hepatitiswa Newsletter

Issue 11 | March 2015

TESTING FOR HEPATITIS IS AS EASY AS

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PERSONAL PERSPECTIVE: MICHELLE'S STORY | HEPATIDINGS | WASUA'S DOMAIN

MARCH 2015

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LETTER FROM THE EDITOR

Welcome to the March 2015 edition of the HepatitisWA Newsletter! This issue covers a range of articles on hepatitis A, B and C. Our "Going Viral" section features an article on the imported frozen berries possible hepatitis A contamination, and an article on USA's Food and Drug Administration, rescinding the "breakthrough" status on Merck's hep C drug. The personal perspective story is written by Michelle. She shares her story about being diagnosed with hepatitis B and breaking the cycle of infection from mother-to-child. Other feature articles are "PrEP users' acquiring hepatitis C sexually, suggests the need for routine testing", "The cost-effectiveness of hep C treatment for patients in early stages of liver disease," "Combo drug shows high hepatitis C cure rates in patients with HIV", "Risk factors for exposure to HCV Infection", "Hepatitis C risks for baby boomers", and an abstract on an Australian study assessing knowledge and understanding of the effect, transmission, and treatment of hepatitis B among chronically infected individuals. In our health and lifestyle section we feature an article on "Complementary therapies for hepatitis C", plus a delicious and healthy burrito recipe. Lastly, HepatitisWA shares our community activities in 'Hepatidings' while WASUA shares their experience during Sexual Health Week.

Felicia Bradley

Editor

ON THE COVER

Testing for hepatitis is as easy as ABC
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It's easy to get tested for hepatitis A, B, and C. Contact HepatitisWA or your local GP for further information. Cover image designed by Felicia Bradley.

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hepatitiswa Newsletter

Editor Felicia Bradley
Graphic Artist Felicia Bradley

Postal Address
PO Box 67
Francis Street
Northbridge, WA 6865

Information & Support Line
Monday - Friday 9am - 5pm
(08) 9328 8538 Metro
1800 800 070 Country

Office
134 Aberdeen Street
Northbridge, WA 6003
Telephone: (08) 9227 9802
Fax: (08) 9227 6545
Web: www.hepatitiswa.com.au

Proof Reading
Frank Farmer
Sally Rowell

Email the Editor resources@hepatitiswa.com.au

HepatitisWA (Inc).
HepatitisWA is a community based organisation which provides a range of services to the community in response to viral hepatitis, particularly hepatitis A, B and C.

Please contact us for more information, or make an appointment to call by and talk with an appropriate member of our staff.

MICHELLE'S STORY

BREAKING THE CYCLE OF HEPATITIS B INFECTIONS FROM MOTHER-TO-CHILD

Michelle is one of 1.25 million Americans who are living with chronic hepatitis B. Michelle was born in 1969 to an American father and Vietnamese mother, who had met and married during the Vietnam War.

She grew up healthy and happy in Kentucky, unaware that her mother had unknowingly passed on the hepatitis B virus to her at birth. When Michelle was born, there was no hepatitis B vaccine available to prevent this infection. Had she been immunized within 12 hours of birth, she would be free of infection today.

"I found out about my infection through a routine blood test during my first pregnancy in 2000," she said. Kentucky is one of the few states in the country that require pregnant women to be screened for hepatitis B. "The nurse called me at home to tell me my hepatitis B test had come back positive. I immediately thought it was a lab error."

"Eight years earlier, I had donated blood and was told that I had hepatitis B. I was re-tested and they told me I had never been exposed to hepatitis B and was free of infection," she recalled. But after the hepatitis B test came back positive during Michelle's pregnancy, she went to see a specialist for more tests. This time, he confirmed she had chronic hepatitis B. Most teens and adults infected with the hepatitis B virus experience only a brief or acute infection. However, when newborns like Michelle are infected, they face a 90 percent risk of developing a chronic or life-long hepatitis B infection.

"Needless to say, after my diagnosis I experienced the emotional succession of denial, depression and then acceptance of my hepatitis B infection," she said.

Her immediate concern was to make sure her newborn daughter would not be infected with hepatitis B.

"During my delivery, I made sure the hospital staff was aware of my hepatitis B, and I constantly reminded them to make sure my baby received the hepatitis B vaccine within 12 hours of her birth, which prevents mother-to-child infection 90 percent of the time.

Fortunately, the hospital staff was on top of things and my daughter was vaccinated properly and today is free of hepatitis B."

Michelle's husband also tested negative for hepatitis B after her diagnosis and was quickly vaccinated.

After much pressuring, Michelle had her parents tested for hepatitis B. "When my mom asked her doctor to test her for hepatitis B, her doctor asked 'Why?' He saw no reason to test her, even though Asian-Americans are at extremely high risk of hepatitis B."

Her mother's hepatitis B test came back positive. Later that year, Michelle found out that her maternal grandmother, who lives in

the United States, also tested positive for hepatitis B. "After this revelation, our family history came pouring out," Michelle explained. "I learned that another of my mom's sisters also has hepatitis B, as do other family members.

Vietnam, like other countries in Asia, has very high rates of chronic hepatitis B infection, which is why one in eight Vietnamese-Americans has chronic hepatitis B. Hepatitis B is the second-leading cause of cancer death in Vietnamese -American men because it is often not diagnosed or treated until serious liver disease has occurred."

Today, Michelle has a second child, who was also promptly vaccinated at birth and remains free of hepatitis B.

"Knowing that both my children were properly immunized against hepatitis B at birth gave me great confidence that they would be free of hepatitis B," said Michelle.

"Sadly though, this means that only my children's branch of my family tree will be free of hepatitis B. I wish I could say the same for the rest."

"Knowing that both my children were properly immunized against hepatitis B at birth gave me great confidence that they would be free of hepatitis B."

Story originally published by the Hepatitis B Foundation www.tinyurl.com/michelles-story

GOING VIRAL

A ROUND-UP OF ARTICLES ON VIRAL HEPATITIS

FDA RESCINDS 'BREAKTHROUGH' STATUS FOR MERCK'S HEPATITIS C DRUG

The rare move by the FDA follows the market debut of two new hepatitis C treatments in the last year.

The US Food and Drug Administration will rescind Merck's "breakthrough designation" for an experimental hepatitis C treatment, the pharmaceutical giant said Wednesday. The move is the first time the FDA has rescinded a breakthrough designation, according to the agency's public data.

A breakthrough designation is a program offered by the FDA to speed access to experimental drugs. It lets drugmakers work closely with regulators to analyse clinical trials and expedite the application process. Such a designation is designed for innovative new treatments that represent a "substantial improvement" over current available therapies, according to the FDA's description.

Merck's hepatitis C treatment is up against two new treatments for the disease that hit the market in the last year, one by Gilead Sciences and another by AbbVie. Both new treatments have higher cure rates and fewer side effects than previous drugs on the market.

Hepatitis C has become a high-profile disease target as of late, consuming discussions of skyrocketing prices for specialty drugs. Gilead Science's drug, Solvadi, costs $84,000 USD for a 12-week treatment, though the company has been heavily discounting it, to the detriment of its bottom line. AbbVie's Viekera Pak, which has similarly high cure rates as its competitor, lists for $83,319 USD for a 12-week regimine.

