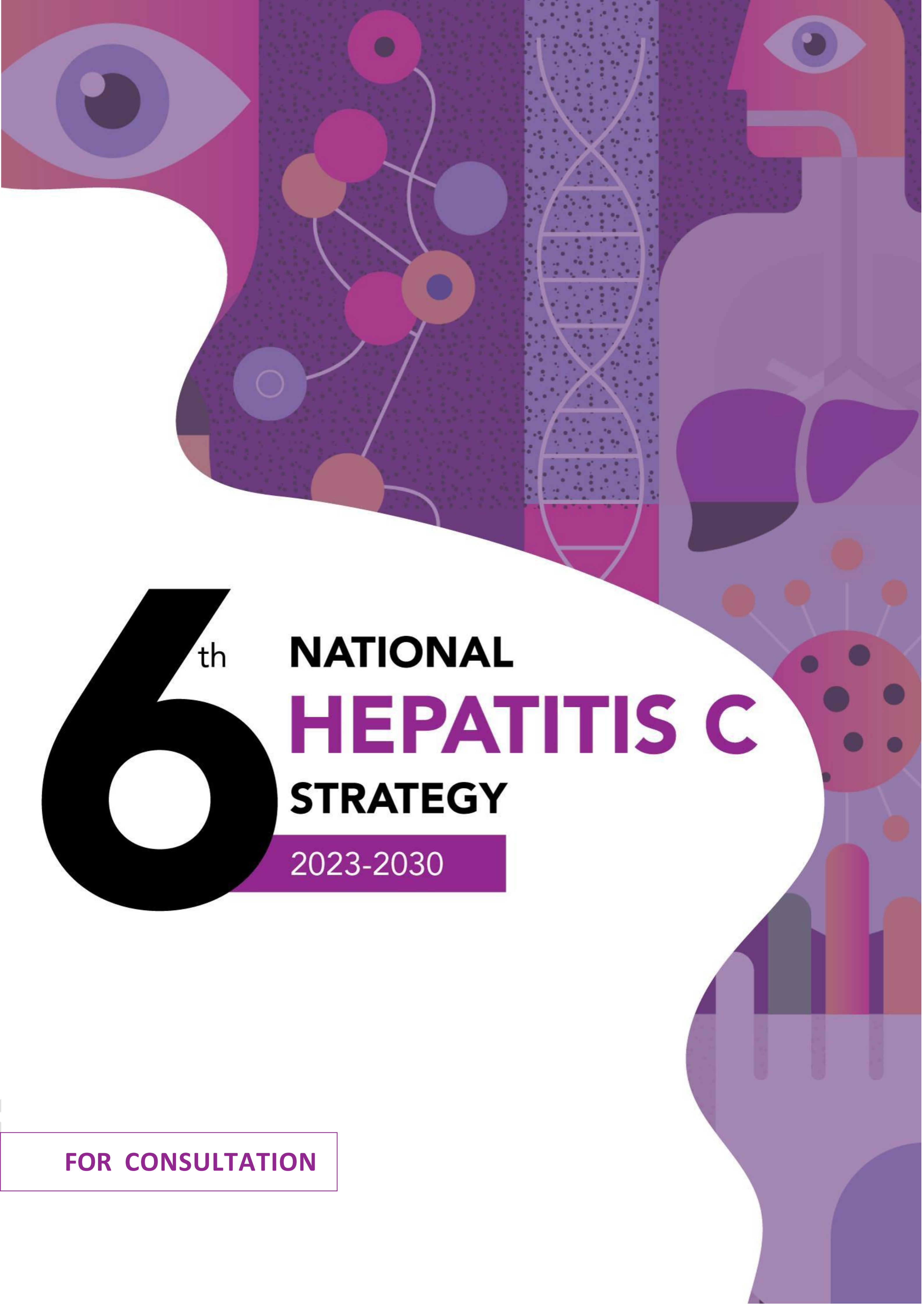


6th
NATIONAL
HEPATITIS C
STRATEGY

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 C 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.

CONTENTS

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 C will be eliminated as a public health threat in Australia. Everyone will have equitable access to safe, affordable, and effective prevention, harm reduction, education, testing, and treatment including appropriate person-centred care and support. People impacted by hepatitis C are active decision makers in their care, live free from stigma, discrimination, and racism and lead healthy and productive lives.

1. INTRODUCTION

Hepatitis C is a preventable but potentially life-threatening blood borne viral infection that primarily affects the liver.

The Sixth National Hepatitis C Strategy 2023–2030 (the Strategy) guides Australia's strategic response to eliminating hepatitis C as a public health threat by 2030. People affected by hepatitis C are at the centre of the Strategy. This includes a focus on better understanding the culturally, ethnically, linguistically socially, and geographically diverse populations affected by hepatitis C, and enabling community leadership in all aspects of the national, jurisdictional, and local responses. Taking a person-centred approach to hepatitis C also necessitates a shift from a disease and transmission-centric focus, to one that also considers quality of life and the needs of people post-cure. By supporting meaningful partnerships with affected communities, the national response to hepatitis C will enhance equity and ensure no one is left behind.

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

Some of the key drivers of the hepatitis C epidemic 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 C as a priority within intersecting health and social policy contexts.

Opportunities to scale up and enhance existing approaches to hepatitis C prevention, harm reduction, testing, diagnosis, treatment, and post-cure care are also prioritised. Greater attention needs to be placed on liver health (including cancer and cirrhosis) attributable to hepatitis C, noting that actions to address hepatitis C 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 C workforce and implementing a hepatitis C specific community and peer workforce. Innovations in testing and treatment, including point-of-care testing, self-testing and further decentralisation to primary care and community settings, must be leveraged. This Strategy enables the adoption of such innovations by ensuring the requisite systems, workforce, community leadership and policy infrastructure are strong.

The duration of this Strategy is aligned with the *World Health Organization (WHO) global health sector strategies on respectively HIV, 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 meet 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 C. This Strategy is informed by consultation, particularly with key stakeholders including affected communities, national peak bodies, peer and community organisations, governments, clinicians and the multidisciplinary workforce, and researchers (see Table 1 below) in the national response to hepatitis C.

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 C. 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 C and other blood borne viruses and sexually transmissible infections.

Partnership

Partnership is at the heart of Australia's response to hepatitis C. It is a long-standing tenet recognised by successive national hepatitis C and other blood borne 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, policymaking, 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

Australia's response must centre people affected by hepatitis C, work to their benefit and prioritise them. It positions affected individuals, their families, and communities at the centre of policies, research and programs across all domains (e.g., prevention, harm reduction, testing, treatment, care and support), and evaluation, surveillance and monitoring. This also means that the needs of people affected by hepatitis C 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.

Meaningful involvement of priority populations

Meaningful involvement of priority populations in all aspects of the hepatitis C response is essential to the development, implementation, monitoring and evaluation of effective policy, programs, and research. The diversity and specific needs of priority populations is acknowledged and responded to effectively, having regard to the various settings and needs of their communities. This approach underpins the other guiding principles and contributes to reducing stigma and discrimination and increasing the effectiveness and appropriateness of Australia's response.

4

Human Rights

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

Australia's response to hepatitis C 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.[3] Further, the national response must have particular regard for the rights of people in prisons to access the same standard of healthcare, as enshrined in the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) and in the Basic Principles for the Treatment of Prisoners (United Nations General Assembly resolution 45/111).

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 drug use, sex work, race, gender, age, disability, income, culture, language, and religion.

The goals of this Strategy will not be achieved without addressing the inequalities that drive the hepatitis C 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 inequitable access to services and health outcomes.

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.

6

Health promotion

The Ottawa Charter for Health Promotion[4] and the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development[5] provide the framework for effective action 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 when delivered by those communities, in partnership with governments, health workers, community organisations researchers, and other relevant organisations.

7

Prevention

The transmission of hepatitis C can be prevented through the appropriate combination of evidence-informed social, biomedical, and behavioural approaches within a supportive and enabling environment, including prevention interventions and measures which reduce exposure to the virus. Enhancing and strengthening all primary prevention strategies (including comprehensive access to harm reduction measures for people in prisons and in the community), will help embed primary and secondary 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.[5]

8

Harm reduction

Harm reduction approaches underpin effective measures to prevent transmission of hepatitis C and related harms.

Grounded in justice and human rights, harm reduction aims to minimise adverse health, social and legal impacts through policies, programs, practices, and involvement of priority populations. It focuses on working with people without judgement, coercion, discrimination, or requiring a change in behaviour as a precondition of support. Examples of effective, evidence-based harm reduction include needle and syringe programs (both in prisons and in community settings), safer drug consumption sites, safer sex practices, peer support, drug law reform (e.g., decriminalisation/legalisation) and other law reform across different jurisdictions (such as legalisation of sex work in relevant jurisdictions).

