

A stylized illustration in shades of green and brown. It features a profile of a person's head and shoulders on the left, looking towards the right. The background is filled with various scientific and medical motifs, including a DNA double helix, a microscope, a petri dish with cells, and various geometric shapes and patterns. The overall style is modern and graphic.

4th NATIONAL HEPATITIS B STRATEGY

2023-2030

Fourth National Hepatitis B Strategy
2023-2030

FOR CONSULTATION

Acknowledgement of Country

In the spirit of reconciliation, the Department of Health and Aged Care acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

Acknowledgement of lived experience

The Department of Health and Aged Care acknowledges the individual and collective expertise of people with Hepatitis B and affected communities. We recognise their vital contribution at all levels for the purpose of learning and growing together to achieve better outcomes for all.

Draft for consultation

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GLOSSARY

The following acronyms and terms have been used throughout this document.

Acronym	Term
AIDS	Acquired immunodeficiency syndrome
BBV	Blood borne viruses
COVID-19	Coronavirus disease
GPs	General Practitioners
HIV	Human immunodeficiency virus
STI	Sexually transmissible infections/Sexually transmitted infections
WHO	World Health Organization

VISION STATEMENT

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

1. INTRODUCTION

Hepatitis B is a preventable but potentially life-threatening bloodborne viral infection that primarily affects the liver.

The Fourth National Hepatitis B Strategy 2023-2030 (the Strategy) guides Australia's strategic response to eliminating hepatitis B as a public health threat by 2030. People affected by hepatitis B are at the centre of the Strategy. This includes a focus on better understanding the culturally, ethnically, linguistically, socially, and geographically diverse priority populations affected by hepatitis B. This increased focus will enable leadership in all aspects to drive national, jurisdictional, and local prioritisation and invest in hepatitis B, relative to its scale and the elimination opportunity. Taking a person-centred approach to hepatitis B also supports a shift from a disease and transmission centric focus, to one that also considers familial and social contexts, needs, and the quality of life for people living with hepatitis B. By supporting more meaningful partnerships with affected communities, the national response to hepatitis B will enhance equity and ensure no one is left behind.

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

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

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

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

The duration of this Strategy is aligned with *the World Health Organization (WHO) global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections 2022-2030*. This eight-year duration enables a longer-term vision, policy and program implementation, as well as reinforcing Australia's commitment to meeting our international obligations and targets. Ongoing surveillance, monitoring, periodic reviews and evaluation will ensure the focus and actions of the Strategy remain relevant and effective.

Partnership remains at the heart of Australia's response to hepatitis B. This Strategy is informed by consultation with key stakeholders including affected communities, national peak bodies, peer and community organisations, governments, clinicians, the multidisciplinary workforce and researchers (see Figure 1) in the national response to hepatitis B.

Table 1: Blood borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS)

Peak organisations	State and territory governments
Hepatitis Australia	ACT Health
Australian Injecting and Illicit Drug Users League (AIVL)	NSW Health
Scarlet Alliance, Australian Sex Workers Association	NT Health
National Aboriginal Community Controlled Health Organisation (NACCHO)	Queensland Health
Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)	South Australian Health
Australian Federation of AIDS Organisations (AFAO)	Tasmanian Department of Health
National Association of People with HIV Australia (NAPWHA)	Victorian Department of Health
	WA Health
	Australian Government Department of Health and Aged Care

2. GUIDING PRINCIPLES

This Strategy includes guiding principles to support a high-quality, evidence-informed and equitable response to hepatitis B. The guiding principles are informed by effort over time to respond to the successes, challenges, opportunities and impacts of Australia's national response to hepatitis B and other blood borne viruses and sexually transmissible infections.

Partnership



Partnership is at the heart of Australia's response to hepatitis B. It is a long-standing tenet, recognised by successive national hepatitis B and other bloodborne virus strategies. The 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, and respectful dialogue, and appropriate and equitable resourcing to achieve the goals, targets, and actions of the Strategy. Partnership includes leadership from the community and leadership, collaboration and alignment from the Commonwealth, state and territory governments, and the full cooperative efforts of all members of the partnership to implement agreed actions.

Communities and civil society also make pivotal contributions to advocacy, service delivery, policy making, surveillance and monitoring, evaluation, and initiatives to address social and structural barriers. This enables the decentralisation of Australia's response, that is, decision-making, service delivery and initiatives which relate to this Strategy are shifted into community settings and feature community leadership.

Person-centred response



People affected by hepatitis B must be central to Australia's response, and position 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), and evaluation, research, surveillance and monitoring. This also means that the needs of people affected by hepatitis B are acknowledged from a whole of person, whole of life perspective and responded to within a system that enables choice, flexibility, responsiveness and appropriate resourcing.

3 Meaningful involvement of priority populations



Meaningful involvement of priority populations in all aspects of the hepatitis B response is essential to the development, implementation, monitoring and evaluation of effective policy, programs and research. The diversity and specific needs of priority populations is acknowledged and responded to effectively, having regard to 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.

4 Human Rights



Australia recognises that valuing and upholding human rights for all is essential to preventing the transmission of hepatitis B and to mitigating the health, social and other impacts of disease. People affected by hepatitis B have the right to enjoy the highest attainable standard of living, without stigma or discrimination regardless of their culture, ethnicity, language, age, sex, sexual orientation and gender identity, disability status, legal status, religion, sex work or drug use.

Australia's response to hepatitis B must work to tackle racism. The national response must also dismantle the ongoing effects of colonisation. This work must be done in the context of upholding the rights of Aboriginal and Torres Strait Islander peoples, as enshrined in the United Nations Declaration on the Rights of Indigenous Peoples.¹

5 Health equity



Health equity is the absence of remediable disparities in health status and outcomes which result from unfair social conditions. This principle recognises that health is a socially determined outcome. Therefore, it requires the active implementation of policies and interventions which remove discriminatory social, structural and institutional conditions which result in the inequitable distribution of power and exclusion of people on the basis of race, gender, age, disability, income, culture, language, religion, drug use, and sex work.

The goals of the Strategy will not be achieved without addressing the inequalities that drive the hepatitis B epidemic and prevent people from accessing health services and being active in improving their own health. Additional efforts are needed to improve equity for people from culturally, ethnically and linguistically diverse communities and Aboriginal and Torres Strait Islander peoples who face multiple layers of stigma and discrimination, and for whom there is 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 Promotion² and the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development³ provide the framework for effective action in health promotion under this Strategy. 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 and will be delivered by those communities, in partnership with governments, health workers, community organisations, researchers and others.

Prevention



The transmission of hepatitis B can be prevented through the appropriate combination of evidence-informed social, biomedical, and behavioural approaches within a supportive enabling environment. The cornerstone of hepatitis B primary prevention in Australia is vaccination; however, enhancement and strengthening of all primary prevention strategies (such as community education, safer blood supplies and medical procedures, needle and syringe programs, including in prisons, and access to condoms and lubrication for safer sex practices) will help embed prevention across the life course 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 2021-2030.⁴

Harm reduction



Harm reduction approaches underpin vaccination and other effective measures to prevent transmission of hepatitis B.

Grounded in justice and human rights, harm reduction aims to minimise adverse health, social and legal impacts through policies, programs, practices, and involvement of key affected 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 (both in prisons and community settings), drug consumption sites, safer sex practices, peer support, drug decriminalisation and other law reform across different jurisdictions (such as legalisation of sex work).

Access and quality health services



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

Quality accessible health services are reliant on a multidisciplinary hepatitis B workforce, including peers, that delivers person-centred, whole of life, effective, safe, and appropriate care. Coordination and integration of hepatitis B services across priority settings is also essential.

Commitment to evidence- informed policy and programs

The national response to hepatitis B is built on and values different forms of evidence and knowledge, research, surveillance, monitoring, and evaluation, and strong community-driven interventions. Meaningful involvement of community, alongside the health workforce and decision makers, in all stages of research priority-setting and co-design, from development to application, allows for greater integration between research and the use of evidence. A strong, and constantly refined, evidence base supported by the First National BBV and STI Research Strategy 2021-2025 is essential to meet new challenges, evaluate current and new interventions, develop effective policy, implement innovations and meet the goals of this Strategy.

