6th NATIONAL HEPATITIS C STRATEGY

2025–2030

Australian
Centre for
Disease
Control

© Commonwealth of Australia as represented by the Australian Centre for Disease Control

Title: Sixth National Hepatitis C Strategy 2025–2030

Creative Commons Licence

This publication is licensed under the Creative Commons Attribution 4.0 International Public License available from https://creativecommons.org/licenses/by/4.0/legalcode ("Licence"). You must read and understand the Licence before using any material from this publication.

Restrictions

The Licence may not give you all the permissions necessary for your intended use. For example, other rights (such as publicity, privacy and moral rights) may limit how you use the material found in this publication.

The Licence does not cover, and there is no permission given for, use of any of the following material found in this publication:

- the Commonwealth Coat of Arms. (by way of information, the terms under which the Coat of Arms may be used can be found on the Department of Prime Minister and Cabinet website
- any logos and trademarks;
- any photographs and images;
- any signatures; and
- any material belonging to third parties. The third party elements must be included here or have a footnote reference throughout the document showing where they are

Attribution

Without limiting your obligations under the Licence, the Australian Centre for Disease Control requests that you attribute this publication in your work. Any reasonable form of words may be used provided that you:

- include a reference to this publication and where, practicable, the relevant page numbers;
- make it clear that you have permission to use the material under the Creative Commons Attribution 4.0 International Public License;
- make it clear whether or not you have changed the material used from this publication;
- include a copyright notice in relation to the material used. In the case of no change to the material, the words "© Commonwealth of Australia (Australian Centre for Disease Control) 20XX" may be used. In the case where the material has been changed or adapted, the words: "Based on Commonwealth of Australia (Australian Centre for Disease Control) material" may be used; and
- do not suggest that the Australian Centre for Disease Control endorses you or your use of the material.

Enquiries

Enquiries regarding any other use of this publication should be addressed to the Communication and Public Information Section, Strategy and Engagement Branch, Australian Centre for Disease Control, GPO Box 798, Canberra ACT 2601, or via e-mail to Comms@cdc.gov.au.

Minister’s foreword

The Hon Mark Butler MP

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

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

Most cases of hepatitis C are curable or manageable. Our health system must ensure that this care reaches those who need it, when they need.

This strategy sets a strong direction for our national goal of virtual elimination of hepatitis C as a public health threat by 2030. It is ambitious but achievable.

Key achievements for Australia’s hepatitis C response include:

- over half of those affected by hepatitis C have initiated treatment
- high treatment uptake among those who inject drugs
- Needle and Syringe Program coverage in the community remains high
- decrease in hepatitis C notifications and positive test results
- a decline in hepatitis C attributable deaths.

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.

It is the community’s advocacy to secure equitable health outcomes for people affected by hepatitis C that has brought us where we are today. I would like to recognise the significant work of state and territory governments, national peak bodies and community organisations, national research centres of excellence, the Blood Borne Viruses and Sexually Transmissible Infections Standing Committee, and the public for their contributions in the development of this strategy.

Under this strategy, we aim to:

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

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

Our goal is elimination of hepatitis C 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 public health.

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 this strategy’s development, those who participated in workshops to inform indicators, targets, and priorities, and those who participated in stakeholder consultations and contributed to this strategy’s development process.

Acknowledgement of lived experience

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

Contents

Australian Centre for Disease Control

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]
DUO	Drug user organisation
GP	General practitioner
HCEF	Health Chief Executives Forum
HIV	Human immunodeficiency virus
IRID	Injecting-related related injury or disease
MBS	Medicare Benefits Schedule
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
RNA	Ribonucleic Acid
STI	Sexually transmissible infections/sexually transmitted infections
WHO	World Health Organization

Executive summary

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

This strategy's vision is to **eliminate hepatitis C as a public health threat by 2030** while supporting equitable access to safe, affordable, and effective prevention, harm reduction, education, testing, treatment, and person-centred care.

The 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. The partnerships between the Australian Government and the state and territory governments, who continue to work hard to eliminate hepatitis C in Australia, have also been key to the development and delivery of hepatitis C work.

Hepatitis C in Australia

- Hepatitis C is a preventable but potentially life-threatening bloodborne viral infection that causes inflammation and damage to the liver.
- Hepatitis C is not currently vaccine preventable.
- Hepatitis C can be cured through the use of highly effective and safe direct-acting antiviral medication.
- Prior to the introduction of highly curative hepatitis C treatments subsidised on the Pharmaceutical Benefits Scheme in 2016, there were an average of 10,000 new hepatitis C notifications per year.

In 2023, an estimated **68,890** people were living with chronic hepatitis C in Australia, disproportionately affecting people with a history of injecting drug use and Aboriginal and Torres Strait Islander People.[9]

- There were **7,602** hepatitis C notifications, an increase from 6,766 notifications in 2022.[9]
- Treatment with direct-acting antiviral medication can result in cure for **over 94%** of people with chronic hepatitis C.[9]
- All Australians who are Medicare eligible and people in prison can access **unrestricted treatment** subsidised through the Pharmaceutical Benefits Scheme.

Goals of the Sixth National Hepatitis C Strategy 2025–2030

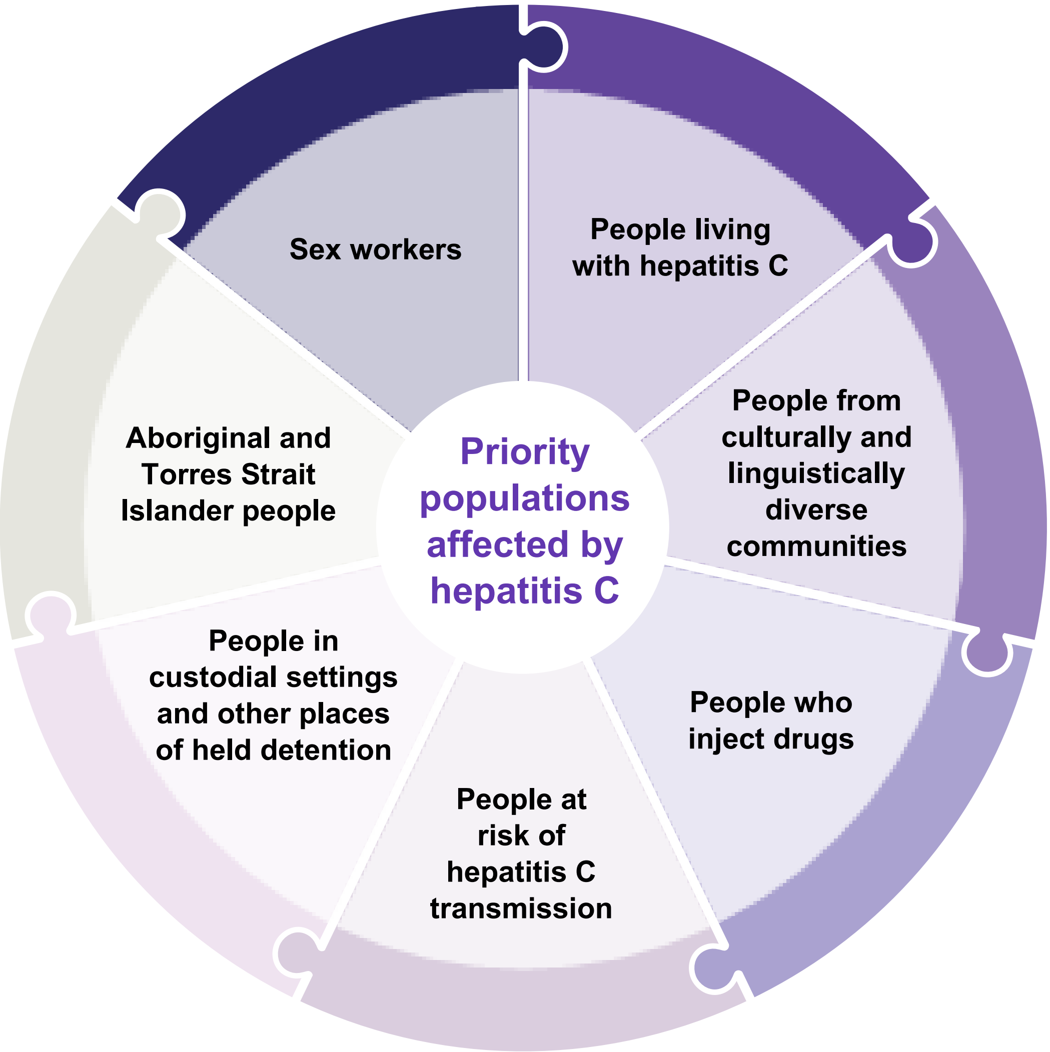
Virtually eliminate hepatitis C transmission by 2030

Reduce mortality and morbidity related to hepatitis C

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

Minimise the personal and social impacts of hepatitis C

Priority populations affected by hepatitis C



Priority areas for action

Equitable access to, and coordination of, care and support

Key actions from this strategy include supporting innovative models of hepatitis C care and enabling the national scale up of successful models; and exploring opportunities to remove barriers in accessing hepatitis C care.

Addressing stigma and creating an enabling environment

Actions to reduce stigma include co-designing national policy in partnership with people living with or who have lived experience of hepatitis C; increasing anti-stigma (and other) training for healthcare providers; and exploring opportunities aimed at addressing systemic contributors to poor hepatitis C outcomes.

Workforce

Key workforce actions include developing a national hepatitis C multidisciplinary workforce development plan; and exploring opportunities to strengthen the community and peer workforce.

Data, surveillance, research, and evaluation

Key actions include working with the community to update both the National Bloodborne Viruses and Sexually Transmissible Infections Surveillance and Monitoring Plan, and National Bloodborne Viruses and Sexually Transmissible Infections Research Strategy.
Affected communities and priority populations should be embedded in all aspects of research.

Testing, treatment, and management

Scaling up hepatitis C testing; implementing a nationally consistent notification follow up process; and supporting Australia’s liver cancer response are all key actions from this strategy.

Education and prevention

Key actions include working in partnership with state and territory governments to explore options to expand Needle and Syringe Programs to ensure regulated access to sterile injecting equipment where needed; and implementing educational community-led harm reduction and health promotion initiatives for the benefit of priority populations and the general community.

Vision statement

By 2030, hepatitis C will be eliminated as a public health threat.[1] Everyone will have equitable access to: safe, affordable, and effective prevention, harm reduction, education, testing, and treatment; and appropriate person-centred care and support. People affected by hepatitis C will be active decision makers in their care; live free from stigma, discrimination, and racism; and enjoy the best possible health.

---

[1] *The World Health Organization defines elimination of hepatitis C 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 C as defined by the World Health Organization is an 80% reduction in incidence and 65% reduction in mortality compared to the 2015 baseline.*

1. Introduction

Hepatitis C is a preventable and curable but potentially life-threatening bloodborne virus (BBV) that can be transmitted by blood-to-blood contact. It causes inflammation and damage to the liver, and can lead to serious liver disease, including cirrhosis and liver cancer.

The Sixth National Hepatitis C Strategy 2025–2030 (this strategy) guides Australia's strategic response to achieve elimination of hepatitis C as a public health threat by 2030. People affected by hepatitis C are at the centre of this strategy. This includes a focus on better understanding the culturally, ethnically, linguistically, socially, and geographically diverse populations affected by hepatitis C and enabling community leadership in all aspects of the national, jurisdictional, and local responses. Taking a person-centred approach to hepatitis C supports a shift from a disease and transmission-centric focus to one that also considers quality of life and the needs of people post-cure. By supporting leadership of and meaningful partnerships with affected communities, the national response to hepatitis C will enhance equity and ensure no one is left behind. Some of the work to achieve elimination is already underway across Australia. However, a number of actions will require further consideration, including where further funding is required.

Building on the achievements and lessons learned in the 2 decades since Australia's *First National Hepatitis C Strategy 1999–2000*, this strategy considers the changing context and epidemiology of the hepatitis C epidemic. Under the *Fifth National Hepatitis C Strategy 2018–2022*, Australia made significant progress towards national targets, including a relative halving of the prevalent population since the introduction of unrestricted access to curative direct-acting antiviral medicines. This strategy seeks to drive Australia's next phase of hepatitis C elimination with an increasing focus on equity and engaging people that remain unreached in our elimination efforts.

Some of the key drivers of the hepatitis C epidemic in Australia are stigma, racism, discrimination, criminalisation and 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 C as a priority within intersecting health and social policy contexts.