A spokeswoman for the FDA declined to comment on the news; federal law prohibits the agency to discuss products under review.

The breakthrough designation can speed up approval of some drugs by two to three months. Analysts told Reuters that Merck's two-drug treatment would likely now require a standard 10-month review. Merck said it still plans to file a new drug application within the first half of this year and that the FDA's move to rescind the breakthrough designation will not affect its timing.

Merck also reported quarterly earnings Monday that surpassed analyst estimates and provided a 2015 earnings estimate. This year's revenue is expected to reach between $38.3 billion USD and $39.8 billion USD. That would make 2015 revenue the lowest since before Merck's 2009 purchase of Schering-Plough.

BY LAURA LORENZETTI

Feb 04, 2015 Fortune Magazine.
www.tinyurl.com/mercks-hep-c

FOUR MORE HEPATITIS A CASES LINKED TO NANNA'S FROZEN BERRIES

Health authorities have confirmed four new cases of hepatitis A linked to frozen berries, bringing the number of people infected in the outbreak to 18.

In NSW, two people, aged 65 and 73, have been diagnosed with the illness while two Queensland cases involve a 25-year-old and a 54-year-old.

"Many will have no symptoms at all with children most likely to have a mild illness."

The 18 people are believed to have contracted hepatitis A from eating Patties Foods' Nanna's frozen mixed berries. Seven are in NSW, seven in Queensland, three in Victoria and one in Western Australia.

The federal Department of Health said the disease was not life-threatening and most people recovered with rest and fluids.

It may, however, cause severe illness in older people, those with chronic liver disease and those who have poor immune systems.

"Of those who catch hepatitis A, not all will develop all of the symptoms," a department spokeswoman said. "Many will have no symptoms at all with children most likely to have a mild illness so they may not even be recognised as hepatitis A cases.

"Hepatitis A is a nationally notifiable disease so we know how many confirmed cases there are and by the end of February last year there were 65 cases, without any suspected outbreak.

"This compares to the numbers of cases today of 36 cases."

Hepatitis A is passed through contact with material that has been contaminated with faeces from an infected person.

Patties Foods have recalled their Nanna's mixed berries products as well as their Creative Gourmet's mixed berries and Nanna's raspberries packs as a precaution.

The berries were grown in Chile and China before being packaged at a Chinese factory, according to the department.

The Department of Agriculture is speaking to other food companies which have imported Chinese berries and has also requested a review of frozen berries from Food Standards Australia and New Zealand (FSANZ).

Patties Foods maintained samples of the berry products were tested four times using Australian food standards and they have also been working with the FSANZ to keep the public informed of their investigations.

Its chief executive Steven Chaur said there was still no "firm association [of hepatitis A] with our recalled products".

"Many Chinese food production facilities also supply European and Japanese food markets, and they also have extremely strict hygiene and quality standards," he said in a press release.

"Despite public misconceptions, many Chinese food production facilities are at least as hygienic as those in Australia and operate to similar regulatory compliance regimes."

FOOD LABELLING IN SPOTLIGHT

The outbreak has highlighted concerns about country-of-origin labelling on food.

Consumer group Choice has tested 55 packs of frozen mixed fruits and mixed vegetables and found nearly half the labels on the packs had "vague" or "unhelpful" information.

Choice said some of the worst claims included "Packed in New Zealand", "Packed in Chile from imported and local ingredients" and "Processed in Belgium".

It also found 12 per cent of its 700 members were not able to understand the meaning of "Made in Australia".

"These claims offer very little information about a product's origin and are largely meaningless to consumers," Choice spokeman Tom Godfrey said.

"Consumers deserve to know where their food comes from which is why we have launched a petition calling on the Minister for Agriculture, Barnaby Joyce, to take action on country of origin labelling."

Mr Joyce has supported changes to the country-of-origin labelling laws to stop manufacturers from using "sneaky terms" to "earn a premium" on cheaply made products.

Under current laws, the term "made from Australian and imported ingredients" is common, providing no detail on the exact origins of all the ingredients in a product or where it was packaged.

"There is a good way that you can avoid all of this and that is to make sure you eat Australian product," Mr Joyce said on Wednesday.

"I want to make sure I do everything in my power to say to people your safest food is your domestic food. That is why you pay a premium for Australian product. It is clean, green and healthy."

Mr Joyce's spokesman confirmed a white paper on the potential legislation changes is due to go before the cabinet.

BY SU-LIN TAN

Feb 21, The Sydney Morning Herald.
www.tinyurl.com/oz-hep-a-outbreak

PrEP USERS' SEXUALLY ACQUIRED HEP C SUGGESTS NEED FOR ROUTINE TESTING

PrEP (pre-exposure prophylaxis) refers to an antiretroviral (ARV) drug that can be taken by an HIV negative person before potential HIV exposure to reduce risk of HIV infection. While PrEP for HIV prevention is a new approach to reduce HIV transmission, "prophylaxis" is not a new concept or practice. Prophylaxis is simply taking medications prior to germ or virus exposure to prevent infection. Taking malaria drugs before traveling to countries where there is malaria is an example of prophylaxis. Currently, Truvada is the only ARV drug that has been approved for use as PrEP. No other drugs have been approved as PrEP to date, though other drugs are being tested.

Evidence of sexual acquisition of hepatitis C virus (HCV) among men who have sex with men (MSM) receiving pre-exposure prophylaxis through a San Francisco clinic has prompted a call for routine monitoring for the virus among PrEP users. In a letter to the editor in Clinical Infectious Diseases, clinicians from Kaiser Permanente San Francisco Medical Center describe new cases of hep C among 2 men out of 485 HIV-negative MSM receiving PrEP at the clinic between February 2011 and December 2014.

Considering the infections occurred during 304 person-years of follow-up, the hep C incidence rate was 0.7 per 100 person-years. This infection rate is lower than those observed among populations of HIV-positive MSM in published research. But the two cases add evidence to previous findings that the risk of sexual transmission of hep C is likely not reserved to those who are living with HIV. Additionally, however small the risk of hep C may be, its existence adds to the larger dialogue about having sex without a condom while on PrEP (or not on it, for that matter).

One of the men who contracted hep C was a 46-year-old MSM who started taking Truvada (tenofovir/emtricitabine) as PrEP in August 2013. Through July 2014, he was diagnosed with syphilis twice, rectal gonorrhea once and rectal chlamydia once. In June 2014, he reported having condomless receptive intercourse with a man who had a penile piercing. The following month, he said he was the receptive partner during group sex. He said he had not used injection drugs, been tattooed or had a piercing—all of which are major risk factors for contracting hep C. His liver function tests became abnormal in September 2014, at which time he tested positive for hep C.

The other man was a 37-year-old MSM who started PrEP in October 2013. Between then and November 2014, he was diagnosed with rectal chlamydia three times, rectal gonorrhea twice, and syphilis once. He also denied having any of the three major non-sexual risk factors. His liver function test became abnormal in March 2014, when his hep C test came up positive. For two months prior he had been experiencing nausea, weight loss, joint pain and fatigue. He subsequently underwent 12 weeks of interferon treatment and was cured of the virus.