3. Snapshot of Hepatitis B in Australia



Hepatitis B is a bloodborne viral infection that primarily affects the liver and is potentially life-threatening. Hepatitis B is vaccine preventable; however, for those already living with chronic hepatitis B, the disease is highly stigmatised, lifelong and incurable. If left untreated, hepatitis B can cause liver inflammation which can lead to liver disease, cancer, and death.

Prevalence

At the end of 2020, an estimated 222,559 people were living with chronic hepatitis B in Australia, that equates to approximately 1 in 100 people in Australia.⁵ Hepatitis B disproportionately affects the priority populations identified in this Strategy. For example, in 2020, nearly 70% of people living with chronic hepatitis B in Australia were born overseas. Aboriginal and Torres Strait Islander Australians are also disproportionately affected by hepatitis B, representing 7.2% of hepatitis B cases in Australia.

Compared with a national rate of 0.86%, hepatitis B prevalence in 2020 was highest in very remote (2.98%; more than triple the national average), and remote regions (1.37%). Prevalence was lowest in inner regional parts of Australia (0.47%).⁶

New diagnoses

There were an estimated 5,106 notifications of newly diagnosed hepatitis B in 2020.⁵ These notifications represent a material reduction from 5,809 the previous year; likely due to impacts of the COVID-19 pandemic. These impacts include a reduction in testing rates, border restrictions into Australia and effects on migration between Australia and countries with higher hepatitis B prevalence.⁷

In 2020, the proportion of people living with chronic hepatitis B who have been diagnosed is estimated to be 73%.⁸ Sustained declines have been recorded for

the past decade among younger people (<25 years) due to infant and catch-up vaccination programs. Notification rates remain higher in older age groups.

What health issues can it cause?

Chronic hepatitis B is one of the primary risk factors in the development of cirrhosis and liver cancer (the seventh most common cause of cancer mortality in Australia).⁹ If left untreated, hepatitis B can lead to liver cirrhosis and cancer in up to 25% of people, despite being generally asymptomatic.¹⁰ People living with hepatitis B require treatment where clinically indicated and lifelong monitoring to inform treatment decisions, and to assess for disease progression, liver damage, and liver cancer.¹¹

In 2020 there were an estimated 364 hepatitis B-related deaths, compared to 412 deaths in 2016.⁵ This decrease is due to the introduction and scaling up of effective antiviral treatment in Australia in the last two decades.

The risk of developing a chronic infection is very high for children who are infected perinatally or during infancy (90%) whereas a minority of people infected during adulthood (<5%) will develop chronic hepatitis B.

How is it managed?

Chronic Hepatitis B is a chronic disease that requires lifelong management. Six-monthly clinical assessments, including blood tests to identify changes in liver function, are recommended. Further, annual tests to assess viral replication, detect liver scarring, and liver ultrasounds and blood tests for liver cancer surveillance, are suggested where clinically indicated.



Antiviral treatment should be used to treat chronic hepatitis B, where indicated.

Routes of transmission

Most people with chronic hepatitis B in Australia were infected at birth or at an early age in other countries. In Australia, historically, vertical transmission (mother to child) and horizontal transmission (between children and family members) contributed to the prevalence of hepatitis B among Aboriginal and Torres Strait Islander peoples and people from culturally, ethnically and linguistically diverse backgrounds (from intermediate and high prevalence regions). Vertical transmission is now far less common in Australia, as is horizontal transmission. Other routes of transmission include the use of unsterile injecting equipment, and sexual contact without using preventive measures, for example condoms and lubrication.

Prevention

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

In 2020, vaccination coverage for Aboriginal and Torres Strait Islander children aged 12 months and 24 months was 93.2% and 97.3% respectively. Amongst non-Indigenous children, vaccination coverage was 95.3% at 12 months and 96.3% at 24 months.

Other primary prevention strategies for hepatitis B include community education and awareness on preventing transmission, screening of blood donors, perinatal protocols and access to preventive measures such as sterile syringes and needles, condoms and lubrication.

Treatment and care

By the end of 2020, an estimated 23% of people diagnosed with chronic hepatitis B, were receiving regular clinical care and 11% were receiving antiviral treatment.⁶ By comparison, clinical guidelines recommend that all people living with hepatitis B should be engaged in care and the estimated proportion eligible for treatment is 30%.⁸

The proportion of people receiving treatment for hepatitis B has increased over time, from 8.5% of the prevalent population in 2016 to 10.7% in 2020.⁸

Of those receiving treatment for hepatitis B, the proportion prescribed treatment for hepatitis B by a GP (exclusively, or in shared care with a specialist) has increased gradually over time, from 17.3% in 2016 to 22.8% in 2020. Further increases in 2020, possibly reflected transitions from specialist to GP services in response to disrupted health service provision due to COVID-19.⁶

4. ABOUT THIS STRATEGY

This Strategy builds on previous strategies and sets the direction for Australia's continuing response to hepatitis B from 2023 to 2030.

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

These five strategies are:

1. Fourth National Hepatitis B Strategy 2023–2030 (this Strategy)
2. Sixth National Hepatitis C Strategy 2023–2030
3. Sixth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2023–2030
4. Ninth National HIV Strategy 2023–2030
5. Fifth National Sexually Transmissible Infections Strategy 2023–2030.

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

These strategies are supported by the First National Blood Borne Viruses and Sexual Transmissible Infections Research Strategy 2021-2025 (the Research Strategy). The Research Strategy establishes the aims and objectives of multi-disciplinary research activities to support the implementation of the National BBV and STI Strategies.¹²

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

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

1. State and territory viral hepatitis strategies
2. Global Health Sector Strategies on, respectively, HIV, Viral Hepatitis and Sexually Transmitted Infections for the period 2022-2030¹³
3. National Immunisation Strategy 2019-2024¹⁴
4. National Drug Strategy 2017–2026¹⁵
5. Long-term National Health Plan¹⁶
6. National Preventive Health Strategy 2021–2030⁴
7. International Covenant on Economic, Social and Cultural Rights¹⁷
8. The United Nations Common Position on Drug Policy¹⁸

9. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)¹⁹
10. Australian Cancer Plan 2023-2033
11. National Anti-Racism Framework (concept paper)²⁰
12. Australia's Primary Health Care 10 Year Plan²¹
13. National Aboriginal and Torres Strait Islander Health Plan²²
14. National Agreement on Closing the Gap and associated implementation plans²³
15. National Strategic Framework for Chronic Conditions²⁴
16. Nurse Practitioner 10 Year Plan²⁵
17. National Framework for Communicable Disease Control.²⁶

This Strategy also supports progress towards Sustainable Development Goal 3 ('Ensure healthy lives and promote wellbeing for all at all ages') of the United Nations 2030 Agenda for Sustainable Development.²⁷ 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 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 action plan, is provided under Section 9, 'Implementing this Strategy'.

5. KEY ACHIEVEMENTS

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







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

- By the end of 2020, over 95% of all children (and 97.3% of Aboriginal and Torres Strait Islander Australian children), were vaccinated against hepatitis B by 24 months of age.⁵ This has been a major success story for the National Hepatitis B Strategy. Significant declines (around 50%, for those aged 0-29 years) in the rate of hepatitis B diagnosis have been observed between 2011 and 2019 amongst younger age groups, most likely due to the effect of childhood vaccination for hepatitis B introduced nationally for infants in Australia in 2000 (and in many countries with high migration to Australia in the 1990s).⁵
- In 2020, an estimated 162,480 people living with hepatitis B had been diagnosed, representing 73% of all Australians living with hepatitis B. This continues a trend of modest improvement, having increased from 65% diagnosed in 2011 and 70% diagnosed in 2017. Modelled estimates (based on current progress, trends in notification rates and future migration) suggest Australia will reach the previously identified 2022 goal of 80% diagnosed by 2027 and achieve the current 2030 global target of 90% in 2035.⁸ The rate of diagnosis must therefore increase substantially to drive sufficient progress towards 2030 target.
- In Aboriginal and Torres Strait Islander Australian populations, available data showed a 21% decrease in the rate of hepatitis B notifications between 2016 and 2020.⁵ However, the rate in 2020 (30.7 per 100,000) was more than one and a half times higher than the non-Indigenous population (16.9 per 100,000).⁸
- In 2020, an estimated 50,229 people were engaged in care (that is, receiving guideline-based hepatitis B monitoring including treatment, where indicated) for chronic hepatitis B, representing 22.6% of all Australians living with hepatitis B. This represents a marginal improvement on the estimated 22% engaged in care in 2017. Modelled estimates and current trends suggest Australia will reach its 2022 (former) National Strategy proportion in care target of 50% in 2045.⁸