Opportunities to scale up and enhance existing approaches to hepatitis C prevention, harm reduction, testing, diagnosis, treatment, and post-cure care are also prioritised. Greater attention needs to be placed on liver health (including liver cancer and cirrhosis) attributable to hepatitis C, noting that actions to address hepatitis C can help reverse the upward trend of liver cancer and liver cancer deaths in Australia. This will be reliant on ensuring sufficient capacity of the existing clinical hepatitis C workforce and strengthening a hepatitis C specific community and peer workforce. Innovations in testing and treatment, including point-of-care testing, self-testing and further decentralisation to primary care and community settings, must be leveraged. 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 (WHO) global health sector strategies, on respectively, HIV (human immunodeficiency virus), viral hepatitis and sexually transmitted infections 2022–2030.*[2] This duration enables a longer-term vision, policy, and program implementation, as well as reinforcing Australia's commitment to meet our international obligations and targets. Ongoing surveillance, monitoring, periodic reviews, and evaluation will ensure the focus and actions of this strategy remain relevant and effective.

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

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: the Australian Injecting and Illicit Drug Users League (AIVL); Hepatitis Australia; 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 C. 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 C and other bloodborne viruses (BBV) and sexually transmissible infections (STI).

Person-centred response	People affected by hepatitis C 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 C 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, culturally, and linguistically appropriate supports and services. People affected by hepatitis C must be supported to be active participants in their own healthcare.
Partnership	Partnership is at the heart of Australia's response to hepatitis C. It is a long-standing tenet recognised by successive national hepatitis C 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 contributions, 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 that relate to this strategy, which are increasingly shifting into community and peer-based settings and feature community leadership.

Human rights

Australia recognises that valuing and upholding human rights for all is essential to preventing the transmission of hepatitis C and to mitigating health, social, and other impacts of disease.

People affected by hepatitis C have the right to enjoy the highest attainable standard of living free from stigma due to drug use, comorbidities, 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 C 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 supporting 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.*[3] 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)*[4] *and in the Basic Principles for the Treatment of Prisoners (resolution 45/111).*[5]

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 which remove discriminatory social, structural, and institutional conditions that result in the inequitable distribution of power and resources, and the exclusion of people on the basis of race, national or ethnic origin, age, sex, sexual orientation, gender identity, intersex status, drug use, disability, immigration status, comorbidities, or profession.

The goals of this strategy can only be achieved through addressing the inequities that drive the hepatitis C 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 for Aboriginal and Torres Strait Islander people who face multiple layers of stigma and discrimination, and for whom there are 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 under this strategy.[6,7] These instruments facilitate the active participation of affected communities and priority populations to increase their influence over the determinants of their health and the formulation and application of laws and public policies to support 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 transmission of hepatitis C can be prevented through the appropriate combination of evidence-informed social, biomedical, and behavioural approaches within a supportive and enabling environment, including prevention interventions and measures that reduce exposure to the virus. Enhancing and strengthening all primary prevention strategies will help embed primary and secondary 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.*[8,21]
Access and quality health services	Hepatitis C 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 C 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 C services across priority settings is essential.
Harm reduction	Harm reduction approaches underpin effective measures to prevent transmission of hepatitis C and related harms. Grounded in justice and human rights, harm reduction aims to minimise adverse health, social, and legal impacts through policies, programs, practices, and the involvement of 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, safer drug consumption sites, drug services, safer sex practices, peer support, and law reform across different jurisdictions (such as decriminalisation of sex work in relevant jurisdictions).

Meaningful involvement of priority populations	Meaningful involvement of priority populations in all aspects of the hepatitis C response is essential to the development, implementation, monitoring and evaluation of effective policy, programs, and research. The diversity 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 C is built on and values different forms of evidence and knowledge, research, surveillance, monitoring, evaluation, and strong community-driven interventions. Meaningful involvement of peer leaders, 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.[9] 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 social policy, and meet the goals of this strategy.[10]

3. Snapshot of Hepatitis C in Australia

What is hepatitis C?

Hepatitis C is a preventable but potentially life-threatening bloodborne viral infection that causes inflammation and damage to the liver. Hepatitis C can be cured through the use of highly effective and safe direct-acting antiviral medication; but is not currently vaccine preventable. Reinfection can occur if risk factors are ongoing as a previous infection does not confer immunity. If someone is reinfected, they can be retreated. If left untreated, chronic hepatitis C can cause liver inflammation, which may lead to liver disease, cancer, and death.

Prevalence

At the end of 2023, an estimated 68,890 people were living with chronic hepatitis C in Australia.[9] An estimated 50 million people have chronic hepatitis C worldwide.[11] In addition, the global prevalence of hepatitis C among people who inject drugs is estimated to be close to 43.6%.[12] Hepatitis C disproportionally affects priority populations: including people who currently inject drugs or who have a history of injecting drug use, people in custodial settings, Aboriginal and Torres Strait Islander people, and the other priority populations identified in this strategy.

How is hepatitis C managed?

Treatment with direct-acting antiviral medication can result in a cure for over 94% of people with chronic hepatitis C.[9] All Australians who are Medicare eligible and people in prison can access unrestricted treatment subsidised through the Pharmaceutical Benefits Scheme (PBS), prescribed by medical practitioners or authorised nurse practitioners. People who are cured with ongoing liver complications and people not cured following treatment require ongoing care and monitoring in specialist settings. Community and peer organisations support those affected by hepatitis C to navigate and access, testing, treatment, and ongoing care.

What health issues can hepatitis C cause?

Approximately 75% of hepatitis C cases are estimated to advance to chronic infection.[13] People with chronic hepatitis C are at risk of progressive liver fibrosis leading to cirrhosis, liver failure, and hepatocellular carcinoma (liver cancer). If not treated, approximately one in 5 people with chronic infections develop cirrhosis, generally after 20–30 years of infection.[14] These harms may occur post-cure for those who have already experienced liver damage prior to treatment. Combined, hepatitis C and hepatitis B are the primary cause of liver cancer, Australia's fastest growing cause of cancer death.[15]

In 2023, there were an estimated 530 hepatitis C-related deaths in Australia.[9] An estimated 16,400 people living with chronic hepatitis C had severe fibrosis, and 11,650 had hepatitis C-related cirrhosis.[9]

New diagnoses

In 2023 there were 7,602 notifications, an increase from 6,766 notification in 2022 but a decrease from 9,165 notifications in 2019.[9] The overall hepatitis C notification rate declined by 36% over the 10-year period 2014 to 2023, from 43.9 to 28.1 per 100,000 population.[9] Fluctuations from 2020 may be influenced by impacts of the COVID-19 pandemic, including significant disruptions to hepatitis testing.[16]

Aboriginal and Torres Strait Islander people are disproportionately affected by hepatitis C and have not experienced equitable benefit from the national response to date:

- In 2016, Aboriginal and Torres Strait Islander people made up 3% of the Australian population and 16% of all people living with hepatitis C. In 2020, that proportion had grown to 18%.[17]
- The 17% decline between 2016 and 2020 in the number of Aboriginal and Torres Strait Islander people living with hepatitis C is overshadowed by a 39% reduction for all populations nationally in the same period.[17]
- Notification rates of hepatitis C among Aboriginal and Torres Strait Islander people declined by 22% from 2019 to 2023 (faster than the 16% decline among non-Aboriginal and Torres Strait Islander people), but remaining more than 6 times greater than the non-Aboriginal and Torres Strait Islander population.[17]

At the end of 2023, an estimated 84% of all people living with hepatitis C had been diagnosed, and 90% of those diagnosed had received a ribonucleic acid (RNA) test to confirm chronic infection.[9]

Routes of transmission

Hepatitis C virus is transmitted through blood-to-blood contact. In Australia, hepatitis C is mainly transmitted through receptive sharing of injecting equipment disproportionally affecting people who inject drugs nationally. It can also be transmitted through exposure to infected blood in healthcare settings, non-sterile tattoos or body piercings, non-sterile personal care items, unscreened blood products and organ transplants, vertical (pregnant woman to child) transmission, and less commonly through unprotected sex. [2] Transmission during sex is rare but there are heightened risks among men who have sex with men including in the setting of HIV pre-exposure prophylaxis (PrEP).

There are heightened risks for transmission in custodial settings due to higher rates of chronic infection, increased prevalence of risk factors, higher rates of exposure and transmission, reinfection of hepatitis C, and an inconsistent equivalence of care to people in prison (including comprehensive access to evidence-based harm reduction).

Prevention

The primary hepatitis C prevention strategies for people who inject drugs include harm reduction, Needle and Syringe Programs, peer education, opioid dependence treatment and other treatments for injectable drugs of dependence in community and corrections settings.

While sexual transmission is uncommon, strategies to reduce sexual transmission (particularly barrier protection) are important for priority populations. Standard infection control procedures in Australia have virtually eliminated the risk of transmission in medical settings, however, risks remain from medical and dental procedures in other countries. In Australia, stringent regulation applies to the collection, processing, testing, release for supply, and quality assurance of blood and blood components.

---

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

Treatment and care

Of the 162,590 people living with chronic hepatitis C at the end of 2015 (the baseline for national and global hepatitis C service coverage targets), it is estimated that altogether, 105,960 Australians have received the highly effective hepatitis C treatments (including those who have been cured).[9] When subsidised interferon free direct-acting antiviral regimens became available in Australia in 2016, uptake of these highly effective hepatitis C treatments was high, but since then, treatment uptake has declined from 32,460 in 2016 to 5,500 in 2023.[9] Of those receiving direct-acting antiviral treatment since 2016, 6,482 individuals received at least one further treatment course due to reinfection.[9]

4. About this strategy

This strategy builds on previous strategies and sets the direction for Australia's continuing response to hepatitis C 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. Sixth National Hepatitis C Strategy 2025–2030 (this strategy)
2. *Fourth National Hepatitis B 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 common 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 multidisciplinary research activities to support the implementation of the 5 national BBV and STI strategies.[18]

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

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

1. State and territory viral hepatitis strategies
2. *WHO Global Health Sector Strategies on, respectively, HIV, Viral Hepatitis and Sexually Transmitted Infections for the period 2022–2030*
3. *National Immunisation Strategy For Australia 2025–2030*[19]
4. *National Drug Strategy 2017–2026*[20]
5. Long Term National Health Plan[21]
6. *National Preventive Health Strategy 2021–2030*[8]
7. The United Nations International Covenant on Economic, Social and Cultural Rights[22]
8. The United Nations Common Position on Drug Policy[23]

---

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

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

9. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)[4]
10. Australian Cancer Plan 2023–2033[24]
11. Aboriginal and Torres Strait Islander Cancer Plan[25]
12. The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)[3]
13. National Anti-Racism Framework Scoping Report[26]
14. Australia's Primary Healthcare 10 Year Plan[27]
15. National Strategic Framework for Chronic Conditions[28]
16. Clinical Practice Guidelines Pregnancy Care 2020 Edition[29]
17. National Aboriginal and Torres Strait Islander Health Plan[30]
18. National Agreement on Closing the Gap and associated implementation plans[31]
19. Nurse Practitioner 10 Year Plan[32]
20. National Framework for Communicable Disease Control[33]
21. Roadmap to Liver Cancer Control in Australia[34]
22. International Covenant on Civil and Political Rights[35]
23. Convention on the Rights of Persons with Disabilities[36]
24. International Convention on the Elimination of all Forms of Racial Discrimination[37]
25. Convention on the Elimination of all Forms of Discrimination against Women[38]
26. National Women's Health Strategy 2020–2030.[39]

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.[40] 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 significant progress towards meeting the goals of the *Fifth National Hepatitis C Strategy* and the hepatitis C elimination targets of the *WHO global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030*. Progress has been most notable for certain priority populations where there has been adequate investment and action over time, for example Australia's Needle and Syringe Program network and in the continued delivery of safe blood supplies and safe injections in healthcare settings.

5.1 Key achievements under the *Fifth National Hepatitis C Strategy 2018–2022*

- **Over 50% of people living with hepatitis C have initiated treatment.**

  105,960 people living with hepatitis C initiated direct-acting antivirals from 2016–2023. Of the people receiving treatment, 10,567 people (10%) were retreated at least once.[41]

- **Treatment uptake among people who inject drugs is a leading success story of the national response.**

  Among an estimated 75,000 people who inject drugs regularly in Australia, the number of people with chronic hepatitis C infection declined from 51% in 2015 to 12% in 2023.[9]

  Among those with chronic hepatitis C, the majority (78% in 2019 and 84% in 2023) had been diagnosed. The proportion of those treated and assumed to have been cured remained steady at 94% between 2016–2023.[9]

  This progress reflects the commitment of people who inject drugs to their own health and the health of their community, the leadership of peers and peer-based drug user organisations (DUO) and other community organisations, and the services and champions who focus on at-risk priority populations.

