Australian
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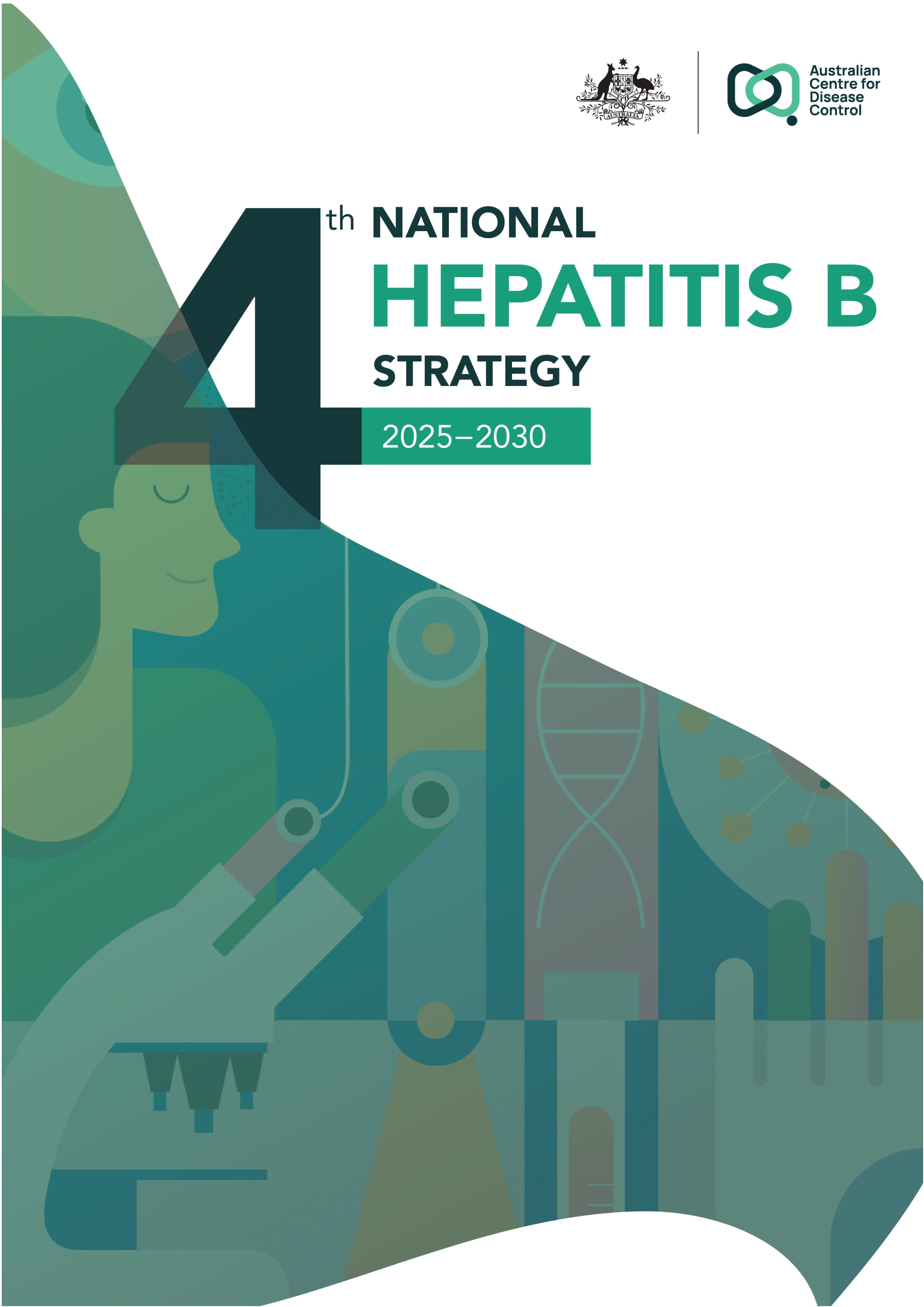
Control

4th NATIONAL HEPATITIS B STRATEGY

2025–2030



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Title: Fourth National Hepatitis B Strategy 2025–2030

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Minister's foreword

The Hon Mark Butler MP

Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme

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Australia is committed to eliminating bloodborne viruses (BBV) and sexually transmissible infections (STI) as a public health challenge by 2030.

For hepatitis B, this means focusing on reduced transmission, morbidity and mortality, and expanding access to culturally safe, appropriate and inclusive care that meets the needs of people affected by hepatitis B.

Hepatitis B is vaccine preventable and treatable through anti-viral medication. We must work together to ensure that people are informed about their condition and get the care that they need, when they need it.

Key achievements of Australia's hepatitis B response include:

- high rates of childhood hepatitis B vaccination by 24 months of age
- improved rates of hepatitis B diagnosis
- increased rates of hepatitis B vaccination and improved outcomes for Aboriginal and Torres Strait Islander peoples.

This strategy was developed in partnership with governments, national peak bodies and community organisations, national research centres of excellence, and the public. Throughout our consultations, we consistently heard that the communities affected have experienced profound disparities in health outcomes, along with the persistent challenges of stigma and discrimination that often shape their daily lives.

This strategy identifies priority populations, key settings, and areas for action to guide our efforts toward achieving elimination. It is ambitious but achievable if we all work together in strong partnership.

Under this strategy, we aim to:

- reduce mortality and morbidity related to hepatitis B
- eliminate the negative impact of stigma, discrimination, and legal and human rights impacts on people’s health
- minimise the personal and social impacts of hepatitis B.

We want to ensure everyone affected by hepatitis B can have healthy lives, free of stigma and discrimination.

Our vision is to achieve virtual elimination of hepatitis B as a public health threat by 2030. Beyond 2030, we will continue to pursue better health outcomes and maintain our reputation as a world leader in the public health response to hepatitis B.

Acknowledgement of Country

The Australian Government acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea, and community. We pay our respects to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander people.

Acknowledgements

The Australian Government acknowledges the many organisations and representatives that participated in consultations during the formative stages of the strategy's development, those who participated in workshops to inform indicators, targets, and priorities, and those who participated in stakeholder consultations and contributed to the strategy's development process.

Acknowledgement of lived experience

The Australian Government acknowledges the individual and collective expertise of people affected by hepatitis B and affected communities. We recognise their vital contribution at all levels of the local and national response.

Contents

Abbreviations

Term	Definition
ACCHO	Aboriginal Community Controlled Health Organisation
AHPC	Australian Health Protection Committee
AIVL	Australian Injecting and Illicit Drug Users League
AMS	Aboriginal Medical Service
BBV	Bloodborne viruses
BBVSS	Blood Borne Viruses and Sexually Transmissible Infections Standing Committee
COVID-19	Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)[1]
GP	General practitioner
HCEF	Health Chief Executives Forum
HIV	Human immunodeficiency virus
INPUD	International Network of People who Use Drugs
MMM	Modified Monash Model
NACCHO	National Aboriginal Community Controlled Health Organisation
NAPWHA	National Association of People with HIV Australia
PBS	Pharmaceutical Benefits Schedule
PHN	Primary Health Network
PrEP	Pre-exposure prophylaxis
STI	Sexually transmissible infections/sexually transmitted infections
WHO	World Health Organization

Executive summary

Australia’s Fourth National Hepatitis B Strategy 2025–2030 provides a high-level roadmap to improve outcomes for people living with hepatitis B in Australia.

This strategy’s vision is to **eliminate hepatitis B as a public health threat by 2030**, while supporting equitable access to safe, affordable, and effective vaccines, as well as prevention, education, testing, management, treatment, and care for all.

This strategy is oriented around 4 goals and 6 priority areas for action in pursuit of this vision. The strategy has been developed in collaboration with affected communities, community peak bodies, state and territory governments, the Australian Government, researchers, and clinicians to ensure it guides the national response to achieve elimination by 2030. Ongoing partnerships between the Australian Government and state and territory governments have also played a crucial role in the development and delivery of initiatives to eliminate hepatitis B in Australia.

Hepatitis B in Australia

- Hepatitis B is a bloodborne viral infection that can be spread by blood-to-blood contact, sexual fluids, from pregnant woman to child during birth or at an early age (particularly in other countries).
- Hepatitis B is vaccine preventable.
- Hepatitis primarily affects the liver, causing liver inflammation which can lead to liver damage, cirrhosis and cancer.
- While there is no cure for hepatitis B, regular monitoring and treatment, when needed, can significantly reduce the risk of liver cirrhosis and liver cancer.

In 2023, an estimated **219,800** people were living with chronic hepatitis B in Australia, representing **0.8%** of the population,[19] disproportionately affecting priority populations including Aboriginal and Torres Strait Islander people and people from culturally, ethnically and linguistically diverse communities.

- There were an estimated **460** hepatitis B-related deaths, compared to **433** in 2016.[19]
- Without access to antiviral treatment over the last 2 decades, it is estimated nearly **800** people would die every year due to chronic hepatitis B.[19]
- An estimated **24%** of people living with hepatitis B were receiving regular care for this condition, and **13%** were receiving antiviral treatment.[19]

Goals of the Sixth National Hepatitis C Strategy 2025–2030

Virtually eliminate hepatitis B transmission by 2030

Reduce mortality and morbidity related to hepatitis B

Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health

Minimise the personal and social impacts of hepatitis B

Priority populations affected by hepatitis B

Priority populations affected by hepatitis B

Sex workers

People from culturally and linguistically diverse communities

People living with hepatitis B

People at risk of hepatitis B transmission

Pregnant women living with hepatitis B

Aboriginal and Torres Strait Islander peoples living with or who are not vaccinated against hepatitis B

Priority areas for action

Equitable access to, and coordination of, care and support

Key actions include exploring opportunities to improve access to care and support; and expanding the provision of culturally and linguistically appropriate hepatitis B services to priority populations.

Addressing stigma and creating an enabling environment

Actions to reduce stigma include co-designing national policy with people living with hepatitis B; increasing anti-stigma (and other) training for healthcare providers; and exploring opportunities aimed at addressing systemic contributors to poor hepatitis B outcomes.

Workforce

Key actions focused on strengthening the hepatitis B workforce include increasing learning opportunities for clinical and community workforce; considering a national hepatitis B multidisciplinary workforce plan; and meaningfully involving priority populations in the development of workforce activities.

Data, surveillance, research, and evaluation

Actions include improving the timeliness and consistency of hepatitis B data collection; supporting hepatitis B curative research; and enabling more community leadership in research planning, design, and implementation.

Testing, treatment, and management

Key actions include supporting strong diagnostic approaches; and committing to exploring options for universal hepatitis B testing. Informed consent will continue to be central to all testing, treatment, and management programs.

Education and prevention

Key actions include strengthening educational materials as well as increasing awareness of, and access to, free hepatitis B vaccinations. Harm reduction strategies, such as Needle and Syringe Programs and liver health monitoring, will continue to complement vaccination in preventing progression of hepatitis B to liver disease and liver cancer.

Vision statement

By 2030, hepatitis B will be eliminated as a public health threat in Australia.[1] Everyone will have equitable access to safe, affordable, and effective vaccination, prevention, education, testing, management, treatment, and care including appropriate person-centred care and support. People affected by hepatitis B will be active decision-makers in their care, live free from stigma, discrimination, and racism, and lead healthy and productive lives.