- During 2020, 23,787 people were dispensed drugs for the treatment of hepatitis B through the Pharmaceutical Benefits Scheme, representing an estimated 10.7% of people living with hepatitis B in Australia. To reach the global 2030 target of 80% treated, the number of people receiving antiviral treatment in Australia will need to increase from 23,787 in 2020 to 55,774 in 2030. Since 2015, an average annual increase of 1.7% in treatment uptake for eligible people was observed; if this trend were to remain stable, Australia will reach the WHO 2030 elimination target in 2046.⁸
- In 2020, an estimated 364 deaths in Australia were attributable to chronic hepatitis B, continuing a gradual decline from 535 in 2007 but plateauing in recent years (e.g., with 373 deaths in 2017) due in part to an increasing aging population and treatment uptake not increasing sufficiently. The mortality target (30% reduction) is achieved when hepatitis B attributable deaths fall below 263 in Australia. Modelled estimates, based on current trends, suggest in 2030 the estimated reduction in attributable deaths in Australia (compared to 2017 baseline) will be 9.8%. The global 2030 target (65% reduction) requires fewer than 143 deaths by 2030.

The following table presents progress made under the Third National Hepatitis B Strategy 2018–2022 as at the end of 2020.

Table 2: Progress against the National Hepatitis B Strategy 2018–2022

Progress against National Hepatitis B Strategy 2018–2022 targets, as at the end of 2020	
Key:	 Not yet achieved  Partly achieved  Insufficient data
	Achieve and maintain hepatitis B childhood vaccination coverage of 95% at 12 and 24 months
In 2020, hepatitis B vaccination coverage at 12 months was 93.2% among Aboriginal and Torres Strait Islander Australian children and 95.3% among non-Indigenous children, reaching 97.3% and 96.3% at 24 months.	
	Reduce the number of newly acquired hepatitis B infections across all age groups by 50%, with a focus on priority populations
<p>There is no published annual estimate of the number of newly acquired hepatitis B infections available nationally. Instead, acknowledging certain limitations, newly acquired notification rates are published as proxy measures.</p> <p>The notification rate for newly acquired cases (i.e., diagnosed cases in which transmission is assessed to have occurred within 2 years prior) remained steady at 0.7 per 100,000 between 2016 and 2019. In 2020 it declined to 0.4 per 100,000, likely due to the impact of COVID-19 on hepatitis testing uptake.</p>	
	Increase the proportion of people living with chronic hepatitis B who are diagnosed to 80%

Progress against National Hepatitis B Strategy 2018–2022 targets, as at the end of 2020

In 2020, an estimated 73% of people living with chronic hepatitis B in Australia had been diagnosed.



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

In 2020, an estimated 22.6% of all people living with chronic hepatitis B were receiving care.



Increase the proportion receiving antiviral treatment to 20%

In 2020, an estimated 10.7% of all people living with chronic hepatitis B were receiving antiviral therapy.



Reduce hepatitis B attributable mortality by 30%

In 2020, an estimated 364 deaths were attributable to chronic hepatitis B, a 2.4% reduction compared to baseline in 2017.



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

There is no published data to establish a baseline against which progress for stigma reduction can be measured.

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

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

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

More implementation projects, systemic reform and research to tackle stigma, discrimination and racism is needed.²⁸ Increased meaningful involvement of people living with hepatitis B and priority populations (particularly Aboriginal and Torres Strait Islander peoples and people from culturally, ethnically and linguistically diverse backgrounds born in countries where hepatitis B is endemic) is imperative to the success of Australia's response.

Lastly, the success of the Strategy also relies on building strong evidence with priority populations through monitoring and research to better inform Australia's response and evaluate approaches to identify gaps and what is most effective.²⁹

Draft for consultation

6. MEASURING PROGRESS

This Strategy has overarching goals, targets and priority areas which will guide the national response to hepatitis B from 2023-2030. The targets balance ambition with feasibility, ensuring no one is left behind in the pursuit of Australia's commitment to elimination by 2030.

The goals of the National Hepatitis B Strategy 2023-2030 are to:



Eliminate hepatitis B as a public health threat by 2030



Reduce mortality and morbidity related to hepatitis B



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









Minimise the personal and social impacts of hepatitis B.

Equity and intersectionality are central to the framing and tracking of progress towards targets within this Strategy. As such, an equity threshold has been included whereby these targets are considered achieved when they have been reached by relevant priority populations, jurisdictions, and regions (where it is feasible to assess progress).

In acknowledgement of the longer timeframe of the Strategy, progress targets to 2025 and 2030 elimination targets have been identified. Indicators and associated data sources for measuring progress towards each target and for the validation of elimination will be included in an updated National BBV and STI Surveillance and Monitoring Plan (see Table 3). Where relevant, progress is measured against baseline at end of 2015.

Table 3: Hepatitis B - 2025 and 2030 Measuring Progress Targets

Domain	2025 Target	2030 Target
Childhood Vaccination 	95% timely completion of 3-dose schedule of infant hepatitis B vaccine. >90% timely hepatitis B birth dose.	95% timely completion of 3-dose schedule of infant hepatitis B vaccine. >95% timely hepatitis B birth dose

Prevention of mother to child transmissionⁱ 	95% of mothers living with chronic hepatitis B and their infants receive guideline-based care to prevent mother/birthing parent-to-child transmission during pregnancy and birth.	>95% of mothers living with chronic hepatitis B and their infants receive guideline-based care to prevent mother/birthing parent-to-child transmission during pregnancy and birth.
Incidence Reduction 	$\leq 0.1\%$ hepatitis B surface antigen prevalence in ≤ 5 yr olds. $\leq 2\%$ mother/birthing parent-to-child transmission rate.	$\leq 0.1\%$ hepatitis B surface antigen prevalence in ≤ 5 yr olds. $\leq 1\%$ mother/birthing parent-to-child transmission rate.
Proportion Diagnosed 	$\geq 85\%$ people living with chronic hepatitis B are diagnosed. Reduce to $\leq 5\%$ the proportion of people living with chronic hepatitis B diagnosed with liver cancer or decompensated cirrhosis, whose hepatitis B was diagnosed late.	$\geq 90\%$ people living with chronic hepatitis B are diagnosed. Reduce to $\leq 2\%$ the proportion of people living with chronic hepatitis B diagnosed with liver cancer or decompensated cirrhosis, whose hepatitis B was diagnosed late.
Proportion in Care 	$\geq 65\%$ of all people living with chronic hepatitis B are in care.	$\geq 80\%$ of all people living with chronic hepatitis B are in care.
Proportion Receiving Treatment 	22% of all people living with chronic hepatitis B are receiving treatment.	27% of all people living with chronic hepatitis B are receiving treatment.
Attributable Mortality 	Reduce by 15% hepatitis B - attributable mortality. ≤ 1.2 deaths per 100,000 population.	Reduce by 30% hepatitis B - attributable mortality. ≤ 1.0 deaths per 100,000 population.

ⁱ Where these targets refer to 'women', including 'pregnant women', the Strategies defer to established language most easily understood by priority populations in 2022, noting also that data sources are not yet adapted to record gender identity (being based almost exclusively on sex recorded at birth). It is acknowledged that further work needs to be undertaken to ensure that these Strategies and associated implementation, monitoring, surveillance, and reporting work are gender responsive and non-discriminatory. Efforts to better capture all pregnant people and their infants need to be prioritised to prevent the erasure of people who do not identify within the binary gender convention.