- **Needle and Syringe Program coverage in the community remains high.**

  In 2023, the Australian Needle and Syringe Program Network consisted of 4,442 outlets (a 27% increase from 3,509 in 2016) and distributed 50.8 million sterile needles and syringes.[42] This equates to an estimated syringe coverage per injection of 114% among the population of people who inject drugs on a regular basis. Syringe coverage greater than 100% is required to accommodate syringes used by people who inject drugs occasionally and syringes that are not used for an injection.[42]

- **Decrease in positive test results.**

  Among participants in the Australian Needle and Syringe Program Survey, between 2015 and 2023, the proportion testing hepatitis C antibody positive reduced from 57% to 45%, the proportion testing RNA positive (with current infection) reduced from 51% to 12%, and lifetime treatment for hepatitis C increased from 11% to 75%.[9] Among Aboriginal and Torres Strait Islander populations in the Australian Needle Syringe Program Survey, there was a significant increase in the proportion reporting ever having hepatitis C treatment, from 10% in 2015 to 66% in 2023.[43]

- **Hepatitis C attributable deaths have declined.**

  There was a 26% reduction in the estimated number of deaths attributable to chronic hepatitis C between 2015 and 2023.[9]

- **Decrease in notifications.**

  Overall, there has been a steady 36% decline in the rate of hepatitis C notifications from 43.9 per 100,000 population in 2014 to 28.1 per 100,000 in 2023.[9] This is despite increased notifications in 2016 associated with increased testing for the introduction of direct-acting antiviral therapies. In the decade to 2023, the rate of notifications among people aged 15–24 years (used as a proxy indicator for incidence of hepatitis C) has reduced by 28% (from 35.5 to 25.6 per 100,000 population), with greater declines recorded among females compared with males.[9]

- **Progress has been made among Aboriginal and Torres Strait Islander people in the national response to hepatitis C.**

  In the 8 years to 2023 following the PBS listing of direct-acting antivirals in 2016:

  - The estimated proportion of Aboriginal and Torres Strait Islander people living with hepatitis C declined by 17%.[17]
  - An estimated 12,875 Aboriginal and Torres Strait Islander people took up antiviral treatment for hepatitis C.[17]
  - Among Aboriginal and Torres Strait Islander participants in the Australian Needle and Syringe Program Survey (ANSPS), the proportion of people with evidence of ever having a hepatitis C infection declined from 70% in 2015 to 36% in 2022.[43]
  - The proportion of Aboriginal and Torres Strait Islander respondents to the ANSPS who tested positive for a current hepatitis C infection (having received RNA testing) declined from 41% in 2016 to 15% in 2023.[44,45]
  - In 2022, of Aboriginal and Torres Strait Islander ANSPS participants, the proportion reporting a hepatitis C test in the previous 12 months was 51% and the proportion of participants who reported ever having had a hepatitis C test was 78%.[43]
  - The proportion of Aboriginal and Torres Strait Islander respondents to the Australian Needle and Syringe Program Survey self-reporting ever having hepatitis C treatment increased from 10% (in 2015) to 68% in 2023.[9]

5.2 Areas where further efforts are required

Despite these successes, none of the targets from the *Fifth National Hepatitis C Strategy 2018—2022* were met and people who inject drugs, Aboriginal and Torres Strait Islander people and people in prisons are still disproportionally affected by hepatitis C compared to the rest of the population.

Table 1: Progress against the Fifth National Hepatitis C Strategy

Progress against the Fifth National Hepatitis C Strategy's targets

Reduce the number of newly acquired hepatitis C infections, with a focus on priority populations by 60% [compared with/based on 2016 data]

(!) Insufficient data

Insufficient data to confirm. There is no published 2016 estimate of the number of newly acquired hepatitis C infections nationally. Instead, acknowledging certain limitations, newly acquired notification rates are published as proxy measures. The rate of notifications among those aged 15–24 years (used as a proxy for the incidence of hepatitis C infection) declined by 28% between 2014 and 2023 (from 35.5 per 100,000 in 2014 to 25.6 per 100,000 in 2023).[9] A portion of the decline from 2019 to 2022 may be due in part to the impact of COVID-19 restrictions on hepatitis testing uptake.

Increase the proportion of people living with hepatitis C who are diagnosed to 90%

● Not yet achieved

At the end of 2023, an estimated 84% of people affected by hepatitis C were diagnosed.[9]

Increase the cumulative proportion of people living with chronic hepatitis C who have initiated direct-acting antiviral treatment to 65% [compared with/based on 2016 data]

● Not yet achieved

Between 2016 and 2022, the estimated cumulative proportion of people initiating direct-acting antiviral treatment for hepatitis C increased from 20% to 60%. In 2023 treatment coverage was estimated to be 63%.[9]

Reduce hepatitis C attributable mortality overall by 65% [compared with/based on 2016 data]

● Not yet achieved

Estimated number of hepatitis C-related deaths reduced by 26% from 2015 to 2023.[9]

Reduce the reported experience of stigma among people living with hepatitis C by 50%, and the expression of stigma, in respect to hepatitis C status [baseline to be determined]

● Not yet achieved

Progress not achieved. In 2023, a 'Stigma snapshot' of a survey of people who inject drugs found that more than half of respondents (52%) reported experiencing stigma within the last 12 months in relation to their hepatitis C, with 7% reporting that they 'often' or 'always' experienced stigma, with these proportions not significantly different from those reported in 2018.[46] Within healthcare settings, the proportion of health workers who expressed stigma at least some times towards people living with hepatitis C has reduced, from 54% in 2016 to 32% in 2023.[46] While the demographic profiles of the 2018 sample were noted to be significantly different from the 2021 and 2022 samples, the results highlighted that stigma and negative behaviours towards population groups affected by BBVs, including people living with hepatitis C, persist throughout the Australian healthcare system.

Progress against the targets of the previous *Fifth National Hepatitis C Strategy* highlight that more action is needed to ensure that hepatitis C is eliminated as a public health threat by 2030.

Increased meaningful engagement with people across all priority populations is imperative to the success of Australia's response, particularly people with elevated risk factors, people whose hepatitis C status is unknown, and those who are lost to follow up or otherwise disengaged from care for their hepatitis C.

In Australia, prisons are the primary setting of hepatitis C transmission. It is therefore essential for governments to explore scaling up, implementing, and adequately resourcing evidence-based prevention and harm reduction programs across all priority settings, with innovative interventions targeting priority populations and supporting people who inject drugs to prevent hepatitis C transmission and other injecting-related injury and disease (IRID).[47]

Stigma, discrimination, racism, and health inequity, including in prisons, are major barriers to the successful implementation of this strategy.[2] There is a need for more implementation projects, regulatory and systemic reform and research to tackle stigma, discrimination, and racism, in collaboration with priority populations.[46,48]

Enhancements and innovations in hepatitis C testing, treatment, management, and post-cure care remain critical to reducing hepatitis C-related morbidity and mortality, including as a result of liver cancer. This includes further decentralisation of care to community and primary care settings to reach those not engaged in the national response to date.

Greater resilience is also needed in the national hepatitis C response to prevent or reduce the impacts of future health emergencies on progress. This was seen, for example, through declining hepatitis C testing as a result of COVID-19 pandemic restrictions.

The success of this strategy also relies on building a strong evidence base in partnership with priority populations. Appropriate monitoring and research are needed to better inform Australia's response. This evidence will help evaluate approaches to identify what is most effective, and further strengthen the multi-sectorial workforce, partnerships and connections to priority populations.[49]

6. Measuring progress

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

6.1 Goals

The goals of the Sixth National Hepatitis C Strategy 2025–2030 are to:

Virtually eliminate hepatitis C transmission by 2030.

Reduce mortality and morbidity related to hepatitis C.

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

Minimise the personal and social impacts of hepatitis C.

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.

The hepatitis C gap is widening for Aboriginal and Torres Strait Islander people since the cure became available in 2016.

With the right investment, capacity, and prioritisation in Aboriginal community-led organisations, and in prisons, significant change is achievable. The Aboriginal Community Controlled Health Organisations (ACCHO) sector can be a leader in the hepatitis C response and can help to meet health equity thresholds.

A new response is urgently needed that prioritises and resources actions for Aboriginal and Torres Strait Islander people, including as part of the Closing the Gap Priority Reforms,[5] this strategy, and the hepatitis C equity threshold. 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 is remedied as a key priority in progressing towards the 2030 elimination goal.

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 updated National BBV and STI Surveillance and Monitoring Plan (see **Table *2***).

---

[5] *https://www.closingthegap.gov.au/national-agreement/priority-reforms*.

Table 2: Hepatitis C 2030 measuring progress targets[6]

1	**Reduce by 90**% the incidence of hepatitis C.[7]
2	**5 or less** cases per 100,000 population per year.[8]
3	**2 or less** cases per 100 people who inject drugs per year.[9]
4	Increase the proportion of people living with hepatitis C who are diagnosed (confirmed hepatitis C RNA positive) to **90%.**
5	**Reduce to 2%** or less of the proportion of people with hepatitis C diagnosed with liver cancer or decompensated cirrhosis, whose hepatitis C was diagnosed late.
6	**85%** of people living with hepatitis C are cured.[10]
7	**Reduce by 65%** hepatitis C attributable mortality.[11]
8	**1 or less** deaths per 100,000 population per year.[12]
9	**Greater than 95%** completion of Aboriginal and Torres Strait Islander status across data sets.
10	**Reduce to zero** the expression of hepatitis C-related stigma and discrimination in healthcare settings. **Reduce by 75%** the experience of hepatitis C-related stigma among people who have ever lived with hepatitis C.
11	**95%** of people affected by hepatitis C report a good quality of life.
12	**Reduce the negative impact** of legal and human rights issues on the health and wellbeing of people affected by hepatitis C.

---

[6] *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] *Progress against the incidence reduction target is measured against baseline at the end of 2015.*

[8] *Progress against the incidence reduction target is measured against baseline at the end of 2015.*

[9] *Progress against the incidence reduction target is measured against baseline at the end of 2015.*

[10] *Progress against the proportion cured target is measured against baseline at the end of 2015 plus subsequent cases.*

[11] *Progress against the attributable mortality target is measured against baseline at the end of 2015.*

[12] *Progress against the attributable mortality target is measured against baseline at the end of 2015.*

7. Priority populations and settings

Hepatitis C disproportionately impacts several key populations. This strategy identifies priority populations and sub-populations, acknowledging diverse intersecting characteristics and risk factors unique to each individual. Intersectional approaches to hepatitis C responses are needed to ensure that multiple social and structural determinants of health can mutually reinforce and improve equitable hepatitis C 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, race, cultural identities, language spoken, geographic settings, risk factors, drug use, gender expression and experiences, disability, sexual orientations, religious affiliations, profession, and socio-economic and visa status.

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

7.1 Priority populations

People affected by hepatitis C

The description ‘people affected by hepatitis C’ is used as an inclusive term describing the large and diverse population of people who have lived with, who are living with (whether undiagnosed or diagnosed, untreated or undergoing treatment, or reinfected), and/or are at risk of hepatitis C, and all priority populations. This also includes people who have been cured of hepatitis C, with ongoing health and social impacts and associated support needs. This strategy refers to ‘people affected by hepatitis C’ to collectively frame the following hepatitis C priority populations.

