success in increasing hepatitis C testing and linkage to treatment, may become more of a priority in 2021 as we try reach a new cohort of people who have never been tested.

The integration of the Aboriginal Health Strategy across the EC Australia program will provide additional support for Aboriginal Community Controlled Health Organisations (ACCHOs) to expand successful models and increase coverage of hepatitis C treatment for Aboriginal and Torres Strait Islander people. Harmonising efforts across the workforce development and evaluation and surveillance components will provide the platform to develop a national database for hepatocellular carcinoma (HCC) surveillance for people who have been cured and assess the impact of DAA on hepatitis C related liver deaths, liver cirrhosis and liver cancer.

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

A further piece of work to be expanded in 2021 involves using Australia's surveillance systems to identify people diagnosed with hepatitis C (either recently or in the past) and ensure they are linked into treatment. It is essential that this system is enhanced to ensure that all people who have an initial hepatitis C antibody test (the marker of exposure to hepatitis C) have a hepatitis C RNA test (the marker of ongoing infection) so they have a complete test event. It is also imperative that those individuals who are hepatitis C RNA positive are started on treatment. This requires the development of innovative nurse-led and peer-led approaches to support diagnosing doctors and the individual diagnosed with hepatitis C to commence treatment. This work will include the development and submission of an NHMRC Partnerships Grant focussed on "*Using notification data to increase access to the hepatitis C cure*". This partnership grant will be undertaken in collaboration with every state and territory health department and key community organisations.

Another critical piece of work in 2021 involves research exploring how to reduce barriers to hepatitis C testing. This will be done through an innovative series of studies exploring how best to use point of care diagnostics to engage people at risk of hepatitis C to test, to test more frequently and ensure that they have a complete test event (both an antibody and RNA test) and start treatment, improving the care cascade.

EC Australia continues to strengthen relationships with state/territory partners, including community organisations, health services and government. The decision to adapt the Annual National meeting to a four-part Webinar Series held in November 2020 enabled us to showcase our partners work and provide a platform for collaboration and information sharing.

Year 2 (Q4) – Program milestones and deliverables

Component	Milestone	Deliverable
Health promotion	National Health Promotion Campaign design phase continues	Co-design method produced National Health Promotion Campaign with linkage to development and planning of Aboriginal Health Promotion Campaign Strategy 3/6 design workshops completed
Education and workforce development	Continuation of education and workforce development activities	A webinar series showcasing WDHSD projects; to share key learnings and insights developed
Implementation Research	Identify new priority project for pilot & implementation	Development of NHMRC Partnership Grant submission focussed on *Using notification data to increase access to the hepatitis C cure;* including and national partner engagement and agreements.
Surveillance and evaluation	Year 2 Progress Report	Release of Year 2 Progress Report
Aboriginal and Torres Strait Islander Health Strategy	National Reference Group convened, priorities identified and workplan developed	National Leadership Group formation Health Promotion campaign co-design Review and analysis of mapping exercise Aboriginal Health Worker/ Practitioner workforce development

Progress Report: April 2020 – November 2020

1. Health Promotion Campaign

Milestone: Delivery of online co-design workshops

Deliverable(s): Co-design method produced, 3/6 design workshops completed, linkages established with Aboriginal Health Promotion Strategy

Table 1. Status of deliverables for Health Promotion Campaign

Deliverables	Status
Co-design method produced	Completed
3/6 design workshops completed	Completed
National Health Promotion campaign linked with the development of the Aboriginal Health Promotion Strategy	Completed

Campaign Development Phase

From April through to the end of September, the campaign design work – to be completed by the National Reference Group – was on a soft pause due to COVID-19. The National Reference Group agreed to this pause in March with the onset of the pandemic. Despite this, the National Reference Group held 5 meetings during this reporting period.

The key purpose of these meetings was to exchange information on the impact of COVID-19 in relation to hepatitis C testing and treatment; the social and medical issues people (who inject drugs) faced with increased restrictions; and to monitor the COVID restrictions with the aim to resume co-design activities face-to-face, while also exploring online design options for the campaign. Key insights shared in this period confirmed that a hepatitis C treatment campaign to boost hepatitis C messaging via peer engagement would be lost in the noise of COVID-19 messaging. During the March - September period, the priority community need was for people to be able to respond, adjust and cope with increased government restrictions and police enforcement, and health and community services were focussed on reorienting their services to minimise face-to-face contact and adhere to government guidelines.

Coinciding with COVID-19 cases stabilising at low levels across all States and Territories, the Reference group agreed in September that it was time to resume the co-design work given

the improved enabling environment for both the design and delivery of the campaign. The reference group still maintains that face-to-face meetings are the preferred option for the co-design work. However, in the context of the second COVID-19 wave in Victoria, a hybrid model would be needed for the group to meet online in the initial stages and then an option to meet face-to-face when possible. *Clear Horizon* developed a hybrid co-design workshop program which outlined options of working online and face-to-face. Working online would require shorter sessions (2 hours), and space in between workshops was included for reflection and the group would use Trello as an interactive tool in this process. A workshop schedule was developed and design work resumed in October 2020 and will run through to March/April in 2021.

Online Co-design Workshops

The Reference Group completed four facilitated workshops during October and November. Two workshops in October moved through the 'Discovery Phase' which analysed and pulled out insights from the pre-existing research on hepatitis C testing and treatment through the lens of people with lived expertise. At the end of the Discovery phase, the Reference Group defined its key campaign audience as *people who inject and who may not be accessing services for hepatitis C testing and treatment.* The Reference Group also described the scope and objectives for the campaign and the types of ingredients that could be used during the campaign (shown in Table 2).

Table 2: Objectives and ingredients needed for the campaign

Question	Answer
Based on what we know now, what exactly are we trying to achieve?	Our campaign audience is people who currently inject drugs who are not well connected to mainstream services and are delaying and/or avoiding treatment. We want the campaign to stimulate conversations about treatment and for peers and services to 'finish' conversations. We are trying to shift perceptions about treatment, and increase motivation/confidence to take up treatment. We want to change the situation for people and for them to feel valued and that their health matters. We also want to share information and knowledge to build health literacy and capacity to put this knowledge into practice. We want to focus specifically on helping people to get ready to access a testing and treatment service.
To do this, what key ingredients do we need?	Direct messaging to the community. Can include peer-based conversations to share treatment experiences and/or identify reasons for seeking treatment. Requires collateral to do so. Identifying and building a network of trusted services (e.g. NSP, pharmacies, food vans, washing machine vans and STI clinics, street-based outreach services and shelters). This can be done using visual cues (i.e. a

	red pin). [Services as a communication channel, not a target audience]. Can provide these services with a toolkit. Clear definitions and criteria (i.e. what do we mean by a trusted service?) Review examples to know what has and hasn't worked. Peer accredited/ capacity building training for service providers that make them more accessible. Incentives and to review examples of script subsidy/brokerage.
Do these key ingredients look different for each State and Territory?	Essential service ingredients (structures) are available across the States and Territories. Not every jurisdiction has the same technological, medical and resourcing opportunities (i.e. POC testing). Peer capacity across each State and Territories needs to be considered and supported.