Indigenous Status Identification Data Completion	<i>This has been left intentionally blank as discussions on the draft National Aboriginal and Torres Strait Islander BBV and STI Strategy 2023-2030 are ongoing.</i>	<i>This has been left intentionally blank as discussions on the draft National Aboriginal and Torres Strait Islander BBV and STI Strategy 2023-2030 are ongoing.</i>
Stigma Reduction 	<p>Reduce to zero the expression of hepatitis B-related stigma and discrimination in health care settings.</p> <p>Establish a baseline of the reported experience of stigma among people living with chronic hepatitis B.</p>	<p>Reduce to zero the expression of hepatitis B-related stigma and discrimination in health care settings.</p> <p>Reduce by 75% the reported experience of stigma among people living with chronic hepatitis B.ⁱⁱ</p>
Quality of Life 	<p>75% of people living with chronic hepatitis B report a good quality of life.ⁱⁱⁱ</p> <p>Establish a baseline of the reported quality of life among people living with chronic hepatitis B.</p>	<p>95% of people living with chronic hepatitis B report a good quality of life.^{iv}</p>
Legal and Human Rights 	<p>Reduce the negative impact of legal and human rights issues on people's health and wellbeing by improving access to justice and an enabling legal environment for people affected by hepatitis B.</p> <p>Establish a baseline of the negative impact of legal and human rights issues in people's health and wellbeing for people affected by hepatitis B.</p>	<p>Reduce the negative impact of legal and human rights issues on people's health and wellbeing by improving access to justice and an enabling legal environment for people affected by hepatitis B.^v</p>

ⁱⁱ This number is subject to change and will be based on work to establish a baseline in 2025, noting too parity is being sought with the National Hepatitis C Strategy 2023-2030 and the National HIV Strategy 2023-2030 stigma targets.

ⁱⁱⁱ Parity is being sought with the National HIV Strategy 2023-2030 quality of life target.

^{iv} This number is subject to change and will be based on work to establish a baseline in 2025, noting too parity is being sought with the National HIV Strategy 2023-2030 quality of life target.

^v This target may be numerated based on work to establish a 2025 baseline.

7. PRIORITY POPULATIONS AND SETTINGS

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

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

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

7.1 PRIORITY POPULATIONS

People affected by hepatitis B

‘People affected by hepatitis B’ is an inclusive term describing the large and diverse population of people living with and/or at risk of hepatitis B and affected families and communities. ‘People affected by hepatitis B’ therefore includes unvaccinated people at risk of exposure, people who have been exposed to and are living with (or at risk of developing) chronic hepatitis B infection, whether undiagnosed or diagnosed, engaged in care, untreated or receiving treatment, engaged in liver cancer surveillance, and/or receiving support for other health and social impacts.

Hepatitis B also affects families, with infection often confirmed in multiple family members and occurring intergenerationally.³⁰

It is anticipated that a cure for hepatitis B will become available in the coming decade, meaning that the lens of ‘people affected by hepatitis B’ may need to be expanded to include people who have been cured of hepatitis B/people with lived experience of chronic hepatitis B.

People living with hepatitis B

‘People living with hepatitis B’ is a heterogeneous group and includes individuals undiagnosed or diagnosed. ‘People living with hepatitis B’ also includes the following sub-populations:

- People living with hepatitis B and women who are pregnant
- People living with hepatitis B who are not eligible for subsidised care
- People who have been living with hepatitis B for longer than 20 years or who have received a late hepatitis B diagnosis

- People living with hepatitis B who have cirrhosis or liver cancer
- People who have had hepatitis B and have had liver transplants
- People living with hepatitis B who have a hepatitis D co-infection
- People undergoing chemotherapy or immunosuppressive therapy.

People at risk of hepatitis B transmission

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

People who are at risk of hepatitis B transmission are:

- Adults and children who are unvaccinated for hepatitis B
- Adults and children who are only partially vaccinated/have not received all doses of vaccine.

If not vaccinated against hepatitis B, people in the following groups are at risk of hepatitis B transmission:

- Adults living with hepatitis B who do not know their hepatitis B status
- People who inject drugs and those who do not have access to sterile injecting equipment
- People in corrections settings and other places of held detention
- Partners and other household and intimate contacts of people who have acute or chronic hepatitis B
- People who have medical procedures using unsterile equipment and/or using unscreened blood products
- People who undergo tattooing and body piercing without access to sterile equipment
- Men who have sex with men or people who have sex without using preventive measures, for example, condoms, lubrication.

Women/people living with hepatitis B who are pregnant

Women/people^{vi} living with hepatitis B who are pregnant, and their children, partners and extended families are a priority population.

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

Reducing the rates of early transmission to and among children remains a priority, as does ensuring appropriate linkage to care for the mother. Increasing health literacy on

^{vi} Where the Strategy refers to women it uses language most commonly used by priority populations in 2022, noting also that data sources are not yet adapted to record gender identity. Work must be done to ensure that this Strategy and associated implementation, monitoring, surveillance, and reporting work is gender responsive and non-discriminatory.

the need for antenatal testing and care, particularly amongst culturally, ethnically and linguistically diverse populations, is integral to preventing vertical (mother-to-child) transmission within this population and their family units.

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

Note: This section has been left blank intentionally, further linkage work with Aboriginal and Torres Strait Islander BBV/STI Strategy 2023-2030 is needed.

People from culturally, ethnically and linguistically diverse communities

In 2020 in Australia an estimated 68.4% of the hepatitis B prevalent population were born overseas.⁶ There are an estimated 32,371 Australian-born people living with hepatitis B with culturally, linguistically and ethnically diverse backgrounds and do not identify as Aboriginal and Torres Strait Islander peoples, and do not identify as men who have sex with men or people who inject drugs. Further, a number of people from culturally, linguistically and ethnically diverse communities have not been vaccinated against hepatitis B in their country of birth.

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

For some communities, there is a tension between the lived experience of hepatitis B, including beliefs embedded within cultural understandings of health, and ways of conceptualising intergenerational impacts of hepatitis B within families, and Australia's predominant biomedical, public health and Western medicine approaches. Additionally, the absence of linguistically appropriate information about hepatitis B and how to access care through the health system is a significant barrier. Further work needs to be done with culturally, ethnically, and linguistically diverse communities (who are living with hepatitis B or who have not been vaccinated against hepatitis B) and their sub-populations to ensure appropriate, tailored implementation and actions.

Whilst this strategy uses the term 'culturally, ethnically 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 B
- Australian-born children of people born in countries with high prevalence of hepatitis B
- People who do not speak English as their first/preferred language
- People living with hepatitis B who are not eligible for subsidised care
- People from countries with high prevalence of hepatitis B who access legal and migration and/or multicultural groups/services
- International students and people on temporary visas from countries with high prevalence of hepatitis B.

Australia also has a role to play as leaders in hepatitis B elimination internationally, and more specifically in the Western Pacific Region.¹² An estimated 116 million people in the Western Pacific Region live with hepatitis B and many remain undiagnosed and untreated. It is estimated that 1,500 deaths per day are attributable to viral hepatitis, a higher mortality rate than HIV/AIDS, malaria and tuberculosis combined.¹³

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 of the [World Hepatitis Alliance](#).

Sex Workers

Sex workers, particularly those living with hepatitis B or who have not been vaccinated against hepatitis B, are a priority population due to the potential increased hepatitis B exposure risk.³¹ More research and quality data are required to fully understand the burden of hepatitis B in this population.

Sex workers experience barriers to accessing health services including high levels of stigma and discrimination.³² 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.³³ These barriers create a complex system of impediments to evidence-based prevention, access to testing and healthcare services. They can result in increased risk of BBV and STI, loss of livelihood, and risk to personal and physical safety. Evidence shows that decriminalisation of sex work is linked to the reduction of stigma, improved access to health promotion and access to workplace health and safety.³⁴

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 worker sub-populations including migrant and Aboriginal and Torres Strait Islander sex workers, that address stigma and discrimination and the regulatory and legal barriers experienced by sex workers are required.

Other groups

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

- People at risk of/living with a hepatitis C co-infection
- People at risk of/living with HIV co-infection
- People accessing HIV Pre-Exposure Prophylaxis (PrEP)
- People who have had transfusions of unscreened blood and blood products in Australia before 1990.

7.2 PRIORITY SETTINGS

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

De-centralising care outside of specialist services into primary care and community-based responses should be prioritised. Health equity principles, and a commitment to leaving no-one behind, also necessitate a broadening of focus to settings with variable

prevalence rates. Importantly, high, and low prevalence settings will be dynamic as the priority populations shift and change over the life of this Strategy. This requires mobile action with established hepatitis B expertise which is agile and responsive.