9

Access and quality health services

Hepatitis C 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.

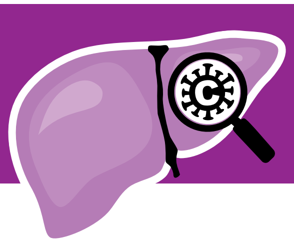
Quality accessible health services are reliant on a multidisciplinary hepatitis C workforce, including peers, that delivers person centred, whole of life, effective, safe and appropriate care. Coordination and integration of hepatitis C services across priority settings is also essential.

10

Commitment to evidence-informed policy and programs

The national response to hepatitis C is built on and values different forms of evidence and knowledge research, surveillance, monitoring, 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 social policy, and meet the goals of this Strategy.

3.Snapshot of Hepatitis C in Australia



Hepatitis C is a virus that causes inflammation and damage to the liver. Hepatitis C can be cured through the use of highly effective and safe medications; but is not currently vaccine preventable. Reinfection can also occur if risk factors are ongoing because previous infection does not confer immunity. If left untreated, chronic hepatitis C can cause liver inflammation which can lead to liver disease, cancer, and death.

Prevalence

At the end of 2020, an estimated 117,810 people were living with chronic hepatitis C in Australia[7], with 58 million people chronically infected worldwide.[8] Hepatitis C disproportionally affects priority populations including people with a history of injecting drug use, people in custodial settings, Aboriginal and Torres Strait Islander people and the other priority populations identified in this Strategy.

In 2020, hepatitis C prevalence was highest in remote regions (1.2%), very remote regions (1%), and outer regional areas (1.06%) sitting well above the national average (0.78%).[9]

New diagnoses

From 2019 to 2020 there was a decrease in notifications from 9,187 to 7,990. Between 2015 and 2019, the newly acquired hepatitis C notification rate declined by 9% from 3.5 to 3.2 notifications per 100,000 population and then decreased by a further 16% to 2.7 notifications per 100,000 in 2020.[10] Fluctuations in 2020 may be influenced by impacts of the COVID-19 pandemic, including significant disruption to hepatitis testing.[11]

In 2020, rates of hepatitis C notifications were nearly six times greater among the Aboriginal and Torres Strait Islander population compared to the non-Indigenous population.[10] At the end of 2020, an estimated 77% of people living with hepatitis C had been diagnosed, and 75% of those diagnosed had received a ribonucleic acid (RNA) test to confirm chronic infection.[10]

What health issues can it cause?

Hepatitis C progresses to chronic infection in about 75% of cases. People with chronic hepatitis C are at risk of progressive liver fibrosis leading to cirrhosis, liver failure and hepatocellular carcinoma (liver cancer). If not treated, approximately 1 in 5 people with chronic infection develop cirrhosis, generally after 20-30 years of infection.[12] These harms may occur post-cure for those who have already experienced liver damage prior to treatment. Combined, hepatitis C and hepatitis B are the primary cause of liver cancer, Australia's fastest growing cause of cancer death.[13]

In 2020, there were an estimated 423 hepatitis C related deaths in Australia. An estimated 21,642 people living with chronic hepatitis C had severe fibrosis, and 6,635 had hepatitis C related cirrhosis.[10]

How is it managed?

Treatment with direct-acting antiviral medication can result in cure for over 95% of people with chronic hepatitis C.[7] All Australians who are Medicare eligible and people in prison can access unrestricted treatment subsidised through the Pharmaceutical Benefits Scheme, prescribed by medical practitioners or authorised Nurse Practitioners. People who are cured with ongoing liver complications, and people not cured following treatment, require ongoing care and monitoring in specialist settings. Community organisations including peers support people living with hepatitis C to navigate and access treatment and ongoing care.

Routes of transmission

Hepatitis C virus is transmitted through blood-to-blood contact. In Australia, hepatitis C is most commonly transmitted through the use of unsterile injecting equipment. It can also be transmitted through exposure to infected blood in health care settings, non-sterile tattoos or body piercings, shared personal care items, unscreened blood products and organ transplants, vertical (mother-to-child) transmission and less commonly through unprotected sex.[14] Transmission during sex is rare but there are heightened risks among men who have sex with men including in the setting of HIV pre-exposure prophylaxis (PrEP).

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

Prevention

Harm reduction and demand reduction are the primary hepatitis C prevention strategies for people who inject drugs, incorporating needle and syringe programs, peer education, opioid agonist treatment and other treatments for injectable drugs of dependence.

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

Treatment and care

Of the 188,690 people living with chronic hepatitis C at the end 2015 (the baseline for national and global hepatitis C service coverage targets), it is estimated that 95,395 individuals (51%) had received treatment at the end of 2021, and 94% of those treated were cured.[7] When subsidised interferon free direct-acting antiviral regimens became available in Australia in 2016, access to these highly effective hepatitis C treatments was high. Each subsequent year treatment uptake has declined from 33,201 in 2016 to 6,474 in 2021. Of those receiving direct-acting antiviral treatment since 2016, some 6,808 individuals (7%) received at least one further treatment course. The total number of re-treatment courses was 7,948; with 52% of those due to reinfection and 48% due to virological failure.[7]

4. ABOUT THIS STRATEGY

This Strategy builds on previous strategies and sets the direction for Australia's continuing response to hepatitis C 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. Sixth National Hepatitis C Strategy 2023–2030 (this Strategy)
2. Fourth National Hepatitis B 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 Sexually 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.[16]

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

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

1. State and territory viral hepatitis strategies
2. Global Health Sector Strategies on, respectively, HIV, Viral Hepatitis and Sexually Transmitted Infections for the period 2022-2030
3. National Immunisation Strategy 2019-2024
4. National Drug Strategy 2017–2026
5. Long-term National Health Plan
6. National Preventive Health Strategy 2021–2030[5]
7. International Covenant on Economic, Social and Cultural Rights
8. The United Nations Common Position on Drug Policy[17]

9. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)[18]
10. Australian Cancer Plan 2023-2033
11. National Anti-Racism Framework[19]
12. Australia’s Primary Health Care 10 Year Plan[20]
13. National Aboriginal and Torres Strait Islander Health Plan[21]
14. National Agreement on Closing the Gap and associated implementation plans[22]
15. Nurse Practitioner 10 Year Plan[23]
16. National Framework for Communicable Disease Control.[24]

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

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

An estimated 51% of people (95,395 individuals) living with hepatitis C (at the end of 2015) had initiated treatment by 2021, following the introduction of the Pharmaceutical Benefits Scheme listing of direct-acting antivirals in early 2016. Of those, an estimated 7% (6,808 individuals) were retreated at least once.[7]

Treatment uptake amongst people who inject drugs is a leading success story of the national response. Among an estimated 75,000 people who inject drugs regularly in Australia, the number with chronic hepatitis C infection declined from 32,619 (44%) in October 2015 to 12,679 (17%) in October 2019. The majority (78% in 2015 and 2019) of people who inject drugs reported having ever being tested for hepatitis C, while the proportion of those diagnosed who were treated increased from 3% in 2015 to 47% in 2019. Among those treated, the proportion who were assumed to have been successfully cured, increased from 27% in 2015 to 88% in 2019.[25]This progress reflects the commitment to harm reduction and treatment amongst people who inject drugs, the leadership of peers and peer-based drug user and other community organisations, and the services and champions who provide a priority focus on at-risk populations.

Needle and Syringe Program coverage in the community remains high. In 2021, the Australian Needle and Syringe Program Network consisted of 4,218 outlets (a 20% increase from 3,509 in 2016) and distributed 50.2 million sterile needles and syringes (a 2% increase over five years). This equates to an estimated syringe coverage per injection of 121%. Syringe coverage greater than 100% is required to accommodate syringes utilised by people who inject drugs occasionally and syringes that are not used for an injection.[26]

Amongst participants in the Australian Needle and Syringe Program Survey, between 2015 and 2021 the proportion testing hepatitis C antibody positive reduced from 57% to 36%, the proportion testing RNA positive (with current infection) reduced from 51% to 16%, and lifetime treatment for hepatitis C increased from 11% to 62%.[27] Among Aboriginal and Torres Strait Islander populations in the Australian Needle Syringe Program Survey, there was a significant increase in the proportion reporting ever having hepatitis C treatment, from 10% in 2015 to 52% in 2020.[27]

Hepatitis C attributable deaths are declining. In 2020, an estimated 476 deaths in Australia were attributable to chronic hepatitis C. This represents a 32% reduction from 696 in 2015.