While the Centers for Disease Control and Prevention recommends hepatitis C testing before starting PrEP, the agency does not recommend ongoing testing for the virus. The authors of the letter to the editor posit that the cases of these two men suggest a need for routine monitoring, as well as counseling about the risk of sexually contracting hepatitis C.

Source: AIDSMEDS Your Ultimate Guide to HIV Care. Available at http://tinyurl.com/prep-users-hep-c (23 Feb 2015).

FEATURE

COST-EFFECTIVENESS OF HEPATITIS C TREATMENT FOR PATIENTS IN EARLY STAGES OF LIVER DISEASE

ABSTRACT FROM THE HEPATOLOGY JOURNAL

New treatments for hepatitis C virus (HCV) may be highly effective but are associated with substantial costs that may compel clinicians and patients to consider delaying treatment.

This study investigated the cost-effectiveness of these treatments with a focus on patients in early stages of liver disease.

We developed a state-transition (or Markov) model to calculate costs incurred and quality-adjusted life-years (QALYs) gained following HCV treatment and we computed incremental cost-effectiveness ratios (cost per QALY gained, in US$2012) for treatment at different stages of liver disease versus delaying treatment until the subsequent liver disease stage. Our analysis did not include the potential treatment benefits associated with reduced non liver-related mortality or preventing HCV transmission. All parameter values, particularly treatment cost, were varied in sensitivity analyses. The base case scenario represented a 55-year-old patient with genotype 1 HCV infection with a treatment cost of $100,000 and treatment effectiveness of 90%. In this scenario, a 55-year-old patient with moderate liver fibrosis (Metavir stage F2), the cost-effectiveness of immediately initiating treatment at F2 (vs. delaying treatment until F3) was $37,300/QALY. For patients immediately treated at F0 (vs. delaying treatment until F1), the threshold of treatment costs that yielded $50,000/QALY and $100,000/QALY cost-effectiveness ratios were $22,200 and $42,400, respectively.

Conclusion: Immediate treatment of HCV-infected patients with moderate and advanced fibrosis appears to be cost-effective.

Immediate treatment of patients with minimal or no fibrosis can be cost-effective as well, particularly when lower treatment costs are assumed.

Note: All figures mentioned in this article are in US Dollars (USD).

BY A. LEIDNER ET AL

Feb 18, 2015 Wiley Online Library.
tinyurl.com/hep-c-treatment-liver-disease

FEATURE

COMBO DRUG SHOWS HIGH HEPATITIS C CURE RATES IN PATIENTS COINFECTED WITH HIV

An interferon/ribavirin-free pill that combines two drugs to treat patients with certain genotypes of hepatitis C who are also infected with HIV was found to be highly effective in a 12-week trial, clearing the hepatitis C virus from almost all the patients involved, according to results released at the 2015 Conference on Retroviruses and Opportunistic Infections in Seattle, Washington.

It is estimated that 7 million people around the world are infected with both HIV and hepatitis C. Historically patients who were infected with the hepatitis C virus and HIV did not respond well to treatments with interferon and ribavirin. With sofosbuvir-based regimens, coinfected patients have obtained similar sustained virologic response (SVR) rates as those infected only with hepatitis C, according to the study abstract presented by Susanna Naggie, MD, MHS, Duke Clinical Research Institute, in Durham, North Carolina.

A once-daily combination pill of 400 mg of sofosbuvir, a nucleotide analog polymerase inhibitor, and 90 mg of the NS5A inhibitor ledipasvir was given to patients who were coinfected with hepatitis C and HIV. The patients had not been treated for hepatitis C but were on stable, approved antiretroviral regimens for HIV treatment.

Patients with compensated cirrhosis were allowed to enroll in the trial. Antiretroviral regimens of tenofovir and emtricitabine with raltegravir, efavirenz, or rilpivirine were permitted. Patients were monitored for adverse events, standard laboratory measurements, enhanced renal toxicity, CD4 count, and HIV-1 RNA levels.

The study's primary efficacy endpoint was SVR at 12 weeks.

Out of the 335 patients enrolled in the study, 75 percent had genotype 1a hepatitis C, 23 percent had genotype 1b, and 2 percent had genotype 4, according to the study abstract. Most were men (82 percent), white (61 percent) and ranged in ages from 26 to 72 years old with an average age of 52.

Study results indicate that overall the SVR12 rate was 96 percent (320 out of 335 patients). There were two patients who had on-treatment virologic failure and 10 patients who had virologic relapse after discontinuing treatment, according to the abstract. Among non-cirrhotic and cirrhotic patients the SVR12 was similar (96 percent and 94 percent, respectively). It also was similar among treatment-naïve and treatment-experienced patients (94 percent and 97 percent respectively).

No patient had confirmed HIV virologic rebound. None stopped taking study drug as a result of an adverse event. The most common adverse events were headache, fatigue, and diarrhea.

The study authors concluded that the single-tablet, interferon- and ribavirin-free regimen of ledipasvir and sofosbuvir administered daily for 12 weeks was highly effective and well tolerated in treatment-naïve and treatment-experienced patients with genotype 1 or 4 hepatitis C also infected with HIV-1, including patients with cirrhosis.

Source: HCP Live – Medical News and Conference Coverage for Physicians. Available at http://tinyurl.com/combo-drug-high-cure (03 March 2015).

WE NEED YOU

- Enjoy reading the HepatitisWA Newsletter?
- Articles and features relevant to you?

Let us know by doing a quick 10 question survey!

To take the online survey, just scan this barcode on your smart phone, or visit this URL: www.tinyurl.com/HWA-Survey-2015