Primary and tertiary healthcare

There are a range of primary and tertiary healthcare settings in which people with hepatitis B can be reached. Multicultural and migrant health services are particularly critical in providing hepatitis B services to culturally, linguistically and ethnically 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 a culturally appropriate and accessible way.

Other primary and tertiary care settings in which people affected by hepatitis B can access healthcare include, bilingual and bicultural healthcare providers, maternal and child health, sexual health and family planning services, Aboriginal community-controlled health organisations, emergency departments, liver specialist services, cancer services, palliative care, and pharmacies.

Community-based settings

Engaging people living with hepatitis B in the 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, support for chronic disease management, health system navigation, linkages to appropriate healthcare and other social and health support services, and access to appropriate and safe health promotion and education. Importantly, as healthcare for hepatitis B becomes more de-centralised, these settings will increasingly provide critical healthcare services to people living with hepatitis B and key priority populations.

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

Community Hepatitis Organisations

State and territory-based community hepatitis organisations are critical infrastructure through which people living with hepatitis B can be engaged and supported. This includes a primary and specific focus on hepatitis-related prevention, harm reduction and referral, the promotion (and in some cases provision) of testing, peer support, education, training, individual and systemic advocacy, and information sharing.

Multicultural BBV and STI services

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

Aboriginal Community Controlled Health Organisations/Aboriginal Medical Services

Note: This section is intentionally left blank. Guidance is needed from the Aboriginal and Torres Strait Islander BBV/STI Strategy.

Peer based drug user organisations

These organisations provide access to de-stigmatised, peer-based support, information, education, advocacy, harm reduction services and services which aim to reduce the transmission of hepatitis B with drug use.

Needle and Syringe Programs

Needle and syringe programs are critical for prevention, to ensure that people who inject drugs have access to a range of supports 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 reached in the national response. Sex worker peer organisations provide essential prevention education conducted by peers as well as critical linkages to testing treatment and ongoing management and care.

Geographic settings

Generally, the prevalence of hepatitis B (as a proportion of the population) is highest in rural and remote areas, whilst treatment and care uptake are lowest in these areas in contrast to metropolitan areas. As such, greater focus and effort is needed to address this disparity and remedy the inequitable health outcomes. Increased efforts are also needed in areas of increased prevalence, where progress to elimination is slow, and where inequitable hepatitis B outcomes are being observed.

Legal settings

Corrections settings and other places of held detention

Corrections settings, including justice health and forensic mental health settings, and other places of held detention (e.g., immigration detention), are settings with an elevated prevalence of hepatitis B. It is estimated that 16% of people in prisons have evidence of past or current infection and 3% of people in prisons have evidence of chronic hepatitis B (which represents three and a half times the rate of all populations nationally).³⁵ High prevalence in these settings can be explained by a number of social and structural determinants, including the hyper-incarceration of Aboriginal and Torres Strait Islander people, the criminalisation of people who use drugs, and the absence of evidence-based harm reduction measures in prisons. It is critical that these access barriers are addressed as a part of the national response if elimination is to be achieved.

Legal, migration, refugee, and settlement services

Hepatitis B can affect visa pathways and options for migration and settlement. Legal, migration, refugee, and settlement services are often a first point of contact for people living with hepatitis B who are seeking support for visa applications and related assessment processes, including government-mandated health assessments and screening. Therefore, these settings can provide information and linkages to care, community-based support, and adjacent services for migrants and refugees who may have low access to healthcare.

Other settings

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

- Mental health services
- Alcohol and other drug services
- Homelessness services
- Educational institutions.

Draft for consultation

8. PRIORITY AREAS FOR ACTION

This section outlines actions necessary for the elimination of hepatitis B as a public health threat by 2030. Importantly, each action will be implemented to ensure that these are 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 B in priority populations and health workers to support increased engagement in testing, prevention, vaccination, monitoring, treatment, and care including liver health.
- Promote awareness and strengthen uptake of hepatitis B vaccination among priority populations, including strengthening national and jurisdictional immunisation programs to ensure universal access.
- Enhance and improve access to hepatitis B community and peer education.
- Ensure education and prevention activities address the familial, social, cultural, and linguistic contexts of target audiences, as well as the secondary harms arising from hepatitis B including liver disease and liver cancer.
- Raise hepatitis B awareness in the general community, including in relation to vaccination, the effectiveness of treatment and stigma reduction.

Improved awareness and understanding of hepatitis B among priority populations, health services and the broader community is critical to achieving elimination of hepatitis B by 2030. Priority population appropriate initiatives that target misconceptions and gaps in knowledge can significantly reduce stigma and discrimination, increase rates of testing and engagement in care and reduce the overall impact of infection.³⁶ The lived experience of hepatitis B, and associated health literacy, is culturally situated and understood.³⁷ Hepatitis B education and health promotion initiatives should, therefore, be community-led and/or designed and reflective of the individual, familial, social, cultural and linguistic dimensions of the target audience. Health literacy related to hepatitis B will be enhanced through community-led education and prevention activities which can occur through community organisations including Community Hepatitis Organisations, culturally, ethnically, and linguistically diverse community-based organisations, Aboriginal Community Controlled Health Organisations, peer-based drug user organisations, and their respective national peak bodies.

Primary prevention of hepatitis B involves strategies to prevent infection. Vaccination is the cornerstone of hepatitis B primary prevention, complemented by other means of prevention. This includes harm reduction strategies, such as sterile needle and syringes and condoms, to reduce transmission risks associated with injecting drug use and unprotected sexual activity. Secondary prevention involves strategies to prevent or reduce the impact of disease such as chronic disease self-management, treatment, liver health monitoring, liver cancer surveillance and community/peer support. Combined, hepatitis B and hepatitis C are the primary cause of liver cancer, Australia's fastest growing cause of cancer death.³⁸ Prevention of chronic hepatitis B infection and secondary harms, is a cost effective way to prevent liver cancer and reverse the trend of increasing liver cancer mortality.³⁹

A person with hepatitis B may be unaware that they have the virus due to the absence of recognisable symptoms both at the time of transmission and in the early stages of liver disease. This often leads to a substantial delay in diagnosis.^{40,41} During this time, further inadvertent transmission can occur, as can preventable deterioration in liver health. Additionally, many people may have been diagnosed overseas in non-health services including through workplace, immigration, and education settings, and not provided with basic information about the infection. It is crucial that priority populations have access to trusted, reliable, and appropriately targeted health promotion and education activities on hepatitis B that include information on transmission risks, vaccination, harm reduction, the importance of early detection and testing, the effectiveness of treatment, ongoing monitoring, liver health, cancer prevention, chronic disease management and how to access health services and support.

KEY AREAS FOR ACTION – PREVENTION, HEALTH PROMOTION AND EDUCATION

1

Increase awareness of, and access to, nationally consistent, free hepatitis B vaccination for the whole population, with specific efforts to improve uptake in priority populations including through national and state-based immunisation programs.

2

Implement community awareness, health promotion and public education initiatives for priority populations and the general community, including national and local hepatitis B campaigns and World Hepatitis Day in Australia.

3

Enhance and maintain the National Hepatitis Info Line as the national centralised point of contact for the Australian community to access information and support on hepatitis B, including capacity to provide localised responses.

4

Scale up access to appropriate and tailored information, education, and prevention programs (through community/peer-based organisations in first/preferred language and low literacy) targeting priority and unreached populations to:

- a. ensure understanding of the Australian health care system in relation to hepatitis B testing, monitoring, treatment and care, and differences with countries of origin.
- b. increase hepatitis B related health literacy including knowledge of routes of transmission, risk factors, vaccination, harm reduction and other evidence-based prevention, the importance of early detection, testing, treatment adherence, ongoing monitoring, liver health/cancer prevention, and available health services and support.
- c. facilitate the sharing, adaptation (including to different languages and for different cultural groups) and implementation of successful hepatitis B prevention initiatives and resources for priority populations and settings.

5

Increase access to hepatitis B harm reduction measures including sterile needles and syringes and condoms, including through peer delivery, in priority settings. This includes implementing Needle and Syringe Programs to ensure regulated access to sterile injecting equipment in corrections settings and other places of held detention (including immigration detention).

