**UK National Screening Committee Screening for HEPATITIS B and C 31 12 2015**

**To ask the UK National Screening Committee to make a recommendation, based upon the**

**evidence presented in this document, to improve screening for Hepatitis B and C viruses in maternity, schools, migrant populations, high street venues and occupations.**

This document provides background and reviews the evidence for screening for HBV and HCV as per WHO 1999 guidelines used globally.

**Current recommendation**

The 2015review of screening for Hepatitis B and Cconcluded that systematic population screening is not recommended. The Screening denied Includes **failing to adopt**

1. Screening for the HBV fathers and previously infected HBV mothers
2. Screening for the 3 to 5% of migrants with HBV and HCV post visa granting
3. Screening migrant schools and communities to note HBV growth levels
4. Screening all FGM survivors
5. Screening all refused for donation for tattoo and piercing infection levels
6. Screening baby boomers as a once life check at 40 plus

The above failings in screening are because we have no prevalence since 1993 for HBV and HCV and therefore imagine it has not arrived at a 10 to 25,000 annual rate since and that the 500% boom in cirrhosis and liver cancer is because we drink 15% less and other causes.

**Review**

*Reason for review* – With maternity testing indicating migrant mums to be 1.6% HBV positive over 12 years, a huge boom in HBV infections has been recorded. With men nearly twice as infected as women a 2.3% migrant prevalence for our 20 million migrants and subsequent generations is clearly suggested, they are in dire need of discovery fast. In the HBV Trust Report “Going Endemic” simple counting of the new demographics in the UK and sentinel surveillance and target testing suggests huge levels of endemic localities now exist in our inner cities, almost none have access to screening or vaccination as recommended for them by WHO since 1993. As predicted in 1999 poor look back hbv n hcv testing has occurred and a 500% boom in liver disease has been noted.

*Conclusion against the criteria* - The conclusion of the current review is that population screening for Hepatitis B and C should be recommended. The key needs relate to

1. Maternity Screening for the HBV fathers and previously infected HBV mothers
2. Border Screening for the 3 to 5% of migrants with HBV and HCV post visa granting
3. Screening migrant schools and communities to note HBV.HCV growth levels
4. GP Screening all FGM survivors
5. Blood Bank Screening all refused for donation for tattoo and piercing infection levels
6. GP look back MOT Screening baby boomers as a once life check at 40 plus
7. GP Union Screening workforces to establish risk and motor vaccination

**Screening for the HBV fathers and previously infected HBV mothers**

Fathers, averaged at 70% more infected as HBV mums of whom 45,000 have been diagnosed since 2002, will number some 70,000 since 2002, giving approximately 140,000 children in the UK with an undiagnosed HBV father. Two helpline calls describe this well one Kai a Somali lady had a hbv positive partner and requested vaccinations which the 3 children did not receive. All 3 eventually tested positive for HBV and the middle child, a girl, has an active infection. Meena a sixteen year old had a undiagnosed dad given insulin and again all 3 children became infected via needlestick and razor sharing.

Anti – HBs Mothers, mums who have caught HBV themselves when young and luckily cleared it, will outnumber HBV positive mums by a ratio of at least 3 to 1, giving a further 130,000 mums who very often expose the children to the risks they ran eg unvaccinated travel to homeland and other infected family members or FGM and Haj. We find on the national helpline mothers who discover they have anti-HBs, meaning HBV has infected and tried to kill them already, strongly wish they had been tested sooner as they discover other infected family members more often than not. A third of a million utterly vulnerable UK children are living with or extremely likely to face exposure to HBV and we are doing zilch in maternity for them! 270,000 parents with HBV or cleared HBV and their 540,000 children have a right to know HBV is so close. If we add in dads who clear we have 950,000 children with immediate family infections occurring at high and visible risk. If you had caught and cleared meningitis wouldn’t you want your child vaccinated?

**Screening for the 3 to 5% of migrants with HBV and HCV post visa granting**

France notes migrants on the Paris Eurostar are 3% HBV positive, like the United States and WHO they count this figure, not in their minds or with mathematics, but with accurate globally best practice screening programmes. Yet when they arrive in London they are well all cured by the journey. This is how we have behaved since 1993, in 2006 Penny Wilson Webb CBE compiled “The Rising Curve” noting a boom doubling UK HBV to 360,000 infections by counting these infections. In “Going Endemic” we have added the effects of the mass migrations since using demographics and our excellent maternity and sentinel figures and limited local studies available. With maternity showing a 0.55% for women a national 0.75% HBV prevalence is a least case scenario, giving 480 to 500,000 HBV cases and growing. Although the migrants infections vanish at border level the 2014 CUSHI B study of 22 liver units nationally noted over 80% of HBV and HCV patients were migrants. If 1 in 4 humans catch a deadly virus and 1 in 12 keep it we need to test enough at the borders to know! Testing for HBV needs to be mandatory for the 100 nationalities with “odds on” risk of being exposed, this would include all onward from sub Saharan Africa and the entire pacific rim. Numerous studies have been done that demonstrate migrants are always affected and are becoming as or more infected than their nations of origin. Bassendine Foster Chakrabharti Chan Bradford Liverpool South Asian Muslim. Our borders must stop being kinder to plants and cats than humans.

**Screening migrant schools and communities to note HBV growth levels**

The HBV Trust estimate some 40,000 children are out there with HBV and a lower number with HCV and we now need screening to find them to avoid their being 1% end stage at 16. Testing of migrant children in other first world nations reveals their rate of infection at home and at school. Our US sister charity is clear on the lessons learnt there they checked their Chinese children and noted a 1 in 40 annual community to child rate indicating they have avoided some 450,000 child hbv cases due to vaccinating since 1990 and that the bulk of cases would have been horizontal. Globally it is understood maternity testing avoids the risk from mothers, 10% of child infections, but universal vaccination removes the other 90% from Dads, Siblings, Homelands, FGM etc. In the UK tragedy we have tested a Liverpool Somali community and seen a 1 in 50 catch it rate from a 5.6% infected community in 2002 and done nothing. We have also seen 9% of total Asian infections to be under 16 years indicating half of their chronic infections are happening in childhood. After the first 1000 calls on the national HBV helpline from people with child acquired HBV, we started contacting health services in all countries of origin or at least their published medical facts, all report HBV is mainly a horizontal child acquired infection with numerous common transmission routes, it is rare to find a family member exposed and not another. We have 20 schools who have had parental reports of HBV issues to test.

With communities we have to admit the scale of infection shown up in maternity instead of archiving the fact. If pregnant migrant mums are 1.6% HBV positive for 12 years, it means they and their communities are officially testing endemic...period. We cannot then not test them and pretend they are not as we have anymore, as this quintiples the chance of HBV killing them. HBV is so family infectious there is clear evidence a 3% infected community can boom up to higher levels without screening and vaccinations. WHO has recommended endemic communities for screening since 1990.

**Screening all FGM survivors**

FGM nations have the highest rates of HBV on Earth, on the helpline we have noted for years the amount of FGM ladies in touch, when the girls go yellow after FGM in Somalia it’s called agarbarshoe, when the girls go yellow afterwards in Kurdistan it’s called Zerreck, this little phenomena perhaps indicates the huge link between FGM and HBV. One cutter party often infects every child attending and we have driven the practice underground lately with some 5 to 10,000 ever younger cases. Screening survivors gives a chance to educate the 14 morbidities of FGM and the 4 wheels that have done so much to eradicate the practice since 1995 across Africa.

**Screening all refused for blood donation due to tattoo and piercing infection levels**

In the early Nineties the Blood Bank refused all donations from those with tattoos or piercings as a proportion were found to be infected with HBV or HCV and in the window period before demonstrating an infection in a blood test. Now this window is fairly tiny and this proportion was high enough to be viewed as infectious as unprotected anal sex with a stranger. Now for over 20 years and the most astonishing boom in tattooing, piercing, shaving and an addition of an array of new dangers, botox, acupuncture, sharia and tribal practitioners, threading, nail tech shops, beauty treatments that are semi surgical, a profusion of easy buy equipment, a one direction harry styles self scratch boom.

For all this we have no screening to see how much more infectious it has become, bearing in mind in Texas they note tattoos are infecting more people than injecting can we in a collaborative way ask the blood bank to take samples from this cohort and see?

Right now I have a Turkish barber in Islington using an infectious caustic stick, I have a tattooist who is infecting in Harrow, unvaccinated for HBV she does not believe in it or the 5 transmission routes I saw watching her, at 18 her victim and many go chronic. With the caustic stick we have a mass product that when sold to contact sport or hairdresser venues is garanteed to transmit HBV and has no fatally dangerous if shared warning. Contaminated blood is killing 100 million people and not a barber or beautician in the UK knows!

Finally on this we have fought long and hard to see a decent Tattoo Handbook for safety but we need this screening to give it a chance to be used, currently the sector is almost without sterile venues and that is the view of the best piercers and tattooists in the UK who want to ban the piercing gun and sales without hygiene training and a license of tattoo guns. We have dozens of calls from Beauty staff and Colleges with no access to HBV vaccination or education. Just once it would be nice to shut a place and poster a big warning and test for infections

**Screening baby boomers as a once life check at 40 plus**

In the UK rather weirdly we forgot the fact of **look back** screening as the only “cure” for viral hepatitis in 1999 and have never done any. The result of this was predicted in the report by Koop and to the Commons by us in 2004 as a 500% boom in Liver Cancer and cirrhosis which has duly occurred. The paradigm here is if 1 in 4 humans have already caught child HBV and 1 in 40 healthcare users has caught HCV, we do NOT decide oh injectors and gays catch it a lot and are at risk showing 500 acute infections a year and we must test only them. We decide 4,000 HBV mothers were diagnosed this year suggesting screening their nationalities are proven to be endemic in the UK.