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[1] *The World Health Organization defines elimination of hepatitis B as a public health threat as 'reduction of disease incidence, prevalence, morbidity or mortality to a level below which the public health burden is considered negligible'. The target level for hepatitis B as defined by the World Health Organization is a 95% reduction in incidence and 65% reduction in mortality compared to the 2015 baseline.*

1. Introduction

Hepatitis B is a preventable but potentially life-threatening bloodborne viral infection that primarily affects the liver. The virus can be transmitted by blood-to-blood contact, sexual fluids, or from pregnant woman to infant during birth. [2]

The Fourth National Hepatitis B Strategy 2025–2030 (this strategy) guides Australia's strategic response to achieve elimination of hepatitis B as a public health threat by 2030. People affected by hepatitis B are at the centre of the strategy. This includes a focus on better understanding the culturally, linguistically, socially, and geographically diverse priority populations affected by hepatitis B. Taking a person-centred approach to hepatitis B supports a shift from a disease and transmission centric focus to one that also considers familial and social contexts, needs, and quality of life for people affected by hepatitis B. By supporting more meaningful partnerships with affected communities, the national response to hepatitis B will enhance equity and ensure no one is left behind. Much of the work to achieve elimination is already underway across Australia, however, a number of actions will require further consideration including further funding.

Building on the achievements and lessons learned since Australia's *First National Hepatitis B Strategy 2010–2013*, this strategy considers the changing context and epidemiology of the hepatitis B epidemic. Although progress was made under the *Third National Hepatitis B Strategy 2018–2022*, particularly in relation to vaccination targets, renewed efforts and an ongoing coordinated response is required to achieve targets, reduce transmission, and improve testing, management, harm reduction, treatment, and linkages to care.

Some of the key drivers of the hepatitis B epidemic in Australia are stigma, racism, discrimination, legal issues, and other social and structural determinants of health that exacerbate health inequities. This strategy places greater emphasis on the systems-oriented actions needed to overcome these barriers. In part, this includes and is contingent on elevating hepatitis B as a priority within intersecting health and social policy contexts.

Opportunities to scale-up and enhance existing approaches to hepatitis B prevention, harm reduction, testing, diagnosis, treatment, management, care, and ongoing support are also prioritised. Greater attention needs to be placed on liver health (including liver cancer and cirrhosis) attributable to hepatitis B, noting that actions to address hepatitis B can reverse the upward trend of liver cancer and liver cancer deaths in Australia. This will rely on ensuring sufficient capacity of the existing hepatitis B clinical workforce and developing a hepatitis B-specific community and peer workforce.

While there is currently no cure for hepatitis B, recent scientific progress has increased the feasibility of curative treatments within the life of this strategy.[2] Importantly, there are highly effective treatments that can stop the advancement of liver disease and reduce the risk of liver cancer that must be scaled up. Innovations in testing and treatment including further decentralisation to primary care, community and peer settings are also required. This strategy enables the adoption of such innovations by ensuring the requisite systems, workforce, community leadership, and policy infrastructure are strong.

The duration of this strategy is aligned with the *World Health Organization's (WHO) global health sector strategies on, respectively, human immunodeficiency virus (HIV), viral hepatitis and sexually transmitted infections 2022–2030.*[3] This duration enables for a longer-term vision, policy and program implementation, as well as reinforcing Australia's commitment to meeting our international obligations and targets. Ongoing surveillance, monitoring, periodic

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[2] *The term 'pregnant woman' is used throughout this strategy, however we acknowledge that not all people who can become pregnant identify as women.*

reviews, and evaluation will ensure the focus and actions of the strategy remain relevant and effective.

Partnership remains at the heart of Australia’s response to hepatitis B. This strategy is informed by consultation with key stakeholders including affected communities, national peak bodies, peer and community organisations, governments, clinicians, the multidisciplinary workforce, and researchers in the national response to hepatitis B.

The following peak organisation members of the Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS) have played, and continue to play, a critical role in the success of Australia’s response to viral hepatitis: Hepatitis Australia; the Australian Injecting and Illicit Drug Users League (AIVL); the Scarlet Alliance, Australian Sex Workers Association; the National Aboriginal Community Controlled Health Organisation (NACCHO); ASHM Health, and supported by Health Equity Matters and the National Association of People with HIV Australia (NAPWHA).

2. Guiding principles

This strategy includes guiding principles to support a high-quality, evidence-informed, and equitable response to hepatitis B. The guiding principles are informed by efforts over time to respond to the successes, challenges, opportunities, and impacts of Australia's national response to hepatitis B and other bloodborne viruses (BBV) and sexually transmissible infections (STI).

Person-centred response

People affected by hepatitis B must be central to Australia's response. This approach positions affected individuals, their families, and communities at the centre of policies, research, and programs across all domains (e.g. prevention, harm reduction, testing, management, treatment, care, and support). This also means that the needs of people affected by hepatitis B are acknowledged from a whole of person, whole of life perspective. They must be responded to within a system that enables choice, flexibility, responsiveness, appropriate resourcing, and culturally and linguistically appropriate supports and services. People affected by hepatitis B must be supported to be active participants in their own healthcare.

Partnership

Partnership is at the heart of Australia's response to hepatitis B. It is a long-standing tenet, recognised by successive national hepatitis B and other BBV strategies. Partnership is a cooperative effort between affected communities, national peak bodies, peer and community organisations, governments, the clinical and multidisciplinary workforce, and researchers.

Partnership is characterised by consultation, meaningful contribution, empowerment, respectful dialogue, and appropriate and equitable resourcing to achieve the goals, targets, and actions of this strategy. Partnership includes leadership from the community, collaboration and alignment from the Australian Government and state and territory governments, and the full cooperative efforts of all members of the partnership to implement agreed actions.

Affected communities and civil society also make pivotal contributions to advocacy, service delivery, policymaking, surveillance and monitoring, research, evaluation, and initiatives to address social and structural barriers. This enables the decentralisation of Australia's response including decision-making, service delivery, and initiatives which relate to this strategy increasingly shifting into community settings and featuring community leadership.

Human rights

Australia recognises that valuing and upholding human rights for all is essential to preventing the transmission of hepatitis B and mitigating the health, social, and other impacts of disease. People living with hepatitis B have the right to enjoy the highest attainable standard of living free from stigma due to comorbidities, drug use, or profession; and without discrimination based on race, national or ethnic origin, age, sex, sexual orientation, gender identity, intersex status, disability or immigration status.

Australia's response to hepatitis B must work to tackle racism. The national response must also help dismantle the ongoing effects of colonisation. This work must be done in the context of the principles that underpin the rights of Aboriginal and Torres Strait Islander people, as enshrined in the *United Nations Declaration on the Rights of Indigenous Peoples*.[4] In addition, the rights of migrants and refugees must also be upheld.

Further, the national response must have particular regard for the rights of people in custodial settings to access the same standard of healthcare, as enshrined in the *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*[5] and in the *Basic Principles for the Treatment of Prisoners (resolution 45/111).*[6]

Health equity

Health equity is the absence of remediable disparities in health status and outcomes that result from either or both unfair social conditions and the distribution of health resources. This principle recognises that social determinants can affect health outcomes. Therefore, it requires the active implementation of policies and interventions that remove discriminatory social, structural, and institutional conditions which result in the inequitable distribution of power and the exclusion of people on the basis of race, national or ethnic origin, age, sex, sexual orientation, gender identity, intersex status, disability, immigration status, comorbidities, drug use, or profession.

The goals of the strategy can only be achieved by addressing the inequities that drive the hepatitis B epidemic and by ensuring it does not entrench further inequality. Additional efforts are needed to improve equity for people from culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander people who face multiple layers of stigma and discrimination, and for whom there are already inequitable health outcomes and access to services.

Importantly, this strategy promotes equity by measuring progress against the targets for all priority populations and geographic areas. This is essential to ensuring that no one is left behind.

Health promotion

The *Ottawa Charter for Health Promotion* and the *Shanghai Declaration on Promoting Health* in the 2030 *Agenda for Sustainable Development* provide the framework for effective action in health promotion under this strategy.[7,8] These instruments facilitate the active participation of affected communities and priority populations to increase their influence over the determinants of their health. They also support the formulation and application of laws and public policies to enable and encourage healthy behaviours and respect for human rights.

Health promotion programs for affected communities and priority populations are more effective when delivered by those communities in partnership with governments, health workers, community organisations, researchers, and other relevant organisations.

Prevention

The cornerstone of hepatitis B primary prevention in Australia is vaccination. In turn, this needs to be supported with the appropriate combination of evidence-informed social, biomedical, and behavioural approaches within a supportive enabling environment to reduce exposure to hepatitis B. Primary prevention strategies should be enhanced to help embed prevention across the life course of the strategy and create long-term, sustainable improvements in health and wellbeing, and support the implementation of Australia's *Long Term National Health Plan* and *National Preventive Health Strategy 2021–2030*.[9,10] This includes measures to promote the prevention of mother-to-infant transmission, people living with or at risk of hepatitis B, and catch-up vaccination programs for adults.

Access and quality health services

Hepatitis B care in Australia should be accessible, high quality, affordable to all, and based on need. Consideration and effort must be applied to address the social and structural determinants of health and reduce the inequalities that lead to a lack of accessible and equitable healthcare, particularly for priority populations.

High-quality, accessible health services rely on a multidisciplinary hepatitis B workforce including peers and people with lived experience to deliver person-centred, non-stigmatising, whole of life, effective, safe, and appropriate care. Coordination and integration of hepatitis B services across priority settings is essential.

Harm reduction	Harm reduction approaches underpin vaccination and other effective measures to prevent transmission of hepatitis B. Grounded in justice and human rights, harm reduction aims to minimise adverse health, social, and legal impacts through policies, programs, and practices that involve priority populations. It focuses on working with people without judgement, coercion, discrimination, or requiring a change in behaviour as a precondition of support. Examples of effective evidence-based harm reduction include Needle and Syringe Programs, safe drug consumption sites, drug testing services, safer sex practices, peer support, and law reform across different jurisdictions (e.g. exploring opportunities to decriminalise sex work in relevant jurisdictions).
Meaningful involvement of priority populations	Meaningful involvement of priority populations in all aspects of the hepatitis B response is essential to the development, implementation, monitoring, and evaluation of effective policy, programs, and research. The diverse and specific needs of priority populations are acknowledged and responded to effectively with regard to the various settings and needs of their communities. This approach underpins the other guiding principles and contributes to reducing stigma and discrimination and increasing the effectiveness and appropriateness of Australia's response.
Commitment to evidence-informed policy and programs	The national response to hepatitis B is built on and values different forms of evidence and knowledge, research, surveillance, monitoring and evaluation, and strong community-driven interventions. Meaningful involvement of community and peers, alongside the health workforce and decision-makers, in all stages of research priority-setting and co-design, from development to application, allows for greater integration between research and the use of evidence. A strong and constantly refined evidence base supported by the *First National Blood Borne Viruses and Sexually Transmissible Infections Research Strategy 2021–2025* is essential to meet new challenges, evaluate current and new interventions, develop effective policy, implement innovations, and meet the goals of this strategy.[11]

3. Snapshot of Hepatitis B in Australia

What is hepatitis B?

Hepatitis B is a bloodborne viral infection that can be transmitted by blood-to-blood contact, sexual fluids, from mother-to- infant during birth or at an early age, through sharing injecting equipment, and unprotected sex. Hepatitis B is vaccine preventable. It primarily affects the liver, causing liver inflammation which can lead to liver damage, cirrhosis, and cancer. Regular monitoring, and treatment when indicated, reduces the risk of liver cirrhosis and liver cancer.

Prevalence

At the end of 2023, an estimated 219,800 people were living with chronic hepatitis B in Australia, equating to approximately 0.82% of the Australian population. Hepatitis B disproportionally affects the priority populations identified in this strategy. For example, in 2023, over two-thirds of the people affected by chronic hepatitis B in Australia were born overseas.[12] Aboriginal and Torres Strait Islander people are also disproportionately affected by hepatitis B, representing 6.7% of people living with hepatitis B in Australia.[12]

Compared with a national prevalence of 0.82%, hepatitis B prevalence in 2023 was highest in very remote (1.63%; double the national average), and remote regions (1.07%).[12] The prevalence was lowest in the inner regional parts of Australia (0.39%).[12]

How is hepatitis B managed?