6

Implement perinatal and maternal and child health guidelines to prevent vertical transmission of hepatitis B and increase monitoring of these protocols.

7

Investigate and strengthen opportunities to support hepatitis B immunisation programs in source countries for immigration to Australia (e.g. alongside other regional public health activities).

8.2 TESTING, TREATMENT, AND MANAGEMENT

- Ensure all adults in Australia know their hepatitis B status.
- Maximise the number of people living with hepatitis B who are diagnosed through: population-wide universal offer of hepatitis B testing, guideline-based testing of priority populations; and follow-up of family and close contacts for opportunistic testing, all with informed consent.
- Strengthen monitoring and appropriate care for pregnant women living with hepatitis B and their children including promotion of vaccination, testing, treatment, monitoring and antenatal care guidelines.
- Increase the availability, adoption and use of hepatitis B testing and treatment technologies, including self-testing and point of care testing, to drive person-centred care.
- Ensure testing for hepatitis D virus is offered to people diagnosed and living with, chronic hepatitis B.

Hepatitis B testing for priority populations and among people whose hepatitis B status is unknown enables not only early diagnosis, but also access to monitoring, treatment, ongoing care, vaccination, and education to prevent transmission. Late diagnosis can lead to ongoing transmission and poor health outcomes, as opportunities to prevent progression to advanced liver disease and cancer are missed. Efforts to increase testing for hepatitis B in Australia must remain based on the principles of informed consent, and ensure that testing is voluntary, accessible, non-discriminatory, confidential, and of clear benefit to the person being tested.⁴²

With the exception of universal screening during antenatal care (through which a substantial proportion of women are first diagnosed) guideline-based testing has had limited success in meaningfully increasing the proportion of people diagnosed with hepatitis B in the past decade.³⁹ In contrast, population-wide testing mechanisms have been found to be cost-effective in countries with prevalence well below the 1% prevalence of hepatitis B in Australia.

Population-wide testing mechanisms, such as the offer of testing for all Australians aged 20-79 years with undocumented hepatitis B status, offer great potential to increase the number of people tested, vaccinated if not immune, diagnosed, and engaged in care.³⁹ Concurrently, guideline-based testing in priority populations, as outlined in the National Hepatitis B Testing Policy⁴³, must be maintained to reach unvaccinated persons at higher risk of infection or the consequences of infection.⁴²

Engagement with priority populations is likely to be further improved through the use of self, rapid and point-of-care testing technologies when available, due to the mobile nature of these diagnostic technologies which can be increasingly performed at home or by community and peer workers. Self-testing may also decrease any stigma associated with testing, as it provides an opportunity for key populations to test themselves discreetly and conveniently.⁴⁴ Models and infrastructure will be required in Australia to enable linkage to care for those undertaking self-testing; adapting models from other communicable diseases, such as COVID-19, may be useful.

Hepatitis B treatment is highly effective at slowing the progression of cirrhosis, reducing incidence of liver cancer and improving long term survival.⁴⁵ Not all people with hepatitis B may require or want treatment, but regular monitoring is critical to identify liver damage which may necessitate commencement of treatment, including oral antiviral agents. Authorised GPs can prescribe hepatitis B antiviral treatment in Australia; but more can be done to support clinical management transitioning from specialist to primary care services including addressing knowledge, management processes and financial support for hepatitis B management.⁴⁶

Hepatitis B is one of the key risk factors for the development of primary liver cancer in Australia. Building the capacity of people living with chronic hepatitis B and localised services to support lifelong monitoring, including biannual blood tests supported by periodic non-invasive methods of fibrosis assessment, is the cornerstone of appropriate hepatitis B care. Liver cancer is often asymptomatic in its early stages and grows very quickly, meaning that ongoing six-monthly surveillance is key to ensuring patients can be diagnosed while liver cancer is still treatable.⁴⁷

Improved adherence to antenatal treatment protocols and neonatal vaccination protocols, alongside management and care for women living with hepatitis B, is also critical, particularly given the significant long-term health consequences and increased association with liver cancer that follow hepatitis B infection at birth (vertical transmission).⁴⁸

Hepatitis D virus (also known as hepatitis delta virus) only infects individuals with current hepatitis B infection. Infection with hepatitis D can occur simultaneously with hepatitis B (i.e. co-infection) or it may occur in a person already chronically infected with hepatitis B (i.e. as a superinfection). Co-infection with hepatitis D can result in more rapid progression of liver disease and liver cancer. Testing for hepatitis D should be routine in all people with hepatitis B as there is evidence hepatitis D is substantially under-diagnosed in Australia.⁴³

KEY AREAS FOR ACTION – TESTING, TREATMENT, AND MANAGEMENT

1	Implement population-wide universal offer of hepatitis B testing with informed consent for adults, ensuring quality diagnosis and linkage to care.
2	Support active case finding and linkage to care, including through: <ul style="list-style-type: none"> a. utilisation of public health notifications for patient follow-up for people who have previously tested positive for hepatitis B, b. networks-based contact tracing approaches among people living with chronic hepatitis B and their family, household, and community contacts.
3	Expand the roll out and availability of new hepatitis B testing technologies with linkage to care, including community-led promotion, and implementation capacity for self-testing and point of care testing within a broader suite of testing approaches nationally.
4	Continue to implement all national hepatitis B testing, treatment, monitoring and care guidelines.
5	Strengthen monitoring and appropriate care for pregnant women living with hepatitis B and their children and promotion of treatment and antenatal care guidelines.
6	Enhance hepatitis B monitoring, liver monitoring and cancer prevention activities for people living with hepatitis B, including expanded primary care access to non-invasive diagnostic tools for assessing liver disease severity and associated health messaging.
7	Enhance processes and systems that support patient choice regarding access hepatitis B treatment.
8	Continue to improve hepatitis B treatment prescribing rates in areas with unmet need.
9	Support unrestricted viral load testing (i.e. removing the current limit of one subsidised viral load test per 12 months).
10	Prepare for the rollout of curative treatments for chronic hepatitis B by undertaking implementation projects, in collaboration with community, to design and prepare systems, workforces, and policy settings.
11	Ensure that testing for hepatitis D is offered, and supported by Medicare, for all people living with hepatitis B.

12

Identify and address the resourcing, policy, legal, regulatory and structural barriers that impede equitable hepatitis B outcomes and national prioritisation.

13

Explore opportunities for scaling up chronic hepatitis B registries to support liver cancer prevention.

8.3 EQUITABLE ACCESS TO AND COORDINATION OF CARE AND SUPPORT

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

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

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

Person-centred care for hepatitis B requires health system responses and services to be organised around a person's needs. Differentiated and decentralised service delivery models support person-centred care through adapting health services across the care cascade to support the specific needs of people based on their circumstances. This will enable testing, treatment, care, harm reduction, and the provision of other social and health-based supports and services through primary care, community and peer-based services which reach people in the community.¹³ Existing successful and innovative person-centred models of care, such as the Hep B PAST program in the Northern Territory, should be considered for expansion and national scale up, including in rural and remote and other underserved areas.

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

KEY AREAS FOR ACTION – TESTING, TREATMENT, AND MANAGEMENT

1

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

- a. Enable the national scale-up of successful models of care for hepatitis B prevention and management, particularly models that have demonstrated success with priority populations, in rural and remote areas, and areas of workforce shortage.
- b. Support nurse-led models of hepatitis B care including in primary care, rural and remote areas, and other settings.
- c. Develop, implement, and evaluate chronic disease management models for hepatitis B care including community-based long-term care, navigation, and support.
- d. Support digital models of hepatitis B care, including telehealth and telehealth interpreters, to overcome access barriers.
- e. Develop and implement community and peer-based models such as people with lived experience of hepatitis B as peer navigators for all priority populations (e.g. programs for subsidised sex worker access to vaccination, treatment, and care).

2

Improve the coordination of hepatitis B care between affected communities, community organisations, primary care, pharmacy, and specialist services. Ensure appropriate linkages between primary care and specialist tertiary hepatitis B services to support prescribers for referral, consultation, and advice regarding patients with serious complications.⁴⁷

3

Ensure people have had their diagnosis, ongoing care requirements, and other key management decisions explained to them in their first/preferred language (using an accredited interpreter and/or Aboriginal health practitioner or bilingual health worker) within six months of diagnosis, to ensure timely, culturally safe care, and linkage to community and support organisations has been offered.