Achieving the National Hepatitis C Strategy 2022 mortality target (65% reduction; hepatitis C attributable deaths below 244) was considered by experts to be unfeasible by 2022 and an equivalent measure (<1.0 per 100,000 population per year) adopted as a National Hepatitis C Strategy 2023-2030 mortality reduction target.[10]

Overall, there has been a steady 31% decline in the rate of hepatitis C diagnosis from 45.1 per 100,000 population in 2011 to 32.1 per 100,000 in 2020. This is despite increased diagnosis in 2016 associated with the introduction of direct-acting antiviral therapies. In this time, the rate of notifications among people aged 15-24 years (used as a proxy indicator for incidence of hepatitis C) has reduced by 20% (from 36.3 to 29.2 per 100,000 population), mostly among females.[10]

Notification rates of hepatitis C among Aboriginal and Torres Strait Islander people have declined by 12.5% between 2016 and 2020 (slower than the 35.2% decline among non-Indigenous Australians), remaining nearly six times higher than the non-Indigenous population.

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

Table 2: Progress against the Fifth National Hepatitis C Strategy 2018-2022

Progress against National Hepatitis C Strategy 2018–2022 targets, as at the end of 2020[10]

Key: 🔴 Not achieved ❗ Insufficient data

❗ **Reduce the number of newly acquired hepatitis C infections, with a focus on priority populations, by 60%**

Insufficient data to confirm. There is no published annual estimate of the number of newly acquired hepatitis C infections nationally. Instead, acknowledging certain limitations, newly acquired notification rates are published as proxy measures. The rate of notifications among those aged 15–24 years (used as a proxy for the incidence of hepatitis C infection) declined by 21% from 37.0 per 100,000 in 2015 to 29.2 per 100,000 in 2020, although mostly amongst women. [10] The rate of newly acquired notifications (for which transmission is assessed to have occurred within 2 years prior) declined by 23% from 3.5 per 100,000 in 2015 to 2.7 per 100,000 in 2020. The portion of the decline from 2019 to 2020 may be due in part to the impact of COVID-19 restrictions on hepatitis testing uptake.[10]

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

At the end of 2020, an estimated 77% of people living with hepatitis C were diagnosed.

🔴 **Increase the cumulative proportion of people living with chronic hepatitis C who have initiated direct-acting antiviral treatment to 65%**

Since 2016, an estimated 51% of all people living with hepatitis C have received direct-acting antiviral treatment.

🔴 **Reduce hepatitis C attributable mortality overall by 65%**

Estimated number of hepatitis C-related deaths declined by 32% from 2015 to 2020.

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

Insufficient data to confirm. In 2018, approximately 53% of people living with hepatitis C reported that they had experienced stigma or discrimination because of their hepatitis C status in the previous 12 months, down from 55% in 2016.[2] In 2020, 30% of participants of a mirrored Stigma Indicator survey administered online to the Australian general public (n=2,010) indicated that they would behave negatively towards other people because of their hepatitis C status, compared with 50% of the adult Australian population via the Australian Survey of Social Attitudes (AuSSA: n=1,001) sample.[29]

The progress against the targets of the previous National Hepatitis C Strategy highlights that more action is needed to ensure that hepatitis C is eliminated as a public health threat by 2030.

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

Receptive syringe sharing is the major risk factor for the transmission of hepatitis C among people who inject drugs. Whilst the Australian Needle Syringe Program network is expanding and the quantum of sterile equipment distributed increasing, the proportion of the Aboriginal and Torres Strait Islander survey participants reporting receptive syringe sharing in the last month (before participating in the survey in 2021) was significantly higher (at 24%) compared with non-Aboriginal and Torres Strait Islander participants (13%).[10]

Australian prisons, currently, do not yet offer regulated access to sterile injecting equipment, despite prisons becoming primary settings of hepatitis C transmission in Australia. Subsequent National Hepatitis C Strategies must prioritise actions to address this unmet need. There is an urgent need to scale up, implement and adequately resource prevention and harm reduction programs across all priority settings, with innovative interventions targeting priority populations and supporting people who inject drugs to prevent hepatitis C transmission and other related harms.[30]

Stigma, discrimination and racism are major barriers to the successful implementation of the Strategy.[2] There is a need for more implementation projects, systemic reform and research to tackle stigma, discrimination and racism in collaboration with priority populations.[10,30]

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

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

The success of the National Hepatitis C Strategy 2023-2030 relies on building strong evidence with the priority populations to better inform Australia’s response and evaluate approaches to identify what is most effective, and further strengthening the workforce, partnerships and connections to priority populations.[6]

6. MEASURING PROGRESS

This Strategy has overarching goals, targets and priority areas which will guide the national response to hepatitis C for 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 C Strategy 2023-2030 are to:

- Eliminate hepatitis C as a public health threat by 2030
- Reduce mortality and morbidity related to hepatitis C
- Eliminate the negative impact of stigma, discrimination, and legal and human rights issues on people's health
- Minimise the personal and social impacts of hepatitis C

Equity and intersectionality are central to the framing and tracking of progress towards the targets. 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 the end of 2015.

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

Domain	2025 Target	2030 Target
Incidence reduction	**Reduce by 60%** the incidence of hepatitis C. **≤8 cases** per 100,000 population per year. **≤3 cases** per 100 people who inject drugs per year.	**Reduce by 90%** the incidence of hepatitis C. **≤5** cases per 100,000 population per year. **≤2 cases** per 100 people who inject drugs per year.
Proportion Diagnosed	Increase the proportion of people living with hepatitis C who are diagnosed to: • 90% (including notifications made on the basis of hepatitis C antibody status), and	Increase the proportion of people living with hepatitis C who are diagnosed (confirmed hepatitis C RNA positive) to 90%. Reduce to ≤2% the proportion of people with hepatitis C diagnosed

	- 80% (confirmed hepatitis C RNA positive) Reduce to ≤5% the proportion of people with hepatitis C diagnosed with liver cancer or decompensated cirrhosis, whose hepatitis C was diagnosed late.	with liver cancer or decompensated cirrhosis, whose hepatitis C was diagnosed late.
Proportion Cured	65% of people living with hepatitis C are cured.	85% of people living with hepatitis C are cured.
Attributable mortality	**Reduce by 40%** hepatitis C attributable mortality. ≤1.6 deaths per 100 000 population per year.	**Reduce by 65%** hepatitis C attributable mortality. ≤1.0 deaths per 100 000 population per year.
Indigenous status identification data completion	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.	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.
Stigma reduction	**Reduce to zero** the expression of hepatitis C - related stigma and discrimination in health care settings. **Reduce by 75%** the experience of hepatitis C -related stigma among people who have ever lived with hepatitis C.[1]	**Reduce to zero** the expression of hepatitis C - related stigma and discrimination in health care settings. **Reduce by 75%** the experience of hepatitis C -related stigma among people who have ever lived with hepatitis C.[2]
Quality of life	**75%** of people affected by hepatitis C report a good quality of life. **Establish a baseline** of the reported quality of life among people living with chronic hepatitis C.	**95%** of people affected by hepatitis C report a good quality of life.[3]
Legal and human rights	**Reduce the negative impact** of legal and human rights issues on people affected by hepatitis C. **Establish a baseline** of the negative impact of legal and human rights issues in people's health and wellbeing for people	**Reduce the negative impact** of legal and human rights issues on people affected by hepatitis C.[4]

---

[1] Parity with the National HIV Strategy 2023-2030 stigma target is being sought. Number is subject to change based on this.

[2] Parity with the National HIV Strategy 2023-2030 stigma target is being sought. Number is subject to change based on this.

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

[4] This target may be numerated based on work to establish a 2025 baseline.

	affected by hepatitis C.	

7. PRIORITY POPULATIONS AND SETTINGS

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

In accordance with the guiding principles of this Strategy, the diverse challenges and experiences within all priority populations need to be considered in the national response. This includes, but is not limited to, 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 C 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 C

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

People living with hepatitis C

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

- People living with hepatitis C who inject drugs and/or have injected drugs

- People living with hepatitis C who are not eligible for subsidised care or do not access health services related to hepatitis C or hepatitis C risk transmission
- People living with hepatitis C who have cirrhosis, or liver cancer
- People who have had hepatitis C and have had liver transplants
- People living with hepatitis C without current risk factors
- People who acquired hepatitis C pre-DAAs or are partially diagnosed with hepatitis C and are lost to follow-up
- People living with hepatitis C who access opioid agonist treatment or other drug treatment services.

The proportional makeup of the prevalent population and the distribution of hepatitis C across these sub populations has, and will continue to, change over time. The people living with hepatitis C who were "willing and waiting" for treatment are different to those people living with hepatitis C who have not yet undergone treatment and are "hesitant" or "doubtful, uncertain or unaware of treatment". Maintaining and strengthening Australia's current approach to at-risk populations is crucial – including continuing to promote harm reduction and 'treatment as prevention' in communities of people who inject drugs. Concurrently, broader strategies are needed to engage people living with hepatitis C who are not currently injecting drugs, or who contracted hepatitis C in other ways than injecting drugs and who constitute a significant proportion of the prevalent population.