People living with hepatitis C

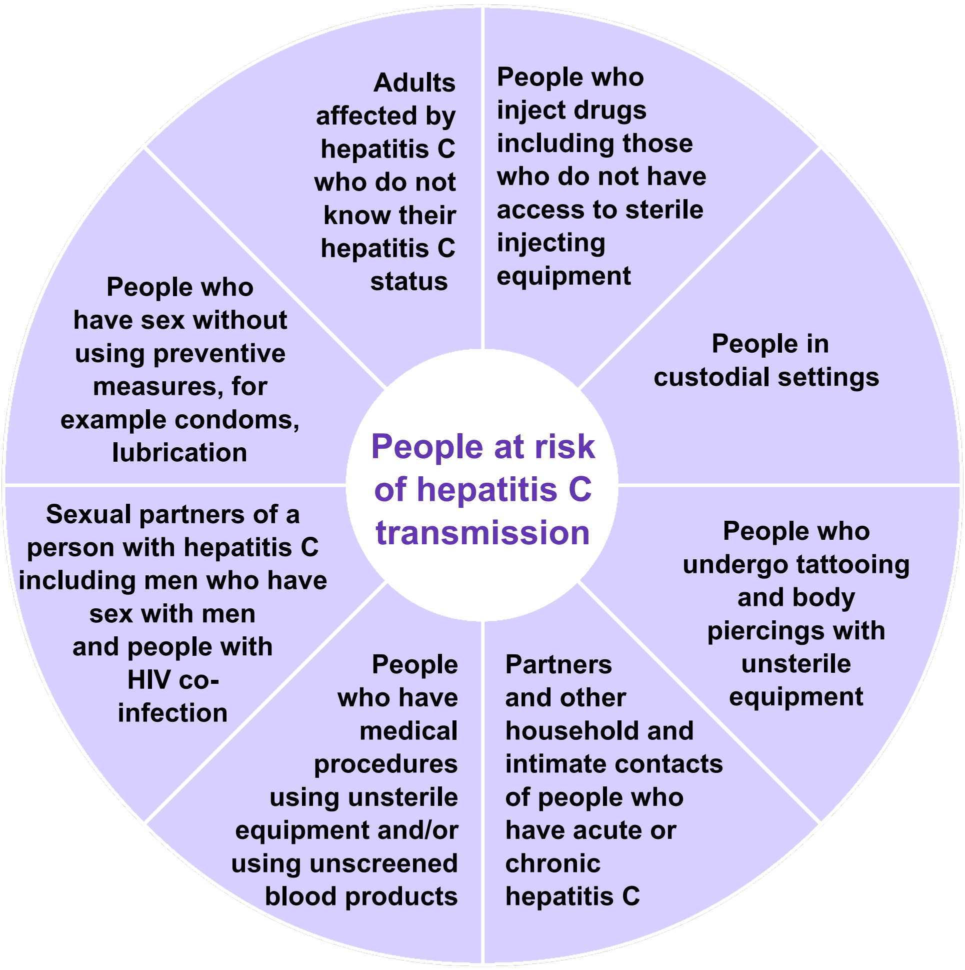
‘People living with hepatitis C’ includes individuals who are fully diagnosed, partially diagnosed (no RNA test), not yet diagnosed, those whose hepatitis C has relapsed post-treatment, and people who have been reinfected post-cure. It also includes the following sub-populations:

- people living with hepatitis C who inject drugs and with a history of injecting drugs
- people living with hepatitis C who use drugs (smoking, snorting, bumping, etc) and who may be sharing equipment
- people living with hepatitis C who are in custodial settings or other places of held detention
- people living with hepatitis C who are not eligible for subsidised care or do not access health services related to hepatitis C or hepatitis C risk transmission
- people who acquired hepatitis C before direct-acting antivirals and are lost to follow-up
- people who receive a late hepatitis C diagnosis
- people living with hepatitis C who access opioid agonist treatment or other drug treatment services
- people living with hepatitis C who have cirrhosis, or liver cancer
- people living with hepatitis C without current risk factors.

The proportional makeup of the prevalent population and the distribution of hepatitis C across these subpopulations has, and will continue to, change over time.[50] The people living with hepatitis C who were ‘willing and waiting’ for treatment are different from those who have not yet undergone treatment and are ‘hesitant’ or ‘doubtful, uncertain or unaware of treatment’.[50] Maintaining and strengthening Australia’s current approach to priority populations is crucial, including continuing to promote prevention, harm reduction and hepatitis C treatment uptake in communities of people who inject drugs.[50] Concurrently, broader approaches are needed to engage people living with hepatitis C who no longer inject drugs or who contracted hepatitis C through other transmission routes.

People at risk of hepatitis C transmission

Since 2016, people living with hepatitis C in Australia have benefited from unrestricted direct-acting antiviral medicines. People living with chronic infection and engaged in care can now be cured. However, there are communities within which infection, reinfection and transmission risks remain high. People who are at risk of acquiring hepatitis C are shown in the **figure** below.



People who inject drugs

Unsterile injecting drug use is a major transmission risk factor in Australia.[13] Barriers to accessing harm reduction measures, including sterile injecting equipment in custodial settings and in rural, regional, and remote Australia, create additional risk for people who inject drugs in those settings. Ongoing investment into harm reduction strategies is necessary to continue actively reducing the impact of hepatitis C for this priority population. Sub-populations (and intersecting identities) of people who inject drugs that are at an increased risk of exposure to hepatitis C include Aboriginal and Torres Strait Islander people, men who have sex with men, people in custodial settings, young people and people experiencing mental illness or homelessness.

Aboriginal and Torres Strait Islander people affected by hepatitis C

In 2023, the hepatitis C notification rate among Aboriginal and Torres Strait Islander people was 165.5 per 100,000, more than 6 times as high compared with non-Aboriginal and Torres Strait Islander Australians (25.7 per 100,000).

Chronic hepatitis C infection is associated with liver cirrhosis, fibrosis, and cancer. The incidence of liver cancer is almost 2.5 times greater among Aboriginal and Torres Strait Islander people compared with the non-Aboriginal and Torres Strait Islander population.

Liver cancer is the second highest cause of cancer-related deaths in Aboriginal and Torres Strait Islander people – over 2 times greater than the non-Aboriginal and Torres Strait Islander population.

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), a lack of 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 risks and burden of hepatitis C.

Aboriginal and Torres Strait Islander people are therefore disproportionately impacted by hepatitis C when compared with the non-Aboriginal and Torres Strait Islander population. 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, culturally safe primary healthcare services enables appropriate testing, monitoring, treatment and care. Alongside effective community development, and health promotion determined by communities themselves, Aboriginal and Torres Strait Islander communities also require access to culturally safe testing, harm reduction, treatment and care programs, and antenatal care delivered through ACCHOs, Aboriginal Medical Services (AMS) and mainstream primary care.

To ensure that Aboriginal and Torres Strait Islander priority populations are not left behind in the national hepatitis C 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,*

---

[13] *The Australian NSP Survey National Data Report 2019–2023 reported hepatitis C antibody prevalence for people who inject drugs.*

National Aboriginal and Torres Strait Islander Health Plan 2021–2030, and incorporation of the 4 *Priority Reforms of the National Agreement on Closing the Gap 2020–2030*.

People from culturally and linguistically diverse communities affected by hepatitis C

People affected by hepatitis C from culturally and linguistically diverse communities include people born in countries with high prevalence of hepatitis C, refugees, humanitarian entrants, and Australian-born descendants of parents from countries with high prevalence of hepatitis C.

In countries with high prevalence of hepatitis C, common transmission risks come from medical and dental procedures, transfusion of unscreened blood, custodial settings, and occupational settings. Further work needs to be done with culturally and linguistically diverse communities and sub-populations within this group to ensure appropriate, tailored implementation and actions.

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

- people born in countries with high prevalence of hepatitis C
- Australian-born children of people born in countries with high prevalence of hepatitis C
- people who speak a language other than English as their first/preferred language
- people affected by hepatitis C who are not eligible for subsidised care
- people from countries with high prevalence of hepatitis C, who access legal and migration and/or multicultural groups/services
- international students and people on temporary visas from high prevalence countries.

Australia is a member of the WHO Regional Committee for the Western Pacific, and researchers and civil society are active in the Western Pacific region, including through membership in the World Hepatitis Alliance and in collaboration with the International Network of People who Use Drugs (INPUD). In 2022, an estimated 7.1 million people in the Western Pacific Region live with hepatitis C, many remain undiagnosed and untreated.[12] Globally, approximately 1.3 million people died of viral hepatitis in 2022, similar to the number of deaths caused by tuberculosis.[12] Viral hepatitis and tuberculosis were the second leading causes of death among communicable diseases in 2022, after COVID-19.[12]

People in custodial settings and other places of held detention

Custodial settings are now the primary site of hepatitis C transmission nationally.[51] Incarceration is recognised as an independent and elevated risk factor for hepatitis C transmission and there is a greater risk, incidence, and prevalence of hepatitis C in custodial settings. Further, a lack of access to evidence-based harm reduction, prevention and education, use of unsterile tattooing and body piercing, fighting, blood spills, condomless sex, and shared use of personal effects has led to increased exposure risks and higher rates of hepatitis C among prison populations.

Due to the social, economic, and structural determinants of health and wellbeing, there is significant intersectionality for people in custodial settings with other priority populations and settings. In particular, Aboriginal and Torres Strait Islander people are overrepresented, as are people who inject drugs, and people with mental health conditions.

Sex workers

Sex workers are a priority population due to a potentially higher exposure risk to hepatitis C. More research and quality data are required to fully understand hepatitis C incidence within 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. This in turn 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 BBV rates, improved access to health promotion and access to workplace health and safety.[54] Peer education through peer-based sex worker organisations is essential for promoting prevention, testing and treatment for sex workers. Within this population, tailored approaches for sex workers who inject or have injected drugs 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.

Other groups

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

- women affected by hepatitis C
- people at risk of or living with hepatitis B co-infection
- people at risk of or living with HIV co-infection
- people who have had transfusions of unscreened blood and/or blood products in Australia before 1990
- people with other concurrent liver disease.

7.2 Priority settings

Hepatitis C responses can be better positioned and delivered within the social and cultural contexts of affected communities and priority sub populations by taking settings-based approaches.

De-centralising care outside of specialist services into more primary care and community-based responses should be further prioritised, including through Primary Health Network (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 C expertise that is agile and responsive.

Community-based settings

Engaging people affected by hepatitis C in places where they live, work, and socialise is critical, particularly for priority populations who may experience barriers to accessing mainstream primary and tertiary health services. These settings play a number of different roles, including testing, treatment, and ongoing care; provide linkages to appropriate healthcare and other social and health support services; and provide access to appropriate harm reduction and prevention interventions, and safe health promotion and education. Importantly, as healthcare for hepatitis C becomes more decentralised, these settings will increasingly provide critical healthcare and support services to people affected by hepatitis C and key priority populations.

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

Drug user organisations (DUOs)

These organisations provide access to de-stigmatised and culturally appropriate hepatitis C-focussed peer-based support, information, harm reduction services, education, advocacy, referral, and navigation, and other services that aim to reduce the transmission of hepatitis C associated with drug use.

Community hepatitis organisations

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

Needle and Syringe Programs

Needle and Syringe Programs are critical for prevention, ensuring 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.

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.

Aboriginal Community Controlled Health Organisations/Aboriginal Medical Services

ACCHOs are primary healthcare services initiated and operated by the local Aboriginal and/or Torres Strait Islander community 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 C, providing community-controlled services to large, remote and/or high prevalence communities. Dedicated and ongoing investment in ACCHOs is required to reduce the prevalence and harms of hepatitis C.

An Aboriginal Medical Service is a health service funded principally to provide services to Aboriginal and Torres Strait Islander people. 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.

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 healthcare sectors to advocate for better health and wellbeing outcomes for culturally, and linguistically diverse communities.

Primary, secondary, and tertiary healthcare settings

People with hepatitis C 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 C 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 C can access healthcare include bilingual and bicultural healthcare providers, birthing parent and child health, sexual health and family planning services, ACCHOs, emergency departments, liver specialist services, cancer services, palliative care, and pharmacies.

Geographic settings

Generally, rural and remote areas have the highest prevalence of hepatitis C (as a proportion of the population) and the lowest levels of treatment and care uptake.[55] As such, greater focus and effort is needed to address this disparity and remedy the resulting inequitable health outcomes. This includes considering how health workforce classifications, including the Modified Monash Model (MMM), support building capacity and channelling resources into areas of unmet need, and 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 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. Peer outreach and connection to DUO peer-based harm reduction services can help reduce stigma, increasing the likelihood of people who inject drugs accessing services and improve health equity. Increased efforts are also generally needed in areas of increased prevalence, where progress to elimination is slow, and where inequitable hepatitis C 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 C and are high-risk areas for transmission. 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 custodial settings
- the number of people who inject drugs in custodial settings
- inconsistent access to comprehensive evidence-based harm reduction measures.