In the remaining November workshops, the group will move through the 'Ideation Phase'. Using the scope and ingredients in Table 1, the group will explore "How Might We"-questions. This will allow the group to explore a range of solutions for the target audience, seeking agreement around what lever the campaign will aim to shift and what the key ingredients will be in order for this to be achieved.

Interconnections with the Aboriginal Health Promotion Strategy

During this period, the EC Australia Program Managers established feedback loops between the National Health Promotion Campaign and the Aboriginal Health Promotion Campaign in the design phase. Two Aboriginal and Torres Strait Islander community representatives were invited to sit on the National Reference Group for the campaign (in addition to the membership of the EC Australia Aboriginal Health Strategy Program Manager). This membership was established in recognition that the target audience for the national campaign will focus on people who are not engaging with services as a priority group, some of whom will be Aboriginal and Torres Strait Islander peoples, and that the implementation of this approach would be need to be culturally responsive. Prototypes will undergo focused testing with a wide audience, and the Aboriginal community representatives will be able to undertake this focus testing with their community members who inject and Aboriginal Health and Community workers.

The interlinking feedback loops were also identified as integral to the development of the Aboriginal Health Promotion campaign and the need to have its own community-led process. Refer to Section 5 for more detail.

Lessons Learned

A key success for the Heath Promotion Component during this period has been the shift to online work. With the continued meetings through the pause period, peer members of the reference group familiarised themselves with the Zoom format. This increased members'

comfort levels to both utilise technology and to discuss topics relating to drug use online. However, challenges remain to this online format which require ongoing management. For example, the ability for facilitators and the broader group to "read the room" is reduced; IT issues affect members at different times impeding participation; and the process is spread across multiple days in comparison to meeting face-to-face for one day sessions. The online sessions are 2 hours in length (for fatigue management) and are spaced fortnightly for reflection and input in between meetings.

Future work

From December 2020 through to April 2020, the reference group will complete the remaining codesign workshops either online, or if interstate travel is possible, we will meet face-to-face. Community piloting of campaign products will occur during January and February and by the end of April, the campaign prototype will be ready for production and the implementation strategy will be completed.

Table 3: Timeline of future work

Month	Workshop Output
December 2020	A prototype and a method for community testing
January 2021	Community testing
February 2021	Protype refinement and community testing
March 2021	Finalising the product and planning the implementation
April 2021	Setting up the evaluation methods

2. Workforce Development and Health Service Delivery

Milestone: Continuation of education and workforce development activities

Deliverable: A webinar showcasing WDHSD projects; to share key learnings and insights developed across the component

Table 4. Status of deliverables for Workforce Development and Health Service Delivery

Deliverable	Status
A webinar showcasing WDHSD projects; to share key learnings and insights developed	Complete

On 4 November 2020, EC Australia held an online webinar to showcase the work of funded partners' delivered during 2020. All WDHSD project partners were invited to participate through an expression of interest form, of which six partners expressed interest to participate.

The webinar involved six projects presenting a short overview of their project, highlighting key learnings and future plans and/or recommendations including:

- VHHITAL: Increasing the Capacity of Primary Care in the fight against Hepatitis C – a whole of practice approach
- Hepatitis WA: Regional Clinical Development Project
- Tasmanian MoC: Eliminating Hepatitis C in Tasmania – Working with priority populations
- ASHM: Beyond the C: Hepatitis C Elimination in Your Practice
- Peer Based Harm Reduction WA: Hepatitis C peer-based harm reduction education project
- QuIHN: Prison Transition Service

One hundred and five people registered to attend this webinar; 67 attended (excluding EC Australia staff and presenters). Attendees were asked to provide feedback at the conclusion of the webinar, 36 responded (54% response rate). The feedback indicated the majority of attendees learnt something from the webinar that was relevant to their practice (97%) and were likely to share these learnings with their colleagues (97%). All presentations were considered useful to attendees' work/practice, with the Peer Based Harm Reduction WA and QuIHN prison transition projects were most frequently identified as useful to attendees.

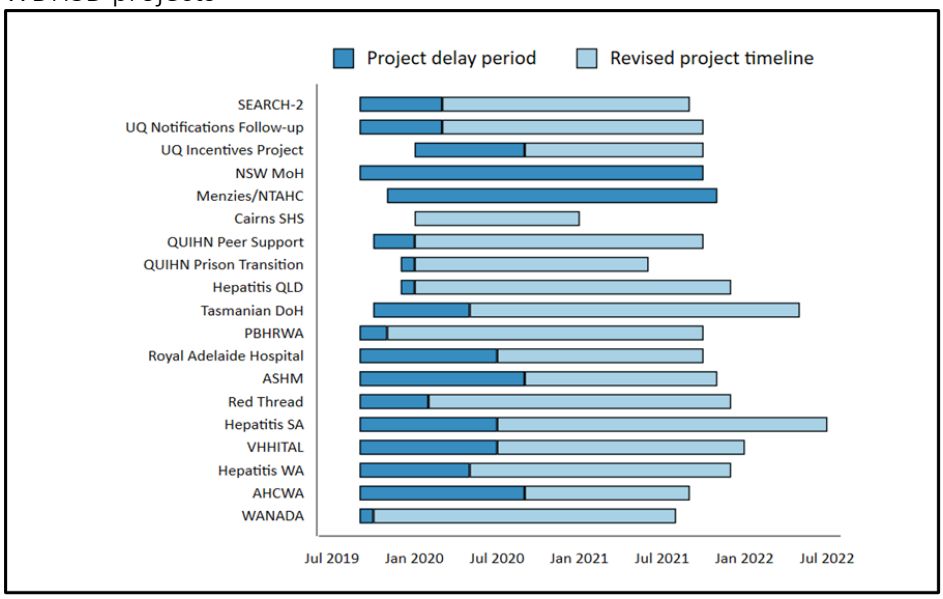
During the webinar there was significant interaction between attendees and presenters via the Zoom chat function. These interactions resulted in the formation of new relationships and the sharing of resources and tools between jurisdictions. The success of this webinar has encouraged further consideration of the development of virtual Communities of Practice

focusing on specific topic areas or ways of working. The suggested format will include EC Australia partners presenting aspects of their projects and then holding a facilitated discussion, with participation from both within the EC Australia partnership membership and the broader hepatitis C sector.