People at risk of hepatitis C transmission

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

People who are at risk of hepatitis C transmission are:

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

People who inject drugs

Unsterile injecting drug use is a major transmission risk factor in Australia, reinforced by the negative health impacts of stigma, discrimination and the criminalisation of people who use drugs. Barriers to access for harm reduction measures, including sterile injecting equipment in corrections settings and other places of held detention, and in rural, regional, and remote Australia create additional risk for people who inject drugs in those settings. Sub-populations of people who inject drugs that are at an increased risk of exposure to hepatitis C include Aboriginal and Torres Strait Islander people, men who have sex with men, people in custodial settings, young people and people experiencing mental illness or homelessness.

Aboriginal and Torres Strait Islander peoples

Note: This section is intentionally left blank. Linkage work with the Aboriginal and Torres Strait Islander BBV/STI Strategy is yet to occur.

People in corrections settings and other places of held detention

Corrections settings are now the primary site of hepatitis C transmission nationally. Incarceration is recognised as an independent and elevated risk factor for hepatitis C transmission. There is a greater risk, incidence, and prevalence of hepatitis C in corrections settings and other places of held detention (including immigration detention) resulting from the criminalisation of drug use and the incarceration of people who use drugs. Further, a failure to ensure access to comprehensive evidence-based harm reduction and other means of prevention, high rates of hepatitis C amongst prison entrants, and other risk factors such as unsterile tattooing and body piercing, fighting, blood spills, unprotected prison sex, and shared use of personal effects kits (such as toothbrushes) leads to increased exposure risks.

Due to the socio-economic determinants of health and well-being, there is significant intersectionality for people in corrections settings with other priority populations and settings. In particular, Aboriginal and Torres Strait Islander peoples are over-represented, as are people who inject drugs and people with mental health conditions.

Other places of held detention (for example, immigration detention in Australia and offshore) are settings with an elevated prevalence of hepatitis C and barriers to accessing timely access to treatment and care. For example, in 2020 the average length of time for people with hepatitis C in immigration detention to commence antiviral treatment was 573 days.

Sex workers

Sex workers are a priority population due to the potential higher exposure risk to hepatitis C. More research and quality data are required to fully understand hepatitis C incidence within this population.

Sex workers experience barriers to accessing health services including high levels of stigma and discrimination.[33] They also face a range of regulatory and legal issues including decriminalisation, licensing, registration, mandatory testing, and a lack of anti-discrimination protections in some jurisdictions.[34] 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 BBV rates, improved access to health promotion and access to workplace health and safety.[35] Peer education through peer-based sex worker organisations is essential for promoting prevention, testing and treatment for sex workers. Within this population, tailored approaches for sex workers who inject or have injected drugs and Aboriginal and Torres Strait Islander sex workers that address stigma and discrimination, and the regulatory and legal barriers experienced by sex workers are required.

People from culturally, ethnically, and linguistically diverse communities

People from culturally, ethnically, and linguistically diverse communities includes people born in countries with endemic hepatitis C, refugees, humanitarian entrants, and Australian-born children of parents from countries with endemic hepatitis C.

Risks of transmission for hepatitis C from medical and dental procedures, transfusion of unscreened blood transmission for hepatitis and blood products, places of held detention, and occupational settings are commonly faced by people from culturally, ethnically and linguistically diverse communities. Injecting drug use through receptive needle and syringe sharing also remains an exposure risk within this priority population. Further work needs to be done with culturally, ethnically, and linguistically diverse communities and sub-populations within this group 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 C
- Australian-born children of people born in countries with high prevalence of hepatitis C
- People who don’t speak English as their first/preferred language
- People living with hepatitis C who are not eligible for subsidised care
- People from countries with high prevalence of hepatitis C who access legal and migration and/or multicultural groups/services
- International students and people on temporary visas from high prevalence countries.

Australia also has a role to play as leaders in hepatitis C elimination internationally, and more specifically in the Western Pacific Region.[12] An estimated 10 million people in the Western Pacific Region live with hepatitis C and many remain undiagnosed and untreated, and it is estimated that 1,500 deaths per day are attributable to viral hepatitis, a higher mortality rate than HIV/AIDS, malaria and Tuberculosis (TB) 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.

Other groups

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

- The families of people affected by hepatitis C
- Women affected by hepatitis C
- People at risk of / living with hepatitis B co-infection
- People at risk of / living with HIV co-infection
- People who have had transfusions of unscreened blood and blood products in Australia before 1990.

7.2 PRIORITY SETTINGS

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

Decentralising care outside of specialist services, into more 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 expertise which is agile and responsive.

Community-based settings

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

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

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 C associated with drug use.

Community Hepatitis Organisations

State and territory-based community hepatitis organisations are critical infrastructure through which people living with hepatitis C 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.

Needle and syringe programs

Needle and syringe programs are critical for prevention, ensuring 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.

Aboriginal Community Controlled Health Organisations/Aboriginal Medical Services

Note: This section is intentionally left blank. Linkage work with the Aboriginal and Torres Strait Islander BBV/STI Strategy is yet to occur.

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.

Primary and tertiary healthcare settings

There are a range of primary and tertiary healthcare settings in which people with hepatitis C can be reached. Multicultural and migrant health services are particularly critical in providing hepatitis C 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 C 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.

Geographic settings

Generally, the prevalence of hepatitis C (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 to remedy the inequitable health outcomes which result from it. Increased efforts are also needed generally in areas of increased prevalence, where progress to elimination is slow, and where inequitable hepatitis C 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 high-risk environments for hepatitis C transmission and they are settings which have a high prevalence of hepatitis C. 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 peoples, the criminalisation of drugs, the over-representation of people who inject drugs in prisons, and the absence of comprehensive evidence-based harm reduction measures. It is critical that these access barriers are addressed as a part of the national response if elimination is to be achieved.

Legal services

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

Other settings

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

- Alcohol and other drug services including opioid agonist treatment services
- Mental health services
- Homelessness services
- Migration, refugee, and settlement services.

8. PRIORITY AREAS FOR ACTION

This section outlines actions necessary for the elimination of hepatitis C 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 C in priority populations and health workers to support engagement in prevention, harm reduction, awareness of cure, testing, treatment, monitoring and management post-cure including liver health.
- Provide equitable access to the full suite of harm reduction and prevention measures for all priority populations, including sterile injecting equipment through Needle and Syringe Programs in the community and in prisons.
- Enhance and improve access to hepatitis C community and peer education.
- Ensure education and prevention activities address the secondary harms arising from hepatitis C including liver disease and liver cancer.
- Raise hepatitis C awareness in the general community, including the availability of the cure, the effectiveness of treatment and support stigma reduction.

There is no vaccine against hepatitis C, with prevention dependent on reducing the risk of exposure to the virus.[1] Primary prevention of hepatitis C transmission is supported through evidence-informed education, health promotion, harm reduction and demand reduction strategies. Secondary prevention of hepatitis C is focused on factors impacting the progression of hepatitis C-related liver disease and associated harms.

Improved awareness and understanding of hepatitis C among priority populations, health services and the broader community is critical to achieving elimination of hepatitis C by 2030. Priority population appropriate interventions that target misconceptions and gaps in knowledge can significantly reduce stigma and discrimination, increase rates of testing and engagement in care.[36] Hepatitis C 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. Peers are credible, trusted sources of information and assist in engaging unreached populations using innovative methods, this approach is particularly useful in engaging people who inject drugs.[37,38]

This strategy promotes equitable access to the full suite of harm reduction and prevention measures for all priority populations, including sterile injecting equipment through Needle and Syringe Programs in the community and in prisons. The vast majority of new cases of hepatitis C in Australia occur from the use of unsterile injecting equipment, and primary prevention efforts are largely focused on addressing the risks associated with injecting drug use.[10] Needle and Syringe Programs (NSPs) play a key role in hepatitis C prevention and harm reduction education.

NSPs are very cost-effective, with modelling over a 10-year period estimating that over 96,000 new hepatitis C infections were averted and, for every dollar invested in NSPs, more than four dollars were returned (additional to the investment) in direct healthcare cost savings.[39]

International evidence demonstrates that introduction of NSPs in corrections settings and other places of held detention significantly reduces transmission of hepatitis C.[40,41] Corrections settings and other places of held detention in Australia should implement the full suite of evidence based harm reduction measures, including regulated access to sterile injecting equipment as a means of reducing hepatitis C transmission and reinfection, and achieving human rights obligations on equivalency of care. There are also opportunities to improve equitable access to both sterile injecting equipment, drug treatment programs and peer education in the general community to reduce hepatitis C transmission.[42]

A person living with hepatitis C may be unaware that they have the virus due to the absence of recognisable symptoms both at the time of transmission and in the early stages of liver disease. This often leads to substantial delays in diagnosis.[40,41] During this time, further inadvertent transmissions can occur, as can preventable deterioration in liver health. Hepatitis C remains a major contributor to liver cancer in Australia, the fastest growing cause of cancer death. Prevention of chronic hepatitis C virus infection, and secondary harms, is cost effective liver cancer prevention that could help to reverse the trend of increasing liver cancer mortality.