Chronic hepatitis B is a disease that requires lifelong management to assess for disease progression and inform treatment decisions.[13] Six-monthly clinical assessments are recommended. These include blood tests to detect changes in liver function and for liver cancer surveillance; and liver ultrasounds.[14] Antiviral treatment is indicated to suppress chronic hepatitis B and prevent complications. Although treatment is effective for controlling hepatitis B and preventing complications, treatment is long-term.

What health issues can hepatitis B cause?

Chronic hepatitis B is one of the primary risk factors in the development of liver cirrhosis and liver cancer (the sixth most common, and fastest increasing cause of cancer mortality in Australia).[15] If left untreated, hepatitis B can lead to liver cirrhosis and cancer in a substantial proportion of people, despite being generally asymptomatic.[16]

In 2023, there were an estimated 460 hepatitis B-related deaths compared to 433 deaths in 2016.[17] Without access to antiviral treatment over the last 2 decades, it is estimated nearly 800 people would die every year due to chronic hepatitis B.

The risk of developing a chronic infection is very high for children who contracted hepatitis B perinatally or during infancy (90%) whereas a minority of people who contracted the virus during adulthood (less than 5%) develop chronic hepatitis B.[18]

New diagnoses

There were an estimated 5,390 notifications of hepatitis B cases in 2023.[19] These notifications represent a material reduction from 5,782 in 2019, the comparable pre-pandemic year.[19] The impacts of the COVID-19 pandemic included a reduction in testing rates, border restrictions, and effects on migration.[19,20] As a result, the number of people living with hepatitis B in Australia fell in 2020–2021; however, the resumption of migration from 2022 has seen this number increase again.[15]

In 2023, the proportion of people living with chronic hepatitis B who have been diagnosed was estimated to be 69%.[19] Sustained declines in notification rates have been recorded for the past decade among younger people (less than 25 years) due to infant and catch-up vaccination programs. Notification rates remain higher in older age groups.

Among Aboriginal and Torres Strait Islander people there has been an 18% decrease in the rate of hepatitis B notifications between 2019 and 2023, higher than the 4% decrease amongst the non-Aboriginal and Torres Strait Islander population. Despite this, the notification rate among Aboriginal and Torres Strait Islander people in 2023 (20.5 per 100,000 population) was still higher than the non-indigenous population (17.2 per 100,000 population).[19]

Routes of transmission

Most people with chronic hepatitis B in Australia contracted the virus at birth or at an early age in other countries. In Australia, historically, vertical transmission (mother-to-infant) and horizontal transmission (between individuals outside pregnancy or childbirth) contributed to the elevated prevalence of hepatitis B among Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds (from intermediate and high prevalence regions).[19] Vertical transmission is now far less common in Australia, as is horizontal transmission. Other routes of transmission include the use of unsterile injecting equipment and sexual contact without using preventive measures, for example, condoms and lubrication.

Prevention

Hepatitis B is a vaccine preventable disease, and Australia has implemented a universal infant vaccination program since 2000, including a dose at birth.[19] Catch-up vaccination programs are also in place for people who may be at risk of hepatitis B and for priority populations with elevated prevalence. These programs need to be expanded to ensure greater access and free coverage for all priority populations.

In 2023, 89.9% (at 12 months) and 95.5% (at 24 months) of Aboriginal and Torres Strait Islander children were vaccinated against hepatitis B, compared with 93.5% and 95.6% of non-Indigenous children at the same ages.[19]

Treatment and care

At the end of 2023, an estimated 24.5% of people living with chronic hepatitis B were receiving regular clinical care, and 12.6% were receiving antiviral treatment.[12] By comparison, clinical guidelines recommend that all people living with hepatitis B should be engaged in care and the estimated proportion eligible for treatment is 30%.[17]

The proportion of people receiving treatment for hepatitis B has increased over time, from 9.3% of those living with chronic hepatitis B in 2016 to 12.6% in 2023.[12]

Of those receiving treatment for hepatitis B, the proportion prescribed treatment by a general practitioner (GP) (exclusively or in shared care with a specialist) has increased gradually, from 18.7% in 2020 to 21.9% in 2023.[12]

4. About this strategy

This strategy builds on previous strategies and sets the direction for Australia's continuing response to hepatitis B from 2025 to 2030.

It is one of 5 national strategies that, together, outline a framework for a high-quality and coordinated national response to BBV and STI in Australia. These 5 strategies are:

1. Fourth National Hepatitis B Strategy 2025–2030 (this strategy)
2. *Sixth National Hepatitis C Strategy 2025–2030*
3. *Sixth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2025–2030*[3]
4. *Ninth National HIV Strategy 2024–2030*
5. *Fifth National Sexually Transmissible Infections Strategy 2025–2030.*[4]

Each strategy has a specific focus but shares some structural elements including guiding principles, goals, targets, priority areas, defined priority populations, and key priority areas for action.

These strategies are supported by the *First National BBV and STI Research Strategy 2021—2025*. The research strategy establishes the aims and objectives of multi-disciplinary research activities to support the implementation of the 5 national BBV and STI Strategies.[11]

This strategy aims to provide a framework for the efforts of all partners in responding to hepatitis B, to guide resourcing decisions, and to monitor progress. It is informed by progress made under the *Third National Hepatitis B Strategy 2018–2022*, effectiveness of current and past responses to hepatitis B in Australia and internationally, the identification of gaps and opportunities, and consultation with governments, affected communities, peak bodies, community organisations, researchers, health workers, and other stakeholders. This strategy is also informed by research and surveillance data on hepatitis B in Australia.

This strategy complements other national, jurisdictional, and international policy documents that contribute to the hepatitis B response and support the achievement of existing commitments. These include:

1. State and territory viral hepatitis strategies
2. *National Immunisation Strategy For Australia 2025–2030*[21]
3. *National Drug Strategy 2017–2026*[22]
4. Long Term National Health Plan[9]
5. *National Preventive Health Strategy 2021–2030*[10]
6. Australian Cancer Plan 2023–2033[23]
7. Aboriginal and Torres Strait Islander Cancer Plan[24]
8. National Anti-Racism Framework Scoping Report[25]
9. Australia's Primary Healthcare 10 Year Plan[26]
10. National Strategic Framework for Chronic Conditions[27]

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[3] *Pending publication at the time of writing.*
[4] *Pending publication at the time of writing.*

11. Clinical Practice Guidelines Pregnancy Care 2020 Edition[28]
12. National Aboriginal and Torres Strait Islander Health Plan[29]
13. National Agreement on Closing the Gap and associated implementation plans[30]
14. Nurse Practitioner 10 Year Plan[31]
15. National Framework for Communicable Disease Control[32]
16. Roadmap to Liver Cancer Control in Australia[33]
17. *WHO Global Health Sector Strategies on, respectively, HIV, Viral Hepatitis and Sexually Transmitted Infections for the period 2022–2030*[3]
18. International Covenant on Economic, Social and Cultural Rights[34]
19. United Nations Common Position on Drug Policy[35]
20. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)[36]
21. United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)[4]
22. International Covenant on Civil and Political Rights[37]
23. Convention on the Rights of Persons with Disabilities[38]
24. International Convention on the Elimination of all Forms of Racial Discrimination[39]
25. Convention on the Elimination of all Forms of Discrimination against Women[40]
26. National Women's Health Strategy 2020–2030.[41]

This strategy also supports progress towards Sustainable Development Goal 3 (‘Ensure healthy lives and promote wellbeing for all at all ages’) and 3.3 (‘combat hepatitis’) of the United Nations 2030 Agenda for Sustainable Development.[42] This strategy acknowledges that some states and territories have set or may set different targets to drive progress, and that the goals and targets of this strategy are intended to facilitate national and jurisdictional efforts. Wherever possible, jurisdictions are encouraged to match or exceed the targets of this strategy.

Further detail on the implementation of this strategy including the associated Implementation Action plan, is provided in **Section 9**, ‘Implementing this strategy’.

5. Key achievements

Australia has made progress towards the goals of the *Third National Hepatitis B Strategy 2018–2022* and the hepatitis elimination targets of the *WHO global health sector strategies on, respectively, HIV, viral hepatitis and STIs for the period 2022–2030*, particularly where there has been adequate investment and action over time. This is most notable in childhood vaccination and the continued assurance of safe blood supplies and safe injections in healthcare settings. Elsewhere, there have been incremental improvements, such as in diagnosis, engagement in care and treatment, and mortality. Renewed effort and further progress are required to achieve targets and ensure no one is left behind. Improving knowledge and awareness, uptake of testing, diagnosis, monitoring, treatment, support, and ongoing care is critical to eliminating hepatitis B as a public health threat and reducing morbidity and mortality associated with chronic hepatitis B.

5.1 Key achievements under the *Third National Hepatitis B Strategy 2018–2022*

- **High rates of childhood vaccination.**

  By the end of 2023, over 95% of all children were vaccinated against hepatitis B by 24 months of age.[19] This has been a major success story for the *Third National Hepatitis B Strategy 2018–2022*. Significant declines (over 50%) in the rate of hepatitis B notification for those aged 0 to 29 years were observed between 2014 and 2023.[19] This decline is most likely due to the effect of childhood vaccination for hepatitis B, introduced nationally for infants in Australia in 2000 (and in many countries with high migration to Australia in the 1990s).[19]

- **Steady diagnosis rates.**

  In 2023, an estimated 151,161 people living with hepatitis B had been diagnosed, representing 68.8% of all Australians affected by hepatitis B.[17] Modelled estimates (based on current progress, trends in notification rates, and future migration) suggest Australia will reach the previously identified 2022 goal of 80% diagnosed in 2042 and achieve the National Strategy 2030 target of 90% after 2050. The rate of diagnosis must therefore increase substantially to drive progress towards 2030 targets.[17]

- **Improvement among Aboriginal and Torres Strait Islander people.**

  Progress is being made among Aboriginal and Torres Strait Islander people in the national response to hepatitis B:

  - In 2023, 89.9% (at 12 months) and 95.5% (at 24 months) of Aboriginal and Torres Strait Islander children were vaccinated against hepatitis B, compared with 93.5% and 95.6% of non-Aboriginal and Torres Strait Islander children at the same ages.[19]

  - The Northern Territory has the highest prevalence of hepatitis B in Australia at 1.79% of the population in 2023.[12] Aboriginal and Torres Strait Islander people comprise over 26% of the total population in the Northern Territory.[43] The ground-breaking Hep B PAST (Partnership Approach to Sustainably eliminating Chronic hepatitis B in the Northern Territory) initiative has contributed to capacity building of Aboriginal and Torres Strait Islander health workers and leaders, through new interactive electronic resources in local languages to raise awareness and increase knowledge. This initiative has led to substantial increases in the number of people aware of their infection and engaged in care.[44]

- **More work is required to reach care targets.**

  In 2023, an estimated 53,765 people with chronic hepatitis B were engaged in care (that is, receiving guideline-based hepatitis B monitoring including treatment where indicated) representing 24.5% of all Australians living with hepatitis B.[9] This represents a marginal improvement on the estimated 23.5% engaged in care in 2016. Modelled estimates and current trends suggest Australia will reach its 2022 (former) Third National Hepatitis B Strategy proportion in care target of 50% after 2050.[17]

  During 2023, a total of 27,641 people were dispensed drugs for the treatment of hepatitis B through the Pharmaceutical Benefits Scheme (PBS), representing an estimated 12.6% of people living with hepatitis B in Australia.[17] Modelled estimates and current trends suggest Australia will reach its 2022 (former) Third National Hepatitis B Strategy proportion receiving treatment target of 20% in 2039.[17] In recent years, the number of people receiving treatment has increased over time (by 30% between 2018 and 2023); however, the number of new initiations per year has plateaued.