Your feedback is appreciated

hepatitis wa

COMMUNITY GRANTS

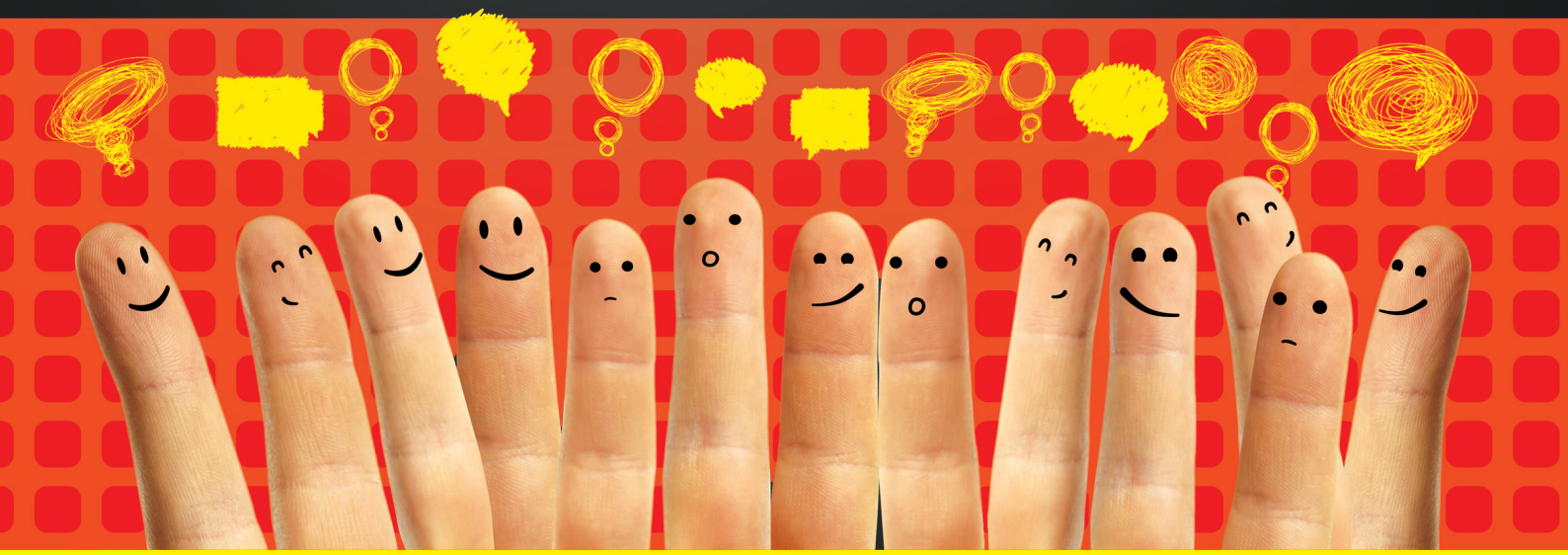
27th July - 2nd Aug

Organisations have the opportunity to apply for a grant up to $1K to host a viral hepatitis awareness community event, clinical or community consultation or social media campaign*.

Organisational partnerships and collaborations are encouraged.

- QUIZ NIGHTS
- SOCIAL MEDIA CAMPAIGNS
- TESTING & VACCINATIONS BOOTH
- EDUCATION AROUND VIRAL HEPATITIS

Refer to the application pack for more info.



THE DEADLINE FOR APPLICATIONS IS 12TH OF JUNE 2015.

Download the application pack at www.tinyurl.com/HAW2015 or call Felicia on (08) 9227 9802.

www.hepatitiswa.com.au

INQUIRY INTO HEPATITIS C

HepatitisWA has welcomed the announcement in November 2014, that following a referral received from the Minister for Health, The Hon Peter Dutton MP, the Standing Committee on Health will inquire into and report on Hepatitis C in Australia.

The Committee invited interested persons and organisations to make a submission addressing the terms of reference. The deadline for submissions was Friday, 27 February 2015 and 22 submissions were received by the due date.

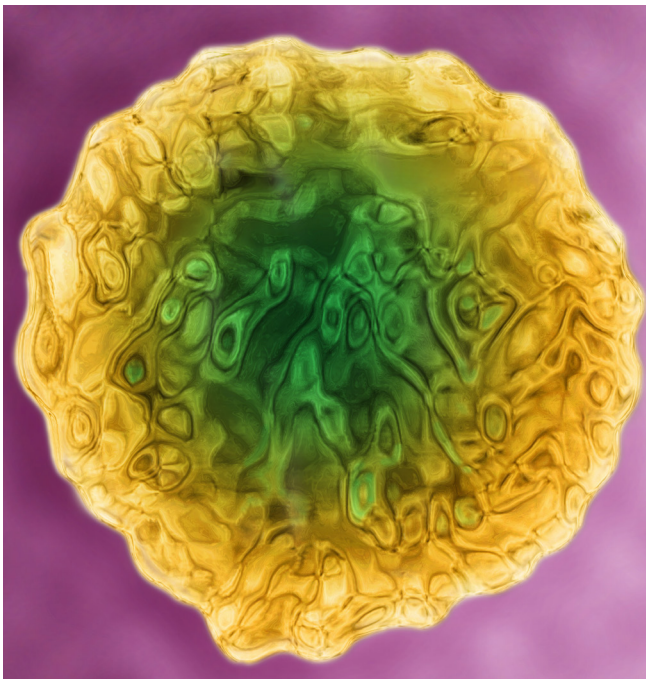
The committee held public roundtable hearings in Melbourne on the 21 January 2015 and Sydney in 22nd January 2015. HepatitisWA has provided a written submission to the Committee and will address the Committee at the Hearing to be held in Perth on the 10th of March. One other hearing has been announced and that will take place in Canberra on the 20th of March.

The Committee will hear from a number of advocacy bodies, selected experts, pharmaceutical companies, health officials and people living with hepatitis C.

Committee Chair Steve Irons MP said 'The roundtables will enable the Committee to learn more about the prevalence of hepatitis C in Australia, the options for treatment and what it is like to live with the disease. In addition, the roundtables provide a means for identifying which aspects of Australia's past responses to hepatitis C have worked well, and where there may be room for improvement."

The Committee is investigating the disease's prevalence, the early testing and treatment options, and the short-and long-term costs associated with treatment. Methods to improve prevention of new hepatitis C infections, as well as methods to reduce the stigma associated with a positive diagnosis, are also key areas of focus for the Committee.

Excerpts taken from Media Release 19th January 2015 Parliament House Canberra.



FEATURE

RISK FACTORS FOR EXPOSURE TO HCV INFECTION

PEOPLE WITH A HISTORY OF INJECTING DRUG USE

Over 80% of existing and almost 90% of all new HCV infections are among people with a history of injecting drug use (IDU). People with a history of IDU often experience significant barriers to accessing health services including hepatitis C virus (HCV) testing and treatment services. In this context, it is critical that testing is conducted in an appropriate and non-judgemental setting to assist people with a history of IDU through the testing and diagnosis process. This will have a profound effect on a person's understanding of their condition and their likelihood of future engagement with the health system. Staff in specialist and primary health care services should be cognisant of issues relating to illicit drug use, harm reduction, addressing stigma and discrimination and managing vein care issues.

PEOPLE WHO HAVE EVER BEEN INCARCERATED

Imprisonment is an independent risk factor for HCV transmission. HCV prevalence for all prisoners in Australia is estimated at 30–40% and is higher for women at 50–60%. A history of previous incarceration is a very strong indication to offer testing for HCV and it should be offered with appropriate discussion of risk and benefits. For those currently incarcerated, indicators to discuss testing should be based on thorough risk assessment, including any history of drug use or previous incarceration. A positive anti-HCV result should lead to appropriate assessment for current infection and the nature and severity of any liver disease. It may be appropriate to refer for treatment while people are still in custody but not all jurisdictions can offer this across the prison system.

RECIPIENTS OF ORGANS, TISSUES & BLOOD BEFORE FEB 1990

HCV is efficiently transmitted by transfused blood or blood products. Infections acquired in this way account for 5–10% of all cases in Australia. Individuals in Australia, or other major developed countries, who were transfused or received organ or tissue donations or blood products before HCV testing commenced (February 1990 in Australia) who have not been tested or who do not know test results should be offered testing. A number of countries (predominantly in low-resource settings) still do not screen all donated transfusion blood for transmissible infections, including HCV. People who received blood products or organ or tissue donations at any time in overseas countries where screening of the blood/organ donor population has not been routine, or where the screening policy at the time of transfusion or receipt of organ or tissue donation is uncertain, should be offered testing. In Australia, recipients and organ donors are screened for HCV at the time a donation is made. An HCV-positive organ may still be used in an HCV-positive recipient.