This Strategy raises hepatitis C awareness in the general community, including the availability of the cure, the effectiveness of treatment and supports stigma reduction. For example, prior infection with hepatitis C does not confer immunity. It is therefore important that health promotion, education, regular testing, timely access to re-treatment, and access to the means of prevention continue for people with ongoing risk of reinfection.

KEY AREAS FOR ACTION - EDUCATION AND PREVENTION	
1	Implement Needle and Syringe Programs to ensure regulated access to sterile injecting equipment in corrections settings and other places of held detention, alongside the full suite of other hepatitis C harm reduction and prevention measures including safer tattooing and piercing, opioid agonist treatment, other treatments for injectable drugs of dependence, safer sex, condoms, and lubrication.
2	Implement community awareness health promotion and public education initiatives for priority populations and the general community, including national and local hepatitis C public campaigns and World Hepatitis Day in Australia.

3	Facilitate the sharing, adaptation, scale up and implementation of successful hepatitis C prevention initiatives (including community/peer-based programs, in first/preferred language and low literacy) to other priority populations and settings, including corrections settings and other places of held detention.
4	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 C, including capacity to localised responses.
5	Increase access to sterile injecting equipment, and information on safer injecting, among people who inject drugs across all priority settings, including through supervised-injecting facilities and peer-based/community harm reduction initiatives, education, and equipment distribution (including peer distribution).
6	Support an increase in equitable access to evidence-based opioid agonist therapy and other treatments for injectable drugs of dependence in priority populations and priority settings and address key barriers to access.
7	Support the role of primary care, including GPs and nurses in raising awareness of infection and reinfection, and primary and secondary prevention measures.
8	Identify and address the resourcing, policy, legal, regulatory and structural barriers that impede equitable hepatitis C outcomes and national prioritisation.

8.2 TESTING, TREATMENT, AND MANAGEMENT

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

Testing for hepatitis C among priority populations and in priority settings enables not only early diagnosis, but also access to curative treatment and education to prevent transmission. Late diagnosis may 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 all people affected by hepatitis C 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.[45]

Finding everyone currently undiagnosed, partially diagnosed (no confirmatory RNA test) and/or not engaged in active management of their hepatitis C infection is essential to improve linkage to care and treatment uptake and a major focus for investment to achieve 2030 goals. There has been a steady decline in the estimated proportion of people living with hepatitis C who are diagnosed (from 81% in 2016 to 77% in 2020), explained in part by rates of testing and diagnosis not keeping pace with treatment uptake. From 2013-2015 to 2016-2018 as treatment uptake almost tripled, hepatitis C diagnostic (RNA) testing increased by 37%.[2] Modelling suggests that hepatitis C diagnostic (RNA) testing in Australia would need to increase by at least 50% for the Global 2030 hepatitis C elimination targets to be achieved.

There continues to be a significant "fall off" in the cascade of care following people being diagnosed and notified but not starting treatment. An improved and nationally consistent mechanism for the follow up of hepatitis C notifications is needed to ensure that all people diagnosed as antibody positive have a complete test event and then if RNA positive, are linked to care in a timely way through a variety of mechanisms. Community, including peer delivered models of hepatitis C testing, will further improve the availability, usability, and acceptability of hepatitis C testing for all priority populations. This includes scaling up use of mobile diagnostic technologies, such as self, rapid, and point-of- care testing when available, which can be increasingly performed at home or by community and peer workers. Studies from overseas show that self-testing diversifies testing locations, safeguards confidentiality, and simplifies the process of diagnostic testing. Self -testing may also decrease any stigma associated with testing, as it provides an opportunity for key populations to test themselves discreetly and conveniently.[46] Models and infrastructure are required in Australia to enable linkage to care for those undertaking self-testing; adapting models from other communicable diseases, such as COVID-19, may be useful.

To achieve elimination, Australia must maintain unrestricted and subsidised access to hepatitis C curative treatments, without restrictions based on a patient's stage of liver disease or current injecting behaviours. Treatments can be prescribed by GPs, nurse practitioners, alcohol and other drug physicians and sexual health physicians, helping to expand access to care.[47] Further decentralisation of the care cascade into primary care and community settings is necessary to better engage people unreached in the response to-date. Access to specialist care remains important for the management of people living with hepatitis C who have more complex needs, such as those with liver cirrhosis or other comorbidities and/or co-infections.

Modelling and empirical evidence demonstrate the effectiveness of 'treatment-as-prevention' approaches in hepatitis C elimination, which need to be complemented by a full suite of harm reduction and other measures. Additionally, access to re-treatment including in corrections settings and other places of held detention where re-infection levels are significantly higher than the general population is critical.[43,44]

Increased focus, including in primary care, is required to monitor people who have experienced hepatitis C related liver damage, placing them at risk of liver cancer, including post cure and for those who continue to inject drugs.[vi] In addition, the small proportion of people who are not cured following treatment require regular liver health assessments and need to be considered as candidates for new treatments.

KEY AREAS FOR ACTION – TESTING TREATMENT AND MANAGEMENT	
1	Scale-up quality guideline-based hepatitis C testing and linkage to care with priority populations, including through community/peer led models.
2	Expand the roll out and availability of new hepatitis C testing technologies with linkage to care and continue to improve hepatitis C treatment prescribing rates in areas with unmet need.
3	Improve the utilisation of recommended testing procedures for hepatitis C by clinicians, including routine use of reflex testing, and exploring the feasibility of automatic hepatitis C RNA testing for priority populations.
4	Support and increase best-practice case finding, contact tracing, testing, treatment and management for hepatitis C in priority settings including primary care and prisons.
5	Implement a nationally consistent mechanism for follow up of hepatitis C notifications to ensure that all people diagnosed as antibody positive receive testing and care in a timely way.
6	Strengthen Australia's liver cancer response, including: a. Ensure all people living with hepatitis C have appropriate liver fibrosis assessment prior to treatment to determine whether they have cirrhosis and require hepatocellular carcinoma (HCC) surveillance post-cure. b. Expand primary care access, including overcoming financial barriers, to non-invasive diagnostic tools for assessing liver disease severity, with rapid access to specialist review and associated health messaging. Ensure appropriate data recording and collection of these assessments.

7	Address limitations within Medicare Benefits Schedule (MBS) items for hepatitis C testing, including making hepatitis C RNA testing exempt from episode coning to prevent patients incurring out of pocket expenses and creating financial incentive for pathology providers to perform hepatitis C reflexive testing.
8	Ensure that testing, and subsequent integrated care, is available to people living with hepatitis C for other BBV co-infections impacting on liver disease progression and survival including hepatitis B and HIV.
9	Identify and address the policy, legal, regulatory, and structural barriers that impact on people's access to hepatitis C testing, treatment and management.

8.3 EQUITABLE ACCESS TO AND COORDINATION OF CARE AND SUPPORT

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

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

Person-centred care for hepatitis C requires health system responses and services to be organised around a person's needs. Differentiated and decentralised service delivery models support person-centred care through adapting health services across the cascade of care to support the specific needs of people based on their circumstances. They will enable further testing, treatment, care, harm reduction, and the provision of other social and health-based supports and services through primary care, community-led services and peer-based services which reach people in the community.[2]

Stronger communication and linkages between hepatitis C priority populations, community organisations (including peer-based organisations), primary care and specialist services are needed to better coordinate care. This includes for people in corrections settings, other places of held detention and during their transition back into the community.[48] For example, case management during the post-release transition period offers benefits in supporting treatment adherence and follow-up testing, monitoring for people at elevated risk of hepatocellular carcinoma, and helps prevent hepatitis C reinfection. Broader linkages with other psychosocial health areas are also needed to improve holistic care, post-cure support, health outcomes and to address the social determinants of health that impact on quality of life for people living with hepatitis C. This includes linkages with liver cancer prevention, control and treatment services who are key partners in addressing hepatitis C attributable mortality.

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

KEY AREAS FOR ACTION - EQUITABLE ACCESS TO AND COORDINATION OF CARE AND SUPPORT

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

a. Enable the national scale-up of successful models of care for hepatitis C prevention and treatment 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 C testing and care including in primary care, regional and remote areas, corrections settings and other places of held detention.

c. Expanding community and peer-based models for hepatitis C prevention and care.

d. Support digital models of hepatitis C care, including telehealth and telehealth interpreters, to overcome access barriers.