This is how the **“Look Back”** works globally if they are endemic 2% we must screen them all for their safety, a timely £5 check avoids all the costs of cirrhosis and cancer here in the vast bulk of cases, it is always cost effective to screen endemic communities this is patently obvious. With the bulk of global HBV (60%)and HCV(90%) from healthcare we need to admit our own and the overseas transmission routes publicly at last and test them too.

They have a right to know that their Egyptian injection means a 1 in 9 HCV risk and so on. The politics of the UK cover up of its HCV infections is endless but the fact remains UK elders were highly exposed to prison blood banking post war until 1985. Yet we have never tested them to care, with the clear admission surgery was 2.6% HCV infectious before 1985 and that national prevalence was 1.07% (500,000) then, we need to warn and screen these souls too and admit it is very cost effective to do so. The entire NHS cohort of pre 1985 users has a right to some care here, but the key group who had the 2 million units used on them each year are on file, the list to target can be focussed to dialysis, surgery, transfusion, c-sections, transplant, poor LFT’s especially persistently high ALTs and blood product users. These elders are statistically 20% expected to be medicated or 21 units advised to death at mean age 58. WHO modelling suggests 100,000 NHS survivors.

* + **Diagnosed early HBV and HCV need cause no harm at all**
  + **Diagnosed late they kill 1 in 3 and maim 1 in 3 more**

There is consistent and conclusive evidence to show that early treatment for **HBV and HCV** is more effective in screen detected populations than current treatment of clinically detected cases. Basically as all the liver units know we are not diagnosing them they are turning up at A n E dying or damaged in 40% of cases.

The greatest tragedy of waiting for what we call cirrhosis or cancer diagnosis’s, is we cannot cure either condition. With both very fatal we have practiced a 20 year wait and see, imagining a ticking time bomb is present and we have time to listen when actually the unmitigated slaughter has been booming 500%, by far the worst EU boom has happened to the only prison blood nation to ban its healthcare look back, and to our 100,000 survivors we have added at least 10,000 a year for 2 decades from overseas with healthcare HBV and HCV.

**GP Union Screening workforces to establish risk and motor vaccination**

With this sector we note the helpline has consulted on some 4 to 500,000 staff type vaccinations

prisons do some 70,000 a year, maternity is on 10,000 plus with mums and partners etc and just one major employer and we deal with over a 100, St John has some 20,000 ongoing and 50,000 first aider trainees in need annually. The sector is riven with conflicting access to risk advice and vaccination we note perhaps half of callers unsatisfactorily advised or vaccinated.

There is a real need to understand the array of infections and deaths arising from occupational hepatitis b and c, vast numbers of zero hour contract workers are doing roles that work with blood especially cleaners, security, first aiders, carers, beauty staff, we forwarded a list of 289 calls relating to occupational risk, death or infection to the HPA who concurred on our nurses being 1.5% HCV infected in2000.

The screening we have found extremely efficient is to HBV test when vaccinating and this service Synergy Labs offer us free when we titer test post HBV course. This emerges a prevalence which is a real tool in being able to educate the industry. The NHS is ground zero for this disaster with 1.3 million staff most of whom have never been tested for HBV, with 1.5% positive for HCV in 2000 the more common killer has been overlooked. Staff infections involve original infections that get 3 vaccinations and carry on, staff who work unvaccinated as trainees and staff returning without boosters and finally the elders who often die. Hundreds have contacted us, we had 40,000 views on our ”HBV infected? Work for the NHS” web page.

Details on the many industries and array of new infection routes are in the GP HBV and HCV risk equals test manual, an audit of thousands of calls created the manual. Bottom line blood is the new asbestos and the workers need to know. When we offer vaccinations to staff we work with the following studies which rather reveal how little testing has happened.

Medical Studies of how many workers caught acute HBV before HBV vaccination became common show the **1.4 million British citizens who had exposure to HBV infection in the 1980’s** formed a

1 in 38 National Average at Blood Bank *Tedder et al 1989.*

And that the following professions were at greater risk

1 in 17 Asylum Workers *Holt et al 1985*.

1 in 14 Exposure Prone Health Workers *Fagan et al 1987.*

1 in 19 Hospital Staff *Vandervelde et al 1985*.

1 in 31 Non Exposure Prone Health Workers *Smith at al 1987.*

1 in 10 Crime Scene Officers *Morgan-Capner et al 1988*.

1 in 22 Police Custody Officers *Morgan-Capner et al 1988*.

**The need for tested staff updates after 30 years wait is blatantly obvious, especially with the bulk of staff unvaccinated in huge numbers of job roles Eg we have a nurse in ICU and another dying currently, we have 3 police officers one just HBV cleared, one dying and one needle stuck unvaccinated at the mo on the helpline.**

**The key paradigm of HBV and HCV infections is that the bulk of risk happened in the past, cleaner healthcare means we only need to test these people once, the millions at risk usually just need one check**

**Conclusion**

WE have consulted hundreds of main groups **(for 12 years) and audited some 10,000 patient and organisation callers**

We have had hundreds of responses from GP’s, Patients, sister charities, 20 work with blood industries, overseas health experts, APPG for hepatitis was run by us for years, produced parliamentary reports, done nice tech appraisals, run GP test vaccination projects, run 500,000 people met London street awareness campaigns, worked with layers of local and central govt and layers of NHS, D of H meetings, JCVI meetings have emerged a recommend for HBV universal vaccination but we are still unable to find a Health Minister advised that more than 3 horizontal child infections have happened.

We have a Thousand caller audit, survey monkey doctor,

**Recommendation** The committee is asked to approve the following recommendation:

**Based upon the UK NSC criterion to recommend a population screening programme for HBV and HCV**

**Criteria for appraising the viability, effectiveness and appropriateness of a screening programme for HBV and HCV**

***1. The condition******should be an important health*** *problem as judged by its frequency and/or severity. The epidemiology, incidence, prevalence and natural history of the condition should be understood, including development from latent to declared disease and/or there should be robust evidence about the association between the risk or disease marker and serious or treatable disease.*

**UK TB is 13 per 100,000**

**UK HBV is 750 per 100,000**

**London’s wards tested 2.6% HBV positive in 2012!**

**8.7% of Somali under 5’s had caught HBV in Liverpool in 2002.**

**Liver Cancer has boomed 500%**

Undiagnosed HBV tends to kill up to 30%, access to long term prescriptions, alcohol and obesity motor this. We are in the middle of hepatitis boom in cirrhosis and cancer and about to experience another one if we do not raise our 80% undiagnosed rates, our million heppers are statistically 60% cirrhotic on 5 years of 21 units or 2 years of paracetamol. Both obesity and diabetes are greatly complicated by viral hepatitis.

***2. All the cost-effective******primary prevention*** *interventions should have been implemented as*

*far as practicable.*

Again with Hepatitis we cannot undo the 2.3 billion infections, but Brent GP’s were amazed to see an average of 112 patients per practice completely overlooked for decades. We find when maternity is at 2% locally for HBV among mums just letting the local GP’s know can really get things moving.

Over 6000 GP practices needed help from us understanding HBV test results, in RCGP training we note 25% of their info is wholly wrong. They need screening tools we have noted when equipped 100% said in survey that testing for HBV and HCV is greatly improved via training.

With 50% of city GP’s being from endemic communities a real prevention enthusiasm can emerge.

Dr Hashi Queens Park desperate to protect Somali children,

Dr Dadabhoy Waltham desperate to vaccinate all hajjis before the ritual cut throat shave,

A Barnes Practice Twinexing all children ,

a Southall Dr Ajaib testing every endemic migrant as per the WHO atlas and the 1999 guideline,

a Dr Mann desperate to vaccinate amateur boxers and rugby players and their schools,

a Dr Clin desperate for an Inquiry into why UK Chinese mums are still told they need no HBV vaccinations,

a Tattoo and Piercing Tool kit the creators are desperate to British standard it,

a dying policeman longs to warn the security industry

a dying st john longs to warn the first aid industry

HBV mom infected while NHS employed at Gt Ormond wants maternity packs funded again

We have a list of MP’s and Doctors and Teachers who would like to see real premiership blood hygiene in our schools taught and practised

Most GP’s are very poor indeed at HBV vaccinations and understanding transmission, with Brent we had to point out you are seeing the test and vac as a GUM DAAT tool, you are hiding behind BMA form letters and leaving thousands of staff, migrants and travellers with no notion of their risk or how to vaccinate or their need to safety screen a 80% catch (sub Saharan/Pacific Rim) risk.

*3. the patient identified as a result of screening the natural history of people with this status should* ***be understood, including the psychological implications****.*

The key part of any mass screening for HBV and HCV in the UK is to admit honestly that 1 in 4 people caught hepatitis from healthcare and childhood, the natural history of some billion infections was got born toddled about fell over had plasters went to school had jabs and 1.5 billion of them caught hepatitis B or C by 10, we use the WHO outbreak maps and make clear diagnosed early on there is no problem.

To make absolutely clear that just like diabetes or cholesterol we have simple treatments to guarantee things for hepatitis patients, especially 3 month mums need to get back to blue boots and pink boots worries rather than a terror coaster avalanche of tests where death is possible where infection of all loved ones is possible.. See attach testing posters,

The whole lexicon of chronic carrier is rubbish, we say hbv positive If most of HBV is child acquired we must say child hbv more often than not right, if 90% of HCV is transfusion hepatitis we must say the healthcare infection more often than not mustn’t we?

Truthfulness removes the stigma and your fault and they get it nonsense, children and patients get hepatitis usually from blood is the truth and explained well ends so much psychological pain. Further with zero proof of HCV being sexual and 85% of HBV partners not being infected ever, we need to quickly understand the real risks and more rarely sexually speaking teach low risk and undetectable to people.

Many patients experience a BBV type with a list of notify able disease transmission questions, in this process many newly diagnosed patients are bullied into serious depression quite cruelly and unnecessarily.