- **Hepatitis B mortality.**

  In 2023, an estimated 460 deaths in Australia were attributable to chronic hepatitis B.[19] Deaths from hepatitis B were estimated to fall under the influence of scaling up antiviral access from 476 deaths in 2010 to a low of 416 deaths in 2016.[17] The gradual increase since 2016 is due in part to aging, an increasing number of people affected by chronic hepatitis B, and treatment uptake not increasing sufficiently. Without access to antiviral treatment over the last 2 decades, it is estimated nearly 800 people would die every year due to chronic hepatitis B.[17] To reach the mortality target (30% reduction) the total number of chronic hepatitis B attributable deaths would have needed to fall to 291 deaths in 2023.[17] The global 2030 target (65% reduction) requires fewer than 143 deaths by 2030.

  As a generally low hepatitis B prevalence country, Australia has already met the WHO 2030 elimination target of less than 4 deaths attributable to hepatitis B per 100,000 population.[15] However, there is more work required to achieve the one death attributable to hepatitis B per 100,000 population target in this strategy.

5.2 Areas where further efforts are required

Despite these successes, none of the targets from the *Third National Hepatitis B Strategy 2018–2022* were fully achieved, and only one was partially achieved (based on 2023 data).

Table 1: Progress against the National Hepatitis B Strategy

Progress against Third National Hepatitis B Strategy's targets

Achieve and maintain hepatitis B childhood vaccination coverage of 95% at age 12 and 24 months

🟠 Partly achieved

In 2023, hepatitis B vaccination coverage at age 12 months was 89.9% among Aboriginal and Torres Strait Islander children and 93.5% among non-Aboriginal and Torres Strait Islander children, reaching 95.5% and 95.6%, respectively, at age 24 months.[19]

Reduce the number of newly acquired hepatitis B infections across all age groups by 50%, with a focus on priority populations

❗ Insufficient data

There is no published annual estimate of the number of newly acquired hepatitis B infections nationally. Instead, acknowledging certain limitations, newly acquired notification rates are published as proxy measures.

The notification rate for newly-acquired cases (i.e. diagnosed cases in which transmission is assessed to have occurred within 2 years prior) remained steady between 0.6 and 0.7 per 100,000 population between 2016 and 2019.[45] Between 2019 and 2022, it declined to 0.2 per 100,000 population, likely due to the impact of COVID-19 on hepatitis testing uptake.[45]

Increase the proportion of people living with chronic hepatitis B who are diagnosed to 80%

🔴 Not yet achieved

At the end of 2023, an estimated 68.8% of people living with chronic hepatitis B in Australia had been diagnosed.[17]

Increase the total proportion of people living with chronic hepatitis B receiving care to 50%

🔴 Not yet achieved

In 2023, an estimated 24.5% of all people living with chronic hepatitis B were receiving care.[17]

Increase the proportion receiving antiviral treatment to 20%

🔴 Not yet achieved

In 2023, an estimated 12.6% of all people living with chronic hepatitis B were receiving antiviral treatment.[17]

Reduce hepatitis B attributable mortality by 30%

🔴 Not yet achieved

In 2023, an estimated 460 deaths were attributable to chronic hepatitis B. This is a 10.6% increase compared to baseline in 2017.[17]

Minimise the reported experience of stigma among people affected by hepatitis B and the expression of stigma, in respect to hepatitis B status

ⓘ Insufficient data

Insufficient data is available to assess progress towards the stigma reduction target.

The limited progress against the targets of the *Third National Hepatitis B Strategy 2018–2022* highlights areas where further action is required to eliminate hepatitis B as a public health threat.

The national approach to hepatitis B should be agile, meaning that the system must be prepared to deal with unpredictability, impacts of future health emergencies, and a changing environment. This is demonstrated through the decline in hepatitis B testing as a result of COVID-19 restrictions.

Universal precautions and safety measures must be strengthened to prevent transmission of hepatitis B across a number of settings. This includes monitoring pregnant women living with chronic hepatitis B and their babies, access to and use of sterile needles and syringes and ancillary equipment among people who inject drugs, prevention of sexual transmission, and continued screening of donated blood and blood products.

More implementation projects, systemic reform and research to tackle stigma, discrimination, and racism is needed.[46] Increasing the meaningful involvement of people affected by hepatitis B and priority populations (particularly Aboriginal and Torres Strait Islander people, and people from culturally and linguistically diverse backgrounds born in countries where hepatitis B is endemic) is imperative to the success of Australia’s response.

The success of this strategy relies on building strong evidence with priority populations. Appropriate monitoring and research are needed to better inform Australia’s response. This evidence will help evaluate approaches, identify gaps, and determine what approach is most effective.[11]

6. Measuring progress

This strategy has overarching goals, targets and priority areas which will guide the national response to hepatitis B from 2025–2030. The targets balance ambition with feasibility, ensuring no one is left behind in the pursuit of Australia's commitment to hepatitis B elimination by 2030.

6.1 Goals

The goals of the Fourth National Hepatitis B Strategy 2025–2030 are to:

Virtually eliminate hepatitis B transmission by 2030

Reduce mortality and morbidity related to hepatitis B

Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health

Minimise the personal and social impacts of hepatitis B

This strategy commits to addressing gaps in surveillance data for the purpose of monitoring and reporting on progress against these targets, ensuring that missing or unavailable data are remedied as a key priority in progressing towards the 2030 elimination goal.

Equity threshold

Equity is a key focus of monitoring progress against this strategy. As such, an equity threshold has been included. This means that targets are only considered achieved when they have been reached by all relevant priority populations in all jurisdictions and regions.

As an example, Hep B PAST is a co-designed population-based partnership that uses participatory action research (PAR) methodology. PAR gives power to those most affected by the program's outcomes and is recognised for strengthening social and emotional wellbeing and promoting decolonisation in First Nations peoples research.

Hep B PAST has been found to be an effective model of care, and partner health services are exceeding elimination targets. Hep B PAST demonstrates the impact that can be achieved with an equity-focused program.[44]

Indicators and associated data sources for measuring progress towards each target and for the validation of elimination will be included in the next iteration of the National Bloodborne Viruses and Sexually Transmissible Infections Surveillance and Monitoring Plan (see **Table 2**). The mortality reduction target will be measured against the baseline at the end of 2017.

Table 2: Hepatitis B 2030 measuring progress targets[5]

1	**Greater than 95%** timely hepatitis B birth dose.
2	**Greater than 95%** timely completion of 3-dose schedule of infant hepatitis B vaccine.
3	**Greater than 95%** of pregnant women living with chronic hepatitis B and their infants receive guideline-based care to prevent transmission during pregnancy and birth.
4	**0.1% or less** hepatitis B surface antigen prevalence in children aged under 5 years.
5	**1% or less** mother-to-infant transmission rate.
6	**90% or more** people living with chronic hepatitis B are diagnosed.
7	**Reduce to 2% or less** the proportion of people living with chronic hepatitis B diagnosed with liver cancer or decompensated cirrhosis, whose hepatitis B was diagnosed late.
8	**80% or more** of all people living with chronic hepatitis B linked to care.
9	**27%** of all people living with chronic hepatitis B are receiving treatment.
10	**Reduce by 30%** hepatitis B attributable mortality.
11	**1.0 or less** deaths per 100,000 population.
12	**Greater than 95%** completion of Aboriginal and Torres Strait Islander status across data sets.
13	**Reduce to zero** the expression of hepatitis B-related stigma and discrimination in healthcare settings.
14	**Reduce by 75%** the reported experience of stigma among people living with chronic hepatitis B.
15	**95%** of people living with chronic hepatitis B report a good quality of life.
16	**Reduce the negative impact** of legal and human rights issues on people's health and wellbeing by improving access to justice and an enabling legal environment for people affected by hepatitis B.

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[5] *These targets were developed and agreed through a national consensus-based process with experts from community, research, government, and other key national partners in the national response. This process embodied this strategy's guiding principles, notably partnership and the meaningful involvement of priority populations in all aspects of the response.*

7. Priority populations and settings

Hepatitis B disproportionately impacts several key populations. This strategy identifies priority populations and acknowledges diverse intersecting characteristics and risk factors unique to each individual. Therefore, intersectional approaches to hepatitis B responses are needed to ensure that multiple social and structural determinants of health can mutually reinforce and improve equitable hepatitis B outcomes.

In accordance with the guiding principles of this strategy, the diverse challenges and experiences within all priority populations need to be considered in the national response. This includes, but is not limited to, cultural identities, language spoken, geographic settings, risk factors, gender expression and experiences, disability, sexual orientations, religious affiliations, drug use and socio-economic and visa status.

To enable further progress towards hepatitis B elimination, it is critical that the national response acknowledges that the shape of the epidemic will change. As such, more comprehensive and contemporary understandings of priority populations, their needs, and the distribution of disease throughout the life of the strategy should be developed.

7.1 Priority populations

People affected by hepatitis B

‘People affected by hepatitis B’ is an inclusive term describing the large and diverse population of people living with and/or at risk of hepatitis B and affected families and communities. It is anticipated that a cure for hepatitis B will become available in the coming decade, meaning that the lens of ‘people affected by hepatitis B’ may need to be expanded to include people who have been cured of hepatitis B and people with lived experience of chronic hepatitis B.

People living with hepatitis B

‘People living with hepatitis B’ includes a broad, diverse group and includes individuals who are undiagnosed or diagnosed. ‘People living with hepatitis B’ includes the following groups:

- pregnant women living with hepatitis B
- people living with hepatitis B who are not eligible for Medicare
- people who have been living with hepatitis B for longer than 20 years
- people who have received a late hepatitis B diagnosis
- people living with hepatitis B who have cirrhosis or liver cancer
- people living with hepatitis B who have had liver transplants
- people living with hepatitis B who have a hepatitis D, HIV, or hepatitis C co-infection
- people living with hepatitis B who are also undergoing chemotherapy or immunosuppressive therapy.

People at risk of hepatitis B transmission

Most people who develop chronic hepatitis B acquire the infection at birth or in early childhood. Those exposed to the virus as adolescents or adults will usually clear the infection naturally and develop lifelong immunity. A smaller proportion will develop a chronic infection.

People who are at risk of hepatitis B acquisition are those who are not immune to hepatitis B through past vaccination or previous resolved infection.

If not immune to hepatitis B, people in the following groups are at risk of acquiring hepatitis B:

People at risk of hepatitis B transmission

- **Infants born to people with hepatitis B unless vaccination and other preventive measures are provided**
- **People who inject drugs including those who do not have access to sterile injecting equipment**
- **People who have medical procedures using unsterile equipment**
- **Men who have sex with men**
- **Partners (including sexual) and household contacts of a person with hepatitis B**
- **People who have sex without using preventative measures (e.g. condoms)**
- **People who undergo tattooing and body piercing without access to sterile equipment**
- **People in custodial settings**

Pregnant women living with hepatitis B

Pregnant women living with hepatitis B and their infants, children, partners, and extended families are a priority population.

Testing for hepatitis B infection in pregnancy is recommended, and a substantial proportion of people are diagnosed at that time. Hepatitis B infection can have significant health implications for the mother and baby.

Reducing the rates of early transmission to infants remains a priority, as does ensuring appropriate linkage to care for pregnant women. Increasing health literacy about the need for antenatal testing and care, particularly amongst culturally and linguistically diverse populations, and promoting a birth dose of hepatitis B vaccine for infants is integral to preventing mother-to-child transmission within this population and their family units.