2	Improve the coordination of hepatitis C care between affected communities, community and peer organisations, primary care, pharmacy, and specialist services.[12]
3	Ensure people have had their diagnosis, treatment, 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 C testing, treatment, care, and post-cure for people affected by hepatitis C, including for people who are ineligible for subsidised care.
5	Maintain subsidised unrestricted access to hepatitis C antiviral medications in the community and in corrections settings and other places of held detention.
6	Enhance partnerships between jurisdictional health and corrections systems and facilitate knowledge sharing across systems and jurisdictions regarding hepatitis C prevention, testing, treatment, care, and support services for people in corrections settings and other places of held detention and those recently released.
7	Improve linkage to care for people with hepatitis C to manage co-occurring health issues including liver disease, liver cancer, other chronic disease, mental health and alcohol and other drug issues.
8	Build capacity in broader health care systems and services to embed and prioritise hepatitis C prevention, testing, treatment and care
9	Identify and address the resourcing, policy, legal, regulatory, and structural barriers that impede equitable hepatitis C healthcare access, uptake, outcomes, and human rights.

8.4 WORKFORCE

- Strengthen and sustain the hepatitis C community workforce including the peer workforce.
- Implement a national hepatitis C 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 C.

- Support the education and role of primary care, including GPs, nurse practitioners and primary care nurses, in the cascades of care and use of evidence- informed hepatitis C testing and treatment mechanisms.

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

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

The hepatitis C-specific community workforce is comprised of those working in organisations whose primary focus is addressing hepatitis C, including State and Territory Community Hepatitis Organisations and peer-based drug user organisations. The deep connections they maintain with affected communities, their networks with other key community organisations, and their capacity to deliver decentralised hepatitis C services enables them to engage those not reached elsewhere in the national response. Peer workers have expertise in engaging their communities in non-stigmatising hepatitis C prevention, education, support and linkage to care. The community and peer workforces should be supported and resourced to deliver innovative services and engage with priority populations. Further, as technology develops to make testing, treatment, and care more simplified, the upskilling of peer and community workers to help deliver these services will be crucial. Additionally, the hepatitis C community workforce includes those who address hepatitis C within a broader health or social service context including the community-based settings outlined in this Strategy.

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

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

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

KEY AREAS FOR ACTION - WORKFORCE

1. Strengthen and sustain the community hepatitis C workforce including peer workers. Implement associated projects and workforce supports including profiling, workforce development/training, supervision, communities of practice, scopes of practice and capacity-building.
2. Develop, and implement a national hepatitis C multidisciplinary workforce development plan.
3. Support primary care workforces to deliver hepatitis C care, including:
    a. Provide education and resources to support GPs, nurse practitioners and other prescribers in prescribing direct-acting antivirals, managing patient care, implementing evidence-based hepatitis C testing and treatment mechanisms, and utilising available multidisciplinary referral pathways.
    b. Facilitate and support the involvement of the primary care workforce, including through Primary Health Networks (PHN), in the early detection and treatment of hepatitis C, including access to remote support for prescribers new to treating hepatitis C, upskilling, and training, and other approaches.
    c. Improve patient management systems to better support the primary care workforce to promptly identify and provide treatment and care for people living with hepatitis C and post-cure for people at elevated risk of liver cancer.
    d. Maintain and increase awareness of clinical guidance for hepatitis C management (including liver cancer surveillance) in primary care.
    e. Increase the availability of digital and face to face hepatitis learning opportunities to facilitate a skilled clinical and community workforce.

4	Build capability and capacity to undertake testing, treatment, management, and ongoing care for hepatitis C in decentralised settings including community pharmacy, community hepatitis organisations, and peer-based drug user organisations. Leverage the established networks of alcohol and other drug services to improve hepatitis C health literacy and connection to care.
5	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.
6	Implement hepatitis C capacity building for allied sectors and workforces (such as drug treatment, mental health, homelessness, prisons, community corrections) to undertake relevant hepatitis C interventions (such as screening, referral, prevention/universal precautions) and support partnerships with community hepatitis organisations and other organisations within the hepatitis community workforce.
7	Maintain and strengthen the hepatitis C community and peer workforce to engage diverse hepatitis C priority populations in education, primary and secondary prevention.
8	Enable and expand the provision of culturally, ethnically, and linguistically appropriate hepatitis C services to priority populations, including: a. Engagement, awareness, and ongoing capacity-building of bicultural and bilingual health workers b. Support and build capacity of community hepatitis educators including from priority populations. c. Coordinate and expand access to accredited translation services and ensure their ongoing hepatitis C specific training and capacity building. d. Support the development and maintenance of directories of hepatitis C workers and health care professionals who speak languages other than English.

8.5 ADDRESSING STIGMA AND CREATING AN ENABLING ENVIRONMENT

- Ensure reduction of stigma, racism, discrimination and colonialism are central in national and local responses to hepatitis C and meaningful systems-change to redress identified issues.

- Implement long-term and stable programs that address stigma, discrimination, racism, colonialism, and human rights issues, and minimise their impacts on the health of people affected by hepatitis C.

- Address the legal, regulatory and policy barriers that affect priority populations, and adversely influence hepatitis C outcomes, including the criminalisation of people who use drugs and sex workers.
- Ensure people living with hepatitis C continue to be engaged in, and co-design national policy development, implementation, and evaluation.
- Provide national and international leadership in relation to the elimination of hepatitis C by 2030, including in cross-cutting health and social policy work.

Fostering an enabling environment for hepatitis C elimination requires the removal of stigma, discrimination, racism and colonialism in all its forms, including in systemic, structural, regulatory, and institutional contexts. For people living with hepatitis C, these barriers can contribute to missed and late diagnoses, disease progression, onward transmission, more costly tertiary care, and reduced quality of life.[49] Stigma and discrimination related to hepatitis C are multi-dimensional and multi-layered and can be compounded by the criminalisation of people who use drugs and discrimination associated with race, cultural or ethnic background, gender identity, health status and perceptions of risk. Strategies to address stigma and discrimination must acknowledge and account for intersecting stigmas and racism.

The expression of stigma, discrimination, and racism towards people living with hepatitis C in healthcare settings is common and can prevent individuals and whole communities from accessing hepatitis C prevention and care.[50,51] Every person working with people at risk of, living with, or cured of hepatitis C requires an understanding of the impact of stigma, discrimination and racism, including for intersecting issues such as injecting drug use, and how this impacts on healthcare access and outcomes.

Actions to reduce stigma, discrimination and racism should be a core element of quality health service provision. Education in relation to stigma in healthcare settings is considered an integral part of training programs for staff of all specialists, primary healthcare, and community-based service providers. Research indicates that personally knowing someone from a target group was associated with holding fewer stigmatising attitudes towards that particular group, which provides initial evidence on the importance of peer workers to address stigma.[52]

Legal, policy, social, cultural, and economic barriers also impact on hepatitis C outcomes. Studies have found that removing such barriers and reducing stigma and discrimination increases testing and treatment and contributes to a decrease in incidence and prevalence of various BBV and STI.[53–55] In particular, drug policy and law reform including the delivery of public health approaches as alternatives to incarceration of people who use drugs have capacity to reduce stigma, improve access to hepatitis C care, and ultimately prevent transmission.[56] It is also important to recognise that experiences of stigma, discrimination and social exclusion can continue post-cure. This can enhance the risk of reinfection, increase medical risks, and undermine the promise of the elimination agenda.[57]

To date, hepatitis C has been insufficiently prioritised in broader health system strategies and reforms. 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 C.

Work is needed to ensure that hepatitis C is embedded in cross-cutting national policy, including long-term health plans relevant to health workforces (such as GPs, pharmacists, nurses, and community workers); health reforms (including preventive health); and related disease policy (for example, cancer).

KEY AREAS FOR ACTION - ADDRESSING STIGMA AND CREATING AN ENABLING ENVIRONMENT	
1	Implement long-term and stable programs led by peers, or in partnership with, people affected by hepatitis C aimed at minimising stigma and discrimination, including post-cure across the community, particularly in healthcare settings.
2	Ensure people affected by hepatitis C are meaningfully engaged in, and co-design national policy development, implementation, and evaluation.
3	Continue to incorporate messaging to counteract stigma in hepatitis C health promotion initiatives.
4	Increase anti-stigma, anti-discrimination, and anti-racism training and initiatives for providers of primary care and other health practitioners to people affected by hepatitis C. The training and initiatives should be culturally safe and trauma informed, co-designed in partnership with affected communities, and include strengthening accountabilities for discrimination-free hepatitis C healthcare.
5	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 C outcomes, and identify and implement appropriate actions to address them including legislative reform (such as insurance, social security, drug laws, employment reforms, forced testing).
6	Continue drug policy and law reform to deliver public health approaches as alternatives to criminalisation and incarceration of people who use drugs, including implementing decriminalisation.