Many are nagged in a we are checking if you are infecting way long before they have any idea what HBV or HCV are, or after a read of NHS choices. The questioning on sex has led to abortions, suicides, divorces and many family catastrophes, usually worst behind language and culture lines. More than half of patients became depressed after this call, many for life, failing careers, especially doctors and nurses crack up when questioned. Just as from Trust to Trust we find very different responses to a staff infection, some a full scale security off premises with patient notification excercise Dr Death named with photo up, across to, oh you can tell the nurses with hep from the way they observe gloves and scrubs.

The form letter question set process is worthless and as harmful as the hepatitis often, it needs binning and replacing with funding for decent literature and medically audited social media. Instead of being humiliated with idiotic questions each patient desperately needs access to vaccination schedules and blood hygiene factsheets and the simple list of household products that will kill them. I always think of the client who hung himself post call, his wife found him, blamed for going to Hong Kong....he had dentistry there and like so many returned with HBV, the questioning destroyed him, not hepatitis.

The idiotic parrot phrase 100 times more infectious than HIV must be corrected to read

Blood is 100 times more infectious for HBV than HIV

blood when you have skinned your knuckles in a tussle,

blood on a fresh sharp milk tooth, blood on a fathers razor,

blood on a caustic or chap stick, on some bloody glass on a bar floor,

blood on over a billion needle gun vaccinations.

blood has infected 60 people with HBV for every 1 sex has given HIV and we need to know that plasters are often more important than condoms!

Blood the motor for 2 billion infections is how they are infected and is usually not a key question for the HPA/BBV question harpie. This creates a distrust in doctor education and a feeling persecution in many migrants. The have you had anal sex, multiple sex, unfaithful sex, gay sex, dirty piercings or tattoos, have you been in prison, have you been homeless, do you do crack, snort coke, inject heroin, all this is done simply wrong.

**The first question** is do you have a history of liver disease in the family or remember going yellow at all or when young?

**The second question** is did you have vaccinations at school in the second or third world before 1995? From Zambia to the Mediterranean we also ask about FGM.

**The third question** is work with blood histories, are you a doctor or carer, a cleaner or policeman, a contact athlete or beautician? Sounds way better than prisoner, prostitute!

**The fourth question** the NHS risks they had run if any.

This covers 90% of HBV callers with infections for the last 6 years. Then we touch the mega funded and advertised risks that account for 10% of transmission and all the stigma, it is strange the immoral and the drug addicted catch flu more often yet do not stigmatise it at all!

**Sexual infections** are usually a non sexually infected acute partner infecting their partner. The effort is best aimed at avoiding sexual assumptions and testing and protecting fast and with b and c this is quick and the vaccine effective. The vast bulk of the HBV positive 100,000 strong community have no training in getting a hbv vaccination when needed sexually speaking. (we strongly advocate 4 week courses in many situations, separated HBV dads for instance and medical trainees)

**The gay community** is in need of vaccinations and pre relationship GUM tests need to include HBV with gay couples.

**The injecting drug community** still arrives at the point of injecting without any blood hygiene training from schools or colleges so needle sharing is not known to be dangerous at the start point still.

*4. There should be a simple, safe, precise and* ***validated screening test***

Yep there is, but saliva swabs or pin prick blots for universities and schools would be good, in Soweto 1985 to 94 we toured unis with tests i remember the power of saying UWC was 7% and Vista was 20% plus. 100 swabs and we had a revolution that actually floodlights how infectious UK childhood is for viral hepatitis. The Unis, have fresher’s week that supply infections and calls since 2004 on the helpline. The razor left in the hall poor student is a lot more implicated than sex. However, with HBV being often sexually transmissible in the acute window for 3 months as the load booms to millions, we have noted a wave of fresher infections at November, another wave over new year and another after valentines day, our 700,000 students define best sexual HBV each year, less than 5% understand how HBV transmits even the first aiders across Cambridge had no idea and were unvaccinated, ditto the BBV nurse in Oxford had no idea it is the only unvaccinated unis left on Earth.

*5****. The distribution of test values in the target population should be known*** *and a suitable cut-off level defined and agreed*

Each prevalence can truly save its community, this we found in all our testing in communities, testing happens in a wave of life saving enthusiasm

*6. The test to Delivery of results should be* ***acceptable to the target population****.*

In 200 nations this is a given, it is our responsibility to warn these poor people of their need to test away their risk.

With a silent killer and infector, it is important to stress diagnosis via symptoms later is usually life time painful or fatal. A people don’t die of HBV or HCV they die of ignorance approach.

Each part of our training has a pre and post test counselling factsheet. As part of a cascade of tests all with scary impact affect it is crucial to get the 19 out of 20 clear for acutes and 9 out of 10 are fine with early diagnosis in the front of mind going into testing, with a dollop of better to know on top.

There is the concern it is basically a little immoral to leave the outdated, crass NHS HBV pages up if we plan real testing in the 6 target areas above aimed at the bulk of our patient populations. We have patient friendly up to date rewrites that dovetail with better poster and condition manage patient booklets.

Further isolation of these patients post diagnosis can be absolute, 20% of the Chinese patients in Professor Bassendine’s Study knew they had HBV but would rather get ill than admit it, and this is the effect of our published disinformation. I understand we asked DAT and GUM clinics to look at Hepatitis in 1993, but their efforts cannot help the 2.3 billion infected as children or patients can they? We have to remove Boy George and Russell Brand and replace them with Madam Sadat Imran Khan and Amitabh Bachchan so to speak. Many patients google themselves quite NHSchoicely insane and many never understand what is actually their infection.

There is a crucial need for a decent medically right web forum for our 60,000 HBV mums for instance for our 2 million workers with blood all gain great solace from not being alone and get courage to ask for vaccinations and gloves etc, literally every other patient weeps on the phone as they deisolate and let go of preconceptions. Many are never asked do you think you will live or have kids or a partner or a job again. Many Africans think they have super HIV and become depressed, especially those who have lost relatives, and we get reports of multiple deaths often due to HBV already are not asked this.

Forgive me, I felt in Anne Mackie a deep lifetime of experience in how and where people go with healthcare information and testing, the panic of an HBV check post rape is very different to one at 3 months pregnant and quality assuring is a huge subject. Thousands of partners do not need to feel they are having to vaccinate for HBV and avoid sex for a year because their partners have been caught being unfaithful, this is a screening endgame that can happen and needs preplanning to avoid we have found. Diagnosing a generation of HBV fathers should not create dozens of dads excluded from visits for a year either. In every way testing targets must be cared for with stigma free approaches and problem solving information at the start. This is why the HBV and HCV atlases are so important...the simple truth at a glance. On the wall teaches the staff as fast as the patients

With HBV and HCV the stigma causes 80% of the actual suffering, we note 80% of the diagnosed found HBV a bigger socio emotional problem than an illness with symptoms in a survey of 1000 callers, this group is almost all the ones with no symptoms when diagnosed.

Jade our hbv kid coined it best with the slogan for the 9 out of 10 diagnosed inactive low risk.

**HBV =Great meds n Vaccs n no problem**

NHS Choices have turned it into I got the HIV that is 100 times more infectious, yeah, caught by gay prostitutes on heroin mainly, the one that gives me fibrosis, last 5 years cirrhosis, raised alts, varices, 1% survive liver cancer, yeah the incurable one 90% of your children will catch, the one in the saliva and sweat and pee and pooh and tears. Sob. This awaits every patient currently along with all the wobbles from genotype to e antigen, to LFT’s and liver scan testing. A scan of NHS choices has had patients thrown out of hotels, even their homes, as well as marriages.

Testing being predominately done by sexual health and drug alcohol agencies shows a skew as testing is yet to be done in high risk communities and occupations, I get far more calls from infected staff than sexual ones. Far more calls from child acquired infections than drug induced ones...remember with sex and drugs being quintessentially adult and adults being 20 to 1 at clearing our 600 acutes annually on record provide perhaps 30 sex and 30 drug cHBV infections a year, whereas testing migrants, workers and maternity is producing some 8,000 cHBV a year.

Over and over we find cirrhosis attributed to alcohol, infection attributed to sex and drugs by agencies with no idea of actual infection routes and no awareness that what takes alcohol 50 years to do viral hepatitis can do in 5 with just mild social drinking and prescriptions

Often with schools and community leaders the advocates of no testing needed are the ones who after a 10 minute chat are the ones putting up vaccination posters, especially Afro Asian Muslims. So if we find an idiot who wants to dream hepatitis is rare, we point out lack of diagnosis kills often. In mosques always ask who has lost a loved one to liver disease and the testing arranges itself. We make imams highly aware of the fact and request vaccinations for all Hajiis and they rapid update their flawed ideas. We had a bit of this insanity break out once, see below, the great and good in uk Hepatology test and find 2.8% of 4833 Pakistanis here have hepatitis in 2009.....................................and decide they have not noted hepatitis rates are higher in endemic communities of migrants and they do not know if we should test more, utter madness.