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

Legal services

The intersecting nature of risk factors for hepatitis C (for example, the criminalisation of drugs and injecting drug use) means that people affected by hepatitis C interact with the legal system through the use of a range of services, including community legal services and parole services. Therefore, these settings provide information and linkages to healthcare, community-based support, and adjacent services for people who may experience barriers to healthcare and other types of support.

Other settings

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

- alcohol and other drug services including opioid dependence treatment services
- mental health services
- homelessness services
- migration, refugee, and settlement services.

8. Priority areas for action

This section outlines the actions necessary for the elimination of hepatitis C 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 consistent with the guiding principles outlined in this document.

8.1 Education and prevention

- Improve knowledge, health literacy, and awareness of hepatitis C in priority populations and health workers to support engagement in prevention, harm reduction, awareness of cure, testing, treatment, monitoring, and management post-cure, including liver health.
- Provide equitable access to the full suite of harm reduction and prevention measures for all priority populations, including new injecting equipment, through Needle and Syringe Programs.
- Enhance and improve access to hepatitis C-focused community and peer education.
- Ensure education and prevention activities address the secondary harms arising from hepatitis C, including liver disease, liver cancer and collapsed veins.
- Ensure education and prevention activities address the secondary harms arising from injecting drug use including collapsed veins, abscesses, and other injecting site infections, endocarditis, overdose and poor dentition.
- Raise hepatitis C awareness among people with lived experience of injecting drug use, particularly those with intersecting identities, including the availability of the cure, the effectiveness of treatment, and where further prevention, testing, treatment, support, and post-cure health care is provided.
- Support stigma reduction in health and social education programs, in services accessed by people affected by hepatitis C, and other settings including corrections centres.

There is no vaccine against hepatitis C, with prevention dependent on reducing the risk of exposure to the virus.[57] Primary prevention of hepatitis C transmission is supported through evidence-informed education, health promotion, and harm reduction strategies. Secondary prevention of hepatitis C is focused on factors impacting the progression of hepatitis C-related liver disease and associated harms.

Improved awareness and understanding of hepatitis C among those working with priority populations, in priority settings and health services, is critical to achieving the elimination of hepatitis C by 2030. Priority population appropriate interventions that target prejudice, misconceptions and gaps in knowledge can significantly reduce stigma and discrimination, and increase rates of testing and engagement in care, reducing the overall impact of infection and related harms.[58] Education and health promotion initiatives should be community and peer-led and implemented and reflect the diversity of target audiences. Peer-engagement approaches are particularly effective in engaging people who inject drugs.[59,60]

This strategy promotes equitable access to the full suite of harm reduction and prevention measures for all priority populations. The reuse of needles and syringes that have been used by others (receptive syringe sharing) by people who inject drugs is a major risk factor for transmission of hepatitis C.[9] Needle and Syringe Programs play a key role in hepatitis C prevention and harm reduction education. Needle and Syringe Programs are cost-effective, with modelling over a 10-year period estimating that over 96,000 new hepatitis C infections were averted and, for every dollar invested in Needle and Syringe Programs, more than 4 dollars were returned (additional to the investment) in direct healthcare cost savings.[61]

International evidence demonstrates that introduction of Needle and Syringe Programs in custodial settings significantly reduces transmission of hepatitis C.[62,63] Australian governments should consider evidence from international contexts when exploring harm reduction measures to reduce hepatitis C transmission and reinfection, particularly in priority settings. There are also opportunities to improve equitable access to sterile injecting equipment, drug treatment options, and peer education among the community of people who use drugs, to actively reduce hepatitis C transmission.[64]

A person living with hepatitis C 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 substantial delays in diagnosis. During this time, further inadvertent transmissions can occur, as can preventable deterioration in liver health. Hepatitis C remains a major contributor to liver cancer in Australia, the fastest growing cause of cancer death. Prevention of chronic hepatitis C virus infection and secondary harms is cost-effective liver cancer prevention that could help to reverse the trend of increasing liver cancer mortality and other health issues for ageing people with lived experience of injecting drug use.

This strategy raises hepatitis C awareness in the general community and custodial settings, including the availability of the cure, the effectiveness of treatment, and supports stigma reduction. It is therefore important that health promotion, harm reduction, education, regular testing, timely access to re-treatment, and access to the means of prevention continue for people with ongoing risk of infection and reinfection.

Table 3: Key areas for action – Education and prevention

KEY AREAS FOR ACTION – Education and prevention

1. Explore implementing comprehensive, evidence-based prevention and harm reduction strategies in partnership with state and territory governments, including in custodial settings. This could include safer tattooing and piercing, vein care, opioid dependence treatment, other treatment options for injectable drugs of dependence, safer sex practices, condoms, and lubrication.
2. Implement community-led awareness, health promotion, harm reduction and public education initiatives for priority populations and the general community, including national and local hepatitis C public campaigns, World Hepatitis Day and International Drug Users' Day in Australia.
3. Facilitate the development and expanded access to evidence-based education and referral services, such as peer-based information and multimodal resource hubs, as central points of contact for affected communities to access hepatitis C information and support. This includes:
    a. facilitating the sharing, adaptation, scale up, and implementation of successful hepatitis C prevention and harm reduction initiatives to other priority populations and settings, including custodial settings
    b. supporting the role of primary care, including general practitioners (GPs) and nurses, in raising awareness of infection and reinfection, and primary and secondary prevention measures.

4. Increase access to harm reduction programs for people who inject drugs across all priority settings, such as through Needle and Syringe Programs, supervised-injecting facilities and peer-based/community harm reduction initiatives delivering education and distributing equipment.

5. Support an increase in equitable access to evidence-based opioid agonist therapy options and other treatments for injectable drugs of dependence in priority populations and priority settings and address key barriers to access.

6. Identify and address the resourcing, policy, legal, regulatory, and structural barriers that impede equitable hepatitis C outcomes, including the provision of all available harm reduction measures, and national prioritisation.

8.2 Testing, treatment, and management

- Maximise the number of people living with hepatitis C who are fully diagnosed, undergo treatment, and receive post-cure care (for those who remain at risk of hepatitis C-related complications and liver cancer).
- Increase the availability, adoption, and use of hepatitis C testing and treatment technologies to drive person-centred care, including self-testing and point-of-care-testing.

Testing for hepatitis C among priority populations and in priority settings enables early diagnosis, access to curative treatment, and education to prevent transmission. Late diagnosis can lead to onward transmission, poor health outcomes, and missed opportunities to prevent advanced liver disease and cancer.

Efforts to increase testing for all people affected by hepatitis C in Australia must remain based on the principles of informed consent, ensuring that testing is voluntary, accessible, non-discriminatory, confidential, and of clear benefit to the person being tested.[65]

Finding everyone currently undiagnosed, partially diagnosed, or not engaged in active management of their hepatitis C infection is essential to improve linkage to care and treatment uptake and a major focus for investment to achieve 2030 goals. There has been a steady decline in the estimated proportion of people living with hepatitis C who are undiagnosed (from 22% in 2016 to 16% in 2023).[9] Hepatitis C diagnostic (RNA) testing in Australia would need to substantially increase for national hepatitis C elimination targets to be achieved.

There continues to be a significant drop off in the cascade of care following people being diagnosed and notified but not starting treatment. An improved and nationally consistent mechanism for the follow up of hepatitis C notifications is needed to ensure that all people diagnosed as antibody positive undergo testing for current infection and then, if RNA positive, are linked to care in a timely way through a variety of mechanisms. Community-based, including peer-delivered models of hepatitis C testing, will further improve the availability, usability, and acceptability of hepatitis C testing for all priority populations. This includes scaling up use of mobile diagnostic technologies, such as self, rapid, and point-of-care testing where available, which can be increasingly performed at home or by community and peer workers. Studies from overseas show that self-testing diversifies testing locations, safeguards confidentiality, and simplifies the process of diagnostic testing. Self-testing may also decrease any stigma associated with testing, as it provides an opportunity for key populations to test themselves discreetly and conveniently.[66]

Models and infrastructure are required in Australia to enable linkage to care for those undertaking self-testing; adapting models from other communicable diseases, such as HIV and COVID-19, may be useful.

To achieve elimination, Australia must maintain unrestricted and subsidised access to hepatitis C curative treatments. In addition to specialists, treatments can also be prescribed by GPs, nurse practitioners, alcohol and other drug physicians and sexual health physicians, helping to expand access to care.[67] Further decentralisation of care into primary, community and peer-based settings is necessary to better engage people unreached by the response to date. Access to specialist care remains important for the management of people affected by hepatitis C who have more complex needs, such as those with liver cirrhosis or other comorbidities, co-infections, dependence, collapsed veins, or other potential long-term issues related to injecting drug use.

Enhanced and scaled up access to hepatitis C antiviral treatment needs to be complemented by a full suite of harm reduction and other measures. Additionally, access to re-treatment for all people affected by hepatitis C is critical, including in custodial settings where reinfection levels are significantly higher than the general population.[68,69]

Increased focus, including in primary care, is required to identify and monitor people who have experienced hepatitis C-related liver damage, placing them at increased risk of liver cancer, including post-cure and for those with ongoing transmission risks. In addition, the small proportion of people who are not cured following treatment require regular liver health assessments, specialist care, and may need to be considered as candidates for new treatments.

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

KEY AREAS FOR ACTION – Testing, treatment, and management

7. Scale-up guideline-based hepatitis C testing, treatment and linkage to care for priority populations, including in custodial settings, through community and peer-led models.

8. Continue to explore the roll out and availability of new hepatitis C testing technologies that meet Australian regulatory requirements, with linkage to care, and continue to improve hepatitis C treatment prescribing rates in areas with unmet need.

9. Improve testing processes to ensure utilisation of appropriate testing methods and follow-up testing, including:
    a. improving the utilisation of recommended testing procedures for hepatitis C by clinicians, including routine use of reflex testing, and exploring the feasibility of automatic hepatitis C RNA testing for priority populations
    b. implementing a nationally consistent mechanism for follow up of hepatitis C notifications to ensure that all people diagnosed as antibody positive receive confirmatory testing and care in a timely way
    c. ensuring that testing, and subsequent integrated care, is available to people affected by hepatitis C for other BBV co-infections impacting on liver disease progression and survival including hepatitis B and HIV.

10. Support and increase best-practice case finding, contact tracing, testing, treatment, and management for hepatitis C in priority settings including primary care and custodial settings.

11. Strengthen Australia’s liver cancer response and prevention activities by ensuring all people affected by hepatitis C have appropriate liver fibrosis assessment prior to treatment and expanding primary care access, including overcoming financial barriers to non-invasive diagnostic tools for assessing liver disease.

12. Identify and address the policy, legal, regulatory, and structural barriers that impact people’s access to hepatitis C testing, treatment, and management including understanding limitations claiming services through the Medicare Benefits Schedule and enabling implementation of community-led testing and support.

8.3 Equitable access and coordination of care and support

- Address social, demographic, and geographic inequities in hepatitis C health outcomes by ensuring equitable and universal access to prevention, harm reduction, testing, treatment, care and post-cure support across all priority populations and settings.
- Remove barriers to hepatitis C testing, treatment and management, including for people who are not eligible for subsidised healthcare.
- Improve care coordination between people affected by hepatitis C and community, health, and specialist services.
- Support and expand person-centred, decentralised, and differentiated models of hepatitis C care in primary health and community settings.
- Strengthen intersections and linkages between hepatitis C focused activities and services for associated health conditions, including liver cancer.
- Implement strategies that address the social determinants of health and experiences of priority populations, including incarceration, mental health issues, and substance use.

To ensure no one is left behind in hepatitis C elimination efforts, equitable and universal access to hepatitis C testing, treatment and care is required. Equity in the context of hepatitis C healthcare means ensuring equitable access, utilisation, and outcomes for all people affected by hepatitis C. Geographic, social, and sub-population inequities in hepatitis C-related outcomes remain a major barrier to elimination. Efforts to overcome the structural, systemic, and resourcing barriers that create these inequities should be prioritised.

Person-centred care for hepatitis C requires health system responses and services to be organised around a person’s needs. Differentiated and decentralised service delivery models support person-centred care by adapting health services across the cascade of care to support the specific needs of people based on their circumstances. They will enable further testing, treatment, care, harm reduction, and the provision of other social and health-based supports and services through primary care, community-led services and peer-based services which reach people in the community.