Updates and key learnings relating to ongoing work

As reported in the last progress report, for the period mid-March to May 2020, the commencement of all but one project was delayed (Figure 2). As the first wave of COVID-19 subsided in May/June, business began to return to a new COVID normal (in all jurisdictions except Victoria). Despite this, the commencement of the Northern Territory model of care and the New South Wales Needle and Syringe Program (NSP) project remain on hold. The Doherty Institute project was due to commence in 2020, but given the sustained COVID-19 outbreak and that the implementation was to occur within the Victorian Department of Health and Human Services Health Protection Branch, this project is now scheduled to commence in early 2021. The contract for this project has also not been executed due to significant COVID-19 related delays.

Figure 1: Impact of the COVID-19 pandemic on the timeline of EC Australia funded WDHSD projects



1. Online delivery - workforce development projects

The new COVID environment has led to innovations in the delivery of health care, education and workforce development and peer support. The most obvious and streamlined transition to online delivery occurred for the workforce development projects. After the initial challenges of responding to the pandemic had subsided, feedback was received from primary care and community services that these workforces were increasing their capacity to engage

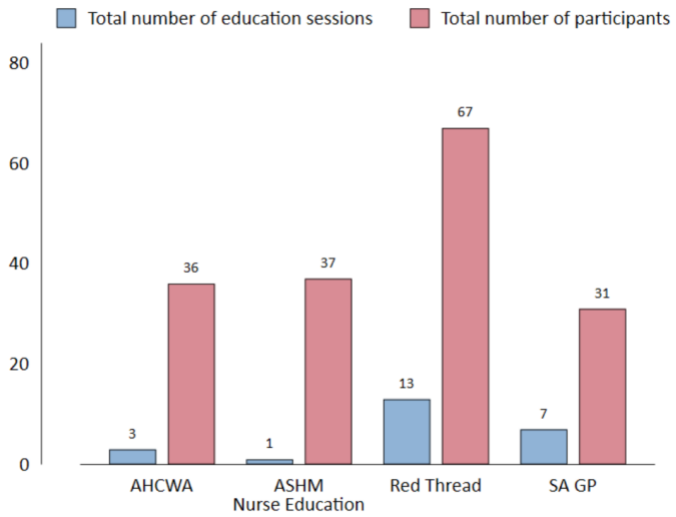
in non-COVID related education. The *Red Thread* workforce development project in Tasmania and the ASHM national nursing education program adapted their previously face-to-face education packages to an online delivery format. The *South Australian (SA) General Practitioner (GP) to GP Education Project* and the *Aboriginal Health Council of WA (AHCWA) Project* have both recommenced with face-to-face delivery. Figure 2 presents the number of sessions and participants who have attended the EC Australia workforce development education projects.

The ASHM 1.5-day nursing education program was transformed to two half day webinar sessions. This involved traditional content delivered via didactic presentations, small group case study discussions conducted in virtual break out rooms and interactive polling to monitor achievement of learning outcomes. The chat function in these sessions was reported as being particularly active, with participants engaging with each other and the presenters and asking questions. Traditionally, face-to-face sessions would attract between 20-25 nurses, however the online education webinars have attracted between 35-40 participants at each session. The move to online delivery has enabled engagement with a larger more geographically diverse audience and ASHM plan to maintain this online delivery going forward.

In Tasmania, *Red Thread* conducted online education sessions with workers from across the state enabling the development of professional networks from geographically diverse regions. Going forward, they plan to deliver these sessions through a combination of online and face-to-face modes.

The SA *GP to GP* education project has taken longer to re-start because of the complexity and stress associated with pandemic planning in primary care. However, after conducting several online sessions through the Adelaide PHN, face-to-face visits have recommenced in partnership between the GP presenter and the local viral hepatitis specialist nurse.

Figure 2: Number of sessions and number of participants attending the EC Australia workforce development projects.



2. Online delivery – Quality improvement projects

The demand for the online delivery of hepatitis C-related quality improvement activities has dramatically increased during the COVID-19 pandemic period. The *Western Australian Network of Alcohol and other Drug Agencies (WANADA)* developed a tool for participants to complete a virtual, facilitated self-review against the Hepatitis C Virus Care Capability in Alcohol and other Drug Treatment (HCVCAT) tool in the implementation of their project. This tool has been completed with 12 programs across six organisations throughout Western Australia. Similarly, the *Victorian HIV, Hepatitis Integrated Training and Learning (VHHITAL)* structured quality improvement activity has enrolled four general practice clinics and has delivered two out of three facilitated learning workshops online. While there were initial challenges related to limited information technology capacity within practices, including lack of cameras and unstable internet connections, feedback from the participating practices has been extremely positive, including that virtual workshops were considered by practices to be more convenient and time efficient than travelling to and from a physical event.

Delivery of virtual mentoring to support general practice clinics conduct clinical audits to identify patients with and at risk of hepatitis C through the *Hepatitis WA Regional Clinical Development Project* has also increased the geographic reach of the project. Prior to the pandemic, the plan was to undertake face-to-face activity in Kalgoorlie with seven practices, however, virtual implementation has meant that the project has engaged with 16 practices, nine GP clinics across the whole Goldfields have been enrolled but all were supported with resources.

The role of specialist hepatitis C nurses in contributing to the sustainability of workforce development activities was highlighted by the SA GP education project and the VHHITAL project. Both these projects have proactively engaged specialist nurses in the delivery of the education program and the subsequent in-practice support to assist with the implementation of new knowledge and skills.

The pandemic has presented opportunities for projects to pivot to online modes of delivery and in some cases increase participant attendance compared to face-to-face delivery. Currently, many projects are anticipating a transition to a hybrid model of education delivery in accordance with jurisdictional COVID safe plans. ASHM intend to continue with online delivery of education into the future due to their national focus and concerns about interstate resurgences of COVID-19. In 2021, ECA will be exploring the opportunity to host an interactive webinar to share learnings about online delivery within the ECA network.