**Prevalence of chronic** **viral hepatitis in people of south Asian ethnicity living in England:**

**The prevalence cannot necessarily be predicted from the prevalence in the country of origin**

G. Uddin,1 D. Shoeb,1 S. Solaiman,1 R. Marley,1 C. Gore,2 M. Ramsay,3 R. Harris,3 I. Ushiro-Lumb,1 S. Moreea,4 S. Alam,4 H. C. Thomas,5 S. Khan,5 B. Watt,6 R. N. Pugh,6 S. Ramaiah,6 R. Jervis,7 A. Hughes,8 S. Singhal,9 S. Cameron,10 W. F. Carman9 and G. R. Foster1 1Queen Marys University of London, Barts and The London School of Medicine; 2The Hepatitis C Trust; 3The Health Protection Agency, London; 4Bradford University Hospital, Bradford; 5The Liver Unit, Imperial at St Marys; 6Walsall Primary Care Trust; 7Sandwell Primary Care Trust; 1 8Walsall Hospitals; 9Sandwell & West Birmingham Hospitals NHS Trust; and 10West of Scotland Specialist Virology Centre **October 2009**

*After discussion.......*

*We* ***assumed*** *that a prevalence five times higher than the UK average (****assumed to be 0.4% for HCV and 0.1% prevalence for HBsAg****) would justify case finding in ethnic minorities.........*

*This study is of viral hepatitis in immigrants from countries of high prevalence living in England. Although we have* ***no data*** *on the prevalence of viral hepatitis in immigrants in other countries, we suspect that the prevalence will be similar. Our study shows that applying current WHO estimates of prevalence in the country of origin are likely to* ***be too crude*** *for health care planning. Geographical variation in prevalence and selective migration, which may differ over time,* ***may*** *confound attempts to estimate prevalence based upon available data.*

***The suggestion that up to one in 20 migrants*** *from Pakistan may be chronically infected with HBV or HCV, harmful but treatable viruses that can be transmitted to others is* ***worrying****, given that over* ***300 000*** *individuals were living in the UK at the time of the 2001 census.*

***Results***

*132 Infections among 4833 tested,* ***a 2.8% level,***

*Hepatitis C infected 75 (1.6%) and Hepatitis B infected 57 (1.2%)*

Here is the rub everyone paid to test and diagnose these infections is writing they may not be there and assume it is not justified to test even if they are!

On the back of testing 5000 Muslims (1 in 36) **2.8%** hep b or c positive, just look at the title, they have decided the fact of much higher viral hepatitis levels among migrants in the study means they are probably not infected much and probably not worth screening for!!

How can we have **data** from dozens of overseas health services that border test migrants and publish them and not a single one be referenced here? All the overseas prevalence studies confirm a global 3% WHO figure for HBV in migrants, the US Hepatitis B Foundation is right up on 3% of US migrants living with HBV for 25 years of audited tests that inform universal vaccination for 25 years. Ditto France on 3.5%, Canada is excellent as they have real care at the border for their Chinese community , Australia are great because they are surrounded by 80% caught 10% have HBV nations.

All the above nations and WHO would bitterly contest the suspicion their data shows no correlation to homeland endemic levels migrating to a degree worth testing vigilantly at borders for which they all do, they have all long ago based their child hbv vaccination policies around the known levels of migrating HBV at their borders, we can get the Hepatitis B foundation US head to concur immediately on this. Dr Block is after all running the legacy of the nobel laureate who discovered hbv and its vaccine.

Above our whole UK HEP team note a 1 in 36 are infected among 5000 Pakistanis and they refer far too little to 1.2 million maternity and sentinel test figures. The best in the UK are squawking 0.1% for a HBV proven in maternity to be at least 0.7% for 12 years consecutively. £5000 of swabs has saved 132 lives here and there is still an air of learning do nothing in the title, **in 200 countries assuming higher prevalence in these endemic communities was the best place to start,** their own study assuming Pakistani’s had higher hepatitis levels due their origin has just discovered a 2.8% hbv and hcv prevalence in a medium affected endemic nationalities more conservative religiously devout group, we have dozens far more affected.

I am overjoyed about wiggle down prevalence testing moments and they occur in many ways we see a dropping now at last in maternity infections from .6 to nearer .4 and this is very much hbv vaccinations from the world use showing up, apart from the UK the world is well on the way to eradication a la smallpox., but we also have wiggle up concerns asylum seekers have come from places where often syringe reuse is common as infra structure fails, that as in the study recent outbreaks of repackaged used syringes are wholesaling again in the sub continent.

How can they do this above? Politics not medicine basically, 1 in 37 infected and that title will kill them all, even when 2.8% are diagnosed they can only suggest a worry and back to happy clappy title! A political title written before the test results and static whatever they were.

The reality of cleaner healthcare in Asian communities in Africa is also a wiggle, having lived and worked across Africa on HIV in the Eighties and Nineties most Asians had their own services run by their own staff. This is rather ignored and the lessons of all 200 borders that screen. This article was another by Ramsey to undo our work rather than talk sense and mass screen away the deadly danger at the border level where it is best diagnosed after residence etc is granted and with no contact from healthcare to home office needed.

**The Intervention**

*7. There should be an* ***agreed policy on the further diagnostic investigation*** *of individuals with a positive test result and on the choices available to those individuals.*

An important aim is to remember we do Viral Hep Checks for B and C together always, not tests for HBV and HCV separately, in GP training we call this **double the good halve the workload**. This very important double the good half the work. Double the Diagnosis for half the counseling.

NICE and the liver units have excellent testing to map virus extent and guidelines to use excellent vaccinations and anti virals. The incredible march of anti viral treatment means no hepatitis patient should get ill if diagnosed early. It is however still noted some GP’s fail to refer patients to specialists, especially on file patients moved to the Practice can sit there for decades, also we lost our 30,000 non a non b hepatitis and transfusion hepatitis paper diagnosis and these still pop up on John Lloyds most often with question marks next to from old GP’s, these ???? often never get attention and are transcribed onto computer files seldom

The care path is totally under developed education and education material wise and the strategies to improve revolve around a real step change in published NHS information and staff training, we actually have far more information’s on this area, interventions than anywhere else.

Very few patients ever gain an informed notion of what their tests and results mean, fully half of the low risk group have no idea they are in it. Very few patients understand HBV is not 100 times more sexually infectious but in 80% of cases not sexually infectious. Poverty of counselling when testing positive is built on these type delusions with most diagnosis presently.

**The tests triggered by a positive are for hbv**

Acute IgM to confirm if so Acute Clearance Pack and 20 to 1 testing until clear, during 2015 we had not one acute that went chronic who used the Pack, again a quality assurance of care.

Acute testing involves a bell curve of results being monitored as HBsAg and HBeAg come and go, a healthy immune response of 2000 ALTs by month 3 and a drop to zero by month 6 with seroconversion to anti HBs and anti HBe visible. 4 things influence acutes,

alcohol,

prescriptions especially anti biotics,

loss of sleep with midwives and security eg with the station commander who left his nominated first aider officer refused for his vaccination, we insisted the officer be removed from night shifts until clear

Being 16 to 20 we over the years have noted large numbers of acutes who went chronic in this age range, many are occupationally infected when most un aware of risk, teenage porters, barmaids, dental and other trainees, tattoos, fresher razor sharing, sexual first relationships these all go chronic noticeably a lot more often.

**Lasting HBV infection tests HbsAg positive**

Having offered a test results explained service to GP’s and some 10,000 callers since 2010, we find it extremely important to note the many areas where testing can heal and harm people with hepatitis.

The full panel of HBV results is always good to explain as the results 90% confirm a low risk infection with HBeAb present and load limited down therefore. With e antigen load from 1million to a billion we will move to the undetectable on anti virals journey. This involves Liver Function Tests, which all improve with treatment, Liver Scan which again can improve and often a baseline biopsy all makes complete sense to patient, especially with a clear undetectable goal for HBsAg in 6 months and a clearance of e antigen hoped for by year3. We do recommend a multi vit for such patients or at least vit d testing after 1 year, especially for African patients.

**We HARM** by failing to have simple explanation and load is often a give up point for half of patients. I mean if you cannot ever understand even the basic how much of it have I got and is that bad? Subtly a patient despair can kick in as they give up on knowing what is wrong because they just cant understand what is being said. They all feel like idiots listening numbly to slide rule figures for 10 minutes are told “You are a healthy chronic carrier of a deadly virus 100 times more infectious than HIV in your kisses with a viral load of 20 to the log in International Units of god knows what.”

The weird numbers the doc spends decades relating is often the main experience of patients.

**We HEAL** by a Keep It Simple approach, high needs undetectable goodies, medium a close eye and undetectable goodies if needed and low means low risk, inactive, with annual monitoring in case a toxin sneaks into the foodchain but usually means grow old and never know you had it.

**Streaming in the subsequent tests with an attitude of confirming everything is easy manage** really helps....onward the cascade has to be viewed from a terrified isolated wholly ignorant NHS choices bewildered perspective as this is where most patients are. We build a new lexicon and use the results as yippee moments as nearly all (90%) confirm a caught in time easy manage infection.

**Other Viral Tests**

With HBV results we have straight away really many linked tests HIV HCV HDV and HBV all tend to happen and patients need to know the viruses seldom co infect and the bulk of co infections are among the gay and injecting drug communities. Many get positive for HBV and well expect HIV and HCV and HDV on top. So this thought is good to destroy quickly.

**Common HBV Test Mis interpretations at primary and secondary care levels**

We help some 7,000 practices with factsheets on this. With HBV there is an real need to avoid results of anti – HBs causing ideas of an actual infection, eg we had a call from a doctor with this result told by Coventry trust he has natural immunity from a cleared infection and is fine to work and then from mid staffs he is told he may be having hbv and needs testing to see if he can still practice.

This problem has caused many to think they are infected who are not at primary and secondary care levels, meaning missed marriages, children etc. The stigma means they are usually too scared to ask for a confirmation, logically 10,000’s of our undiagnosed HBV and HCV patients remember going bright yellow, 2 to 3 million of us have had hep b or c at some point, but do not come forward for further testing. Also rumours of re activation do the rounds at GP level.

HEALING POINT having anti – HBs is thing of great joy not shame.

**Liver Function Blood Tests**

After defining the HBV low or high risk with the HBV tests, maximising the we found it well in time for 80to90% and can easy manage and garantee baby is safe attitude, we move on to see if the virus has had any effect on health and liver health, with 80 to 90% of patients having normal liver results it is crucial to give some closure well we have found an inactive low risk infection that has caused no harm and move onto this is how the other 80,000 patients easy manage and monitor their low risk HBV.

Even healthy patients need to understand their LFT’s and be watching for signs of activity as the decades go by.

Liver tests quickly define an active or becoming active infection and explain a range of controllable activities and sometimes attendant symptoms. For most with such issues we can supply huge reassurances and life direction to the patients and they should be properly and simply explained, we live in a information self grab era and units need to promote this education as we find it greatly engages the patient and stops no shows.