Stronger communication and linkages between hepatitis C priority populations, community organisations (including peer-based organisations), and primary care and specialist services are needed to better coordinate care. This includes for people in custodial settings and during their transition back into the community.[70] For example, case management and peer support during the post-release transition period supports treatment adherence, follow-up testing and monitoring for people at elevated risk of hepatocellular carcinoma, and helps prevent hepatitis C reinfection. It also supports care for other related harms like collapsed veins, drug dependence and prevents overdose deaths. Broader linkages with other psychosocial health areas are also needed to improve holistic care and post-cure support, health outcomes, and to address the social determinants of health that impact the quality of life for people affected by hepatitis C. This includes linkages with liver cancer prevention, diagnosis and treatment services who are key partners in addressing hepatitis C attributable mortality.

Innovative, multidisciplinary models of care tailored to priority populations and local contexts are important, especially in underserviced areas. Approaches and outreach which help address access barriers including in regional, rural, and remote communities and consider the range of healthcare settings commonly used by priority populations are essential. The provision of more peer and community workers, Aboriginal and Torres Strait Islander health workers, nurse-led and pharmacy-based services are a priority focus.

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

13. Support and expand person-centred, decentralised, and differentiated models of hepatitis C care that embed hepatitis C care in primary health and community settings, including:

- a. enabling the national scale-up of successful models of care for hepatitis C prevention, treatment, and management, particularly models that have demonstrated success with priority populations, in rural and remote areas, and areas of workforce shortage
- b. expanding community and peer-based models for hepatitis C prevention and care, including for post-release, rural and intersectional settings
- c. supporting nurse-led models of hepatitis C testing and care including in primary care, regional and remote areas, and custodial settings
- d. supporting digital models of hepatitis C care, including telehealth and telehealth interpreters, to overcome access barriers
- e. improving the coordination of hepatitis C care between affected communities, community and peer organisations, primary care, pharmacy, and specialist services
- f. building capacity in broader healthcare systems and services to embed and prioritise hepatitis C prevention, testing, treatment, harm reduction, management, and care.

14. Ensure people have had their diagnosis, treatment, 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 or peer harm reduction worker) within 6 months of diagnosis, to ensure timely, culturally safe care, and linkage to community and support organisations has been offered.

15. Explore opportunities to remove barriers in accessing hepatitis C testing, harm reduction, treatment, care, and post-cure care for people affected by hepatitis C, including for people who are ineligible for Medicare and address the structural barriers that impede equitable hepatitis C outcomes and national prioritisation.

16. Maintain subsidised unrestricted access to hepatitis C antiviral medications in the community and in custodial settings.

17. Enhance partnerships between jurisdictional health and custodial systems and facilitate knowledge sharing across systems and jurisdictions regarding hepatitis C prevention, harm reduction, testing, treatment, care, and support services for people in custodial settings and those recently released.

18. Improve linkage to care for people affected by hepatitis C to manage co-occurring health issues including liver disease, liver cancer, other chronic conditions, risk of overdose, collapsed veins, mental health, and alcohol and other drug issues.

8.4 Workforce

- Support the strengthening and sustaining of the hepatitis C community workforce and peer workforce.
- Consider a national hepatitis C multidisciplinary workforce development plan and associated capability and capacity building initiatives.
- Facilitate a highly skilled multidisciplinary workforce that is diverse, inclusive, respectful of and responsive to the needs, culture and preferred language of people affected by hepatitis C.
- Support the education and role of primary care, including GPs, nurse practitioners and primary care nurses and pharmacists.

The national response to hepatitis C is reliant on a highly skilled multidisciplinary workforce that is diverse, inclusive, respectful of and responsive to the needs of people affected by hepatitis C.

The multidisciplinary hepatitis C workforce includes community hepatitis workers such as peer workers, Aboriginal and Torres Strait Islander health workers, bilingual and bicultural health workers including GPs, nurses, nurse practitioners, pharmacists, and specialists who deliver quality hepatitis C services for priority populations.

The hepatitis C-specific community workforce is comprised of those working in organisations whose primary focus is addressing hepatitis C, including state and territory community hepatitis organisations and peer-based DUOs.

The deep connections they maintain with affected communities, their networks with other key community organisations, and their capacity to deliver decentralised hepatitis C services enable them to engage those not reached elsewhere by the national response. Peer workers have expertise in engaging their communities in non-stigmatising hepatitis C prevention, harm reduction, education, support, and linkage to care. The community and peer workforce should be supported and resourced to deliver ongoing innovative services and engage with priority populations.

Further, as technology develops to make testing, treatment, and care more simplified, the upskilling of community and peer workers to help deliver these services will be crucial. Additionally, the hepatitis C community workforce includes those who address hepatitis C within a broader health or social service context including the community-based settings outlined in this strategy.

Workers in harm reduction programs, Needle and Syringe Programs, drug treatment services, and other relevant allied workforces including homelessness and mental health services have valuable and established connections with priority populations. Workers in these settings should have strong awareness of hepatitis C and its intersections with the social determinants of health, as well as the capacity to undertake hepatitis prevention and harm reduction education, testing, referral, and shared care.

The hepatitis C clinical workforce includes GPs, nurses, nurse practitioners, specialists, and others across healthcare settings. The continued availability of evidence-based, responsive, and accessible national clinical guidelines and tools are essential in supporting the provision of effective hepatitis C prevention, testing, management, and care. Specific education, ongoing professional development and specialisation opportunities need to be available to support health workers in the development of essential hepatitis C knowledge and skills. This includes ensuring training and education to provide non-stigmatising and non-discriminatory healthcare, particularly for health professionals working alongside priority populations. Opportunities to facilitate the provision of nurse-led services should be a particular focus, including the availability of continuous and sustained funding, education, and professional development opportunities to support ongoing nurse engagement in hepatitis C care. The role of nurses and nurse practitioners in health promotion, prevention, and treatment of hepatitis C should also be strengthened.

Issues in relation to the availability of services and the recruitment and retention of staff need to be addressed, particularly in rural and remote areas, to ensure that sufficient expertise, capability, and capacity exist in all areas. Innovative models of care adapted to local contexts and tailored for priority populations can assist in addressing such challenges by appropriately utilising the skills of the broader hepatitis clinical, community and peer workforce.

Table 6: Key areas for action – Workforce

KEY AREAS FOR ACTION – Workforce

19. Explore opportunities to strengthen and sustain the community and peer hepatitis C workforce, implementing associated projects and workforce supports including training and capacity building, and exploring opportunities to develop a new national hepatitis C multidisciplinary workforce development plan led by community.

20. Support primary care workforces to deliver hepatitis C care, including:

  a. providing education and resources to support GPs, nurse practitioners and other prescribers in prescribing direct-acting antivirals, managing patient care, implementing evidence-based hepatitis C testing and treatment mechanisms, and utilising available multidisciplinary referral pathways

  b. facilitating and supporting the involvement of the primary care workforce, in the early detection and treatment of hepatitis C, including access to remote support, via PHNs, and other approaches

c. improving patient management systems to better support the primary care workforce to promptly identify and provide testing, treatment and care for people affected by hepatitis C and post-cure for people at elevated risk of liver cancer

d. increasing awareness of clinical guidance for hepatitis C management (including liver fibrosis assessment, liver cirrhosis diagnosis, liver cancer surveillance and linkage to care) in primary care

e. increasing the availability of digital and face to face hepatitis learning opportunities to facilitate a skilled clinical and community and peer workforce

f. delivering 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 capability and capacity to undertake testing, treatment, management, and ongoing care for hepatitis C in decentralised settings (including community pharmacy, community hepatitis organisations, and peer-based DUOs, and ACCHOs). This may include:

a. allied health workforce (such as drug treatment, mental health, homelessness, custodial settings, community corrections) to undertake relevant hepatitis C interventions and improve hepatitis C health literacy, harm reduction, and connection to care and support

b. leveraging the established networks of alcohol and other drug services to improve hepatitis C health literacy and connection to care.

22. Enable and expand the provision of culturally and linguistically appropriate hepatitis C services to priority populations by:

a. engaging, awareness-raising, and ongoing capacity-building of bicultural and bilingual health and harm reduction workers

b. supporting and building the capacity of community hepatitis and peer educators including from priority populations

c. coordinating and expanding access to accredited translation services

d. supporting the development and maintenance of directories of hepatitis C peer workers and healthcare professionals who speak languages other than English.

8.5 Addressing stigma and creating an enabling environment

- Ensure the reduction of stigma, racism, discrimination, and colonialism are central in national and local responses to hepatitis C and ensure meaningful 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 affected by hepatitis C.
- Continue to work towards addressing the legal, regulatory and policy barriers that affect priority populations, and adversely influence hepatitis C outcomes, including the criminalisation of people who use drugs and sex workers.

- Ensure people affected by hepatitis C continue to be meaningfully engaged in, and co-design, national policy development, implementation, and evaluation.
- Provide national and international leadership in relation to the elimination of hepatitis C by 2030, including in cross-cutting health and social policy work.

Stigma, discrimination, and racism within the health system can hinder access to hepatitis C prevention and care. These barriers can contribute to missed and late diagnoses, disease progression, onward transmission, more costly tertiary care, and reduced quality of life.[49]
Stigma and discrimination related to hepatitis C are multi-dimensional and multi-layered and can be compounded by the criminalisation of people who use drugs, and the stigma and discrimination associated with race, cultural background, gender identity, health status, injecting drug use, and perceptions of risk. Strategies to address stigma and discrimination must acknowledge and account for these intersectionalities.

The expression of stigma, discrimination, and racism towards people affected by hepatitis C in healthcare settings is common and can prevent individuals and whole communities from accessing hepatitis C prevention and care.[71,72] Every person working with people at risk of, living with, or cured of hepatitis C requires an understanding of the impact of stigma, discrimination, and racism, including intersecting issues such as prejudice against people who use drugs, and how this impacts on healthcare access and outcomes.

Actions to reduce stigma, discrimination and racism should be a core element of quality health service provision. Education, in relation to stigma in healthcare settings, is considered an integral part of training programs for staff of all specialist, primary healthcare, and community-based service providers. Research indicates that personally knowing someone from a target group was associated with holding fewer stigmatising attitudes towards that particular group, which provides initial evidence on the importance of peer workers to address stigma.[73]

Legal, policy, social, cultural, and economic barriers also impact hepatitis C outcomes. Studies have found that removing barriers and reducing stigma and discrimination increases testing and treatment and contributes to a decrease in the incidence and prevalence of various BBV and STI.[74–76] In particular, drug policy and the delivery of public health approaches have the capacity to reduce stigma, improve access to hepatitis C care, and ultimately prevent transmission.[77] It is also important to recognise that experiences of stigma, criminalisation, discrimination and social exclusion can continue post-cure. This can enhance the risk of reinfection, increase medical risks, increase risk of overdose death, and undermine the promise of the elimination agenda.[78]
The implementation of this strategy rests predominantly within health and related sectors, however, many of the enablers for 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 C.

Work is needed to ensure that hepatitis C is embedded in cross-cutting national policy, including long-term health plans relevant to health workforces (such as GPs, pharmacists, nurses, and community and peer workers); health reforms (including preventive health and harm reduction); and related disease policy (for example, 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. Ensure people affected by hepatitis C are meaningfully engaged in, and co-design, national policy development, implementation, and evaluation. This includes leading or co-designing programs aimed at minimising stigma and discrimination, including post-cure across the community, particularly in healthcare settings.

24. Increase anti-stigma, anti-discrimination, anti-racism and decolonisation initiatives for providers of primary care and other health practitioners caring for people affected by hepatitis C by:

a. providing culturally safe and trauma-informed training that is co-designed with community and peers, and incorporates messaging to counteract stigma and discrimination in hepatitis C health promotion and harm reduction initiatives

b. implementing projects to address legal, policy, and systemic barriers (including those related to stigma, discrimination, colonisation, human rights issues, informed consent, and racism) and identify and implement appropriate actions to address them including legislative reform (such as insurance, social security and employment reforms.

25. Continue drug policy reform to deliver public health outcomes for people who use drugs.

26. Identify opportunities to elevate hepatitis C as a national policy priority including in allied health contexts such as preventive health, primary care, cancer, and health and research planning.

27. Ensure people affected by hepatitis C have access to justice and support to meet their legal needs.

28. Maintain Australia's reputation as a global leader in the management of BBV by delivering on national and global hepatitis elimination commitments, maintaining contributions to global health initiatives, retaining state membership of the WHO, and providing strong leadership in the Western Pacific Region with respect to hepatitis C and peer-based harm reduction.