There have been minor cost savings due to the transition to online delivery. Funds allocated to delivering courses face-to-face (including travel, venue hire and catering costs) have been reallocated towards expenses related to online delivery, such as additional work to convert courses to online and associated IT costs associated with this.

3. Targeted clinical outreach

The model of care projects were significantly impacted by the COVID-19 pandemic. Despite this, two of the model of care projects have demonstrated the importance of targeted outreach to settings with known or suspected high prevalence of hepatitis C. For example, prior to the EC Australia funded project, the Tasmanian hepatitis C model of care was focused on hospital-based treatment. However, since the project commenced in May 2020 the *Tasmanian Eliminate Hepatitis C Australia Outreach* project has successfully established nurse-led clinics, patients care pathways and increased capacity through the delivery of education and mentoring within the Tasmanian custodial system, the state-wide Mental Health Service and Hobart-based Needle and Syringe Programs (NSP) – settings with a high prevalence of hepatitis C and identified within the National Hepatitis C Strategy as priority settings.

The EC Australia monitoring and evaluation team has provided intensive support to the *Tasmanian Eliminate Hepatitis C Australia Outreach* nurses through the development of tailored data collection tools to capture the breadth of nursing activity and project outcomes including patient interactions and interventions, and testing and treatment numbers. Up to 30 September, 28 people had been tested at the Hobart NSP service. The number of prisoners accessing treatment has increased from 10 in March to June and 37 between July and October 2020 when the *Tasmanian Eliminate Hepatitis C Australia Outreach* nurse started visiting the prison. The state-wide mental health service has developed a universal testing and linkage to care policy for all community mental health patients, with the plan to

integrate hepatitis C testing and treatment into the clinical scope of mental health professionals by mid-2021; supported by the *Tasmanian Eliminate Hepatitis C Australia Outreach* nurses.

Recognising the importance of building the capacity of the *Tasmanian Eliminate Hepatitis C Australia Outreach* nurses, EC Australia responded to stated needs by supporting them to attend a project an online management course at Swinburne University to support their knowledge and skills in project implementation and monitoring. This skill set will be critical to supporting the sustainability of this project and future funding applications.

Another example of targeted outreach is the Hepatitis Queensland community corrections project. Prior to this innovative project, community corrections had never been targeted as a clinical service delivery setting in Australia. With community corrections ineligible to receive Medicare Benefits Scheme (MBS) rebates for GP-patient interactions (due to commonwealth-state funding agreements), this project will undertake much needed work to develop and evaluate sustainable and cost-effective models, such as nurse practitioner-led and/or nurse-led models of care. In the QLD model, the pandemic impacted the ability of the clinic to operate. In the one clinic offered in August, nine clients were reviewed, five tested positive to hepatitis C RNA and all were prescribed treatment; two of these clients were also diagnosed with advanced liver disease based on a Fibroscan and one referred to a liver clinic. Based on this experience, there is strong interest and commitment to replicate this model of community corrections services in far north QLD and Victoria using a nurse-led approach.

4. Peer-led models and the use of incentives

Two peer-led models of consumer engagement are being supported by EC Australia: the QuIHN Hepatitis C Community Peer Support project and the Peer Based Harm Reduction WA (PBHRWA) project.

The QuIHN model employs two peers (one male who identifies as Aboriginal and one female) who provide outreach and phone support to PWID seeking hepatitis C testing and treatment. In comparison, the WA model recruits peer educators who record hepatitis C-related interactions within their peer network in a diary and are reimbursed for up to eight interactions per month. Between November 2019 and August 2020, 30 peer diaries were submitted which reported on 242 peer interactions. More than half the peers (61%) reached people who had not been tested for more than a year or had never been tested at all, indicating the peers were reaching a cohort who needed testing and were not being routinely reached or not accessing conventional health services for testing.

In QLD two peers were employed in April in the midst of the pandemic, and commenced working in a virtual model, offering both telephone and online support. In May, the peers were both involved in the delivery of a flu vaccination outreach clinic, which allowed the

opportunity to have contact with PWID and incorporate hepatitis C outreach into the flu vaccination work. The number of clients supported was lower than expected because the peers were unable to conduct the targeted outreach to services beyond QuIHN's offices because of the COVID-19 restrictions. A total of 26 clients accessed the QuIHN peers between May to September, of whom five identified as Aboriginal; six have commenced treatment and three have completed treatment.

With the easing of restrictions in both QLD and WA, the peer-led models have been able to re-engage with PWID in a COVID safe way; referral systems are being established in QLD with Opioid Substitution Therapy (OST) prescribers, NSPs, hepatitis C outreach clinics and services targeting marginalised communities, including homelessness services; which are priorities settings outlined in the National Strategy.

The Cairns *Hep C Free* incentive program for PWID ceased promotion between April and June due to COVID restrictions. Despite this, until 30 September, 102 people were enrolled in the project with 99 having had a hepatitis C test. Twenty-seven percent of people enrolled identified as Aboriginal and Torres Strait Islander. Fourteen percent of people enrolled in the project were HCV RNA positive (four results pending) and 11 people commenced treatment. Of note, 11% were engaging with the Cairns and Hinterland Hospital and Health Service for the first time and of this number 85% recorded their first pathology result with Queensland Health. This incentive model provided incremental payments throughout the care cascade, which promoted continued contact with the health service through their hepatitis C journey.

Future work

The EC Australia team met virtually with all the project partners in October 2020, upon receipt of their annual report. These meetings focused on the projects' data plan and explored whether partners were satisfied with the story the data was telling. Subsequent adjustments to several of the projects' monitoring and evaluation plans were made, with the support of the EC Australia team. Ensuring all projects have a contingency plan for future COVID resurgence and contract extensions were also documented.

3. Implementation Research

Milestone: Identify new priority project for pilot & implementation

Deliverable: NHMRC Partnership Grant submission

Table 5. Status of deliverables for Implementation Research

Deliverable	Status
Completion of qualitative research project	Complete
Release of Formative Report on using hepatitis C notifications to increase access to the hepatitis C cure	Complete
NHMRC Partnership Grant submission	In progress

EC Australia has been leading the development of a NHMRC Partnership Grant to undertake national capacity-building to integrate routine follow-up of hepatitis C diagnoses as part of government public health notification systems. National consultations during grant development have resulted in support from every state and territory health department, as well as from ASHM, AIVL and Hepatitis Australia, to join the partnership and contribute significant in-kind support across the life of the grant. Pharmaceutical industry support was also sought to provide financial contributions to the project, with the application being prepared for submission in early December. While industry is supportive of the project, they are currently involved in renegotiating the terms of the next DAA funding agreement with the Commonwealth (due to expire in March 2021), and indicated that they would therefore not be in the position to provide support for a December application. Because of the scope and ambition of this multi-year project, with consultation and implementation worked planned across all seven Australian jurisdictions, a decision was made to delay submission to April 2021 to allow for the provision of anticipated industry financial to support for planned activities.