**ALTs**

are the most common sign of activity and may be from 50 to 200 in some 40% of patients, this defines a liver at work slightly enlarged, occasionally giving right quadrant digestive pain and some tiredness. ALTs often mirror the enormous risks of add on toxins quickly and save patients first. ALTs of over 200 to 1000 are common with alcohol abuse, of 200 to a 1000 with a paracetamol prescription, even from 200 to a 1000 with a McDonalds manager are all common calls. Our ALTs 6 monthly UK liver unit standard can pick up these patterns and patients do use them to save themselves. Further ALTs monitoring gives quick feedback on life style changes and these are responsible for avoiding most morbidity and mortality. Even milk thistle use and zero fried food dramatically affects ALTs scores, alcohol users do quit, the obese lose weight, diets and non red meat diets abound, patients get excited at mastering their ALT scores quite often.

**Bilirubin**

Are key results and usually raised in acute patients and those taking toxins. Tiredness and right quadrant symptoms can emerge from this being high, sleep can become light and sweaty, judgement and emotions cloudy. Again patients get excited when they see Milk Thistle halves this score in 4 weeks.

**AST**

A very common indicator in those who have socially drunk with their undiagnosed hepatitis, giving scores usually from 50 to 200, such cases usually are greatly helped by weight loss or alcohol removal. Again immediate visible cheer them on figures emerge as they life style cure themselves, with drinkers a Monday test for ALTs and AST can be the result that ends the 21 units is good nonsense forever.

**ALP**

Used as a cancer marker and commonly done as a check for liver cancer, it elevates to the hundreds with cancer and to 15 in most pregnancies, I often wish mums had access to the fact in their HBV mom pack as there is some serious panic here on the helpline, a common HBV mum moment.

**Platelets**

these can go low fast with statins, painkillers, tranquillisers etc and hepatitis all competing for liver attention. There is also a body of evidence showing the anti virals leech the vitamin d and calcium from the system. For instance with HCV treatment we advise HBV vaccination before and not near the treatment year. Again there are more bespoke strategies for this and wiggles affecting care but patients can know why we are doing and what we are looking for. A lot of diet problem types can be helped here.

**Fibrosis Scan Tests**

Many patients have some fibrosis and again have no notion it has never killed anyone, as fibroid or scar tissue it is harmless and usually having no effect on liver function, it’s basically dents in paintwork no one can see. Fib 1 2 and 3 are in that category and often remiss a little due to treatment which is offered at fib 2 usually, however far too many patients receive a fib diagnosis as a death sentence and become depressed, the “Oh nearly a 1% survival cancer, but just proof it’s on its way this time, a Fibrosis of 75% stage 3 seems to say soon.” Is what we do not want to be doing with 70% of fib 3 diagnosis so to speak, ladies, veterans of many a breast cancer scan suffer most with this attitude.

**Cirrhosis Liver Cancer Bile Duct Cancer Blood Cancer Kidney Cancer Scan and Tests**

When we scan a liver with awful Liver Function Tests we can find fibrosis stage 4 and cirrhosis. Then we move into an array of liver fail, decompensated cirrhosis levels and rather an avalanche of conditions and ailments and tests, however at this point liver unit care is excellent and with the GP having our attendant ailments factsheet and diet for the liver damaged one and crucially our do not park or binge medicate guide things progress.

For both occupational and financial reasons patients lives are greatly healed and empowered by their having a patient liver file they keep stating they are zero infectious threat low risk or undetectable and having liver results that behove a normal life expectancy. These files are making what I feel is the right use of all these test results and far too few patients have them to ensure gaining mortgages, partners, life insurances, children and their work with blood careers. Major institutions read medical files and never see undetectable or clear, just dozens of bad test pages.

1. *If the test is for a particular mutation or set of genetic variants the method for their selection and the means through which these will be kept under review in the programme*

No simple hbv n hcv target testing of groups at risks for and until at least a prevalence.

*9. There should be an* ***effective intervention*** *for patients identified through screening, with evidence that intervention at a pre-symptomatic phase leads to better outcomes for the screened individual compared with usual care. Evidence relating to wider benefits of screening, for example those relating to family members, should be taken into account where available.*

**NICE** guidelines easily avoid their illness and death with timely monitoring and advice. We now have excellent anti virals to help those with harmful infections. Nations with high diagnosis rates have far better liver disease figures.

The testing of all surrounding a migrant infection is crucial, over 6 years and 10,000 callers we note each patient can diagnose 1 family member on average, some 1 Chinese, I Ghanaian and ! Nigerian have diagnosed more than 5! We call this process kicking the family tree and dont stop until someone is diagnosed at least with anti bodies. Usually with HBV 1 in 3 siblings have been exposed and one parent at least, it is also important to test the parental generation and cousins and this is where the figures get exciting with 3 to 5 infections often found.

*10. There should be agreed evidence based policies covering* ***which individuals*** *should be offered interventions and the appropriate intervention to be offered.*

**NICE** has great guidelines and no diagnosis screening strategy to find any for years. I can do 1 10 or 100 pages on this? The Testing of migrants is in NICE unused already, and at CCG guidance levels for local actions, the testing of workers more in the Green Book. Let’s hang them with their evidence for individual targets. Peter’s excellent approach rather shone out of him when he mentioned sentinel and maternity figures. For 12 years our BME figures have screamed 3% infected HBV positive migrants are here quite clearly. Our numbers are 20 million endemic and we all have a simple human right and WHO recommendation that we are warned and offered look back safety screening, the facts below make it obvious why year after year in fact they make the prevalence simply, blindingly obvious.

*Health Protection Report, Sentinel Figures tend to double street prevalence*

*Vol 4 No. 34 - 26 August 2009 The proportion positive*

***Black or Black British 7.4%***

***Other and/or mixed 8.8%***

***Asian or Asian British 2.6%***

***White non British 1.6%***

***White British 0.8%***

*Table 3. Women testing positive for HBsAg maternity 2010*

***Black or Black British 3.9***

***Other and/or mixed 3.8***

***Unknown ethnic 2.2***

***Asian or Asian British 0.5***

***White or White British 0.3***

***Total 62,968 342 0.5***

**The Screening Programme**

*11. There should be evidence from high quality randomised controlled trials that the screening programme is effective in* ***reducing mortality*** *or morbidity.*

Every one at risk of a silent killer and infector deserves a test and a warning, we all understand a virus as carcinogenic as smoking is best discovered and pacified, at a £50 level early on.

*13. The benefit gained by individuals from the screening programme should* ***outweigh any harms*** *and complications.*

Only OCD patients need be removed from screening repeatedly and rather express vaccinated if their condition is triggered, there has to be serious distribution of HBV diagnostics wheels and charts and vaccination schedules to smooth this. *See below on streaming tests caringly*

*14. The opportunity cost of the screening programme (including testing, diagnosis and treatment, administration, training and quality assurance) should be value for money. Assessment against this criteria should have regard to evidence from cost benefit and/or* ***cost effectiveness*** *analyses and have regard to the effective use of available resource.*

£1 a test hcv swab, £4.90 a GAVI hbv vaccination,

£4,000 HBV annual medication,

£40,000 one time HCV medication,

cirrhosis life time cost £50,000,

transplant £80,000,

death £100,000

We save the health care costs of a smoker quitting every time we diagnose and 80% of patients are not needing anything except advice. 200 nations clearly show screening is cost effective in every prevalence of nation less Iceland and finland. We can work through some of them if needed. But aiming at many tests being an extra circle on a routine blood requests and vaccination titers costs can minimised hugely. The process of some campaign aimed at a temple or surnames on a GP register is hopelessly dependent on the temple or GP actual effort. People always get tested when the GP recommends it, end of.....If we train a GP or they make efforts to buy the Toolkit they get quite carried away asking people to test and making certain children and staff get protected. 100% of GP’s said in Survey Monkey that testing for HBV and HCV is needed afterwards. 100% of the GP’s said toolkits predicted and made easier the process.

The simplest cost effect is to count

* 1 million with HBV and HCV undiagnosed
* Creates 100,000 deaths @£100,000 per death costs £10 billion
* 20 million tests @£10 per test costs £200 million

200 nations rapidly adopted look back screening and universal vaccination however they juggled the cost effect numbers and regardless of prevalence because IT IS so cost effective to screen, we can manufacture tests at £1 each, a transplant costs £100,000. Even a 0.1% prevalence is very cost effective to test! NICE sees it as saving £100,000 of disease costs when we spend £30,000 on removing HCV.

**Section 2 – Implementation criteria**

*15. Clinical management of the condition and patient* ***outcomes should be optimised*** *in all health care providers prior to participation in a screening programme.*

Doing a test CCG with Onkar Sahota following TB lines utilising top down training at the royal college to create GP hepatitis infra structures and care literature. Next meeting 12th January, Dr Dadabhoy has the training available at the RCGP online also and we will factor that and be building a web site patient post test area as well. If we can get a whole city CCG to generate funding for new information trainings and tools on the viruses published in all practices involved. The ignorance is so general among NHS staff we could really use a main makeover of their stated pages quick, to roll with the project, some kind of top down at last rather than NRC asking JVCI asking BMA asking and D of H just ignoring us. With 800,000 out there the need is just to get the non stigmatic facts out at last, we need a not diagnosing an epidemic but checking an old outbreak to calm the public also.

On the flip side liver units and drugs are sky rocketing in jolly world leading options if a little robotic and silent and most GP’s get the basics done eventually.

***16. All other******options*** *for managing the condition should have been considered (eg. improving treatment, providing other services), to ensure that no more cost effective intervention could be introduced or current interventions increased within the resources available.*

No nation has found another option to look back hepatitis testing. We did decide it was cost effective in 1993 to burn the transfusion record and ministerial prison blood notes, but it is always worth testing a 2.4% infected community for HCV, always, and this is the level admitted for UK major surgery during our prison blood period 1945 to 85.