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

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

9 Maintain Australia's reputation as a global leader in the management of blood borne viruses by delivering on national and global hepatitis elimination commitments, maintaining contributions to global health initiatives, retaining state membership of the World Health Organization, and including providing strong leadership in the Western Pacific Region with respect to hepatitis C.

8.6 DATA, SURVEILLANCE, RESEARCH AND EVALUATION

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

Research helps to guide the development, implementation and evaluation of policies and programs at all levels of the national response to hepatitis C. Research is needed to understand the impact of hepatitis C more fully in priority populations. Continuous improvement of data collections and systems, including sharing information across jurisdictions, is important to support a comprehensive understanding of the burden of hepatitis C in Australia and to monitor the impacts of interventions.[6] However, this must be appropriately targeted to ensure its effectiveness; and balanced to minimise data collection burdens on affected communities, community and 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 C (and hepatitis C related morbidity and mortality) in the community.

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

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

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

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

KEY AREAS FOR ACTION - DATA, SURVEILLANCE, RESEARCH AND EVALUATION	
1	In partnership with the community, revise and co-design a 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 C Strategy targets.
2	Update, with involvement from the community, the National BBV and STI and Research Strategy, including to maintain and enhance the timely annual reporting of hepatitis C surveillance and monitoring, including analysis of progress against targets and indicators, disaggregation by sub-populations where possible, and mapping with additional regional specificity.
3	Maintain and enhance the timely annual reporting of hepatitis C surveillance and monitoring, including analysis of progress against targets and indicators, disaggregation by sub-populations where possible, and mapping with additional regional specificity.
4	Embed affected communities and priority populations in all aspects of research including priority setting, modelling, development, implementation, co-authorship, community engagement, and research translation and dissemination.
5	Prepare and undertake Australian validation of hepatitis C 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 Aboriginal and Torres Strait Islander status, country of birth, language spoken, ethnicity, and Medicare eligibility.

7 In partnership with the 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:

   a. Develop target baselines and further quantify targets where required (for example, 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.

   b. Prioritise sub-populations and regional data for equity measures, including establish and implement a quality-of-life measure and associated community-led data set.

   c. Enhance monitoring and measurement of hepatitis C related stigma, discrimination, racism, and other legal and human rights issues.

   d. Produce and publish contemporary estimates of incidence and prevalence of hepatitis C in the Australian community, including linkage of data on the incidence of reinfection. Improve the collection, measurement, and reporting of data on hepatitis C associated morbidity and mortality. Undertake work to improve data collection and understandings about hepatitis C and sex work.

8 Improve hepatitis C data linkage, including to MBS and PBS, and undertake data linkage projects.

9 Enhance community service level data and intelligence to complement epidemiological data, including with community hepatitis organisations via the National Hepatitis Infoline.

10 Build capacity of community to lead, participate in, co-author, and implement hepatitis C research.

11 Support research on emerging hepatitis C issues and risks and associated public health implications. Promote a balance of hepatitis C social, behavioural, epidemiological, and clinical research to better inform all aspects of the response.

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 C data safely and effectively to improve data collection, improve patient follow up and enhance patient centred care.

14	Undertake research to develop a preventive vaccine for hepatitis C.
15	Ensure Australia is at the fore of hepatitis C research innovations, including through expanding a focus on hepatitis C research in existing Australian Government research funding such as the Medical Research Future Fund and NHMRC.
16	Undertake mapping and monitor investment on national hepatitis C elimination, including sufficiency relative to the burden from hepatitis C.
17	Support and maintain Australia's leadership in the hepatitis C research and capacity building globally including with the WHO and other key stakeholders.
18	Evaluate the implementation of the National Strategies (for example, to coincide with the mid-point review of the National Hepatitis C 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 C is built on a model of partnership between affected communities, governments, peak organisations, health and community organisations, researchers, and the multidisciplinary workforce.

The Australian Government is committed to providing strong national leadership by working across portfolios and jurisdictions to achieve the goals of this Strategy. The Australian Government Department of Health and Aged Care leads the coordination of the national response to hepatitis C under the National Hepatitis C 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 C, it is imperative that this is conducted in partnership with communities and is aligned with the priorities of the five national strategies.

The Sixth National Hepatitis C 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

The National Hepatitis C 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 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.

REFERENCES

1. World Health Organization. (2022). *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations.* World Health Organization. https://www.who.int/publications/i/item/9789240052390
2. World Health Organization. (2021). *Global Health Sector Strategies on HIV, Viral Hepatitis and Sexually Transmitted Infections 2022-2030—Draft*.
3. United Nations (General Assembly). (2007). *United Nations Declaration on the Rights of Indigenous Peoples: Resolution adopted by the General Assembly*. https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html
4. World Health Organization. (1986). *Ottawa Charter for Health Promotion*. World Health Organization. https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference
5. Department of Health. (2021). *National Preventive Health Strategy 2021-2030*. Department of Health. https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf
6. Department of Health. (2021). *National blood borne viruses and sexually transmissible infections research strategy 2021-2025*. Department of Health. https://www1.health.gov.au/internet/main/publishing.nsf/content/AE05C032DDCB7533CA257BF00020AAC4/$File/DT0001558%20-%20National%20BBV%20and%20STI%20Research%20Strategy%20-%20web%20-v2.pdf
7. Kirby Institute. (2020). *Monitoring hepatitis C treatment uptake in Australia (Issue 12)*. The Kirby Institute UNSW. https://kirby.unsw.edu.au/sites/default/files/kirby/report/Monitoring-hep-C-treatment-uptake-in-Australia_Iss12-JUL22.pdf
8. World Health Organization. (2021). *Hepatitis C: WHO fact sheet*. https://www.who.int/news-room/fact-sheets/detail/hepatitis-c
9. MacLachlan, J., Stewart, S., & Cowie, B. (2020). *Viral Hepatitis Mapping Project: National Report 2020*. Australasian Society for HIV, Viral Hepatitis, and Sexual Health Medicine (ASHM). https://www.ashm.org.au/programs/Viral-Hepatitis-Mapping-Project/
10. The Kirby Institute. (2022). *HIV, viral hepatitis, and sexually transmissible infections in Australia: Annual surveillance report 2021*. Kirby Institute.
11. WHO Collaborating Centre for Viral Hepatitis, Doherty Institute for Infection and Immunity. (2021). *Impacts of COVID-19 on BBVSTI testing, care and treatment: Medicare data analysis*. Doherty Institute. https://www.doherty.edu.au/uploads/content_doc/COVID-19_impacts_-_BBVSTI_treatment_and_care_(data_to_January2021)_FINAL.pdf
12. Hepatitis C Virus Infection Consensus Statement Working Group. (2020). *Australian recommendations for the management of hepatitis C virus infection: A consensus statement*. Gastroenterological Society of Australia.
13. MacLachlan, J. H., & Cowie, B. C. (2012). Liver cancer is the fastest increasing cause of cancer death in Australians. *Medical Journal of Australia*, *197*(9), 492–493. https://doi.org/10.5694/mja12.11481
14. Centers for Disease Control and Prevention (CDC). (2020). *Hepatitis C questions and answers for the public*. Hepatitis C Questions and Answers for the Public. https://www.cdc.gov/hepatitis/hcv/cfaq.htm#:~:text=The%20hepatitis%20C%20virus%20isto%20prepare%20and%20inject%20drugs.

15. Department of Health. (2021). The First National Blood Borne Viruses and Sexually Transmissible Infections Research Strategy 2021-2025. Australian Government Department of Health https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp -bbvs-1

16. Australian Government Department of Health. (2018). *Fifth National Hepatitis C Strategy 2018-2022*. Australian Government Department of Health.