Aboriginal and Torres Strait Islander people living with hepatitis B or who are not vaccinated against hepatitis B

Aboriginal and Torres Strait Islander people represent 3.8% of the total Australian population, but are estimated to represent 6.7% of those living with hepatitis B, and continue to experience a disproportionate burden.[47]

Elevated rates of newly diagnosed hepatitis B among Aboriginal and Torres Strait Islander people relate to historical, vertical, and early childhood transmission, particularly in the pre-vaccine era, with some additional infections through sexual and blood contact in adolescence and adulthood. Aboriginal and Torres Strait Islander people also have higher rates of risk factors for adult hepatitis B acquisition including receptive syringe sharing among people who inject drugs.[19]

The incidence of liver cancer is 2.4 times greater among Aboriginal and Torres Strait Islander people compared with the non-Aboriginal and Torres Strait Islander population.[48]

Liver cancer is the second highest cause of cancer related deaths in Aboriginal and Torres Strait Islander people. It is over 2 times greater than the non-Aboriginal and Torres Strait Islander population. These disparities are particularly evident in the most remote regions of Australia. In the Northern Territory, liver cancer is associated with a predominance of the hepatitis B sub-genotype ‘C4’ (responsible for a greater risk of more serious and more progressive liver disease).[14] Further research led by Aboriginal and Torres Strait Islander people, communities, and scholars is needed to better understand these associations and the public health implications of the ‘C4’ strain.

There are a range of barriers and challenges contributing to this disproportionate impact. The traumatic legacy of colonisation and the profound consequences of the Stolen Generations, racism and other past discriminatory practices have created historical and ongoing intergenerational disadvantage. Complex social determinants including over-representation in custodial settings, lack of culturally safe services (especially a paucity of appropriately gendered care for men’s and women’s businesses), lack of culturally respectful health education and prevention services, sub-optimal clinical care, poverty, lower health literacy, shame, stigma, and discrimination mean that Aboriginal and Torres Strait Islander people experience heightened risk and burden of hepatitis B.

Despite this, Aboriginal and Torres Strait Islander people and organisations continue to demonstrate resilience and a continued willingness to work in effective partnerships to improve life and health outcomes for Aboriginal and Torres Strait Islander communities.

Access to fully resourced and culturally safe primary healthcare services enables appropriate testing, monitoring, treatment and care. In addition, strong vaccination programs, culturally appropriate education, prevention, harm reduction, and antenatal care delivered through Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Medical Services (AMS), play a critical role.

To ensure that Aboriginal and Torres Strait Islander priority populations are not left behind in the national hepatitis B response, and to accelerate the achievement of specific targets, it is critical that there is alignment and coherence across national policy frameworks and subsequent implementation planning and investment. This includes the *Sixth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2025–2030*, the *National Aboriginal and Torres Strait Islander Health Plan 2021–2030*, and the incorporation of the 4 *Priority Reforms of the National Agreement on Closing the Gap 2020–2030*.

People from culturally and linguistically diverse communities

In 2023 in Australia, an estimated 73% of people living with hepatitis B were born overseas.[19] There are an estimated 31,489 Australian-born people living with hepatitis B with culturally and linguistically diverse backgrounds who do not identify as Aboriginal and Torres Strait Islander people, men who have sex with men, or people who inject drugs.[47] Further, a number of people from culturally and linguistically diverse communities have not been vaccinated against hepatitis B in their country of birth.

The stigma associated with hepatitis B can result in low testing rates and low engagement with ongoing care, treatment and support services. This is compounded by the complexity and inaccessibility of the health system, barriers to accessing health services, concerns about privacy and confidentiality, and barriers associated with language, access to Medicare, and cultural and gender issues.

For some communities, there can be a difference between the lived experience of hepatitis B (including beliefs embedded within cultural understandings of health and ways of conceptualising intergenerational impacts of hepatitis B within families) and Australia’s predominant biomedical, public health and Western medicine approaches. Additionally, the absence of adequately disseminated culturally and linguistically accessible information about hepatitis B and how to access care through the health system is a significant barrier. Further work led by culturally and linguistically diverse communities who are affected by hepatitis B and their sub-populations is needed to ensure tailored actions are implemented appropriately.

While this strategy uses the term ‘culturally and linguistically diverse’ to capture this diverse population, greater sub-population specificity is also required including:

- people born in countries with a high prevalence of hepatitis B
- Australian-born children of people born in countries with a high prevalence of hepatitis B
- people who do not speak English as their first or preferred language
- people living with hepatitis B who are not eligible for Medicare
- people from countries with high prevalence of hepatitis B who access legal, migration or multicultural groups and services

- international students and people on temporary visas from countries with a high prevalence of hepatitis B
- people born before broad implementation of hepatitis B birth-dose vaccination in their country of birth.

Australia also has a role to play as a leader in hepatitis B elimination internationally, and more specifically in the Western Pacific region. In 2022, an estimated 96.8 million people in the Western Pacific region were living with hepatitis B. Many remain undiagnosed and untreated.[49]

Australia is a member of the WHO Regional Committee for the Western Pacific, and Australian researchers and civil society are active in the Western Pacific region including through membership of the World Hepatitis Alliance and in collaboration with the International Network of People who Use Drugs (INPUD).

Sex workers

Sex workers, particularly those living with hepatitis B or who have not been vaccinated against hepatitis B,[50] are a priority population due to the potential increased hepatitis B exposure risk.[51] More research and quality data are required to fully understand the burden of hepatitis B in this population.

Sex workers experience barriers to accessing health services due to high levels of stigma and discrimination.[52] Sex workers also face a range of regulatory and legal issues including criminalisation, licensing, registration, mandatory testing and a lack of anti-discrimination protections in some jurisdictions.[53] These barriers create a complex system of impediments to evidence-based prevention and access to testing and healthcare services. They can result in increased risk of BBV and STI, loss of livelihood, and risk to personal and physical safety. Evidence shows that decriminalisation of sex work is linked to the reduction of stigma, improved access to health promotion and workplace health and safety measures.[54]

Peer education through peer-based sex worker organisations is essential for promoting prevention, testing, and treatment for sex workers. Tailored approaches for sex workers, including migrant and Aboriginal and Torres Strait Islander sex workers, that address stigma and discrimination, and the regulatory and legal barriers experienced by sex workers, are required.

People who inject drugs

The estimated proportion of people living with hepatitis B is also higher among people who inject drugs, with a hepatitis B prevalence of 2.39%.[19] People who inject drugs, particularly those who have not been vaccinated against hepatitis B, are considered a priority population due to the potential increased risk of hepatitis B exposure particularly in relation to sharing equipment.

People who inject drugs experience high levels of stigma, criminalisation, discrimination and marginalisation, systemically, socially and culturally including through traumatic experiences in accessing services and fear of judgement and repercussions. This compounds barriers to harm reduction, education, testing, treatment, and healthcare, increasing the risk of BBV and STI transmission.

Peer-led health promotion and harm reduction education is crucial for promoting prevention, testing, and treatment for people who inject drugs. Evidence shows that tailored peer-based harm reduction is most effective and has the most reach and impact, especially for stigmatised and marginalised priority populations, including people who inject drugs from culturally and linguistically diverse population groups and Aboriginal and Torres Strait Islander people.

Other groups

There are several other population groups that have unique challenges and experiences that must be addressed in the national response. They include:

- people living with hepatitis B at risk of, or living with, hepatitis C co-infection
- people living with hepatitis B at risk of, or living with, HIV co-infection
- unvaccinated people accessing HIV Pre-Exposure Prophylaxis (PrEP)
- people who have received blood transfusions or other blood products overseas (i.e. in areas with elevated hepatitis B prevalence and suboptimal infection control) or in Australia before July 1971.[55]

7.2 Priority settings

Hepatitis B responses can be better positioned and delivered within the social and cultural contexts of affected communities and priority populations.

Decentralising care outside of specialist services into primary care, and community-based responses should be prioritised, including through Primary Health Networks (PHN) commissioning where local need is identified. Health equity principles and a commitment to leaving no one behind also necessitate a broadening of focus to settings with variable prevalence rates. Importantly, high and low prevalence settings will be dynamic as the priority populations shift and change over the life of this strategy. This requires mobile action with established hepatitis B expertise that is agile and responsive.

Primary, secondary, and tertiary healthcare

People affected by hepatitis B can be reached in a variety of primary, secondary, and tertiary healthcare settings, including general practice. Multicultural and migrant health services are particularly critical in providing hepatitis B services to culturally and linguistically diverse communities. These settings can help promote equitable access to services by reducing language barriers and working alongside primary healthcare services and professionals to ensure that services are delivered in accessible, culturally appropriate ways.

Other primary, secondary, and tertiary healthcare settings in which people affected by hepatitis B can access healthcare include through bilingual and bicultural healthcare providers, birthing parent and child health services, sexual health and family planning services, ACCHOs, AMSs, emergency departments, liver specialist services, cancer services, palliative care, and pharmacies.

ACCHOs are primary healthcare services initiated and operated by the local Aboriginal and Torres Strait Islander communities to deliver holistic, comprehensive, and culturally appropriate healthcare to the community which controls it through a locally elected board of management. ACCHOs play a pivotal role in the national response to hepatitis B, providing community-controlled services to large, remote and high prevalence communities. Dedicated and ongoing investment in ACCHOs is required to reduce the prevalence and harms of hepatitis B.

An AMS is a health service funded principally to provide services to Aboriginal and Torres Strait Islander individuals. An AMS is not necessarily community controlled. If an AMS is not community controlled, it will be a government health service run by a state or territory government. These non-community-controlled AMSs mainly exist in the Northern Territory and the northern part of Queensland, many of which are transitioning to community control over time.

Community-based settings

Engaging people affected by hepatitis B in the places where they live, work, and socialise is critical, particularly for priority populations who may experience barriers to accessing mainstream health services. These settings play a number of different roles including:

- testing, treatment, and ongoing care
- support for chronic disease management
- health system navigation
- linkages to appropriate healthcare and other social and health support services
- access to appropriate and safe health promotion, harm reduction and education.

Importantly, as healthcare for hepatitis B becomes more decentralised, these settings will increasingly provide critical healthcare and support services to people affected by hepatitis B and priority populations.

Some community-based settings with a particularly active or focused role in addressing hepatitis B include:

Community hepatitis organisations

Community hepatitis organisations are critical infrastructure through which people affected by hepatitis B can be engaged and supported. This includes a primary and specific focus on hepatitis-related prevention, harm reduction, referral and promotion, and in some cases provision of testing, peer support, education, training, individual and systemic advocacy, and information sharing.

Drug user organisations (DUOs)

These organisations provide access to de-stigmatised peer-based support, information, education, advocacy, harm reduction services, and other services that aim to reduce the transmission of BBV.

Needle and Syringe Program outlets

Primary and secondary Needle and Syringe Program outlets, as well as pharmacy-based settings are critical for prevention. They ensure that people who inject drugs have access to a range of support including sterile injecting equipment, peer support, harm reduction education and health promotion, and linkages and support to access healthcare. Injecting equipment may be provided through fixed based sites, outreach services, dispensing chutes, postal distribution, or through peer-based distribution.

Multicultural BBV and STI services

Multicultural BBV and STI services work with culturally and linguistically diverse communities to ensure equitable access to specific BBV and STI related healthcare, health promotion, education, and community development. They also forge important relationships with the broader BBV and STI and healthcare sector to advocate for better health and wellbeing outcomes for culturally and linguistically diverse communities.

Sex worker peer organisations

Sex worker peer organisations are a priority setting through which sex workers can be engaged in the national response. Sex worker peer organisations provide essential prevention education conducted by peers as well as critical linkages to testing, treatment, and ongoing management and care.