With HBV 200 nations excepting only scandanavia who border screen eradication through vaccination is occurring, only in the UK is a booming undiagnosed reservoir of infection being created, so we have to hope our screening can finally empower our JCVI recommendation to universal vaccinate be implemented. The 6 in 1 pentavalant vaccine is actually same cost as the 5 in 1 we use at the moment.

***17. There should be a plan*** *for managing and monitoring the screening programme and an agreed* ***set of******quality assurance standards****.*

I always felt what short sighted person decided to test all 750,000 mums each year and find 5000 HBV mums HBV positive and a smaller number with HCV each year and not commission a decent booklet and budget a helpline expert 1 hour training for them! It costs £43,000 a year and saves serious extra costs at just £10 a mum, with web forum on top at no extra cost. These wonderful young women are 50% of our diagnosed patients, the team that spread a vaccination and test gospel throughout extended families and the at risk communities in exact proportion the virus prevalence. Not a single NHS employee is available or dedicated to caring for them, not one!

Most end up ringing one of dozens and dozens of sex, drug or HIV counsellors, harvest untold stigma and give up! Terrance Higgins gets £23million a year for 60,000 people with gay HIV, the HBV Trust gets nothing for 60,000 HBV moms and there is no bespoke information! Many mums get £200 of support to quit smoking and hundreds more for things they and baby may need, yet a booklet of HBV mom factsheets even for each maternity units walls...impossible!

There are serious equality quality assurance issues at work here. I have two gays who care for Chem sex infections of HBV.HIV/HCV in such gays in London, a community a several hundred, they got 100% more funding than the mums for instance. Properly done look back screening with US French approaches would aim for 80% diagnosis levels in 2020, or 500,000 new HBV and HCV cases.

Quality assuring care on that level needs input from Prof Williams about secondary hepatitis expert availability, but these poor people will need someone or some web site who understands HBV rather than hoping HIV and HCV advice will be “alright” ish. Just one funded individual can do this...OK I am on call 24 7 for 6 years but it can be done.

The key is to fund the right literature cycle and comprehensive web services and interactive education and insist on training some of our existing teams in basic HBV and HCV care without the sex drugs packaging. Basically with HBV especially having a strictly confidential all hours helpline with qualified hepatitis facts and heaps of patient tools really helps patients, they usually have never had a chat about their illness and a third let go tombstones of confusion and sorrow when educated.

***18. Adequate staffing and facilities*** *for testing, diagnosis, treatment and programme management should be available prior to the commencement of the screening programme.*

The NHS can just adequately do this, trying to educate its staff better is not a reason to halt the testing and allow the deaths to keep happening, I don’t feel horrid stigma lurking on NHS pages and in their minds unreconstructed should stop us from flatlining our liver disease boom with safety screening for HBV n HCV. It is crucial GPs forward patients to liver units and offer vaccinations. We have a post grad hep nurse course and a similar one at the RCGP for GP’s, with nurses at the forefront of meds and vacs and docs more lifestyle and diagnostics and signposting. Staff can rapid learn they just need the tools the truth up and the stigma out.

***19. Evidence-based information******consequences of screening****, investigation and preventative intervention or treatment, should be made available to potential participants to assist them in making an informed choice.*

I find advising them (all migrants and workers with blood and old NHS major surgery patients) of the WHO guideline that they

**ALWAYS** need a safety test as their deadly risk is greater than 1 in 50 and a missed test could therefore be expected to cause incurable cirrhosis or liver cancer.

This is what has never been made available to them all, and there are 20 million of them.

***20. Public pressure for******widening the eligibility criteria*** *for reducing the screening interval, and for increasing the sensitivity of the testing process, should be anticipated. Decisions about these parameters should be scientifically justifiable to the public.*

We have enough pressure from every at risk groups infected leaders. The tables below are excellent for widening studies,

**Table 3. Number tested, and testing positive for HBsAg 2012**

**Number tested Number positive (%)**

|  |  |  |  |
| --- | --- | --- | --- |
| Accident and emergency | 2,347 | 32 (1.4) | |
| Drug dependency services | 1,587 | 11 (0.7) | |
| General practitioner | 57,500 | 1,067  **(1.9)** | |
| GUM clinic | 46,864 | 716 (1.5) | |
| Occupational health | 11,651 | 53 (0.5) | |
| Prison services | 3,441 | 60 (1.7) | |
| Total primary care | 123,390 | 1,939 (1.6) | |
| Fertility services | 9,848 | 57 (0.6) |
| General medical / surgical departments | 8,701 | 105 (1.2) |
| Obstetrics and gynaecology | 4,721 | 37 (0.8) |
| Other ward type (known service)† | 27,011 | 390 (1.4) |
| Paediatric services | 3,365 | 35 (1.0) |
| Renal | 5,465 | 28 (0.5) |
| Specialist HIV services | 676 | 24 (3.6) |
| Specialist liver services | 5,063 | 127 (2.5) |
| Unspecified ward§ | 2,546 | 78 (3.1) |
| Total secondary care | 67,396 | 881 (1.3) |
| Unknown# | 1,403 | 14 (1.0) |
| **Total** | **192,189** | **2,834 (1.5)** |

From Child Wards in 22 locations, at 1% children are testing more infected with cHBV than drug dependents and parents in fertility this onward catastrophe is happening to endemic community children with 1 to 2000 cHBV infections a year being suggested to produce this figure.

General practice has shown up over all Sentinel reports as an ideal cost effective test venue option with 1.9% efficiency and34% of diagnosis.

GUM clinic screening seldom understands the infected person’s siblings are at 3 times the risk of a partner, that a shared razor is 100 times the risk of sex with HBV. GUM clinics often fail to test or vaccinate people also, many callers with infections have often been to GUM clinics, more than average numbers do not get referred. We had a call from a sex party arranger who had a hbv outbreak when at your Oval Show and none of his catalogue of GUM clinic users had been offered vaccination and none remembered being tested.

Again education the same tools really helps them many clinics use our Serological Wheel for results. They just need updated data and booklets, posters etc and some training and the manual. Some GUM and DAAT clinics are kind to HBV dads and use HBV test and vaccination budget on their children, plan B after GP refusal, plan c is chemists at £1200 for a family of 6 ethiopians, plan d is to prebook in destination at £12 a head in Africa. Plan d is a sad best option for 20 million expected onward to endemic risk regions.

Behind all testing for HBV and HCV a step change in attitude is needed, we have lungs so we get flu we have blood so we get HBV.

We found [8% of prisoners](http://www.ncbi.nlm.nih.gov/pubmed/10902255) had anti-HBs around 2000 and look at the tested prevalence and vaccinations. We roll out HBV vaccination training courses in prisons, in house vaccination capability saves them £100,000’s, and are regarded as cost effective life saving heroes by the NHS n Prison staff.

We found [8.7% of migrant under 5’s](http://www.ncbi.nlm.nih.gov/pubmed/12109390) positive for anti-HBs around 2000 (the expected rate) and we have not tested enough to know anything ever since. We had a minister for public health quoting in the House of Commons in 2014 that she had reports of only 3 HBV child infections. We hear of 40 school outbreaks and we are termed medically unqualified, racist, lying, frightening activists by many sometimes all the NHS staff involved, even while trying to vaccinate nursery staff with acute yellow special needs toddlers about.

It’s important to remember migrant children number 3 million and prisoners 150,000.

**Table 4. Number of individuals tested, and testing positive, for HBsAg 2010\***

**Region (number of centres) Number tested Number positive (%)**

East Midlands (1) 13,962 112 (0.8)

East of England (1) 9,077 86 (0.9)

**London (6) 67,056 1,729 (2.6)**

North East (2) 7,940 72 (0.9)

**North West (5) 26,932 424 (1.6)**

South Central (1) 5,622 53 (0.9)

South East Coast (2) 21,706 142 (0.7)

South West (1) 14,207 121 (0.9)

**West Midlands (1) 8,159 138 (1.7)**

Yorkshire & the Humber (2) 18,003 231 (1.3)

**Total, all regions (22) 192,664 3,108 (1.6)**

200,000 tests and a 1.6% national prevalence for HBV on wards is serious evidence over 10 years and suggests a 0.75% on the streets with many London Boroughs going endemic in front of our eyes and a cirrhosis boom should be seen as normal therein. This is very easy to do and much to be expected and planned for in a world where 1 in 20 have HBV and you have the largest migration in its history going on in your capital.

Approximately 2 million tests on wards over 10 years have shown a 1.5% cHBV level clearly suggesting a 0.75% hepatitis b boom and the entire Hep Squad mumbles 0.1% for HBV in 2009 when planning if screening migrants is justified!

This very humbly Anne Mackie and Peter is a care level I hope you and ourselves can improve.

I attach a little of what is happening with the CCG/GLA and the RCGP tools below

If you really want evidence we have

Going Endemic, The 1000 caller Audit, Hepatitis What every GP needs to know, 32 policy med ref presentations, 1 documentary on NHS infections, 275 GP survey monkey, NICE tech appraisals, A 500,000 tube survey, 12 Industry Risk Vacc booklets, 1 Tattoo and Piercing Tool kit

I attach below 5 Wall Posters and 9 patient factsheets and 4 NICE CCG HBV and HCV Test Guidances and a GLA GP Onkar and Dadabhoy and Mann Press Release for London.

**HBV in parts of London and the UK now endemic** 2nd January 2016 22.01 GMT

A new Hepatitis B Trust Report “Going Endemic” revealed that parts of the capital have sky rocketing rates of the very infectious HBV virus. There were more than 100,000 cases of HBV in London alone estimated from sentinel surveillance testing and demographic modelling – about 20% of the UK’s total. The study found a third of London boroughs approaching the World Health Organisation’s (WHO) “high incidence-endemic “ 2% threshold, huge areas of Hounslow, Brent, Harrow, Newham and Ealing already have rates of more than 2,000 per 100,000 people. Taken as a whole, **the UK had 750 cases per 100,000**. HBV is an incurable infectious virus found in blood, it was often passed on through transfusions and healthcare injections in the past especially overseas and in the present when forgetting plasters, sharing razors, tattooing or in contact sports. Most people who get HBV have had it from childhood with boys twice as infected as girls by 14, with most families having multiple infections, the report said. It calls for Londoners to be educated about the disease and for the Greater London authority to include HBV test access and child vaccinations for all migrants and workers with blood.