The aims of the partnership grant are to:

- Broaden national community and stakeholder consultations (including among Aboriginal and Torres Strait Islander organisations and communities) to achieve general agreement on acceptable approaches to using hepatitis C notification data for follow-up;
- Work with state and territory health departments to reach consensus on the permissible use of notification data within existing legislation and regulation for the purpose of increasing access to hepatitis C treatment, and identify and address operational and technical challenges to effective hepatitis C notifications follow-up;
- Implement and evaluate hepatitis C follow-up projects that align with existing state and territory activities and operating environments to identify optimal strategies for using hepatitis C notifications data to enhance treatment uptake;

- Facilitate a shared learning platform across jurisdictions and establish systems and agreed upon processes that sustainably integrate systems for hepatitis C notification follow-up into public health practice across Australia.

To date, all jurisdictional government and community/sector partners have agreed to be part of the Partnership Project and provide in-kind contributions. Industry partner meetings are scheduled for December and early 2021 to establish the level of industry financial support for the project. An outstanding academic team has been constituted from the Burnet Institute, University of NSW, Menzies School of Health Research, and University of Queensland and a complete first draft of the grant has been written and commented on, with refinements to be made leading up to final grant submission in April 2021.

Updates on ongoing work

In the last update, the EC Australia team was in the process of finalising the formative report exploring the use of hepatitis C notification data to increase access to the hepatitis C treatment and cure in Australia. The report was launched on 11 November 2020 and the team held a webinar to discuss the findings that emerged from the key stakeholder interviews, focus groups and an environmental scan of relevant legislation and regulation.

Key findings from this research include:

- Strong support from key stakeholders for the use of notifications data (including historical data) to contact people with HCV to increase access to treatment.
- A dominant perspective that it was unethical not to follow-up HCV diagnoses, but this activity must be balanced against privacy and confidentiality needs.
- The need for further consideration of how contact would be made with people diagnosed with hepatitis C, with divergent views on the roles of clinicians, health department officers or other delegated workers in conducting notification follow-up.
- The need to consider limitations and inaccuracies in notifications data and the potential to use data linkage to strengthen follow-up systems.
- The use of notification data for patient and community benefit appears to be justified and consistent with public health legislation.

This formative project and report have formed the basis of Partnership Grant consultations and will constitute important pilot data to strengthen the application.

On 11 November 2020 EC Australia held a webinar to disseminate findings from the formative report. This was the second webinar in a series of four and was attended by 74 people. The webinar showcased the findings described above and spoke to plans to further develop this work through the Partnership Grant.

Future work

- Finalise and submit the NHMRC Partnership Grant application (see planned activities above).
- Continuation of support to jurisdictions already using notification data to enhance linkage to care, including through EC Australia funded projects in Tasmania, Queensland and Victoria.

4. Evaluation and Surveillance

Milestone: Year 2 Progress Report

Deliverable: Release 2020 National Progress Report

Table 6. Status of deliverables for Evaluation and Surveillance

Deliverable	Status
Release of 2020 National Progress Report	Complete

The second 'Australia's progress towards hepatitis C elimination: annual report 2020' (Annual Report) was published in November 2020. Coordinated by the Burnet Institute and jointly published with the Kirby Institute, the Annual Report collated 21 separate sources to highlight Australia's progress towards hepatitis C elimination. The National Report 2020 has retained its focus on seven key areas: new infections, testing and diagnosis, treatment uptake, morbidity and mortality, stigma and discrimination, prevention of acquisition, health equity and mathematical modelling.

The 2020 progress report also sought to address key gaps identified in the 2019 progress report, specifically in terms of data among prisoners and Aboriginal and Torres Strait Islanders. The 2020 progress report now includes data on hepatitis C testing and treatment among Aboriginal and Torres Strait Islanders from two contributors. In addition, the National Prison Hepatitis Network assisted in providing data on hepatitis C treatment initiations from prisons across all states and territories. It has been a challenge to collate data on morbidity and mortality outcomes for the National Report due to the considerable gap in available data.

On 25 November 2020 EC Australia held a webinar to disseminate findings from the 2020 Progress Report. This was the last webinar in a series of four and was attended by 83 participants. The webinar showcased the findings of the report and enabled the audience to ask questions to the panellists.

Updates on ongoing work

Between April and November 2020, the EC Australia Surveillance and Evaluation team have been focussed on providing support to the WDHSD component of EC Australia. The team have provided tailored support, ranging from providing guidance on evaluation plans to direct project management and building of data collection tools. All projects achieved the goal of completing written monitoring and evaluation plans and reported against those plans in September 2020. The capacity of WFDHSD projects to perform robust monitoring and evaluation remains a challenge. EC Australia has taken a capacity building approach and continue to support projects as much as possible to build evaluation skills sets within the organisations.

There has been ongoing refinement to the ACCESS sentinel surveillance system to increase its capacity to monitor and evaluate activities designed to eliminate hepatitis C. In supporting WFDHSD projects to develop monitoring and evaluation plans, potential clinical sites that could be recruited by ACCESS have been identified, however the COVID-19 pandemic has placed clinic recruitment on hold.

ACCESS currently provides service-level data and reports back to primary care clinics that have received nurse-led interventions as part of the EC Victoria project. These data are being used to refine clinical practice, such as identifying gaps and where improvements can be made to ensure patients move through the hepatitis C cascade of care. This provision of clinical data within site-level reports through ACCESS remains a goal of the EC Australia Evaluation and Surveillance team as the experiences in Victoria have demonstrated its utility for reporting on project outcomes and for guiding improvements in practice. By expanding the ACCESS surveillance system nationally, we hope to build the capacity of health services to use their clinical data to help improve the quality of and retention in hepatitis C care.