PEOPLE WITH TATTOOS OR SKIN PIERCINGS

Skin penetration practices are not independent risk factors for HCV transmission. The indications to test will include a consideration of other factors that may contribute to increased transmission such as population prevalence or poor infection control procedures (e.g. tattooing and skin piercings in custodial settings or any other situation where non-registered tattooists perform the task).

PEOPLE BORN IN COUNTRIES WITH HIGH HCV PREVALENCE

The risk of HCV infection may be greater for people born in or who have spent considerable time in countries where there is a high prevalence of HCV infection than it is for people born in Australia. It is estimated that 11% of people in Australia who have been exposed to HCV are immigrants from countries where there is a high prevalence of HCV. In many of these countries HCV transmission is not predominantly associated with IDU and the disease can be acquired from medical and dental procedures or from occupational exposure to infected materials. Indications to offer testing include a history of HCV in a family member or exposure to medical procedures. In these people, HCV RNA positivity should prompt testing of other family members.

ABORIGINAL & TORRES STRAIT ISLANDER POPULATIONS

In 2006, Aboriginal and Torres Strait Islander people were estimated to account for between 13,000 and 22,000 or 8.3% of all HCV diagnoses, with 16,000 chronically infected. Given that Aboriginal and Torres Strait Islander people constitute just 2.4% of Australia's total population, the disproportionate HCV-related burden of disease borne by this group is striking. Risk factors for increased HCV antibody prevalence in this population include higher rates of unsafe injecting drug use practices and disproportionately high rates of incarceration where risk for HCV acquisition is greatly enhanced.

SEXUAL PARTNERS OF PEOPLE WITH HCV

The risk of heterosexual transmission of HCV is low. There is an increased risk of sexual transmission of HCV for men who have sex with men who are also HIV positive. Testing for infection in this setting should be undertaken regularly. This should take place annually in those who are aware of risk and practising safe sex and every six months for those who have:

- had more than 10 partners in the past 6 months;
- engaged in unprotected anal sex;
- used recreational drugs; and/or
- engaged in group sexual activities. ■

TESTING FOR HEPATITIS

IS AS EASY AS

FOR MORE INFORMATION:

Testing should occur in appropriate settings, such as HIV clinics, sexual health clinics or GP surgeries for those that may have put themselves at risk of infection.

If you have any questions or would like to get tested for HCV, contact HepatitisWA's helpline on (08) 9328 8538.

Source: The Australasian Organisation Supporting the HIV, Viral Hepatitis and Sexual Health Workforce. (ASHM) Available at www.ashm.org.au (26 Feb 2015) www.testingportal.ashm.org.au/hcv/indications-for-hcv-testing

HEPATITIS C RISKS FOR BABY BOOMERS

Baby boomers are five times more likely to have hepatitis C, a leading cause of liver cancer. "I would recommend talking to your doctor about getting tested," said Dr. Akshaya Patel of the Haller, Hazlett & Adams Jewish Physician Group of Louisville, Kentucky.

"When you either come in for your normal physical or when you come in for your medication refills, that'll probably be the best time to."

About 3 million U.S. adults have the hepatitis C virus, and most of them are baby boomers born from 1945 through 1965, according to the U.S. Centers for Disease Control and Prevention (CDC). Spread through contact with tainted blood, it can go undetected for decades.

"Hepatitis C, for many people in the population, goes unnoticed due to the fact that the liver is what we call a non-complaining organ, which means that they can have the disease and not know it," said LaNetta Alexander, a hepatitis C epidemiologist for the Indiana State Department of Health.

The CDC and some other health officials are encouraging baby boomers to get tested for hepatitis C so that those who are infected can get help — if necessary — since the condition can lead to liver scarring and liver failure and is the leading reason for liver transplants.

"This whole population is ageing," said Dr. Anna Hart, an infectious-disease physician with Baptist Medical Associates of Louisville, Kentucky.

"They're living with hepatitis C, not having any symptoms, not getting tested," but "we have such great treatments that if we can catch these folks early with diagnosis, then we can offer them treatment."

Testing may or may not be covered by insurance, depending on which carrier the person has, according to KentuckyOne Health. An initial test determines whether the person ever has been infected with the hepatitis C virus.

Article first published on The Times Herald on 17/02/2015.
Available at http://tinyurl.com/hep-c-risk-baby-boomer (19 Feb 2015).

> *"It's a very simple blood test that can be done at any doctor's office."*

"It's a very simple blood rest that can be done at any doctor's office" Patel said.

A follow-up test determines whether the person is still infected, but it's common for people to miss that step, according to the CDC. You need that second test "to confirm was it a false positive, was it an infection you had in the past but your body kind of took care of it, or is it an active infection that requires treatment?" Hart said. ■

WHO SHOULD GET TESTED? (AUSTRALIA)

Talk to your doctor about being tested if:

- You have shared injecting equipment (needle/syringe, tourniquet, water or spoon).
- Had a tattoo or piercing using unsterile equipment or procedures.
- Worked in an environment which brings you into contact with people's body fluids such as blood (e.g. disability care, nursing, first aid).
- You received a blood transfusion in Australia before February 1990.
- You've had unprotected sex where blood might be present.
- You have experienced dialysis.
- You've had a medical, surgical or dental procedure or immunization overseas.
- You've shared a razor, toothbrush or other sharp grooming instrument with someone who has hepatitis C.
- You've taken part in a ritual involving human blood.
- You've handled blood-stained clothing or attended to a wound without adequate protection (i.e. latex gloves).

BY DARLA CARTER

COMPLEMENTARY THERAPIES FOR HEPATITIS C

The information provided in this feature is for people with hepatitis C who want to know more about complementary and alternative therapies. It is intended as an introductory guide only. Anecdotally, good results have been reported by some people using complementary therapies but others have found no observable benefits—and, as with any treatment, it's important to remember that excessive or wrongly prescribed therapies can cause damage to the liver.

What do the terms complementary and alternative mean?

These terms describe types of medicine that are not presently considered to be part of conventional medicine. 'Complementary therapy' refers to a health practice when it is used alongside a conventional or mainstream health care approach. 'Alternative therapy' refers to a health practice that is not a conventional or mainstream health care approach. Sometimes these terms are used interchangeably.

Why choose complementary and alternative therapies?

Reasons why people with hepatitis C choose complementary and alternative therapies include:

- To improve quality of life by relieving symptoms of chronic infection and/or reduce side effects of conventional treatment.
- To take an active role in decisions about their health care.
- Cultural influences.
- Dissatisfaction with conventional approaches to health care.
- Or concerns about perceived or reported toxicity of conventional prescription medicines.

How effective are complementary and alternative therapies for hepatitis C?

Many people worldwide have found an increase in well-being through using complementary therapies, whether they have hepatitis C or not. However, there is limited research into the effectiveness of complementary and alternative therapies for hepatitis C.