Dr Onkar Sahota, chair of the London assembly’s health committee, called the findings “astounding” and urged Mayor Johnson to act. He said: “If we don’t diagnose London’s HBV epidemic now, the 500% boom in liver disease will get even worse in the years to come. Each diagnosis costs £10 and can save a £100,000 liver transplant. “The mayor needs to take more accountability for HBV, with a liver transplantee in his family and GLA members catching it, he is uniquely placed to drive forward testing and vaccination. **This problem is 100 times the size of TB, already in the schools and workplaces and everyone needs to know.”** Workers with blood, migrants, people with substance abuse issues and children were found to be most at risk of the disease. A total of 500,000 cases were estimated nationwide, representing a tripling of infections since 1990. The Report suggested the London borough of Newham had the highest HBV rates in the country, with **3000 cases per 100,000 people**. Globally 350 million people have HBV and 1 million died from the disease in 2013, with an estimated 90 million total death toll occurring among those who are diagnosed late, according to WHO figures.

**TB rates in London 'worse than Iraq, Eritrea and Rwanda'** 27 October 2015 22.01 GMT

A Tuberculosis Report revealed that parts of the capital have higher rates of the disease than Rwanda, Eritrea and Iraq. There were more than 2,500 new cases of TB in London last year – about 40% of the UK’s total. The study found a third of London boroughs exceed the World Health Organisation’s (WHO) “high incidence” threshold with more than 40 cases per 100,000 people and areas of Hounslow, Brent, Harrow, Newham and Ealing have rates of more than 150 per 100,000 people. WHO figures from 2013 show Iraq had 45 per 100,000 while Rwanda had 69 and Eritrea 92. **The UK had 13 cases per 100,000** in 2015. Tuberculosis is an infectious disease caused by bacteria, which is passed on through coughing and sneezing. Most people who get TB have had prolonged exposure to an infected person, the report said. It calls for Londoners to be educated about the disease and for the Greater London authority to include TB services when dealing with rough sleepers. Dr Onkar Sahota, chair of the London assembly’s health committee, called the findings “astounding” and urged Johnson to act. He said: “If we don’t get a grip on London’s TB situation now, the harder and more expensive it will be to tackle in the years to come. With pressures on health budgets, we can’t afford to take our eye off the ball. “The mayor needs to take more accountability for TB control in London. He is uniquely placed to drive forward measures for TB prevention, as well as better access to treatment.” Prisoners, refugees, migrants, people with substance abuse issues and homeless people were found to be most at risk of the disease. A total of 6,520 cases were recorded, down from 7,257 in 2013. The figures showed the London borough of Newham had the highest TB rates in the country, with **107 cases per 100,00**0 people. Globally 9 million people fell ill with TB and 1.5 million died from the disease in 2013, according to WHO figures.

**Commissioning locally appropriate integrated services for hepatitis B and C testing and treatment**

Local authorities, in particular directors of public health and clinical commissioning groups, should ensure the inclusion of hepatitis B and C in the health and wellbeing board's [joint strategic needs assessment](http://pathways.nice.org.uk/pathways/hepatitis-b-and-c-testing#glossary-joint-strategic-needs-assessment). This should provide information on local prevalence of chronic hepatitis B and C and groups at increased risk, including by country of origin or risk behaviour.

Commissioners should encourage the development of [locally enhanced services](http://pathways.nice.org.uk/pathways/hepatitis-b-and-c-testing#glossary-locally-enhanced-services) for hepatitis B and C in areas where there is a higher than average number of people at increased risk (especially areas with a large migrant population).

Commissioners should regularly undertake a health needs assessment, health equity audit and an audit of hepatitis B and C services as part of the agreed local care pathway and commission testing and treatment services accordingly.

Commissioners should audit the uptake of testing and outcomes, including:

* the number of people tested for hepatitis B and C
* the number of people diagnosed with hepatitis B and C
* the number of people with chronic infection who:
* are referred to a liver unit
* are receiving treatment in accordance with treatment guidelines
* the number of people with hepatitis C who obtain a sustained virological response

Commissioners should develop and commission a fully integrated care pathway, working with services that provide hepatitis B and C testing and treatment in primary and secondary care (in the community or specialist services in hospital). This should:

* take into account the needs of people who test positive for hepatitis B or C infection and are assessed for treatment, including their broader health and psychosocial needs
* consider all venues where testing and treatment services are, or could be offered that can also ensure [continuity of care](http://pathways.nice.org.uk/pathways/hepatitis-b-and-c-testing#glossary-continuity-of-care) and onward referral to specialist treatment for people who test positive (such as pharmacy testing and outreach testing and treatment)
* ensure primary and secondary care staff are educated and trained in hepatitis B and C testing and treatment (see [education for healthcare professionals and others providing services for people at increased risk of hepatitis B or C infection](http://pathways.nice.org.uk/pathways/hepatitis-b-and-c-testing/increasing-the-uptake-of-hepatitis-b-and-c-testing#content=view-node%3Anodes-education-for-healthcare-professionals-and-others-providing-services-for-people-at-increased-risk-of-hepatitis-b-or-c-infection) in this pathway).

Commissioners of hepatitis testing and treatment services should agree local care pathways for people with hepatitis B and C who use drugs or GUM services.

Sources

[Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection](http://guidance.nice.org.uk/PH43). NICE public health guidance 43 (2012)

**Awareness-raising for people at risk of hepatitis B or C**

**Who should take action?**

1. Commissioners and providers of national public health services, for example Public Health England and the NHS Commissioning Board.
2. Local authorities, in particular directors of public health.
3. Local organisations providing for children and adults at risk of hepatitis B or C infection.
4. Local and national organisations that promote testing or provide treatment.

**What action should they take?**

Public Health England, the NHS Commissioning Board and directors of public health should ensure is a national programme of awareness-raising about hepatitis B and C among groups at increased risk.

Local organisations should run awareness-raising sessions to promote hepatitis B and C testing in venues among groups at increased risk. Examples of possible venues include -

1. GP surgeries,
2. Sexual health services,
3. Immigration centres and Institutions.
4. Directors of public health should promote local testing and hepatitis B vaccination services.
5. Organisations should provide awareness-raising material tailored to the needs of groups
6. Local and national organisations should consider offering testing for hepatitis B and C at awareness-raising sessions. If this is not possible, information on where and how to access testing locally should be provided.

**Awareness-raising among the general population**

**Who should take action?**

* GP and secondary care
* Local Commissioners and providers of public health services
* Local authorities and health and wellbeing boards
* the commercial sector, national and local voluntary sector, not-for-profit and non-governmental organisations.

**What action should they take?**

* Conduct awareness-raising campaigns, using campaign material and resources on hepatitis B and C. These should include up-to-date information on:
* the main routes of infection and transmission
* hepatitis B vaccination
* the benefits of early testing and treatment, including the role of earlier treatment in preventing serious illness such as chronic liver disease and liver cancer
* the potential for chronic infection to be asymptomatic, particularly in the early stages.

Ensure national and local awareness-raising campaigns address common misconceptions about the risk of hepatitis B and C that can act as a barrier to testing. Campaigns should also make it clear that testing and treatment is confidential and address the stigma surrounding these infections.

**Developing the hepatitis skills of healthcare professionals**

**Who should take action?**

* Clinical commissioning groups.
* Royal medical and nursing colleges.
* Local authorities, in particular directors of public health.
* Health Education England. Public Health England.
* Local education and training boards.

**What action should they take?**

Ensure education programmes for professionals providing care for people at increased risk of hepatitis B or C infection that address the following core topics and are designed to meet the needs of the target groups:

* Use the recommendations in national guidance to improve identification and testing of people at increased risk of hepatitis B and C infection
* Local education and training boards should ensure that people involved in testing for hepatitis B and C take part in a programme of continuing professional development.
* overcoming social and cultural barriers and improving access to testing and treatment for people at increased risk of hepatitis B and C infection
* reducing morbidity and mortality through early detection and diagnosis
* improving clinical management and quality of life for people diagnosed with hepatitis B and C infection and reducing liver disease.
* Ensure training programme content is accurate and up-to-date.

Directors of public health should ensure all healthcare and public health managers, in collaboration with the local education and training board, use staff annual appraisals and personal development plans to reinforce training and education on hepatitis B and C.