Learnings and insights

- The sector was overwhelmingly supportive of sharing data to include in the National Report, to have a high-quality publication for use by all.
- The Progress Report demonstrates an ongoing trend in the decline of hepatitis C treatment uptake which is likely to be exacerbated by the COVID-19 pandemic. This emphasising the need for ongoing efforts to increase the number of people who are being tested and treated.
- Positively, the report also identified that treatment uptake has been relatively high amongst some priority populations including PWID and HIV-positive gay, bisexual, and other men who have sex with men (GBM).
- We continue to learn about how to increase the monitoring and evaluation skill set of staff within primary care and community-based settings, and a number of projects (including those that took part on the November WFDHSD webinars) have expressed increasing enthusiasm towards the role of quality data for guiding practice and informing program refinements.

Future work

- The third annual National Report will be prepared and launched in 2021. The next six-months will include preparatory work seeking feedback on the 2020 report, engaging stakeholders and sourcing data.
- Over the coming months, WDHSD projects will be offered one-to-one follow up to discuss refining their evaluation plan and identifying any monitoring and evaluation supports needed.

- Analysis of ACCESS data on key trends in hepatitis C testing and positivity, and hepatitis C incidence will be finalised in the next six months. These will be disseminated as peer-reviewed papers and translated into briefing documents for wider dissemination. These analyses will also form the basis of population-level assessments of broad EC Australia program impact.

5. Aboriginal Health Strategy

Milestone: National Reference Group convened, priorities identified and workplan developed

Deliverable: National Leadership Group formation; Health promotion campaign co-design; Review and analysis of mapping exercise; Aboriginal Health Worker/Practitioner workforce development

Table 7. Status of deliverables for Aboriginal Health Strategy

Deliverable	Status
National Leadership Group convened, priorities identified and workplan developed	In progress
Health Promotion campaign codesign	In progress
Review and analysis of mapping exercise	In progress
Aboriginal Health Worker/ Practitioner workforce development	Ongoing

National Leadership Group

Over the course of the year the Aboriginal Health Strategy, National Leadership Group (NLG) was formed. Representation was sought from the Aboriginal Community Controlled Health, viral hepatitis and peer drug user sectors. The NLG aims to inform, guide and provide cultural governance on projects and processes of the Aboriginal Health Strategy. It is planned that the NLG will meet approximately two to three times a year with the first meeting to be held in December 2020. Draft Terms of Reference will be tabled for comment and will be later endorsed at by the NLG in 2021.

National Aboriginal Health Promotion Campaign

As noted in the update on the National Health Promotion Campaign two campaigns will be developed, one with a focus on PWID while the other will have an explicit focus on reaching Aboriginal and Torres Strait Islander PWID. Similar to the National Health Promotion Campaign, the Aboriginal and Torres Strait Islander campaign will apply a peer-led co-design process. Aboriginal representatives on the NRG will have a key role in contributing to the co-design process with respect to shaping the national campaign, informing culturally responsive messaging and/or identifying what prototypes may be applicable to the Aboriginal Health Promotion Campaign.

The aims and objectives of the National Aboriginal Health Promotion Campaign have not yet been defined. The Aboriginal Health Program Manager will draw on a literature and resource review, mapping report, content from the National Health Promotion co-design workshops and advice from the NLG in deciding on its directions.

Workforce Development

A key priority identified within the workforce development component of the Aboriginal Health Strategy is to support Aboriginal Community Controlled Health Organisations (ACCHOs) to expand and develop models of hepatitis C care. During the EC Australia National Consultations in 2018, it was identified that there were limited availability/opportunities for hepatitis C specific training for Aboriginal Health Workers/Practitioners.

On 30 September the Aboriginal Program Manager delivered training to approximately 30 Aboriginal Health Workers/Practitioners studying a Certificate IV in Alcohol and Other Drugs at the Aboriginal Health Medical Research Council of NSW, Registered Training Organisation. The training covered, epidemiology of hepatitis C in Aboriginal Communities, testing, latest treatment options (cure), cascades of care and treatment as prevention models. The training also provided practical examples to Aboriginal Health Workers about what they could be doing in their services to increase testing and treatment.

At this stage there are no plans to continue this training however a relationship has been established and the Program Manager will contact the college again in 2021. On reflection, this session gave EC Australia an understanding of the limited knowledge of Aboriginal Health Workers regarding hepatitis C, including mode of transmission, testing, treatment and care. The below training package being developed in collaboration with the ASHM will aim to address this knowledge gap.

EC Australia collaborated with ASHM to develop and implement an online training package "Hepatitis C for Aboriginal & Torres Strait Islander Health Workers and Health Practitioners". This four hour training (split across two days) aims to strengthen and develop culturally safe hepatitis C care for Aboriginal and Torres Strait Islander people by equipping Aboriginal Health Workers and Practitioners with practical skills and knowledge in hepatitis C diagnosis and care, including confidence to start conversations about hepatitis C and enact a role in supporting clients with treatment adherence and monitoring on treatment. The course also explores Aboriginal Health Workers' role in monitoring clients post-cure, including ongoing monitoring for hepatocellular carcinoma in clients with cirrhosis. The EC Australia Program Manager has had a role in providing expert advice in the development of the package and will be a course facilitator and reviewer of the evaluation and monitoring process of the pilot and ongoing training.

Updates on other work

Surveillance

This year, for the first-time, data from the ATLAS & GOANNA II studies were included in the National Progress Report to HCV Elimination. While these data sources are somewhat limited in their coverage across all jurisdictions, they provide the best source of data specific to Aboriginal and Torres Strait Islander peoples and can provide a useful baseline for future years

as well identify key issues around the uptake of HCV testing and treatment in Aboriginal communities that will inform the workplan for 2021.

The ATLAS network is an established national sexually transmissible infections and blood borne viruses sentinel surveillance network specific to Aboriginal and Torres Strait Islander peoples. ATLAS currently includes 29 Aboriginal Community Controlled Health Services (ACCHS) located in five clinical hubs across QLD, NSW, SA, WA and the Kimberley. These measures include hepatitis C testing rate, treatment uptake and sustained virologic response (SVR). Participants in the ATLAS network are tested for hepatitis C using a risk-based assessment. Approximately 8-10% of people attending ACCHSs were tested for hepatitis C antibodies and/or RNA of which 5% were antibody positive. Females were more likely to be tested for hepatitis C. Between 2016-2019 112 individuals received DAA treatment. Of those tested after receiving treatment, 58% appeared to achieve an undetectable HCV viral load.