Geographic settings

Generally, the prevalence of hepatitis B (as a proportion of the population) is highest in rural and remote areas, treatment and care uptake is also lowest in these areas when compared to metropolitan areas. As such, greater focus and effort is needed to address this disparity and remedy the inequitable health outcomes. This includes considering how health workforce classifications including the Modified Monash Model (MMM) can be used to support the targeting of treatment and care. The MMM defines whether a location is metropolitan, rural, remote or very remote, and assists the Department of Health, Disability and Ageing to distribute the health workforce in rural and remote areas.[56] It recognises that people living in these areas can find it harder to get medical help, and accessing doctors can take longer and cost more. Increased efforts are also needed in areas of increased prevalence, where progress to elimination is slow and where inequitable hepatitis B outcomes are being observed.

Legal settings

Custodial settings

Custodial settings including corrections, forensic mental health settings, and other places of held detention have a high prevalence of hepatitis B and are high-risk areas for transmission. It is estimated that 16% of people in prisons have evidence of past or current infection, and 3% of people in prisons have evidence of chronic hepatitis B (which represents 3.5 times the rate of all populations nationally).[57] High prevalence in these settings can be explained by a number of social and structural determinants including the:

- over-representation of Aboriginal and Torres Strait Islander people in prisons
- criminalisation of people who use drugs
- absence of evidence-based harm reduction measures in prisons.[57]

It is critical that these access barriers are addressed as part of the national response if elimination is to be achieved.

Legal, migration, refugee, and settlement services

Since 2021, hepatitis B no longer impacts a visa applicant's ability to meet the health requirement for the grant of a temporary or permanent visa. Legal, migration, refugee, and settlement services are often a first point of contact for people living with hepatitis B who are seeking support for visa applications and related assessment processes including the health assessments and screening that form part of visa criteria. These settings can provide information and linkages to care, community-based support, and adjacent services for migrants and refugees who may have low access to healthcare.

Other settings

There are a range of other settings in which priority populations can be reached including:

- mental health services
- alcohol and other drug services including opioid agonist treatment services
- homelessness services
- educational institutions
- workplaces
- multicultural organisations.

8. Priority areas for action

This section outlines actions necessary for the elimination of hepatitis B as a public health threat by 2030. Importantly, each action has been designed to ensure that it is appropriate and safe for each relevant priority population and is consistent with the guiding principles outlined in this document.

8.1 Education and prevention

- Improve knowledge, health literacy, training, and awareness of hepatitis B in priority populations and health workers to support increased engagement in testing, harm reduction, prevention, vaccination, monitoring, treatment, and care including liver health.
- Promote awareness and strengthen uptake of hepatitis B vaccination among priority populations including strengthening national and jurisdictional immunisation programs to ensure the offer of universal access.
- Enhance and improve access to hepatitis B community and peer education.
- Ensure education and prevention activities address the familial, social, cultural, and linguistic contexts of target audiences as well as the secondary harms arising from hepatitis B including liver disease and liver cancer.
- Raise hepatitis B awareness in the general community including in relation to vaccination, the effectiveness of treatment, and stigma reduction.

Improved awareness and understanding of hepatitis B among priority populations, health services, and the broader community is critical to achieving the elimination of hepatitis B as a public health threat by 2030. Initiatives that target misconceptions and gaps in knowledge can significantly reduce stigma and discrimination, increase rates of testing and engagement in care, and reduce the overall impact of infection.[58] Education and health promotion initiatives should be community and peer-led, reflecting the individual, familial, social, cultural and linguistic dimensions of the target audience. Health literacy related to hepatitis B will be enhanced through community-led education and prevention activities in priority settings including community hepatitis organisations, ACCHOs, culturally and linguistically diverse community-based organisations, drug user organisations, sex worker peer organisations, and their respective national peak bodies.

Primary prevention of hepatitis B involves strategies to prevent infection. Vaccination is the cornerstone of hepatitis B primary prevention and is complemented by other means of prevention. This includes harm reduction strategies such as peer education and providing sterile needles, syringes, and condoms to reduce transmission risks associated with injecting drug use and unprotected sexual activity. Secondary prevention involves strategies to prevent or reduce the impact of disease such as chronic disease self-management, treatment, liver health monitoring, liver cancer surveillance, and community and peer support. Combined, hepatitis B and hepatitis C are the primary cause of liver cancer, Australia's fastest growing cause of cancer death.[59] Prevention of chronic hepatitis B infection and secondary harms is a cost-effective way to prevent liver cancer and reverse the trend of increasing liver cancer mortality.[60]

A person with hepatitis B may be unaware that they have the virus due to the absence of recognisable symptoms both at the time of transmission and in the early stages of liver disease. This often leads to a substantial delay in diagnosis.[61,62] During this time, further inadvertent transmission can occur, as can preventable deterioration in liver health. Additionally, many people may have been diagnosed overseas in non-health services (e.g. through workplace, immigration, and education settings) and not provided with basic non-stigmatising information about the infection. It is crucial that priority populations have access to trusted, reliable, and appropriately targeted health promotion and education activities on hepatitis B. These should include information on transmission risks, vaccination, harm reduction, the importance of early detection and testing, the effectiveness of treatment, ongoing monitoring, liver health, cancer prevention, chronic disease management, and how to access health services and support. The training of health, peer and community workers to support the delivery of education and prevention measures will be critical to the success of these measures.

Table 3: Key areas for action – Education and prevention

KEY AREAS FOR ACTION – Education and prevention

1. Strengthen access and awareness of hepatitis B vaccination including:
    a. nationally consistent access to hepatitis B vaccination, with specific efforts to improve uptake in priority populations including through national and state-based immunisation programs
    b. investigate and strengthen opportunities to support hepatitis B immunisation programs in source countries for immigration to Australia (e.g. alongside other regional public health activities).
2. Implement perinatal, antenatal, and child health guidelines (informed by affected communities) to prevent vertical transmission of hepatitis B and increase monitoring of these protocols.
3. Develop, implement, and scale-up evidence-based and community-led initiatives that integrate health promotion and education, and referral services for priority populations and the general community, including national and local hepatitis B campaigns and World Hepatitis Day. These initiatives will also focus on delivering culturally appropriate information to improve hepatitis B health literacy and support individuals in navigating the Australian healthcare system. Efforts will also prioritise the adaptation and scaling-up of successful models across communities to ensure broader reach and sustained impact, such as community-based information and multimodal resource hubs.
4. Explore opportunities to increase access to hepatitis B harm reduction measures in partnership with state and territory governments including access to education and support, sterile needles and syringes, condoms and lubrication in priority populations and settings.

8.2 Testing, treatment, and management

- Ensure all adults in Australia know their hepatitis B status.
- Maximise the number of people living with hepatitis B who are diagnosed through a universal offer of guideline-based hepatitis B testing for priority populations, and follow-up of family and close contacts for opportunistic testing – all with informed consent.
- Strengthen monitoring and appropriate care for pregnant women living with hepatitis B and their infants including through promotion of vaccination, testing, treatment, and antenatal care guidelines.
- Explore opportunities to increase the availability, adoption, and use of hepatitis B testing and treatment technologies including self-testing and point-of-care testing, to drive person-centred care.
- Ensure concurrent testing for hepatitis D virus is offered to people diagnosed with chronic hepatitis B during care to ensure early prevention of future health conditions exacerbated by concurrent hepatitis B and hepatitis D infection, including chronic liver disease.

Hepatitis B testing for priority populations and among people whose hepatitis B status is unknown enables early diagnosis, access to monitoring, treatment, ongoing care, vaccination, and education to prevent transmission. Late diagnosis can lead to ongoing transmission and poor health outcomes, missing opportunities to prevent progression to advanced liver disease and cancer. Efforts to increase testing must remain based on the principles of informed consent in peoples preferred language, ensuring that testing is voluntary, accessible, non-discriminatory, confidential, and of clear benefit to the person being tested.[63]

With the exception of universal screening during antenatal care (through which a substantial proportion of pregnant women are first diagnosed), guideline-based testing has had limited success in meaningfully increasing the proportion of people diagnosed with hepatitis B in the past decade.[60] In contrast, population-wide testing mechanisms have been found to be cost-effective in countries with prevalence well below the 1% prevalence of hepatitis B in Australia.[60]

Ongoing implementation of all national hepatitis B testing, education, treatment, monitoring and care guidelines will be critical to ensuring continuous progress towards Australia's 2030 elimination targets.

Increased testing in priority populations, as outlined in the *National Hepatitis B Testing Policy*, is needed to reach unvaccinated persons at higher risk of infection and ensure timely diagnosis and linkage to care.[63] Population-wide testing mechanisms, such as the offer of testing for all Australians aged 20–79 years with undocumented hepatitis B status, may increase the number of people tested, vaccinated (if not immune), diagnosed, and engaged in care.[60]

Engagement with priority populations, including Aboriginal and Torres Strait Islander peoples and people with culturally and linguistically diverse backgrounds is likely to be further improved through the use of self, rapid and point-of-care testing technologies when available. The mobile nature of these diagnostic technologies means they can be increasingly performed at home or by community and peer workers. Self-testing may also decrease any stigma associated with testing as it provides an opportunity for key populations to test themselves discreetly and conveniently.[64] Models and infrastructure will be required in Australia to enable linkage to care for those undertaking self-testing. Adapting models from other communicable diseases, such as COVID-19, may be useful.

The risk of complications (e.g. liver decompensation and liver cancer) is higher in people with cirrhosis. All people diagnosed with hepatitis B should have access to non-invasive tests that can diagnose cirrhosis. All people affected by hepatitis B should have an assessment for cirrhosis at the time of diagnosis and be monitored periodically for the development of cirrhosis.[14]

Hepatitis B treatment is highly effective at slowing the progression of cirrhosis, reducing the incidence of liver cancer, and improving long-term survival.[65] Not all people with hepatitis B may require or want treatment but regular monitoring is critical to identify liver damage that may necessitate the commencement of treatment. Authorised GPs and nurse practitioners can prescribe hepatitis B antiviral treatment in Australia, but more can be done to support clinical management transitioning from specialist to primary care services. This includes addressing knowledge gaps and management processes, and exploring options for medication rescheduling and financial support for hepatitis B management.[66]

Hepatitis B is a key risk factor for primary liver cancer. Building the capacity of people affected by chronic hepatitis B and localised services to support lifelong monitoring (including biannual blood tests supported by periodic non-invasive methods of fibrosis assessment) is the cornerstone of appropriate hepatitis B care. Liver cancer is often asymptomatic in its early stages and grows very quickly, meaning that ongoing 6-monthly surveillance is key to ensuring people can be diagnosed while liver cancer is still treatable.[14] This includes supporting the implementation of chronic hepatitis B registries, which research has shown to promote access to hepatitis B treatment and strengthen liver cancer prevention.[52]

Additionally, improved adherence to antenatal treatment protocols, infant vaccination protocols, and care for pregnant women living with hepatitis B is critical noting the significant long-term health consequences and increased association with liver cancer that follow hepatitis B infection at birth (vertical transmission).[67]

Hepatitis D virus (also known as hepatitis delta virus) only occurs in individuals with a current hepatitis B infection.[68] Infection with hepatitis D can occur simultaneously with hepatitis B (i.e. co-infection) or it may occur in a person already chronically infected with hepatitis B (i.e. as a superinfection). Co-infection with hepatitis D can result in a more rapid progression of liver disease and liver cancer. Testing for hepatitis D should be routine for all people with chronic hepatitis B infection as there is evidence that hepatitis D is substantially underdiagnosed in Australia.[63] Greater treatment options for people living with hepatitis D should be developed with only one treatment with proven but limited anti-viral efficacy available.[63] A number of alternative novel agents are currently being trialled and evaluated.[51]

Table 4: Key areas for action – Testing, treatment, and management

KEY AREAS FOR ACTION – Testing, treatment, and management

5. Explore opportunities for population-wide universal offer of hepatitis B testing with informed consent for adults ensuring quality diagnosis and linkage to care.
6. Support active case finding and linkage to care through public health notifications for follow-up and networks-based contact tracing approaches.
7. Explore opportunities to expand the roll-out and availability of new hepatitis B testing technologies with linkage to care including community-led self-testing and point-of-care testing within a broader suite of testing approaches nationally.
8. Explore opportunities to enhance hepatitis B treatment, monitoring, and liver cancer prevention activities for people living with hepatitis B including expanding primary care access to non-invasive diagnostic tools, supporting options to increase subsidised viral load tests, improving treatment prescribing rates, promoting treatment and pregnancy care guidelines for pregnant women, and strengthening processes to support personal choice regarding treatment access.
9. Prepare for the rollout of curative treatments and other treatment advances for chronic hepatitis B by undertaking implementation projects in collaboration with community and peers to design and prepare systems, workforces, and policy settings.
10. Explore opportunities to scale up chronic hepatitis B registries to support liver cancer prevention.
11. Explore opportunities to promote access to Medicare-subsidised hepatitis D testing for all people affected by hepatitis B.