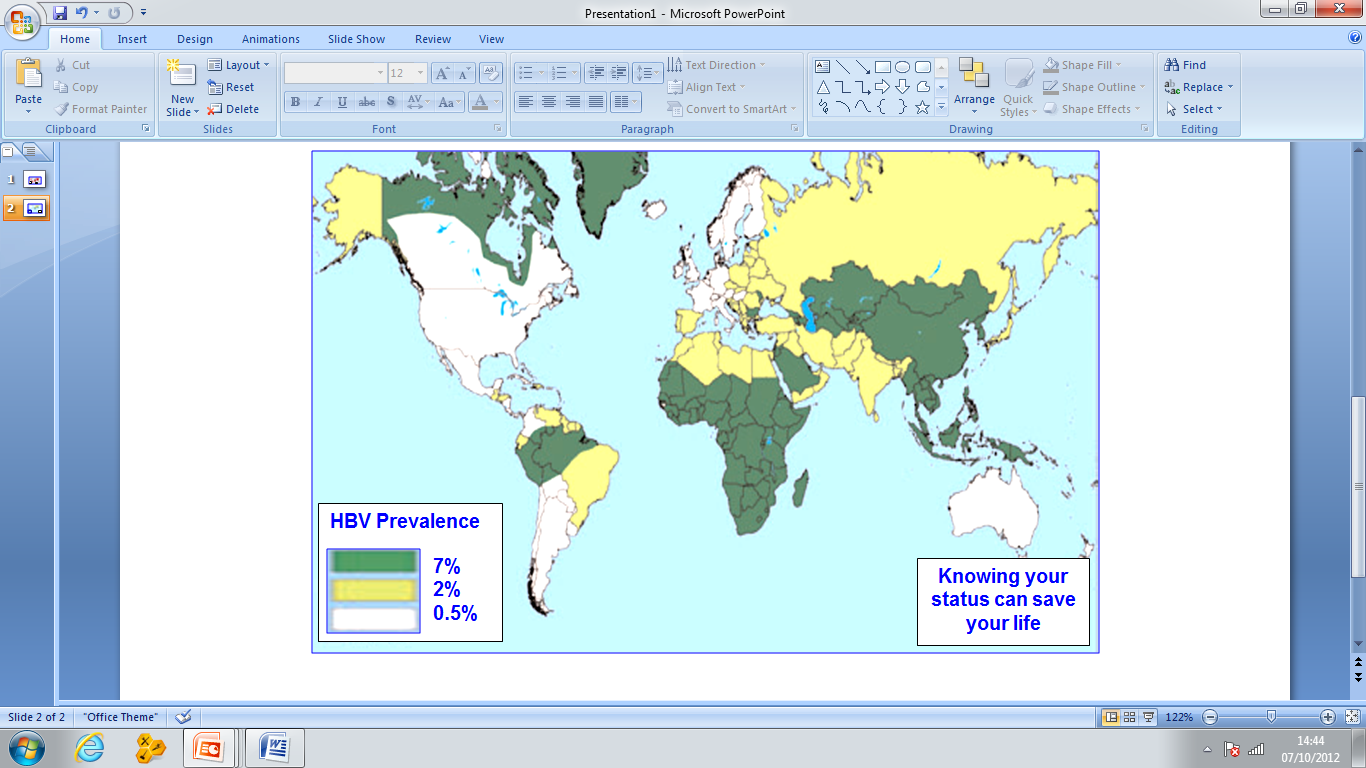
**Training is recommended for :**

* GP’s
* clinical and non-clinical staff in primary and secondary care
* nurses, health visitors, midwives, healthcare assistants support workers
* staff in sexual health, HIV clinics,
* people working in drugs services,
* staff in community-based criminal justice services,
* social workers working with people at increased risk of hepatitis B or C infection,
* statutory and non-statutory staff working with looked-after children,
* prison, youth offender and immigration removal centre staff,
* staff in voluntary and community organisations that care for migrant populations,
* people who inject drugs,
* people with HIV, men who have sex with men,
* people working for the homeless and providing outreach services to homeless people.

Sources [Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection](http://guidance.nice.org.uk/PH43). NICE public health guidance 43 (2012)

**1 in 4 humans innocently catch Hepatitis B (HBV)**

**Testing your risk is nothing to be ashamed of**

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**7%**

**2-7%**

**0.5%**

**2%**

**Knowing your status**

**Can save your life**

**HBV Prevalence**

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Hepatitis B is a virus that over 30 years can “silently” cause cirrhosis and cancer; a million people die each year worldwide due to late diagnosis. Millions of UK citizens are at risk. Hepatitis B infects without symptoms and most catch it as children from:

* Maternity during birth in any of the coloured areas above
* Re-used medical syringes in the coloured areas above
* Spilt blood to an unplastered wound when unvaccinated
* A period of jaundice (going yellow)
* HBV can also be transmitted by unprotected sex and
* The Injecting of illegal drugs (even once)

If you have run any of the above risks or are planning a trip to an endemic area (yellow/brown on map) ask your GP about aHepatitis B Safety Test and Vaccination. Remember Hepatitis B patients often have no symptoms until real damage has been done so knowing your status can help you safeguard your future.

**Remember to ask your GP**

[www.hepbpositive.org.uk](http://www.hepbpositive.org.uk) / Helpline 0800 206 1899 / Map - WHO / Text – Hepatitis, what every GP & family needs to know by Paul Desmond



**Is your job killing you?**

**Nurses Doctors Carers**

**First Aiders Morticians Tattooists**

**Soldiers Sports people Cleaners**

**Police/Security Hairdressers Sewage Workers**

**Dental Assistants Beauticians Custodial Staff**

**Lab Technicians Emergency Workers Sex Workers**

**Viral Hepatitis B & C**

Are very real risks every year for thousands of people, including many from the professions above who come into contact with blood during their work. Hepatitis B & C can silently infect from blood and can also silently cause serious liver damage if left unchecked. It is estimated that every day one UK worker with blood dies from Hepatitis B. If you work or have worked with blood get tested and vaccinated for Viral Hepatitis.

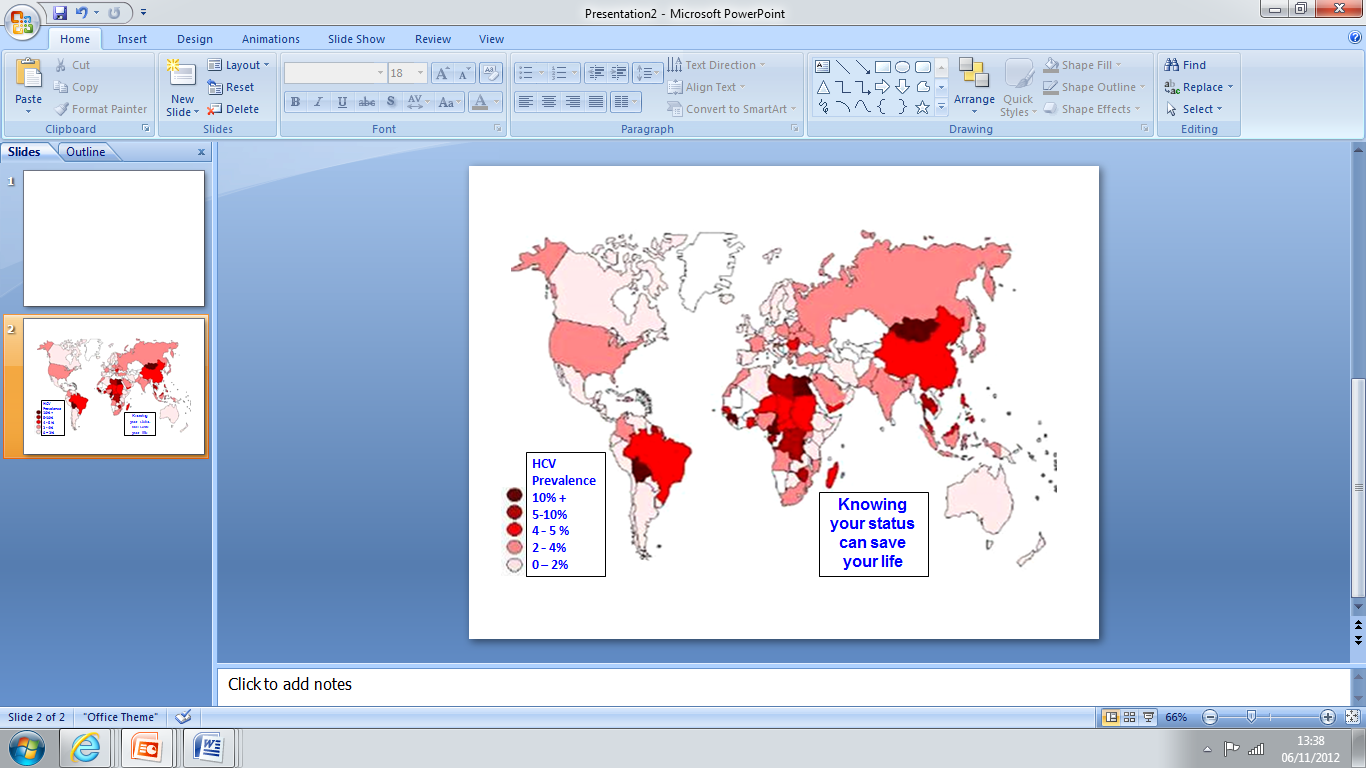
* Remember each needle stick or blood spill to an open wound from an infected source, has a 1 in 3 high infection risk
* One in a hundred of the people in the above professions are Hep B or
* Hep C infected and don’t know
* A Hepatitis B vaccination is your employer’s responsibility if your occupation risks you coming into contact with blood
* Early vaccination and diagnosis is the best way to avoid harm

**Remember to ask your GP**

[www.hepbpositive.org.uk](http://www.hepbpositive.org.uk) / Helpline 0800 206 1899 / Text – Hepatitis, what every GP & family needs to know by Paul Desmond

**Globally 1 in 40 people now have Hepatitis C**

**Mainly from contaminated healthcare**



**HCV Prevalence**

**10%**

**5-10%**

**4-5%**

**2-4%**

**0-2%**

**Knowing your status can save your life**

The Hepatitis C virus can silently cause liver cancer if undiagnosed. You may be at risk of Hepatitis C if you have had:

* Major surgery overseas in one of the red/dark pink areas on the map
* Shared or reused syringe injections in Africa, Asia and Eastern Europe
* NHS major surgery, dialysis or C-Section before 1992

**If your homeland is 2% or more infected Safety Testing is highly recommended.**

Ask your GP about a Hepatitis C Safety Test if you have run any of the above medical risks or have ever injected street drugs. Most Hepatitis C patients show no symptoms until real damage has occurred, so knowing your Hepatitis C status can help safeguard your future.

**Remember to ask your GP**

[www.hepbpositive.org.uk](http://www.hepbpositive.org.uk) / Helpline 0800 206 1899 / Map - WHO / Text – Hepatitis, what every GP & family needs to know by Paul Desmond