8.6 Data, surveillance, research, and evaluation

- Further develop a strong evidence base for local and national responses to hepatitis C in Australia, in collaboration with researchers and people affected by hepatitis C and informed by high quality data and surveillance systems.
- Improve the timeliness and consistency of hepatitis C data collection nationally and jurisdictionally to better support completeness, comparability, and utility.
- Support hepatitis C vaccination research.

- Enable and resource more community and peer leadership in hepatitis C 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 C. To understand the impact of hepatitis C more fully in priority populations research must be linked to the needs of all affected communities. Continuous improvement of data collections and systems, including sharing information across jurisdictions, is important to support a comprehensive understanding of the burden of hepatitis C in Australia and to monitor the impacts of interventions.[49] However, this must be appropriately targeted to ensure it is effective and balanced to minimise data collection burdens on affected communities, community and health services, and frontline staff. The *First National BBV and STI Research Strategy 2021–2025* assists in these endeavours by providing a framework for social, behavioural, epidemiological, clinical, and basic research in developing a strong evidence base for managing and preventing hepatitis C (and hepatitis C-related morbidity and mortality) in the community.

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

Improvements in the granularity of data are needed to better understand the true incidence and prevalence of hepatitis C and identify trends and issues of concern in relation to specific priority and sub-populations and other demographics. Additionally, work is needed to overcome gaps in surveillance data and analysis for measuring, monitoring and clearly reporting on the implementation of this strategy and progress towards targets. This includes, for example, regular publication of reliable, modelled estimates of disease prevalence, the collection of data on gender and sexuality and quantifying the extent of hepatitis C reinfection at a national level. Enabling and exploring data linkages would allow for these data to be collected, and appropriate actions implemented to minimise reinfection in priority populations and priority settings.

The development of preventive vaccines for hepatitis C is recognised by the WHO as an important component of the viral hepatitis research agenda. It would save millions of lives globally and help ensure the elimination of hepatitis C by 2030.

With sufficient resources, the Australian viral hepatitis research sector can deliver a vaccine for hepatitis C with the capacity to effectively stop the transmission of hepatitis C, contribute to a more sustainable health system, eliminate stigma for all people affected by hepatitis C, and provide significant economic benefits.

While the targets of this strategy are informed by but not limited to the Global Health Sector Strategies 2022–2030 target methodology, Australia's eventual elimination of hepatitis C 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's guiding principles in the validation of elimination recognise the central role of civil society and affected communities in the validation process.[79]

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

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

29. In partnership with the community, through established governance structures:

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

b. update the *First National BBV and STI Research Strategy 2021–2025*.

30. Explore opportunities to strengthen data collection and data systems to enhance health outcomes for priority populations by improving data completeness in relation to Medicare status and Aboriginal and Torres Strait Islander people’s identification status, undertaking data linkage projects, ensuring public health units share hepatitis C data safely and effectively, and enhancing community service level data and intelligence.

31. Explore opportunities to strengthen Australia’s hepatitis C research prioritisation by supporting research on emerging hepatitis C issues, promoting a balance of social, behavioural, legal, clinical and epidemiological research, and expanding a focus on hepatitis C research in existing Australian Government research funding, and ongoing research and capacity building globally.

32. Ensure Australia has the evidence base to demonstrate elimination of hepatitis C has been achieved by working in partnership with the community in preparing and undertaking Australian validation of hepatitis C elimination in accordance with WHO guidance. Ensuring current and future programs are evaluated against the priorities of this strategy, and evaluating the implementation of this strategy to determine progress and make necessary adjustments to ensure achievement of the 2030 elimination goal.

33. Maintain and enhance the timely annual reporting of hepatitis C surveillance and monitoring, including analysis of progress against targets and indicators, disaggregation by sub-populations where possible, and mapping with additional regional specificity.

34. Enable capacity building of community and peer-led participation, co-authoring, and implementation of hepatitis C research. Affected communities and priority populations should be embedded in all aspects of research, including priority setting, modelling, development, implementation, co-authorship, community engagement, and research translation, dissemination, and evaluation and monitoring.

35. In partnership with community and peers, address gaps in surveillance data and analysis including:

  a. developing target baselines, prioritising sub-populations and regional data for reporting against equity measures

  b. enhancing monitoring and measurement of hepatitis C-related stigma, discrimination, racism, and other legal and human rights issues, including improving data collection about hepatitis C and sex work

  c. improving the collection, measurement, reporting and publishing of hepatitis C associated morbidity and mortality, and contemporary estimates of incidence and prevalence of hepatitis C including linkage of data on the incidence of reinfection.

36. Support research to develop a preventive vaccine for hepatitis C.

37. Undertake mapping and monitor investment on national hepatitis C elimination, including investment relative to the burden from hepatitis C.

9. Implementing this strategy

9.1 Leadership, partnership, and connections to community

Australia’s response to hepatitis C 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 the national response to hepatitis C under the Sixth National Hepatitis C 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 C, it is imperative that this is conducted in partnership with communities and is aligned with the priorities of the 5 national strategies.

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

The Sixth National Hepatitis C 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 the 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 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 an essential part of remaining accountable to the 2030 elimination goals, as well as ensuring the ongoing relevance of key aspects of the strategies. The identification of areas in need of improvement and action is an essential part of remaining accountable to the 2030 elimination goals, as well as ensuring the ongoing relevance of key aspects of the strategies.

The Strategies 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 these strategies 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.

Appendix: References

1. World Health Organization. (n.d.). *Naming the coronavirus disease (COVID-19) and the virus that causes it*. Retrieved December 4, 2023, from https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it
2. World Health Organization. (2022). Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030. https://www.who.int/publications-detail-redirect/9789240053779
3. United Nations. (2007). *United Nations Declaration on the Rights of Indigenous Peoples*. https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html
4. United Nations. (2015). *The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*. https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf
5. United Nations. (1991). Basic Principles for the Treatment of Prisoners: Resolutions adopted by the General Assembly. https://digitallibrary.un.org/record/105348
6. World Health Organization. (1986). *Ottawa Charter for Health Promotion*. World Health Organization. https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference
7. World Health Organization. (2016). *Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development*. https://www.who.int/publications/i/item/WHO-NMH-PND-17.5
8. Department of Health and Aged Care. (2021). *National Preventive Health Strategy 2021–2030*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030?language=en
9. The Kirby Institute. (2024). *HIV, viral hepatitis and sexually transmissible infections in Australia Annual surveillance report 2024: Hepatitis C*. Kirby Institute. www.kirby.unsw.edu.au/sites/default/files/documents/Annual-Surveillance-Report-2024-HCV.pdf
10. Department of Health and Aged Care. (2021). *National blood borne viruses and sexually transmissible infections research strategy 2021-2025*. Department of Health. https://www.health.gov.au/sites/default/files/documents/2022/05/the-first-national-bloodborne-viruses-and-sexually-transmissible-infections-research-strategy-2021-2025-the-first-national-bloodborne-viruses-and-sexually-transmissible-infections-research-strategy-2021-2025.pdf
11. World Health Organization. (2021). *Hepatitis C: WHO fact sheet*. https://www.who.int/news-room/fact-sheets/detail/hepatitis-c
12. World Health Organization. (2024). *Global hepatitis report 2024*. https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/hepatitis/overview
13. Muller, K., & Hasan. (2021). Treating chronic hepatitis C in general practice. *Australian Journal of General Practice*, *50*(10). https://doi.org/10.31128/AJGP-06-21-6029
14. Gastroenterological Society of Australia. (2022). *Australian recommendations for the management of hepatitis C virus infection: A consensus statement*. https://www.hepcguidelines.org.au/wp-content/uploads/2022/11/hepatitis-C-virus-infection-a-consensus-statement-2022.pdf

15. MacLachlan, J. H., & Cowie, B. C. (2012). Liver cancer is the fastest increasing cause of cancer death in Australians. *The Medical Journal of Australia*, *197*(9), 492–493. https://doi.org/10.5694/mja12.11481
16. Doherty Institute. (2020). *Impacts of COVID-19 on BBVSTI testing, care and treatment: Medicare data analysis*. https://www.doherty.edu.au/uploads/content_doc/COVID-19_impacts_-_BBVSTI_treatment_and_care_(data_to_January2021)_FINAL.pdf
17. The Kirby Institute. (2021). *Progress towards hepatitis C elimination among Aboriginal and Torres Strait Islander people in Australia | Kirby Institute*. https://www.kirby.unsw.edu.au/research/reports/progress-towards-hepatitis-c-elimination-among-aboriginal-and-torres-strait-islander-people-australia
18. Department of Health and Aged Care. (2022). *Fifth National Hepatitis C Strategy 2018–2022*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/resources/publications/fifth-national-hepatitis-c-strategy-2018-2022?language=en
19. Department of Health, Disability and Ageing. (2025). *National Immunisation Strategy For Australia 2025–2030*. https://www.cdc.gov.au/sites/default/files/2025-11/national-immunisation-strategy-for-australia-2025-to-2030.pdf
20. Department of Health and Aged Care. (2017). *National Drug Strategy 2017–2026*. https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026.pdf
21. Department of Health and Aged Care. (2019). *Australia’s Long Term National Health Plan*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/resources/publications/australias-long-term-national-health-plan?language=en
22. United Nations. (1966). *International Covenant on Economic, Social and Cultural Rights*. OHCHR. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights
23. United Nations. (2023). *United Nations Common Position on Drugs Policy*. https://www.unodc.org/res/un-common-position-drugs/resources_html/CP_Drugs_Package_for_Field_Reps.pdf
24. Australian Government. (2023). *Australian Cancer Plan 2023-2033*. https://www.australiancancerplan.gov.au/welcome
25. NACCHO. (2023). *Aboriginal and Torres Strait Islander Cancer Plan*. https://www.naccho.org.au/app/uploads/2024/02/NACCHO_CancerPlan_Oct2023_FA_online.pdf
26. Australian Human Rights Commission. (2022). *National Anti-Racism Framework Scoping Report | Australian Human Rights Commission*. https://humanrights.gov.au/our-work/race-discrimination/publications/national-anti-racism-framework-scoping-report
27. Department of Health and Aged Care. (2022). *Australia’s Primary Health Care 10 Year Plan 2022–2032*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en
28. Department of Health and Aged Care. (2019). *National Strategic Framework for Chronic Conditions*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/resources/publications/national-strategic-framework-for-chronic-conditions?language=en
29. Department of Health and Aged Care. (2020). *Pregnancy Care Guidelines*. Australian

29. Department of Health and Aged Care. (2020). *Pregnancy Care Guidelines*. Australian Government Department of Health and Aged Care. https://app.magicapp.org/?language=en&utm_source=health.gov.au&utm_medium=callout-auto-custom&utm_campaign=digital_transformation#/guideline/jm83RE
30. Department of Health and Aged Care. (2021). *National Aboriginal and Torres Strait Islander Health Plan 2021–2031*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031?language=en
31. Australian Government. (2020). *National Agreement on Closing the Gap*. https://www.closingthegap.gov.au/national-agreement
32. Department of Health and Aged Care. (2023). *Nurse Practitioner Workforce Plan*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/our-work/nurse-practitioner-workforce-plan
33. Department of Health and Aged Care. (2020). *National Framework for Communicable Disease Control*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/resources/publications/national-framework-for-communicable-disease-control?language=en
34. Cancer Council Australia. (2023). *Roadmap to Liver Cancer Control in Australia*. https://www.cancer.org.au/assets/pdf/roadmap-to-liver-cancer-control-in-australia
35. United Nations. (2006). *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*. OHCHR. https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-convention-against-torture-and-other-cruel
36. United Nations. (2008). *Convention on the Rights of Persons with Disabilities*. OHCHR. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities
37. United Nations. (1965). *International Convention on the Elimination of All Forms of Racial Discrimination*. OHCHR. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-elimination-all-forms-racial
38. United Nations. (1979). *Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979*. OHCHR. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women
39. Department of Health and Aged Care. (2019). *National Women's Health Strategy 2020–2030*. Australian Government Department of Health and Aged Care. https://www.health.gov.au/resources/publications/national-womens-health-strategy-2020-2030?language=en
40. World Health Organization. (2015). *The 2030 Agenda for Sustainable Development*. https://sdgs.un.org/publications/transforming-our-world-2030-agenda-sustainable-development-17981
41. The Kirby Institute. (2024). *Monitoring hepatitis C treatment uptake in Australia—2024*. www.kirby.unsw.edu.au/sites/default/files/documents/Monitoring-hepatitis-C-treatment-uptake-in-Australia-Issue-14-July-2024_0.pdf
42. The Kirby Institute. (2023). *Needle Syringe Program National Minimum Data Collection 2023*. https://www.kirby.unsw.edu.au/sites/default/files/documents/Needle-syringe-program-national-minimum-data-collection-2023-national-data-report.pdf
43. The Kirby Institute. (2024). *Tracking the Progress 2023: National Aboriginal and Torres Strait*