Source: Hepatitis Australia
Available at www.hepatitisaustralia.com (23 Feb 2015) www.hepatitisaustralia.com/complementary-therapies

Some people with hepatitis C report good results while using complementary or alternative therapies, while others notice few benefits.

If you pursue complementary and alternative therapies it is important that you tell your liver specialist and GP of any therapies that you have recently used, are using, or plan to use. Your complementary/alternative practitioner should also be aware of what conventional treatments you are accessing. As a rule, every practitioner you see, whether they use conventional or alternative/complementary medicine needs to know of all the therapies you are using. This information will help the practitioner protect your health.

How to choose a practitioner

Some complementary/alternative practitioners are registered with professional bodies, so choose a practitioner who is properly qualified, knows about hepatitis C, and preferably has experience working with people who have hepatitis C and/or other chronic liver disease.

In making this choice, you could consider asking the complementary/alternative practitioner:

- What qualifications or training do you have in relation to particular therapies?
- Are you a registered member of a professional association for that particular therapy?
- What do you know about hepatitis C?

About the therapy and its benefits to you, including:

- Number of treatment sessions and length of treatment.
- What it will require of you.
- How it might improve your health.
- The risks of the therapy.
- How the therapy works in combination with other therapies or conventional treatments.
- What are all the likely costs and charges of this therapy.
- If they are willing and able to visit you at your home or in hospital if necessary.

Hepatitis Councils, liver clinics and some gastroenterologists in each State and Territory can refer people to reputable practitioners.

Commonly used herbs by people with hepatitis C

Although specific natural therapies have been used for chronic hepatitis C infection and the associated symptoms, there haven't been many scientific trials to investigate their effectiveness. With the currently limited information available it is difficult to make any formal recommendations however the more commonly used herbs by people with hepatitis C are:

- St Mary's Thistle (Silybum marianum) also known as Milk Thistle;
- Licorice (Glycyrrhiza glabra);
- Dandelion (Taraxacum officinale); and
- CH100.

Herbs that can damage the liver

Some herbs and combinations of herbs can be harmful to the liver and therefore potentially dangerous for people with hepatitis C. The following list is not exhaustive, but indicates some of the herbs people with hepatitis C may want to **avoid**:

- barberry
- black cohosh
- chaparral
- comfrey
- creosote bush
- germander
- gordolobo yerba tea
- greasewood
- greater celandine
- false pennyroyal
- jamaican bush tea
- Jin Bu Huan
- kombucha tea
- sassafras
- senna
- white chameleon

BURRITO RECIPE

Burritos are a healthy recipe that can be served as a lunch or dinner meal. To increase the nutritional content of this meal Nutrition Australia have recommended adding salad vegetables prior to serving. Vegetables are high in vitamins, minerals and fibre which have been proven to help reduce to risk of certain cancers and other diseases. To reduce the fat content of this recipe it is recommended that the mince meat used is lean and the serving size of mince is reduced and replaced with kidney beans. Kidney beans are legumes that are high in protein and fibre and low in fat. The Department of Health and Ageing recommend that Australian adults aim for 65-100g of lean meat and 5 serves of vegetables daily.

INGREDIENTS

1 Tablespoon Olive oil
1 Clove Garlic (chopped)
500 Gram Mince (lean meat)
1 Tablespoon Coriander (fresh or 1 teaspoon ground)
1 Teaspoon Cumin (ground)
1/2 Teaspoon Chilli Powder
400 Gram Red Kidney Beans
1 Onion (chopped)
1 Jar Pasta Sauce
1 Package Tortillas

NOTES

- The tortilla is a round, flat Mexican bread central to Mexican cuisine.
- The tortilla is made from stone ground corn or wheat flour.

INSTRUCTIONS

1. In a large saucepan heat oil, add onion and garlic. Sauté for a few minutes until onions are translucent

2. Add mince and cook until brown.

3. Meanwhile prepare burritos according to directions on the packet.

4. Add spices to mince, and allow to cook for a few minutes.

5. Add beans and pasta sauce. Allow to heat through.

6. Serve immediately with tomato, lettuce, cucumber, capsicum, mushrooms, avocado and a dollop of light sour cream.

NUTRITIONAL INFO*

** Per serve*
(This recipe serves 5 people)

Energy: 1179kJ
Total sugars: 5g
Protein: 26g
Sodium: 333mg
Calcium: 56mg
Total Fat: 11g
- Saturated: 3.g
Iron: 4mg
Carbohydrates: 15g
Dietary fibre: 6g

Health literacy in patients with chronic hepatitis B attending a tertiary hospital in Melbourne: A questionnaire based survey

BACKGROUND: Current estimates suggest over 218,000 individuals in Australia are chronically infected with hepatitis B virus. The majority of these people are migrants and refugees born in hepatitis B endemic countries, where attitudes towards health, levels of education, and English proficiency can be a barrier to accessing the Australian health care system, and best managing chronic hepatitis B. This study aimed to assess the knowledge of transmission and consequences of chronic hepatitis B among these patients.

METHOD: A prospective study was conducted between May and August 2012. Patients with chronic hepatitis B were recruited from three Royal Melbourne Hospital outpatient clinics. Two questionnaires were administered. Questionnaire 1, completed during observation of a prospective participants' consultation, documented information given to the patient by their clinician. After the consultation, Questionnaire 2 was administered to assess patient demographics, and overall knowledge of the effect, transmission and treatment of hepatitis B.

RESULTS: 55 participants were recruited. 93% of them were born overseas, 17% used an interpreter, and the average time since diagnosis was 9.7 years. Results from Questionnaire 1 showed that the clinician rarely discussed many concepts. Questionnaire 2 exposed considerable gaps in hepatitis B knowledge. Few participants reported a risk of cirrhosis (11%) or liver cancer (18%). There was a high awareness of transmission routes, with 89% correctly identifying sexual transmission, 93% infected blood, and 85% perinatal transmission. However, 25% of participants believed hepatitis B could be spread by sharing food, and over 50% by kissing and via mosquitoes. A knowledge score out of 12 was assessed for each participant. The average score was 7.5. Multivariate analysis found higher knowledge scores among those with a family member also diagnosed with chronic hepatitis B and those routinely seeing the same clinician ($p = 0.009$ and $p = 0.002$, respectively).

CONCLUSION: This is the largest Australian study assessing knowledge and understanding of the effect, transmission, and treatment of hepatitis B among chronically infected individuals. The findings highlight the knowledge gaps and misconceptions held by these patients, and the need to expand education and support initiatives.

Read the full study:
bit.ly/HepBHealthLiteracy

Dahl et al. BMC Infectious Diseases 2014, 14:537

MEDIA RELEASE

23 February, 2015

WORLD HEALTH ORGANIZATION CALLS FOR WORLDWIDE USE OF "SMART" SYRINGES

GENEVA – Use of the same syringe or needle to give injections to more than one person is driving the spread of a number of deadly infectious diseases worldwide. Millions of people could be protected from infections acquired through unsafe injections if all healthcare programmes switched to syringes that cannot be used more than once. For these reasons, WHO is launching a new policy on injection safety to help all countries tackle the pervasive issue of unsafe injections.