4	Remove barriers to accessing hepatitis B testing, treatment, vaccination, and clinical management, including for people who are ineligible for subsidised healthcare.
5	Expand subsidised access to hepatitis B antiviral medicines.
6	Build capacity in broader primary health care systems and services to embed and prioritise hepatitis B activities including multicultural health services, parent and child services, sexual health services and Aboriginal Community Controlled Health Organisations.
7	<p>Enable and expand the provision of culturally, ethnically, and linguistically appropriate hepatitis B services to priority populations, including:</p> <ol style="list-style-type: none"> Engagement, awareness, and ongoing capacity building of bicultural and bilingual health workers. Support and build capacity of community hepatitis educators including from priority populations. Coordinate and expand access to accredited translation services and ensure their ongoing hepatitis B specific training and capacity building. Undertake co-design work to describe peers and peer work in the context of hepatitis B. Support the development and maintenance of directories of hepatitis B workers and health care professionals who speak languages other than English.
8	Identify and address the resourcing, policy, legal, regulatory, and structural barriers that impede equitable hepatitis B outcomes and national prioritisation.

8.4 WORKFORCE

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

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

There is currently a limited hepatitis B-specific community workforce nationally. This has contributed to unequal and insufficient progress nationally. Where a comprehensive hepatitis B-specific community and health workforce capacity is in place, that is, in parts of the Northern Territory, they are leading in the attainment of national hepatitis B targets. The implementation, maintenance, and strengthening of a hepatitis B-specific community workforce, including peers, is critical infrastructure through which national targets can be achieved, care can be decentralised, and responses can be tailored to social, cultural, linguistic, and local contexts.

Peer workers undertaking experience-based roles provide multi-faceted support in the delivery of services. Their lived experience and connection to community mean that peers are often more accessible to people who are otherwise not being reached by the mainstream health system. This includes a primary and specific focus on hepatitis related prevention and referral, the promotion (and in some cases provision) of testing and treatment, peer support, education, training, individual and systemic advocacy, information sharing and awareness raising. Additionally, the hepatitis B community workforce includes those who address hepatitis B within a broader health or social service context including the community-based settings outlined in this Strategy. These organisations and their national peaks work with and maintain valuable linkages to priority populations and therefore form a critical part of the national response and should be strengthened.

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

The clinical workforce addressing hepatitis B includes workers in primary healthcare, such as GPs, nurses, and pharmacists as well as hepatitis B specialists. Greater focus and progress are needed to shift routine testing, treatment, follow-up, and monitoring of hepatitis B to primary care. Opportunities to facilitate the provision of nurse-led services and expand the role of Nurse Practitioners in health promotion, prevention, and management of hepatitis B should also be strengthened.

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

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

KEY AREAS FOR ACTION – WORKFORCE

- 1** Implement, maintain, and strengthen a national hepatitis B-specific community workforce including peer workers. Implement associated projects and supports including workforce development/training, supervision, communities of practice, scopes of practice and capacity building.
- 2** Develop and implement a national hepatitis B multidisciplinary workforce development plan. This includes activities that support longer term workforce planning such as:
 - a. Mapping, describing, and defining the hepatitis B workforce, and their skills and capabilities, including to inform hepatitis B health system planning.
 - b. Enhancing the capacity of multidisciplinary workforces and associated systems to respond to intersecting and priority issues including hepatitis B specific knowledge and skills, inclusivity, cultural and linguistic appropriateness.
 - c. Taking a coordinated a strategic approach to the delivery of hepatitis B workforce development activities.

3

Support primary care workforces to deliver hepatitis B care, including:

- a. Increase enrolment in primary care practitioner training in hepatitis B management (including S100 Prescriber training), particularly bilingual practitioners from high-prevalence countries and in regions with large populations of culturally, ethnically, and linguistically diverse populations.
- b. Increase capacity and availability of hepatitis B prescribers.
- c. Maintain and promote clinical guidelines for hepatitis B management (including liver cancer surveillance) in primary care.
- d. Improve patient management systems to better support the primary care workforce to promptly identify and provide monitoring, treatment and care for people living with hepatitis B.
- e. Increase capacity of nursing and pharmacy workforces to provide hepatitis B prevention, testing and care.
- f. Increase incentives for primary care practitioners to manage hepatitis B via increased funding and time allocation - such as occurs with complex care management plans, or diabetes.

4

Ensure maternity and hospital staff have sufficient training and capacity to undertake early detection, monitoring, work-up and treatment of hepatitis B including utilising available multidisciplinary referral pathways to provide support at the perinatal stages.

5

Ensure the primary care and community workforce has the resources and capabilities it needs to deliver decentralised care including mobile outreach and other innovative service models.

6

Increase the availability of digital and face to face hepatitis B learning opportunities to facilitate a skilled clinical and community workforce.

7

Deliver education to ensure that there is at least one expert in liver cancer monitoring in a private or public setting and facilitate access to training to upskill in this area.

8

Implement hepatitis B capacity building for allied sectors/workforces (e.g., migration, legal, multicultural groups) to undertake relevant hepatitis B interventions (e.g., screening, referral, prevention/universal precautions) and support partnerships with relevant community hepatitis organisations and workers.

9

Leverage the established networks of multicultural health services, alcohol and other drug services, mental health services, and priority population services to improve hepatitis B health literacy and connection to care and support.

10

The implementation, maintenance and strengthening of a hepatitis B community workforce and increased meaningful involvement of people living with hepatitis B and priority populations is imperative to the success of Australia's response (particularly Aboriginal and Torres Strait Islander people and people from culturally, ethnically and linguistically diverse backgrounds born in countries where hepatitis B is endemic).

8.5 ADDRESSING STIGMA AND CREATING AN ENABLING ENVIRONMENT

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

Fostering an enabling environment for people affected by hepatitis B and hepatitis B elimination requires the removal of stigma, discrimination, racism, and colonisation in all forms, including in systemic, structural, regulatory, and institutional contexts. For people living with hepatitis B, 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 B is multi-dimensional and multi-layered and can be compounded by discrimination associated with race, cultural background, migrant or refugee status, gender identity, health status and perceptions of risk. Strategies to address stigma and discrimination must acknowledge and account for intersecting stigmas and racism.

Stigma, discrimination, and racism within the health system can prevent individuals and whole communities from accessing hepatitis B prevention and care. Evidence has demonstrated that approximately 34% of health workers indicated that they would behave negatively toward someone because of their hepatitis B status. To provide efficient and cost-effective services for hepatitis B, the workforce should receive education and training to be aware of the potentially negative impact of stigma on the decisions made by individuals to access health care. This means that health workers should be looking for ways to improve the attitudes, practices and policies that may influence the decisions of people affected by hepatitis B to improve quality of services provided.⁵⁰

Lack of engagement with services among migrant communities has also been linked to pre-existing stigma from countries of origin.⁵¹ Combined with non-Western framings of health and hepatitis, misconceptions about hepatitis B, barriers to health service access, language barriers, and concerns about confidentiality, the communities most affected by hepatitis B may be unaware of their status and experience a range of barriers in accessing care.^{37,52} This can be further intensified with medico-legal concerns related to immigration status, perceived impacts on attainment of Australian residency, and the costs associated with health care for people not eligible for Medicare.⁵³ Legal, policy, social, cultural, and economic barriers also impact on hepatitis B outcomes. For example, Australia's anti-discrimination legislation excludes migration law, which affects many people with hepatitis B. Studies have found that removing such barriers and reducing stigma and discrimination increase testing and treatment and contribute to a decrease in incidence and prevalence of various blood borne viruses and sexually transmissible infections.^{54–56}

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

KEY AREAS FOR ACTION – ADDRESSING STIGMA AND CREATING AN ENABLING ENVIRONMENT

- 1** Implement long-term and stable programs led by, or in partnership with, people living with hepatitis B aimed at minimising stigma and discrimination across the community, particularly in healthcare settings.
- 2** Ensure people living with hepatitis B are engaged in, and co-design national policy development, implementation, and evaluation.
- 3** Support co-designed systems change processes alongside people living with hepatitis B to ensure that health systems are accessible, appropriate, and safe for people from culturally, ethnically, and linguistically diverse communities.
- 4** Incorporate messaging to counteract stigma in hepatitis B health promotion initiatives.