8.3 Equitable access to and coordination of care and support

- Address social, demographic, and geographic inequities in hepatitis B health outcomes by ensuring equitable and universal access to prevention, harm reduction, testing, monitoring, treatment, and care across all priority populations and settings.
- Implement strategies that address the social determinants of health and specific experiences of priority populations including mental health issues, incarceration, employment and migration.
- Explore opportunities to remove access barriers to hepatitis B testing, treatment, and management including for people who are not eligible for Medicare.

- Improve care coordination between people affected by hepatitis B and peer, community, health, and specialist services.
- Support and expand person-centred, decentralised, and differentiated models of hepatitis B care in primary health and community and peer-based settings.
- Strengthen intersections and linkages between hepatitis B focused activities and services for associated health conditions including liver cancer.

To ensure no one is left behind in hepatitis B elimination efforts, equitable and universal access to hepatitis B testing, treatment, harm reduction, education, care, and community and peer support is required. Equity in the context of hepatitis B healthcare means ensuring equitable access, utilisation, and outcomes for all priority populations.

In previous decades, hepatitis B prioritisation and action have not sufficiently reflected the burden of this disease. This has resulted in inequitable outcomes for people affected by hepatitis B when compared to other communicable diseases. Efforts to overcome the structural, systemic, and resourcing barriers to equitable hepatitis B care should be prioritised.

Person-centred care for hepatitis B requires health system responses and services to be organised around a person's needs. Differentiated and decentralised service delivery models support person-centred care through adapting health services across the care cascade to support the specific needs of people based on their circumstances. This will enable testing, treatment, care, harm reduction, and the provision of other social and health-based supports and services through primary care, and community and peer-based services which reach people in the community.[3] Existing successful and innovative person-centred models of care, such as the Hep B PAST program in the Northern Territory should be considered for expansion and national scale-up including in rural and remote and other underserviced areas.[69]

Stronger communication and linkages between hepatitis B priority populations, primary care, community and peer organisations, the health workforce and specialist services are needed to coordinate care. Broader linkages with other social and health service systems are also needed to improve chronic disease management, mental and physical health outcomes, and address the social determinants of health that impact the quality of life for people affected by hepatitis B. This includes linkages with liver cancer prevention, control and treatment services which are key partners in addressing hepatitis B attributable mortality.

Table 5: Key areas for action – Equitable access to, and coordination of, care and support

KEY AREAS FOR ACTION – Equitable access to, and coordination of, care and support

12. Support and expand person-centred, decentralised, and differentiated models of hepatitis B care including scaling up successful models of care, supporting nurse-led models, developing chronic disease management models, supporting digital models of care, developing and implementing community and peer-based models such as people with lived experience as peer navigators for all priority populations, and building capacity in multicultural health services, parent and child services, sexual health services, and ACCHOs.

13. Improve the coordination and linkage of hepatitis B care between primary and specialist tertiary care, affected communities, pharmacy, and community and peer-based organisations.[14]

14. Ensure people have had their diagnosis, ongoing care requirements, and other key management decisions explained to them in their preferred language (using an accredited interpreter, Aboriginal and Torres Strait Islander health practitioner, bilingual health worker or peer worker) within 6 months of diagnosis to ensure timely, culturally safe care, and linkage to community and peer-based organisations.

15. Enable and expand the provision of diverse, culturally and linguistically appropriate hepatitis B services to priority populations including:

a. engagement, awareness, and ongoing capacity building of bicultural and bilingual health and harm reduction workers

b. support and build capacity of community and peer educators including from priority populations

c. coordinate and expand access to accredited translation services and ensure their ongoing hepatitis B-specific training and capacity building

d. support peer leadership to describe peers and peer work in the context of hepatitis B

e. support the development and maintenance of directories of hepatitis B peer workers and healthcare professionals who speak languages other than English.

16. Explore opportunities to address resourcing, policy, legal, regulatory, and structural barriers that impede equitable hepatitis B outcomes and national prioritisation, including options to remove barriers in accessing hepatitis B testing, treatment, vaccination, and clinical management for people who are ineligible for Medicare.

8.4 Workforce

- Explore opportunities to implement, resource, strengthen, and sustain a national hepatitis B-specific community and peer workforce.
- Consider a national hepatitis B multidisciplinary workforce development plan and associated capability and capacity building initiatives.
- Facilitate a highly skilled multidisciplinary workforce that is inclusive, respectful of and responsive to the needs, culture, and preferred language of people affected by hepatitis B.

The national response to hepatitis B is reliant on a highly skilled multidisciplinary workforce that is inclusive, respectful of and responsive to the needs of people affected by hepatitis B. This includes community and peer workers, Aboriginal and Torres Strait Islander health workers, bilingual and bicultural health workers, GPs, nurses, pharmacists, nurse practitioners, community S100 prescribers, midwives, and specialists who deliver quality hepatitis B services for priority populations.

There is currently a limited hepatitis B-specific community and peer workforce nationally, which has contributed to unequal and insufficient progress. The implementation, maintenance, and strengthening of a hepatitis B-specific community and peer workforce is critical infrastructure through which national targets can be achieved, care can be decentralised, and responses can be tailored to social, cultural, linguistic, and local contexts.

Peer workers provide multi-faceted support in the delivery of services. Their lived experience and connection to community makes them more accessible to people who are otherwise not being reached by mainstream health systems. Their focus includes hepatitis-related prevention, harm reduction and referral, the promotion of testing and treatment, peer support, education, training, individual and systemic advocacy, information sharing, and awareness raising. Additionally, the hepatitis B community and peer workforce includes those who address hepatitis B within a broader health or social service context including the community and peer-based settings outlined in this strategy. These organisations and their national peak bodies work with and maintain valuable linkages to priority populations forming a critical part of the national response which should be strengthened.

Other allied workforces and organisations including those delivering homelessness services, mental health services, and alcohol and other drug services are identified as priority interaction settings for people affected by hepatitis B. Workers in these settings should have strong awareness of hepatitis B and its intersections with the social determinants of health as well as the capacity to undertake hepatitis B prevention, education, referral, and shared care.

The clinical workforce addressing hepatitis B includes workers in primary healthcare such as GPs, nurses, specialists, and pharmacists. Greater focus and progress are needed to shift routine testing, treatment, follow-up, and monitoring of hepatitis B to primary care. Opportunities to facilitate the provision of nurse-led services and expand the role of nurse practitioners in health promotion, harm reduction, prevention, and management of hepatitis B should also be strengthened. Further avenues are also required to scale-up management and treatment within primary care through the strengthening of community-based prescriber programs and exploring medication rescheduling.

Specific education, ongoing professional development, and specialisation opportunities need to be available to support the multidisciplinary workforce in the development of essential hepatitis B knowledge and skills to enable them to appropriately identify those with hepatitis B and provide quality health promotion, harm reduction, treatment and care. This includes training and education to provide culturally and linguistically sensitive, non-stigmatising and non-discriminatory services and care, particularly for marginalised and stigmatised populations.

All groups involved in the national hepatitis B response have unique workforce development needs. A national hepatitis B multidisciplinary workforce development plan can guide the delivery of workforce development initiatives (e.g. the priority actions in this strategy), and concurrently strategically plan for and deliver sufficient hepatitis B workforce capacity and growth.

Table 6: Key areas for action – Workforce

KEY AREAS FOR ACTION – Workforce

17. Explore opportunities to implement, maintain, and strengthen a national hepatitis B-specific community and peer workforce to implement associated projects, including through workforce development and training, supervision, communities of practice, scopes of practice, and capacity building.

18. Consider development of a national hepatitis B multidisciplinary workforce development plan. This includes mapping and defining the hepatitis B workforce, enhancing the capacity of multidisciplinary workforces, and taking a coordinated and strategic approach to workforce development activities.

19. Support the workforce to deliver hepatitis B care including:

  a. increase primary care practitioner engagement in training for hepatitis B management, particularly amongst practitioners working within culturally and linguistically diverse communities
  b. increase capacity and availability of hepatitis B prescribers
  c. promote clinical guidelines for hepatitis B management in primary care, including for liver cancer
  d. improve patient management systems to better support the primary care workforce to promptly identify and provide monitoring, treatment, and care for people living with hepatitis B
  e. explore opportunities to increase the capacity of nursing and pharmacy workforces to provide hepatitis B harm reduction, prevention, testing, and care
  f. explore opportunities to increase incentives for primary care practitioners to manage hepatitis B
  g. ensure health workers involved in pregnancy care have sufficient training and capacity to undertake early detection, monitoring, work-up and treatment of hepatitis B including utilising available multidisciplinary referral pathways to provide support at the perinatal stages

h. ensure the primary care and community workforces have the resources and capabilities to deliver and scale-up decentralised care through innovative service models.

20. Deliver education to ensure there is sufficient expertise in liver cancer monitoring across private and public healthcare settings and facilitate access to training to upskill in this area.

21. Build hepatitis B capacity for allied sectors and workforces (e.g. migration, legal, multicultural groups) to undertake relevant health interventions, support partnerships with community organisations, improve hepatitis B health literacy, and connect people to care through established networks of multicultural health, alcohol and other drug, mental health, and priority population services.

22. Increase meaningful involvement of people living with hepatitis B and priority populations including Aboriginal and Torres Strait Islander people, and people from culturally and linguistically diverse backgrounds born in countries where hepatitis B is endemic in the response.

8.5 Addressing stigma and creating an enabling environment

- Ensure reduction of stigma, racism, discrimination, and colonialism are central in all national and local responses to hepatitis B and coupled with meaningful program delivery and systems-change to redress identified issues.
- Implement long-term and stable programs that address stigma, discrimination, racism, colonialism, and human rights issues and minimise their impacts on the health of people living with hepatitis B.
- Address the legal, regulatory, and policy barriers which affect priority populations and adversely influence hepatitis B outcomes.
- Ensure people living with hepatitis B are engaged in and co-design national policy development, implementation, and evaluation with capacity building of peer leadership to support active contribution.
- Provide national and international leadership in relation to the elimination of hepatitis B by 2030 including in cross-cutting health and social policy work.

Stigma, discrimination, and racism within the health system can hinder access to hepatitis B prevention, harm reduction, testing, treatment, and care. These barriers can contribute to missed and late diagnoses, disease progression, onward transmission, more costly tertiary care, and reduced quality of life.[70] Stigma and discrimination related to hepatitis B is multi-dimensional and multi-layered and can be compounded by stigma and discrimination associated with race, cultural background, migrant or refugee status, gender identity, drug use, sex work, health status, and perceptions of risk.[70] Strategies to address stigma and discrimination must acknowledge and account for these intersections.