A 2014 study sponsored by WHO, which focused on the most recent available data, estimated that in 2010, up to 1.7 million people were infected with hepatitis B virus, up to 315 000 with hepatitis C virus and as many as 33 800 with HIV through an unsafe injection. New WHO injection safety guidelines and policy released today provide detailed recommendations highlighting the value of safety features for syringes, including devices that protect health workers against accidental needle injury and consequent exposure to infection.

WHO also stresses the need to reduce the number of unnecessary injections as a critical way of reducing risk. There are 16 billion injections administered every year. Around 5% of these injections are for immunizing children and adults, and 5% are for other procedures like blood transfusions and injectable contraceptives. The remaining 90% of injections are given into muscle (intramuscular route) or skin (subcutaneous or intradermal route) to administer medicines. In many cases these injections are unnecessary or could be replaced by oral medication.

"We know the reasons why this is happening," says Dr Edward Kelley, Director of the WHO Service Delivery and Safety Department. One reason is that people in many countries expect to receive injections, believing they represent the most effective treatment. Another is that for many health workers in developing countries, giving injections in private practice supplements salaries that may be inadequate to support their families."

Transmission of infection through an unsafe injection occurs all over the world. For example, a 2007 hepatitis C outbreak in the state of Nevada, United States of America, was traced to the practices of a single physician who injected an anaesthetic to a patient who had hepatitis C. The doctor then used the same syringe to withdraw additional doses of the anaesthetic from the same vial – which had become contaminated with hepatitis C virus - and gave injections to a number of other patients. In Cambodia, a group of more than 200 children and adults living near the country's second largest city, Battambang, tested positive for HIV in December 2014. The outbreak has been since been attributed to unsafe injection practices.

"Adoption of safety-engineered syringes is absolutely critical to protecting people worldwide from becoming infected with HIV, hepatitis and other diseases. This should be an urgent priority for all countries," says Dr Gottfried Hirnschall, Director of the WHO HIV/AIDS Department.

The new "smart" syringes WHO recommends for injections into the muscle or skin have features that prevent re-use. Some models include a weak spot in the plunger that causes it to break if the user attempts to pull back on the plunger after the injection. Others have a metal clip that blocks the plunger so it cannot be moved back, while in others the needle retracts into the syringe barrel at the end of the injection.

Syringes are also being engineered with features to protect health workers from "needle stick" injuries and resulting infections. A sheath or hood slides over the needle after the injection is completed to protect the user from being injured accidentally by the needle and potentially exposed to an infection.

WHO is urging countries to transition, by 2020, to the exclusive use of the new "smart" syringes, except in a few circumstances in which a syringe that blocks after a single use would interfere with the procedure. One example is when a person is on an intravenous pump that uses a syringe.

The Organization is also calling for policies and standards for procurement, safe use and safe disposal of syringes that have the potential for re-use in situations where they remain necessary, including in syringe programmes for people who inject drugs. Continued training of health workers on injection safety – which has been supported by WHO for decades – is another key recommended strategy. WHO is calling on manufacturers to begin or expand production as soon as possible of "smart" syringes that meet the Organization's standards for performance, quality and safety.

"The new policy represents a decisive step in a long-term strategy to improve injection safety by working with countries worldwide. We have already seen considerable progress," Dr Kelley says. Between 2000 and 2010, as injection safety campaigns picked up speed, re-use of injection devices in developing countries decreased by a factor of 7. Over the same period, unnecessary injections also fell: the average number of injections per person in developing countries decreased from 3.4 to 2.9. In addition, since 1999, when WHO and its partner organizations urged developing countries to vaccinate children only using syringes that are automatically disabled after a single use, the vast majority have switched to this method.

Syringes without safety features cost US$0.03 to 0.04 when procured by a UN agency for a developing country. The new "smart" syringes cost at least twice that much. WHO is calling on donors to support the transition to these devices, anticipating that prices will decline over time as demand increases.

ENDS

For further information please contact:.
Judith Mandelbaum-Schmid
(WHO Communications Consultant)
Telephone: +41 22 791 1993
Mobile: +41 7 92 54 68 35)
Email: schmidj@who.int

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WORKFORCE DEVELOPMENT PROGRAM

HepatitisWA's Workforce Development Officer can provide educational workshops for any interested workforce groups.

There is a very wide variety of topics covered in the workshops:

- The differences between hepatitis A, B, and C
- Statistics around current trends
- The impact on viral hepatitis on the liver
- Living well with viral hepatitis
- Up-to-date information on the latest treatments
- Modes of transmission
- Prevention and harm reduction
- Conducting risk assessments
- OHS/workplace issues (managements of blood and sharps etc)
- Vaccination regime
- Workplace policy formation
- Confidentiality and disclosure
- Testing information
- Psycho-social impact of living with viral hepatitis
- Discrimination

Call Matthew on (08) 9227 9802
or email wdo@hepatitiswa.com.au

HEPAtidings

hepatitiswa Community Activities

A SNAPSHOT OF HEPATITISWA EVENTS

SUPPORT SERVICES

After a great deal of negotiation with the Department of Corrections we have commenced a pilot prisons project at Bandyup prison focusing on hepatitis C treatment. As there is a very small uptake of hepatitis C treatments in prisons it was agreed that HepatitisWA could play a part in identifying women who could be eligible for treatments whilst in prison, and then supporting those women during their treatment journey. During my first meeting in January I spent time with a number of women discussing the criteria for being on treatments, the process of getting onto treatments and the side effects etc, of being on treatments. After discussions with the nurse a decision was made on which women would potentially be the best candidates and so their blood workups will begin. I will continue to meet those women on a regular basis to support them through the process. Treatments are generally only offered to prisoners who have long enough sentences to complete treatments whilst they are incarcerated, however, those who have shorter sentences may still be able to have their blood workups done in preparation to commence treatments on release. We are working towards looking at how our agency may support these women on their release from prison. I had the opportunity to attend a Community Stakeholder Forum with the purpose of this forum being to identify the issues facing asylum seekers and other vulnerable migrants living in Western Australia. It was an opportunity to share information on trends and developments, and discuss ways in which the group can work collectively to meet the needs and raise the quality of life of these vulnerable people using the collective resources of the group. It was also a great opportunity to showcase HepatitisWA and our services.

There have been a number of occasions that I have accompanied the Multicultural Services Officer to CaLD women's community centres to act as an interpreter for Afghan and Iranian communities. This has been a great experience as I have been able to speak to these women in their own language and impress on them the importance of knowing their hepatitis B status, being monitored and treated if they are positive and how to eat healthily. For many of these women whose English is limited I think they have appreciated being given this information to them in their own language.