17. United Nations. (2018). *United Nations system common position supporting the implementation of the international drug control policy through effective inter -agency collaboration*. United Nations. https://unsceb.org/united-nations-system-common-position-supporting-implementation-international-drug-control-policy

18. United Nations Office on Drug and Crime. (2015). *The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela rules)* . United Nations. https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf

19. Australian Human Rights Commission. (2021). *Concept Paper for a National Anti-Racism Framework*. https://humanrights.gov.au/our-work/race-discrimination/publications/developing-national-anti-racism-framework-2021

20. Department of Health. (2022). *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032*. Australian Government Department of Health. https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032

21. Australian Government Department of Health. (2021). *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*. Australian Government. https://www.health.gov.au/sites/default/files/documents/2022/06/national -aboriginal-and-torres-strait-islander-health-plan-2021-2031.pdf

22. Australian Governments, C. of A. and T. S. I. P. O. (2020). *National Agreement on Closing the Gap*. https://www.closingthegap.gov.au/national-agreement

23. Australian Government Department of Health. (2021). *What we're doing for nurses and midwives*. Australian Government. https://www.health.gov.au/health-topics/nurses-and-midwives/what-we-do#nurse-practitioner-10year-plan

24. Australian Government Department of Health. (2016). *A National Framework for Communicable Disease Control*. Australian Government. https://www.health.gov.au/resources/publications/national-framework-for-communicable-disease-control

25. Iversen, J., Dore, G. J., Starr, M., Catlett, B., Cunningham, P., Geddes, L., & Maher, L. (2020). Estimating the Consensus hepatitis C Cascade of Care among people who inject drugs in Australia: Pre and post availability of direct acting antiviral therapy. *The International Journal of Drug Policy*, *83*, 102837–102837. https://doi.org/10.1016/j.drugpo.2020.102837

26. Heard, S., Iversen, J., Geddes, L., Kwon, J., & Maher, L. (2021). *Needle Syringe Program National Minimum Data Collection: 2021 National Data Report* . Kirby Institute UNSW. https://kirby.unsw.edu.au/sites/default/files/kirby/report/NSP-NMDC_2021-National-Data-Report.pdf

27. Heard, S., Iversen, J., & Maher, L. (2021). *Australian Needle Syringe Program Survey National Data Report 2016-2020: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees*. Kirby Institute. https://kirby.unsw.edu.au/sites/default/files/kirby/report/ANSPS_National-Data-Report-2016-2020.pdf

28. Centre for Social Research in Health. (2021). *Stigma Indicators: People who inject drugs & Hepatitis C among people who inject drugs*. UNSW. https://www.unsw.edu.au/content/dam/pdfs/unszw-adobe-websites/arts-design-architecture/ada-faculty/csrh/2021-06-Stigma_Indicators_Summary_IDU_and_Hep_C_phase_2.pdf

29. Bryant, J., Ranke, J., & Treloar, C. (2021). *Annual Report of Trends in Behaviour 2021: Viral Hepatitis in Australia*. UNSW Centre for Social Research in Health. http://unsworks.unsw.edu.au/fapi/datastream/unsworks:76670/bine0958a1b-c32d-4a6c-abfc-d8a768a67b31?view=true&xy=01

30. Southwell, M., Shelly, S., MacDonald, V., Verster, A., & Maher, L. (2019). Transforming lives and empowering communities: Evidence, harm reduction and a holistic approach to people who use drugs. *Current Opinion in HIV and AIDS*, *14*(5), 409–414.

31. Pedrana, A., Munari, S., Stoové, M., Doyle, J., & Hellard, M. (2021). The phases of hepatitis C elimination: Achieving WHO elimination targets. *The Lancet Gastroenterology & Hepatology*, *6*(1), 6–8. https://doi.org/10.1016/S2468-1253(20)30366-6

32. Dore, G. J. (2017). O1 Hepatitis C: the treatment landscape in 2017. *Abstracts of the Australasian Viral Hepatitis Elimination Conference 10-11 August 2017 Caims, Queensland, Australia*, *3*, 1. https://doi.org/10.1016/S2055-6640(20)30884-0

33. Stardust, Z., Treloar, C., Cama, E., & Kim, J. (2021). 'I Wouldn't Call the Cops if I was Being Bashed to Death': Sex Work, Whore Stigma, and the Criminal Legal System. *International Journal for Crime, Justice, and Social Democracy*, *10*(3), 142–157. https://doi.org/10.5204/ijcjsd.1894

34. Boyle, F., Glennon, S., Najman, J. M., Turrell, G., Western, J. S., & Wood, C. (2019). *The sex industry: A survey of sex workers in Queensland, Australia*. Routledge.

35. Brooks-Gordon, B., Morris, M., & Sanders, T. (2021). Harm Reduction and Decriminalization of Sex Work: Introduction to the Special Section. *Sexuality Research and Social Policy*, *18*(4), 809–818. https://doi.org/10.1007/s13178-021-00636-0

36. Xiao, Y., Wallace, J., Thompson, A., Hellard, M., van Gemert, C., Holmes, J. A., Croagh, C., Richmond, J., Papaluca, T., & Hall, S. (2021). A qualitative exploration of enablers for hepatitis B clinical management among ethnic Chinese in Australia. *Journal of Viral Hepatitis*, *28*(6), 925–933.

37. Anisah, R. L., Sofro, M. A. U., & Andriany, M. (n.d.). *Peer Educators' Competences for Inmates with HIV/AIDS: a Systematic Review*.

38. Sun, W. H., Miu, H. Y. H., Wong, C. K. H., Tucker, J. D., & Wong, W. C. W. (2018). Assessing participation and effectiveness of the peer-led approach in youth sexual health education: Systematic review and meta-analysis in more developed countries. *The Journal of Sex Research*, *55*(1), 31–44.

39. Ward, Z., Sweeney, S., Platt, L., Guinness, L., Maher, L., Hope, V., Hickman, M., Smith, J., Ayres, R., & Hainey, I. (2018). The cost-effectiveness of needle and syringe provision in preventing transmission of Hepatitis C virus in people who inject drugs. *Journal of Hepatology*, *68*, S146–S147.

40. Moazen, B., Dolan, K., Saeedi Moghaddam, S., Lotfizadeh, M., Duke, K., Neuhann, F., Stöver, H., & Jahn, A. (2020). Availability, accessibility, and coverage of needle and syringe programs in prisons in the European Union. *Epidemiologic Reviews*, *42*(1), 19– 26.

41. Bielen, R., Stumo, S. R., Halford, R., Werling, K., Reic, T., Stöver, H., Robaeys, G., & Lazarus, J. V. (2018). Harm reduction and viral hepatitis C in European prisons: A cross-sectional survey of 25 countries. *Harm Reduction Journal*, *15*(1), 1–10.

42. Grebely, J., Tran, L., Degenhardt, L., Dowell-Day, A., Santo Jr, T., Larney, S., Hickman, M., Vickerman, P., French, C., & Butler, K. (2021). Association between opioid agonist therapy and testing, treatment uptake, and treatment outcomes for hepatitis C infection among people who inject drugs: A systematic review and meta-analysis. *Clinical Infectious Diseases*, *73*(1), e107–e118.

43. Yeung, A., Palmateer, N. E., Dillon, J. F., McDonald, S. A., Smith, S., Barclay, S., Hayes, P. C., Gunson, R. N., Templeton, K., Goldberg, D. J., Hickman, M., & Hutchinson, S. J. (2022). Population-level estimates of hepatitis C reinfection post scale-up of direct-acting antivirals among people who inject drugs. *Journal of Hepatology*, *76*(3), 549–557. https://doi.org/10.1016/j.jhep.2021.09.038

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

45. Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM). (2020). *National Hepatitis C Testing Policy*. https://testingportal.ashm.org.au/national-hcv-testing-policy/

46. Xu, W., Reipold, E. I., Zhao, P., Tang, W., Tucker, J. D., Ong, J. J., Wang, J., Easterbrook, P., Johnson, C. C., Jamil, M. S., & Wang, C. (2022). HCV Self-Testing to Expand Testing: A Pilot Among Men Who Have Sex With Men in China. *Frontiers in Public Health*, *10*. https://www.frontiersin.org/articles/10.3389/fpubh.2022.903747

47. Kirby Institute. (2017). . *Monitoring hepatitis C treatment uptake in Australia (Issue 7).* Kirby Institute UNSW. https://kirby.unsw.edu.au/sites/default/files/kirby/re port/Monitoring-hep-C- treatment-uptake-in-Australia_Iss7-JUL17.pdf

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

49. Hamlet, J. (2019). *Addressing Systemic Barriers, Stigma and Discrimination Surrounding HIV and Viral Hepatitis: Averting Late Diagnoses and Disease Progression* . ASHM. https://removingbarriers.ashm.org.au/wp-content/uploads/2019/01/Addressing-Systemic-Barriers-Stigma-and-Discrimination-Surrounding-HIV-and-Viral-Hepatitis_Final.pdf

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

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

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

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

54. Harris, M., Guy, D., Picchio, C. A., White, T. M., Rhodes, T., & Lazarus, J. V. (2021). Conceptualising hepatitis C stigma: A thematic synthesis of qualitative research. *International Journal of Drug Policy*, *96*, 103320.

55. Li, C., Lu, X., Xiao, J., & Chan, C. W. (2021). ‘We can bear it!’ Unpacking barriers to hepatocellular carcinoma screening among patients with hepatitis B: A qualitative study. *Journal of Clinical Nursing*.

56. Global Commission on Drug Policy. (2013). *The Negative Impact Of The War On Drugs On Public Health: The Hidden Hepatitis C Epidemic*. Open Society Foundation. http://www.globalcommissionondrugs.org/hepatitis/gcdp_hepatitis_english.pdf

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