The GOANNA Survey is a national sexual health survey of Aboriginal and Torres Strait Islander people aged 16–29 years held at sporting and cultural events around Australia. This survey asks young people about hepatitis C testing and the location of where this testing occurred. There were 407 people who respondents to the survey with 17 indicating that they were hepatitis C positive, nine of which had not been treated. Overall, younger respondents (aged 16-19) were less likely to report being tested in the last year compared to older participants. People living in regional areas were less likely to report being tested for hepatitis C (25%) than those in metropolitan (34%) and remote areas (43%) and most hepatitis C testing was conducted at an Aboriginal Medical Service (52%).

Aboriginal Health Strategy Webinar

To showcase the work across the Aboriginal Health Strategy a webinar was held on 18 November 2020. This was the third webinar in series of four webinars and was attended by 89 participants. The webinar showcased:

- Latest surveillance data from a national sentinel surveillance network of ACCHOs (Atlas) and the Goanna Survey 2 a study of knowledge, risk practices and health service access for STIs and BBVs among young Aboriginal and Torres Strait Islander people. Both datasets showed declines in testing with some improvements noted under the Atlas network in recent years.
- The Institute of Urban Indigenous Health conducted a study on the barriers and enablers of hepatitis C treatment among clients of urban ACCHOs in South East Queensland. Common barriers included cost, paternalism, recall systems and procedures while enablers were commonly structured around relationships. These barriers and enablers were used to inform the development of a culturally safe model of hepatitis C care

- Staff from Derbal Yerrigan Aboriginal Medical Health Service presented an overview how their service has improved hepatitis C testing and treatment rates through the development of better systems and the application of chronic care-coordination principles involving Aboriginal health Workers as champions at each of their four sites.
- Walhallow Aboriginal Health Service presented on their site's participation in an interventional cohort study SCALE-C (Strategies for hepatitis C testing and treatment in Aboriginal communities that Lead to Elimination) with the aim to achieve micro-elimination. This service presented a range of barriers preventing follow up through the cascade of care as well as strategies to engage people into testing and treatment.
- A peer-based model of service delivery which highlighted the importance of having Aboriginal staff in peer-user positions and the importance of self-determination when developing and delivering services to Aboriginal PWID.

Learnings and insights

- Current micro-elimination models of hepatitis C care in ACCHOs are ad-hoc and are being delivered with a lack of coordination and evaluation.
- Competing co-morbidities and other lifestyle priorities are barriers for Aboriginal people with hepatitis C to commence treatment.
- Whilst we have data from the ATLAS network there are large gaps in Aboriginal & Torres Strait Islander notification data to truly estimate prevalence and incidence of hepatitis C in the Aboriginal and Torres Strait Islander community.
- Higher incarceration rates increase risk of hepatitis C transmission and pose challenges for commencing and continuing care for Aboriginal prisoners.
- Stigma and discrimination relating to hepatitis C and/or injecting drug use (a barrier for all PWID, but possibly higher in some ACCHOs and/or Aboriginal communities).
- There is insufficient knowledge about direct acting anti-viral treatment among Aboriginal and Torres Strait Islander people with hepatitis C.

Future work

To inform the development of a National Aboriginal Health Promotion Campaign and Workforce Development activities, a national mapping of hepatitis C and related resources and models of care will be conducted. This mapping will include interviews with Drug Peer User, Hepatitis Councils and Aboriginal Community Controlled Health Organisations, and a review of literature and hepatitis C or related resources. Invitation letters have been sent to stakeholders and interviews are planned for December 2020. Data collected and synthesised from the qualitative interviews and resource review will be used to guide the development of the Aboriginal health promotion campaign, workforce development projects and to identify opportunities to address gaps or build new evidence through implementation projects.

Much more sophisticated surveillance and data is required to support hepatitis C elimination efforts in Aboriginal and Torres Strait Islander communities. In the coming 12 months a key focus of the surveillance component will be to continue to recruit new services into the ATLAS surveillance systems to increase coverage of urban services that better reflect hepatitis C epidemiology. Another focus in the coming 12 months will be to collaborate with the Kirby Institute to improve the estimates of the prevalence of hepatitis C virus infection in the Aboriginal population. This focus will not only map and estimate number of Aboriginal people with chronic hepatitis C but will pull together a range of data sources to report on other elements of the cascade of care (e.g. number of Aboriginal people accessing treatment, number of Aboriginal people with sustained virological response).

In addition, a key element of the workforce development training activities described above, will be to support ACCHOs to conduct clinical audits of their data to prioritise active case finding, follow up of and linkage to care; which should increase coverage of hepatis C treatment for Aboriginal and Torres Strait Islander people.

Additional progress

Cirrhosis and Hepatocellular Carcinoma (HCC) monitoring database

Program deliverables:

1. Development of a database for HCC surveillance for people with hepatitis C post sustained virologic response (SVR)
2. Data on impact of direct acting antivirals (DAAs) on HCV-related liver deaths, liver cirrhosis and liver cancer

Achieved in this reporting period:

a. Ethics submission and approval at three of seven planned HCC management sites across Victoria to capture granular clinical data on all HCV-related and overall HCC cases across Victoria, with data collection occurring at the three sites
b. Agreement and support for a state-wide linkage of the Melbourne Liver Group HCC databases at all seven HCC management sites for Victoria (and Tasmania)
c. Preliminary discussions regarding a state-wide cirrhosis database and data reporting system (this is very complex and will take a long time to develop)
d. Ethics approval to access nationwide HCC death registry data for all liver-related deaths including liver cancer specifically, stratified by underlying liver disease aetiology. We will also have mapped liver disease cofactor and social vulnerability data but this will be matched by postcode, not individually linked data (I believe the Doherty and Kirby are doing HCV notification disease outcome matching, so we have not pursued this for now)
e. Ethics submission preparation to access hospital ICD code data for all hepatitis C (and other liver disease) related hospital admissions data for Victoria, with view to expanding project to all states. These data will provide information about impact of DAAs on hospitalisation rates, cirrhosis complications and liver cancer among people with hepatitis C etc over time
f. HCC surveillance system mapping at major public HCC management centres across Australia (i.e. methods used to identify, link to care and retain patients in HCC surveillance programs)

Cost effectiveness/resource mapping models – Modelling interface for HCV Optima

The modelling team were requested to provide support for the COVID-19 response in Victoria and Australia. This has delayed progress on the online platform, for the cost-effectiveness model. This activity will continue in 2021, and an update provided at the next reporting timepoint (May 2021).