I was also fortunate enough to attend a Simeprevir (Olysio) dinner meeting provided by the Pharmaceutical company Janssen. This meeting included an evaluation of management of hepatitis C with Simeprevir, presented by Dr Ashley Brown who is a Consultant Hepatologist at St. Mary's and Hammersmith Hospitals and Adjunct Reader in Medicine at Imperial College London. This was a very informative and interesting meeting and the audience were given a number of scenarios to work with on how we here in Australia would work with potential patients and situations. It really helped to get people to start thinking of how they work with people and what barriers may exist.
- Amineh

HEP B COMMUNITY ENGAGEMENT

I have had a busy 3 months with delivering 'Liver healthy Life' workshops to CaLD community groups providing education to service providers and planning for two events: Chung Wah Chinese New Year community stall and 'B Positive - a forum for People who work with CaLD communities'. Chinese new year was a great opportunity to

Photo: Chinese Dragon in Northbridge.

Photo: Pauline Koh, winner of the Hepatitis B Quiz. Photo taken and published with permission.

clear up the myths about transmission of hep b and hep A. Eighty-three hep b quizzes were completed and the handycards in Chinese and English were very popular. There was a lot of discussion about the recent contaminated berries outbreak and people wanting to get tested and vaccinated for hep A and B. Overall it was a busy and successful day. I'd like to give a big thanks to volunteers Llewelyn and Veronica for helping in the stall and talking hep B all day.

- Amanda

WORKFORCE DEVELOPMENT

As always, the demand for workforce development slowed down as we drew closer to the end of the year as various agencies and organisations wound down in preparation for the holidays. I worked with a few allied and mental health organisations through November and December such as Meditrain and Clarkson community mental Health. We were invited to speak with the Pharmacy students at UWA in January. I have been developing partnerships with the WA Police Department that has given us the opportunity to provide training to all new recruits as part of induction and also with Acacia prison to provide training to all new officers. Lastly, I have been given the opportunity to provide education to all post graduate mental health nurses studying in the state-wide graduate mental health nursing program.

- Matt

NSP & VOLUNTEER PROGRAM

The NSP has been considerably busy with clients the last couple of months. We have noticed an increase in younger clients accessing the NSP, and an increase in people from marginalised communities accessing our services more regularly. It is really good to see that these community members feel confident coming in to ask for equipment, but also to stop and have a chat with NSP staff about whatever may be concerning them. We have been hearing about the high purity of both heroin and methamphetamine for a few months now through client engagement. Unfortunately, we have also heard of a few regular clients overdosing and passing away as a result of this over the last few months. It's essential we have these candid conversations with clients as it gives us a good understanding of current drug trends and associated behaviours. This leads to increased education in the NSP, such as warning clients about purity and harm reducing behaviours that may avoid overdose. This has also spurred increased promotion of the life-saving Naloxone training program presented by WA Substance Users Association (WASUA), and the Drug and Alcohol Office (DAO). We have referred quite a few clients to this program, and will continue to promote referrals in the future. We have been fortunate to have a Curtin Health Promotion practicum student on board with us for a number of weeks. Bianca has been working hard on developing a health promotion plan for the NSP which spans a 12 month period. This will be an invaluable resource for volunteers working the NSP, and our clients will benefit by learning about fantastic services available in the immediate area, and have the opportunity to be informed about health and safety issues. It has been wonderful to have Bianca here, and we are lucky that she has decided to stay on with us as a permanent volunteer. The next round of volunteer recruitment is currently in progress, with the compulsory training course occurring at the end of March. If you or anyone you know is interested in volunteering with us, please fill in the application form found at www.hepatitiswa.com.au, or contact Nadia on nspvolcd@hepatitiswa.com.au, or (08) 9227 9802 for more information.

- Nadia

Hepatidings Contributors: Amineh, Amanda Matt and Nadia. | **Photographs by:** Amanda.

sexual health week

WASUA promoted "Sexual Health Week" in the front foyer of our needle and syringe exchange. There were resources that directly dealt with STI's and safe sex including condoms galore for people to stock up. It was an opportunity for people to have further time with WASUA's nurse to confirm bloods and have a deeper chat if they felt they may be at risk of having been exposed to an STI or just to settle their minds with certain myths usually carried through society as a type of Chinese whisper rather than from a health professional. Safer sex is somewhat forgotten in some parts of the using community for various reasons from over intoxication, just forgetting, or controlled so much by the drug that complacency is an easy form of denial in the moment.

The belief that sex is better when not using protection for the male or female is not an issue for debate and consensus it's a life altering action with the possibility of catching an annoying but curable condition, manageable with medication but still incurable to cases that are only progressive and can lead to death. Sarah, WASUA's new youth worker and the Hep C Educator visited Passages in Northbridge along with workers from the Red Cross and Family Planning. We were able to set up a stall with a variety of comprehensive information and educational resources covering a very broad variety of different sexual health issues and education.

Resources were also provided by HepatitisWA addressing the sexual risk, as well as promoting the well-known "Blood Rule". Discussions with the kids were very laid back over a BBQ amused by different demonstrations from the workers. In particular there was an activity where you had the choice of wearing night simulated vision or what are called "the drunk goggles". After a couple of spins to help create the feeling of being under the influence and then to their best ability follow a marked line, keeping as straight as possible only to then turn around and try and catch an object. This proved harder than what it looked so it was a way of getting the kids actively involved. Sending harm reduction messages around the table and getting honest feedback was appreciated, with most of the kids getting involved. There were opportunities for both Sarah and myself to link in with those we knew, as well as meet some new faces.

The resources speak for themselves, as they are topic specific, for example; all about "herpes", "pregnancy" and general "sexual health". There was plenty of other space to sit and engage with the young ones on a deeper level, in some cases a little further away for privacy. We ran the stall from 9am to 1pm and had a great lunch with plenty of chances to engage. There were a total of 30 youth who attended the day, all commenting that they thoroughly enjoyed the event. Considering the first 18 months of injecting is the most critical time for prevention, many of the conversations were about how not to put you at risk of blood-borne viruses and what strategies can help keep you safer. Moira from Passages Youth Centre in Northbridge did an excellent job pulling in agencies to attend, bringing different resources that interacted with all the youth who presented themselves on the day. ■

Written by Mikayla-Jay McGinley
Hepatitis C Educator, WASUA.

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MARCH 25TH 2015

"B POSITIVE":

A FORUM FOR PEOPLE WHO WORK WITH CaLD COMMUNITIES

60 – 80 percent of liver cancer is caused by hepatitis B. Over 207,000 people in Australia are living with hepatitis B.

Find out more about this silent epidemic and what you and your organisation can do about it.

Guest Speakers from HepatitisWA, SCGH Liver Clinic & SiREN

"B Positive" Forum

Date: Wednesday 25th of March 2015

Time: 9:30am - 1pm

Location: Herb Graham Recreation Centre

38 Ashbury Crescent, Mirrabooka WA 6061

Cost: FREE

Please Register by March 16th

To register, email your details below to:
hepbcdo@hepatitiswa.com.au or call (08) 9227 9802

Your name | Job Title | Name of organisation

Email | Phone Number | Dietary Requirements

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The peer support group assists people to achieve better health and well being through discussions and activities. The monthly meetings are confidential, free and provide opportunities to share experiences and thoughts with peers in a friendly and non-judgemental way. Healthy and tasty snacks will be provided.

For more information, please contact Amineh on 9328 8538 or support@hepatitiswa.com.au