Islander BBV and STI Strategy. https://www.kirby.unsw.edu.au/sites/default/files/documents/Tracking-the-progress-2023-National-ATSI-Strategy.pdf

44. Heard, S., Iversen, J., & Maher, L. (2021). *Australian NSP Survey National Data Report 2016—2020*. Kirby Institute. https://kirby.unsw.edu.au/sites/default/files/kirby/report/ANSPS_National-Data-Report-2016-2020.pdf
45. Heard, S., & Maher, L. (2024). *Australian NSP Survey National Data Report 2019—2023*. https://www.kirby.unsw.edu.au/sites/default/files/documents/Australian-NSP-Survey-national-data-report_2019-2023.pdf
46. Broady, T., Brener, L., Cama, E., & Treloar, C. (2023). *Stigma snapshot: People living with hepatitis C 2023*. Centre for Social Research in Health, UNSW Sydney. https://unsworks.unsw.edu.au/entities/publication/376d25b9-3910-4f91-b4d2-43005c3d061a
47. Southwell, M., Shelly, S., MacDonald, V., Verster, A., & Maher, L. (2019). Transforming lives and empowering communities: Evidence, harm reduction and a holistic approach to people who use drugs. *Current Opinion in HIV and AIDS*, *14*(5), 409–414. https://doi.org/10.1097/COH.0000000000000566
48. Treloar, C., Cama, E., Lancaster, K., Brener, L., Broady, T. R., Cogle, A., & O'Donnell, D. (2022). A universal precautions approach to reducing stigma in health care: Getting beyond HIV-specific stigma. *Harm Reduction Journal*, *19*(1), 74. https://doi.org/10.1186/s12954-022-00658-w
49. Department of Health and Aged Care. (2021). *National Blood Borne Viruses and Sexually Transmissible Infections Research Strategy*. https://www.health.gov.au/sites/default/files/documents/2022/05/the-first-national-bloodborne-viruses-and-sexually-transmissible-infections-research-strategy-2021-2025-the-first-national-bloodborne-viruses-and-sexually-transmissible-infections-research-strategy-2021-2025.pdf
50. Santen, D. K. van, Sacks-Davis, R., Stewart, A., Boyd, A., Young, J., Valk, M. van der, Smit, C., Rauch, A., Braun, D. L., Jarrin, I., Berenguer, J., Lazarus, J. V., Lacombe, K., Requena, M.-B., Wittkop, L., Leleux, O., Salmon, D., Bonnet, F., Matthews, G., … Hellard, M. (2023). Treatment as prevention effect of direct-acting antivirals on primary hepatitis C virus incidence: Findings from a multinational cohort between 2010 and 2019. *eClinicalMedicine*, *56*. https://doi.org/10.1016/j.eclinm.2022.101810
51. Winter, R. J., Holmes, J. A., Papaluca, T. J., & Thompson, A. J. (2022). The Importance of Prisons in Achieving Hepatitis C Elimination: Insights from the Australian Experience. *Viruses*, *14*(3), 497. https://doi.org/10.3390/v14030497
52. Stardust, Z., Treloar, C., Cama, E., & Kim, J. (2021). 'I Wouldn't Call the Cops if I was Being Bashed to Death': Sex Work, Whore Stigma and the Criminal Legal System. *International Journal for Crime, Justice and Social Democracy*, *10*(3), Article 3. https://doi.org/10.5204/ijcjsd.1894
53. Boyle, F., Glennon, S., Najman, J., Turrell, G., Western, J., & Wood, C. (2019). *The Sex Industry: A Survey of Sex Workers in Queensland, Australia*. https://doi.org/10.4324/9780429433337
54. Brooks-Gordon, B., Morris, M., & Sanders, T. (2021). Harm Reduction and Decriminalization of Sex Work: Introduction to the Special Section. *Sexuality Research & Social Policy: Journal of NSRC: SR & SP*, *18*(4), 809–818. https://doi.org/10.1007/s13178-021-00636-0
55. Lim, D., Phillips, E., Bradley, C., & Ward, J. (2023). Barriers and Facilitators to Hepatitis C

Virus (HCV) Treatment for Aboriginal and Torres Strait Islander Peoples in Rural South Australia: A Service Providers' Perspective. *International Journal of Environmental Research and Public Health*, *20*(5), 4415. https://doi.org/10.3390/ijerph20054415

56. Department of Health and Aged Care. (2023). *Modified Monash Model*. https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm
57. The Kirby Institute. (n.d.). *Hepatitis C*. Retrieved December 4, 2023, from https://www.data.kirby.unsw.edu.au/hepatitis-c
58. Xiao, Y., Wallace, J., Thompson, A., Hellard, M., van Gemert, C., Holmes, J. A., Croagh, C., Richmond, J., Papaluca, T., Hall, S., Hong, T., Demediuk, B., Iser, D., Ryan, M., Desmond, P., Visvanathan, K., & Howell, J. (2021). A qualitative exploration of enablers for hepatitis B clinical management among ethnic Chinese in Australia. *Journal of Viral Hepatitis*, *28*(6), 925–933. https://doi.org/10.1111/jvh.13495
59. Sun, W. H., Miu, H. Y. H., Wong, C. K. H., Tucker, J. D., & Wong, W. C. W. (2018). Assessing Participation and Effectiveness of the Peer-Led Approach in Youth Sexual Health Education: Systematic Review and Meta-Analysis in More Developed Countries. *Journal of Sex Research*, *55*(1), 31–44. https://doi.org/10.1080/00224499.2016.1247779
60. Anisah, R. L. et al. (2017). *Peer Educators' Competences for Inmates with HIV/AIDS: a Systematic Review*. International Conference on Translational Medicine and Health Sciences. https://doc-pak.undip.ac.id/id/eprint/5970/6/ProceedingBook-C25.pdf#page=15
61. Ward, Z., Sweeney, S., Platt, L., Guinness, L., Maher, L., Hope, V., Hickman, M., Smith, J., Ayres, R., & Hainey, I. (2018). The cost-effectiveness of needle and syringe provision in preventing transmission of Hepatitis C virus in people who inject drugs. *Journal of Hepatology*, *68*, S146–S147.
62. Moazen, B., Dolan, K., Saeedi Moghaddam, S., Lotfizadeh, M., Duke, K., Neuhann, F., Stöver, H., & Jahn, A. (2020). Availability, accessibility, and coverage of needle and syringe programs in prisons in the European Union. *Epidemiologic Reviews*, *42*(1), 19–26.
63. Bielen, R., Stumo, S. R., Halford, R., Werling, K., Reic, T., Stöver, H., Robaeys, G., & Lazarus, J. V. (2018). Harm reduction and viral hepatitis C in European prisons: A cross-sectional survey of 25 countries. *Harm Reduction Journal*, *15*(1), 1–10.
64. Grebely, J., Tran, L., Degenhardt, L., Dowell-Day, A., Santo Jr, T., Larney, S., Hickman, M., Vickerman, P., French, C., & Butler, K. (2021). Association between opioid agonist therapy and testing, treatment uptake, and treatment outcomes for hepatitis C infection among people who inject drugs: A systematic review and meta-analysis. *Clinical Infectious Diseases*, *73*(1), e107–e118.
65. Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). (2020). *National Hepatitis C Testing Policy*. https://testingportal.ashm.org.au/national-hcv-testing-policy/
66. Xu, W., Reipold, E. I., Zhao, P., Tang, W., Tucker, J. D., Ong, J. J., Wang, J., Easterbrook, P., Johnson, C. C., Jamil, M. S., & Wang, C. (2022). HCV Self-Testing to Expand Testing: A Pilot Among Men Who Have Sex With Men in China. *Frontiers in Public Health*, *10*. https://www.frontiersin.org/articles/10.3389/fpubh.2022.903747
67. The Kirby Institute. (2017). *Monitoring hepatitis C treatment uptake in Australia—2017*. https://www.kirby.unsw.edu.au/research/reports/monitoring-hepatitis-c-treatment-uptake-australia-issue-7-july-2017
68. Yeung, A., Palmateer, N. E., Dillon, J. F., McDonald, S. A., Smith, S., Barclay, S., Hayes, P. C., Gunson, R. N., Templeton, K., Goldberg, D. J., Hickman, M., & Hutchinson, S. J. (2022). Population-level estimates of hepatitis C reinfection post scale-up of direct-acting antivirals

among people who inject drugs. *Journal of Hepatology*, *76*(3), 549–557. https://doi.org/10.1016/j.jhep.2021.09.038

69. Bhandari, R., Morey, S., Hamoodi, A., Thompson, C., Jones, D., Hewett, M., Hunter, E., Taha, Y., & McPherson, S. (2020). High rate of hepatitis C reinfection following antiviral treatment in the North East England Prisons. *Journal of Viral Hepatitis*, *27*(4), 449–452. https://doi.org/10.1111/jvh.13240

70. Papaluca, T., McDonald, L., Craigie, A., Gibson, A., Desmond, P., Wong, D., Winter, R., Scott, N., Howell, J., & Doyle, J. (2019). Outcomes of treatment for hepatitis C in prisoners using a nurse-led, statewide model of care. *Journal of Hepatology*, *70*(5), 839–846.

71. Saine, M. E., Szymczak, J. E., Moore, T. M., Bamford, L. P., Barg, F. K., Schnittker, J., Holmes, J. H., Mitra, N., & Lo Re III, V. (2020). Determinants of stigma among patients with hepatitis C virus infection. *Journal of Viral Hepatitis*, *27*(11), 1179–1189.

72. Goodyear, T., Brown, H., Browne, A. J., Hoong, P., Ti, L., & Knight, R. (2021). “Stigma is where the harm comes from”: Exploring expectations and lived experiences of hepatitis C virus post-treatment trajectories among people who inject drugs. *International Journal of Drug Policy*, *96*, 103238.

73. Bryant, J., Rance, J., & Treloar, C. J. (2021). *Annual report of trends in behaviour 2021: Viral hepatitis in Australia.* Sydney: UNSW Centre for Social Research. http://unsworks.unsw.edu.au/fapi/datastream/unsworks:76670/bine0958a1b-c32d-4a6c-abfc-d8a768a67b31?view=true&xy=01

74. Broady, T. R., Brener, L., Vuong, T., Cama, E., & Treloar, C. (2021). Online interventions to reduce stigma towards population groups affected by blood borne viruses in Australia. *The International Journal on Drug Policy*, *96*, 103292. https://doi.org/10.1016/j.drugpo.2021.103292

75. Harris, M., Guy, D., Picchio, C. A., White, T. M., Rhodes, T., & Lazarus, J. V. (2021). Conceptualising hepatitis C stigma: A thematic synthesis of qualitative research. *The International Journal on Drug Policy*, *96*, 103320. https://doi.org/10.1016/j.drugpo.2021.103320

76. Li, C., Lu, X., Xiao, J., & Chan, C. W. H. (2022). “We can bear it!” Unpacking barriers to hepatocellular carcinoma screening among patients with hepatitis B: A qualitative study. *Journal of Clinical Nursing*, *31*(21–22), 3130–3143. https://doi.org/10.1111/jocn.16140

77. Global Commission on Drug Policy. (2013). *The Negative Impact Of The War On Drugs On Public Health: The Hidden Hepatitis C Epidemic*. https://www.drugsandalcohol.ie/28474/1/GCDP_HepatitisC_2013_EN.pdf

78. Seear, K., Fraser, S., Farrugia, A., & valentine, kylie. (2021). Beyond a ‘post-cure’ world: Sketches for a new futurology of hepatitis C. *International Journal of Drug Policy*, *94*, 103042. https://doi.org/10.1016/j.drugpo.2020.103042

79. World Health Organization. (2023). Guidance for country validation of viral hepatitis elimination and path to elimination. https://iris.who.int/bitstream/handle/10665/373186/9789240078635-eng.pdf?sequence=1