5	Increase anti-stigma, anti-discrimination, anti-racism and decolonisation training and other initiatives (co-designed in partnership with affected communities, culturally safe, and trauma-informed) for primary care and other health practitioners to work better with priority populations. This should include strengthening accountabilities for hepatitis B health and associated care.
6	Implement projects to address legal, policy and systemic barriers (including those related to stigma, discrimination, colonisation, human rights issues, and racism) that contribute to poor or unintended hepatitis B outcomes and identify and implement appropriate actions, including building cross-sectoral support for priority populations (e.g. in migration and employment).
7	Implement a national project focused on access to justice and support for people affected by hepatitis B to meet their legal needs.
8	Identify opportunities to better elevate hepatitis B as a national policy priority including in allied health contexts, including for example preventive health, primary care, cancer, and health and research planning.
9	Maintain Australia's reputation as a global leader in the management of blood borne viruses by delivering on national and international 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 B.
10	Identify and take action to address system, policy and legal barriers that affect people's ability to prevent hepatitis B transmission and associated issues and access to care.

8.6 DATA, SURVEILLANCE, RESEARCH, AND EVALUATION

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

Research helps to guide the development, implementation and evaluation of policies and programs at all levels of the national response to hepatitis B. Research is needed to understand the impact of hepatitis B more fully in priority populations and must be linked to the needs of all affected communities.

Continuous improvement of data collection and systems, including data linkage and sharing information across jurisdictions, is important to support a comprehensive understanding of the burden of hepatitis B in Australia and to monitor the impact of interventions.²⁹ However, this must be appropriately targeted to ensure its effectiveness; and balanced to minimise data collection burdens on affected communities, health services and frontline staff. The Research Strategy 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 B (and hepatitis B-related morbidity and mortality) in the community.

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

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

Current therapies are unable to cure established chronic hepatitis B infections and only reduce (but do not eliminate) the risk of liver cancer. Researching and developing cures for chronic hepatitis B would save many millions of lives globally and help ensure the elimination of hepatitis B by 2030.

KEY AREAS FOR ACTION – DATA, SURVEILLANCE, RESEARCH, AND EVALUATION

- 1** In partnership with community, revise and co-design the National Blood Borne Viruses and Sexually Transmissible Infections Surveillance and Monitoring Plan to specify the indicators used to monitor progress towards achieving the National Hepatitis B Strategy targets.
- 2** Update, with involvement from community, the National BBV and STI and Research Strategy, including to maintain and enhance the timely annual reporting of hepatitis B surveillance and monitoring, including analysis of progress against targets and indicators, disaggregation by sub-populations where possible, and mapping with additional regional specificity.

3	Embed priority populations and affected communities in all aspects of research, including priority setting, modelling, development, implementation, co-authorship, community engagement and research translation and dissemination.
4	Build capacity of community to lead, participate in, co-author, and implement hepatitis B research.
5	Prepare and undertake Australian validation of hepatitis B elimination, as per World Health Organization guidance, including with community involvement in the validation process.
6	Improve data completeness in clinical, pathology and public health settings in relation to maternal hepatitis B status, Aboriginal and Torres Strait Islander people's status, country of birth, language spoken, ethnicity, Medicare eligibility, and likely place of hepatitis B acquisition, as well as for collecting data on the impact of hepatitis B on unvaccinated adults at high risk of infection.
7	<p>In partnership with community, address gaps in surveillance data and analysis for measuring, monitoring and clearly reporting on the implementation of this Strategy and progress towards targets, and prioritise these for action, including:</p> <ol style="list-style-type: none"> Develop target baselines and further quantify targets where required (e.g. from 2025), ensuring that progress against each of the Strategy's targets and sub-targets is measurable, including for the legal and human rights target and stigma target. Prioritise sub-populations and regional data for equity measures. Establish and implement a community-led hepatitis B quality of life measure and associated data set. Establish monitoring and measurement of hepatitis B related stigma, discrimination, and racism, and other legal and human rights issues. Produce incidence estimates of hepatitis B that differentiate acute and chronic infections. Improve the collection, measurement, and reporting of data on morbidity and mortality attributable to hepatitis B. Undertake work to improve data collection and understanding including about hepatitis B and sex work.
8	Undertake hepatitis B data linkage projects including simplifying access to MBS and PBS data for data linkage purposes.

9	Enhance community service level data and intelligence on hepatitis B to complement epidemiological data, including with community hepatitis Organisations via the National Hepatitis Infoline.
10	Support research on emerging hepatitis B and social determinants of health issues and associated public health and social implications. Promote a balance of hepatitis B social, behavioural, epidemiological, legal, and clinical research to better inform all aspects of the response.
11	Support research and evaluate models of care, including in relation to testing and novel diagnostic methodology to improve treatment uptake and identify barriers to hepatitis B healthcare. Research could include linkage of MBS and PBS data.
12	Ensure current and future programs and activities are evaluated to ensure linkage and alignment to the priorities of this Strategy.
13	Ensure public health units are sharing hepatitis B data safely and effectively to improve data collection, patient follow-up, and enhance person-centered care.
14	Ensure Australia is at the fore of hepatitis B research innovations, including through expanding a focus on hepatitis B research in existing Australian Government research funding such as the Medical Research Future Fund and NHMRC. This includes prioritising research into hepatitis B cures and development of targeted treatments, including direct acting antivirals and immunotherapeutic approaches.
15	Undertake mapping and monitor investment on national hepatitis B elimination, including for sufficiency relative to the burden of hepatitis B.
16	Support Australia's leadership in hepatitis B research and capacity building globally including with the WHO and other key stakeholders.
17	Evaluate the implementation of the National Strategies (e.g., to coincide with the mid-point review of the National Hepatitis B Strategy (informed by 2025 data) to determine progress and make appropriate changes to ensure the goal of elimination by 2030 can be achieved.

9. IMPLEMENTING THIS STRATEGY

Leadership, partnership, and connections to community

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

The Australian Government is committed to providing strong national leadership by working across portfolios and jurisdictions to achieve the goals of this Strategy. The Australian Government Department of Health and Aged Care leads the coordination of the national response to hepatitis B under the National Hepatitis B Strategy 2023-2030. The success of this Strategy is contingent on productive partnerships between Commonwealth, state and territory governments and partners, including community peak organisations, priority populations and affected communities, health workers, researchers, and others. In the case of research on hepatitis B, it is imperative that this is conducted in partnership with communities and is aligned with the priorities of the five national strategies.¹²

The Fourth National Hepatitis B Strategy 2023-2030 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, a continuous monitoring and evaluation of current and emerging interventions will be essential in enabling cost-effective decision making and guiding existing partnerships to implement agreed directions. This requires investment and mobilisation of resources to be across all levels of government from national direction to local jurisdictions. This ensures that resources are utilised to achieve maximum impact and desired outcomes.

Governance, reporting and evaluation

This Strategy (alongside the other national blood borne virus and sexually transmitted infection strategies) is endorsed by Australia's Health Ministers and governed through relevant committees of the Health Chief Executives Forum (HCEF). These include the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections (MACBBVSTI) and the Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS).

The BBVSS coordinates implementation and evaluation efforts across jurisdictions and reports to the Australian Health Protection Principal Committee (AHPPC) on progress in the implementation of the national strategies. BBVSS and the Communicable Diseases Network Australia (CDNA) will jointly monitor progress towards the targets of each Strategy, undertake evaluation and identify emerging issues and opportunities for action.

Review and implementation

This Strategy spans 2023-2030 and represents a departure from the shorter lifespan of previous strategies. The 2025 mid-point targets, as well as the broadening of the reporting framework, will provide data from which a comprehensive review of progress can be undertaken in 2026. This process and timing are consistent with the global strategy. 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 readjusted.

An Action Plan will provide the detail of specific actions for governments and partners. The Action Plan will outline the roles and responsibilities of governments and partners and the time frames for implementation of the actions. Implementation indicators will be identified to help monitor progress, with the Action Plan being reviewed and updated at the mid-point.

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