Surveys of health workers demonstrated that approximately 34% would behave negatively toward someone because of their hepatitis B status. The elimination of hepatitis B requires the removal of stigma, discrimination, racism, and colonisation in all forms. To provide efficient and cost-effective services for hepatitis B, the workforce should receive education and training led by the affected communities on how stigma can negatively impact an individual's decision to access healthcare. Further, information about stigma and discrimination should be embedded within all education and training for the workforce. This means that health workers, harm reduction workers, and employers should improve attitudes, practices, services, and policies that may influence the decisions of people affected by hepatitis B.[71]

Lack of engagement with services among migrant communities has also been linked to pre-existing stigma from countries of origin.[72] Combined with non-Western framings of health and hepatitis, misconceptions about hepatitis B, barriers to health service access, language barriers, and concerns about confidentiality, the communities most affected by hepatitis B may be unaware of their status and experience a range of barriers in accessing care.[73,74] This can be further intensified with medico-legal concerns related to perceived impacts on attainment of Australian residency, and the costs associated with healthcare for people not eligible for Medicare.[75] Legal, policy, social, cultural, and economic barriers also impact on hepatitis B outcomes.[76–78]

To date, the national response to hepatitis B has been insufficiently prioritised, resulting in limited and unequal progress. The implementation of this strategy rests predominantly within health and related sectors; however, many of the barriers that impede progress fall outside of the responsibility of the health system. It is important that effective and meaningful dialogue be maintained across sectors and jurisdictions to support knowledge translation and broader health system enhancements in relation to hepatitis B. Work is needed to ensure that hepatitis B is also embedded in cross-cutting national policy including long-term health plans relevant to health workforces (e.g. GPs, pharmacists, nurses, midwives, and community and peer workers); health reforms (e.g. preventive health); and related disease policy (e.g. cancer).

Table 7: Key areas for action – Addressing stigma and creating an enabling environment

KEY AREAS FOR ACTION – Addressing stigma and creating an enabling environment

23. Implement long-term and stable programs co-designed and led by, or in partnership, with people living with hepatitis B aimed at minimising stigma and discrimination across the community, and to strengthen accountabilities for hepatitis B care, particularly in healthcare settings.

This should include:

a. projects to ensure that health systems are accessible, appropriate, and safe for people from culturally and linguistically diverse communities

b. anti-stigma, anti-discrimination, anti-racism, and decolonisation training and initiatives for health practitioners that are culturally safe, and trauma informed

c. projects addressing legal, policy, and systemic barriers including stigma, discrimination, colonisation, human rights issues, and racism, which contribute to poor or unintended hepatitis B outcomes, and building cross-sectoral support for priority populations.

24. Address systemic, policy, and legal barriers that hinder hepatitis B prevention, harm reduction and access to care by culturally and linguistically populations, including consideration of a national project to ensure access to justice and support for people living with hepatitis B.

25. Identify opportunities to elevate hepatitis B as a national policy priority including in allied health, preventive health, primary care, cancer, and health and research planning.

26. Sustain Australia’s leadership in international bloodborne virus elimination efforts by delivering on national and international hepatitis elimination commitments and strong leadership in the Western Pacific Region with respect to hepatitis B.

8.6 Data, surveillance, research, and evaluation

- Further develop a strong evidence base for local and national responses to hepatitis B in Australia in collaboration with researchers, people affected by hepatitis B, and informed by high-quality data and surveillance systems.
- Improve timeliness and consistency of hepatitis B data collection nationally and jurisdictionally to better support completeness, comparability, and utility.
- Support hepatitis B curative research and prepare for its implementation.
- Enable and resource more community and peer leadership in hepatitis B research planning, design, implementation, and translation.

Research helps to guide the development, implementation, and evaluation of policies and programs at all levels of the national response to hepatitis B. To fully understand the impact of hepatitis B, it must be linked to the needs of all affected communities.

Continuous improvement of data collection and systems including data linkage and sharing information across jurisdictions is important to support a comprehensive understanding of the burden of hepatitis B in Australia and to monitor the impact of interventions; however, this must be appropriately targeted to ensure its effectiveness, and balanced to minimise data collection burdens on affected communities, health services and frontline staff.[11] The *First National BBV and STI Research Strategy 2021–2025* assists in these endeavours by providing a framework for social, behavioural, epidemiological, clinical, and other forms of research in developing a strong evidence base for managing and preventing hepatitis B (and hepatitis B-related morbidity and mortality) in the community.[11]

Affected communities, national peak bodies, community, and peer-based organisations are often the first to identify emerging needs, cultural and social influences, and changes in behaviours among priority populations. Such partnerships are invaluable in research and evaluation endeavours. As both the beneficiaries and subjects of the research, people affected by hepatitis B and peers should drive the research agenda and be central to research planning, design, and implementation.

Opportunities to improve the granularity of data need to be explored to better understand the true incidence and prevalence of hepatitis B and to identify trends and issues of concern in relation to specific priority and sub-populations and other demographics. Other data gaps include hepatitis B-related advanced disease, liver cancer, and stigma and discrimination. Work is also needed to improve identification of infections and enhance understanding of healthcare utilisation in those living with hepatitis B, particularly with respect to monitoring, to better inform healthcare outcomes.

Current therapies are effective and reduce the risk of liver cancer; however, they are unable to cure chronic hepatitis B infections. Researching and developing cures for chronic hepatitis B would save millions of lives globally and help ensure the elimination of hepatitis B by 2030.

While the targets in this strategy are informed by, but not limited to, the global health sector strategies 2022–2030 target methodology, Australia's eventual elimination of hepatitis B will be measured and validated following global criteria and standards. This involves the use of absolute impact targets to validate elimination at the national level. The WHO principals in the validation of elimination recognise the central role of civil society and affected communities in the validation process.

Table 8: Key areas for action – Data, surveillance, research, and evaluation

KEY AREAS FOR ACTION – Data, surveillance, research, and evaluation

27. In partnership with community through established governance structures:

  a. update the National BBV and STI Surveillance and Monitoring Plan to specify the indicators used to monitor progress towards achieving the National Hepatitis B Strategy targets

  b. update the *First National BBV and STI Research Strategy 2021–2025* to maintain and enhance the timely annual reporting of hepatitis B surveillance and monitoring including analysis of progress against targets and indicators, disaggregation by sub-populations where possible, and mapping with additional regional specificity.

28. Strengthen data collection and data systems to enhance health outcomes for priority populations by improving data completeness for pregnant women's hepatitis status, Aboriginal and Torres Strait Islander people's identification status, country of birth, language spoken, cultural background, Medicare eligibility and likely place of hepatitis B acquisition. Consider data linkage projects, enhancing community service level data, and ensuring public health units share data safely and effectively.

29. Strengthen Australia's hepatitis B research prioritisation by supporting research on emerging issues and social determinants of health, models of care, and novel diagnostic methodologies. Additionally, support Australia's leadership in global hepatitis B research and capacity building, including with the WHO and other key stakeholders.

30. Ensure Australia has the evidence base to demonstrate elimination of hepatitis B by working in partnership with community in preparing and undertaking elimination validation as per WHO guidance, ensuring current and future programs are evaluated against the priorities of this strategy, and evaluating the implementation of this strategy to ensure achievement of the 2030 elimination goal.

31. Build capacity of community and peers to lead, participate in, co-author, and implement hepatitis B research. Priority populations and affected communities should be embedded in all aspects of research including priority setting, modelling, development, implementation, co-authorship, community engagement, research translation, dissemination, evaluation, and monitoring.

32. In partnership with the community, address gaps in surveillance data and analysis to measure, monitor, and report on the implementation of this strategy and progress towards the targets including developing target baselines, prioritising sub-populations and regional data, establishing a community-led hepatitis B quality of life measure, monitoring stigma, discrimination, and racism, producing incidence estimates, improving the collection of morbidity and mortality data, and improving data collection on hepatitis B and injecting drug use, and sex work.

33. Ensure Australia is at the forefront of hepatitis B research innovations including through expanding a focus on hepatitis B research in existing Australian Government research funding such as the Medical Research Future Fund and National Health and Medical Research Council. This includes exploring opportunities to prioritise research on hepatitis B cures and development of targeted treatments including direct-acting antivirals and immunotherapeutic approaches.

34. Undertake mapping and monitor investment on national hepatitis B elimination to measure impacts on reducing the burden of hepatitis B.

9. Implementing this strategy

9.1 Leadership, partnership, and connections to community

Australia's response to hepatitis B is built on a model of partnership between affected communities, governments, peak organisations, health, and community organisations, researchers, and the multidisciplinary workforce.

The Australian Government is committed to providing strong national leadership by working across portfolios and jurisdictions to achieve the goals of this strategy. The Australian Government's Australian Centre for Disease Control (Australian CDC) leads national response to hepatitis B under the Fourth National Hepatitis B Strategy 2025–2030. The success of this strategy is contingent on productive partnerships between the Australian Government, state and territory governments, and partners including community peak organisations, priority populations and affected communities, health workers, researchers, and others. In the case of research on hepatitis B, it is imperative that this is conducted in partnership with communities and is aligned with the priorities of the 5 national strategies.[11]

The Australian CDC will work closely with key stakeholders including state and territory governments, and community organisations, the Australian CDC will support and implement evidence-based policies and programs that address the needs of those affected by hepatitis B and achieve the goals set out in this strategy.

The Fourth National Hepatitis B Strategy 2025–2030 is a shared responsibility between governments, community, and the health sector to provide evidence-informed interventions built on high quality research, surveillance, monitoring, evaluation, and the expertise of priority populations, affected communities and community peak organisations. As such, continuous monitoring and evaluation of current and emerging interventions will be essential in enabling cost-effective decision-making and guiding existing partnerships to implement agreed directions. This requires investment and mobilisation of resources across all levels of government from the national level to local jurisdictions. This ensures that resources are utilised to achieve maximum impact and desired outcomes.

9.2 Governance, reporting, and evaluation

This strategy, alongside the other national BBV and STI strategies, is endorsed by Australia's Health Ministers and governed through relevant committees of the Health Chief Executives Forum (HCEF). This includes the BBVSS.

The BBVSS coordinates implementation and evaluation efforts across jurisdictions and reports to the Australian Health Protection Committee (AHPC) on progress in the implementation of the national strategies. BBVSS and the Communicable Diseases Network Australia will jointly monitor progress towards the targets of each strategy, undertake evaluation, and identify emerging issues and opportunities for action. The National Aboriginal and Torres Strait Islander Health Protection subcommittee of AHPC will also be consulted to ensure holistic and culturally safe advice on health protection matters for Aboriginal and Torres Strait Islander people and communities is considered in the context of this strategy.

9.3 Review and implementation

This strategy spans 2025 to 2030 and represents a departure from the shorter lifespan of previous strategies. Developing the next iteration of the National BBV and STI Surveillance and Monitoring Plan will support the review of data for identification of areas in need of improvement. Progress and action are essential to remain accountable to the 2030 elimination goals, as well as ensuring the ongoing relevance of key aspects of the strategies.

The strategy will be implemented in a highly dynamic and unpredictable environment. As we saw with the COVID-19 pandemic, there are unforeseeable point-in-time contextual pressures that may require this strategy to be adjusted.

An Implementation Action Plan will provide the details of specific actions for governments and partners. The Implementation Action Plan will outline the roles and responsibilities of governments and partners and the timeframes for the implementation of the actions. Indicators will be identified to help monitor progress (including relevant alignment with the National Agreement on Closing the Gap Priority Reforms), with the Implementation Action Plan being reviewed and updated as required.

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