Advocacy Strategy

Since appointing an EC Australia Policy Lead an Advocacy Strategy has been drafted, with key policy issues and recommendations mapped out. These areas include testing, liver assessment, treatment, retention in care pathway, HCC surveillance, evaluation and surveillance, harm reduction, stigma and discrimination, and health system factors. Over the coming months advocacy stakeholder reference group will be convened comprising of peak bodies, advocacy priorities will be identified, and a campaign developed for this area of work for 2021 and through to 2022.

Social Outcomes

Social Outcomes has continued their work on a social impact analysis of EC Australia's work. Although we have extended phase 2 beyond July 2020, to account for the disruptions caused by COVID-19 in 2020. Despite the disruptions, great progress has been made on this area of work this year. In this recent phase Social Outcomes prepared and delivered an evidence report: Preparing for the future funding of eliminate hepatitis C Australia – Phase 1: Laying the Foundations Report, to conclude Phase 1's work. Phase 2: Develop an impact measurement framework work commenced and two Theory of Change workshops were held in September and October with internal and external stakeholders with expertise in the HCV and harm reduction space. The aim of these workshops was to develop an evidence-based theory of change (ToC) and impact measurement framework designed to strength funding transactions. The current draft ToC and Measurement for ECA aims to include key 'knock-on' impacts of hepatitis C eradication, including social impacts and systems improvements. The next step in this work is Phase 3: Prepare a transaction proposal which will assist in exploring alternative transaction concepts and financing models.

Policy Update

TGA approved the Cephid Xpert PoC test

In May of this year, the Therapeutic Goods Administration (TGA) approved the Cephid Xpert PoC test, which is great news for the sector, enabling greater access to HCV testing, to aid in the initial diagnosis in individuals at high risk of HCV infection or in anti-HCV positive individuals. This change will also aid in the management of HCV-infected patients undergoing antiviral therapy. While EC Australia did not have a direct role in influencing this change, it is important to acknowledge the positive impact that this will have on the sector, our partner's work, and national efforts towards HCV elimination.

Key Milestones and deliverables for next reporting period – May 2021

Year 3 (Q2) EC Australia Program level Key milestones and deliverables (Report #5)
May 31, 2021

Component	Milestone
Health Promotion	Campaign implementation strategy with products focus tested with communities and workforce
Education and workforce development	End of project report for incentives programs, learnings, and recommendations for future projects
Surveillance and evaluation	HCV cost-effectiveness model web interface
Aboriginal and Torres Strait Islander Health Strategy	Evaluation and Surveillance workplan developed
Advocacy Strategy	Advocacy priorities set and workplan developed

Workplan December 2020 – May 2021

Phase (in time period)	Key Activities	Deliverable(s) associated with this phase	Due date
Working groups activity milestones & deliverables			May 31, 2021
Year 3 (Q2)	**Implementation Research** 1. NHMRC Partnership Grant submission 2. Point of Care testing & Peer Models work	Update on implementation research projects submitted with 6-monthly Report: 1. NHRMC Partnership Grant draft 2. Rapid Point of Care testing & Peer Models pilot data	
	Surveillance and Evaluation 1. Cirrhosis & HCC Monitoring Database progression 2. Expansion of ACCESS sites	1. HCC surveillance system mapping at major public HCC management centres across Australia. 2. Approved use of granular clinical data collection at several HCC management services in Victoria. 3. Ethics approval for nationwide death registry data for all liver-related deaths including liver cancer, mapping data for liver disease cofactors and social vulnerability utilizing post codes. 4. Submission to access Victorian hospital ICD code data for hepatitis C and liver disease related admissions for the exploration of DAAs impact on hospitalization rates, cirrhosis complications 5. New data sets established into Year 2 Surveillance Report - Prisons & ATLAS / GOANNA Study.	
	Impact Evaluation: Social Outcomes – social impact analysis Work plan developed and activities commenced for sustainable funding mechanisms and role of social impact bonds.	Phase 1: Revised Work plan evidenced based for sustainable funding mechanisms and role of social impact bonds submitted with 6-monthly Report / Annual Report.	

	Advocacy Strategy Formation of Working Group comprised of peak bodies. Consensus reached on ECA Advocacy focuses and priorities for next 2 years.	Update submitted in Annual Report. Advocacy Campaign Plan developed in consultation with working group.	
Year 3 (Q2) EC Australia Program level milestones and deliverables			May 31, 2021
Year 3 (Q2)	**Health Promotion** National Health Campaign – preparation for implementation phase; building of relationships, establishment of products for implementation.	5/6 online codesign workshops completed prototypes focus tested with community Campaign implementation strategy to be ready end of April 2021	
	Education and workforce development Priority educational programs implementation & evaluation.	1. Projects funded for 12 months (i.e. those that commenced implementation in Yr2. Q2), with 6-month extensions. 2. Establishment of communities of practice/ mechanism to share learnings of projects.	
	Implementation research *Pending success for the NHMRC Partnership Grant* - Partnership Grant implementation	Evaluation of Year 2 implementation research projects & finalisation of Year 3 implementation research projects submitted with 6-monthly Report.	
	Surveillance and Evaluation Cost effectiveness/resource mapping models.	Functioning web interface for HCV model. Completed and ready to be utilised.	
Working groups activity milestones & deliverables			
Year 3 (Q2)	**Implementation Research** Rapid Point of Care testing & Peer Models work continuing **Surveillance and Evaluation** 1. Hepatitis C elimination Surveillance Report 2. Cirrhosis & HCC Database 3. ACCESS sites	Update on Point of Care testing & Peer Models work. 1. Distribution launch from November 2020 update, progress report - 6-monthly Report. 2. Progression of work within state-wide linkage of the Melbourne Liver	

	Aboriginal & Torres Strait Islander Health Plan Implementation of workplan commenced **Impact Evaluation: Social Impact Analysis** *Potential to extend based on timelines of other activities.* **Advocacy Strategy** Commencement of Advocacy implementation work.	Group HCC databases at sites for Victoria and Tasmania. 3. Plan for expansion of ACCESS sites for 2021, provided in 6-monthly progress report. Update on Aboriginal Health Strategy: National Leadership Group priorities; Health Promotion Campaign; Aboriginal Health Worker/Practitioner Workforce Development; Evaluation and Surveillance opportunities identified. Phase 2: Develop impact measurement framework completed - evidence-based theory of change and impact measurement framework designed to strengthen potential funding transactions. Submit with 6-monthly Report. Update on Advocacy Campaign provided in Annual Report.	

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 key affected populations.

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