Viral Hepatitis Prevention and Management

Policy Position Statement

Key messages:	Effective national responses to hepatitis B and C require the involvement of priority populations, commitment to human rights, ensuring access to quality care, promotion of prevention, harm reduction and health equity; alongside addressing stigma, educating individuals, communities and healthcare settings, and encouraging an individual to seek testing, treatment, and support without fear of discrimination, with a commitment to shared responsibility across government, healthcare, and affected communities, and utilise evidence-based policy and partnerships.
Key policy Positions:	1. Support the full implementation of the Fourth National Hepatitis B Strategy and Sixth National Hepatitis C Strategy including adequate resourcing to achieve their objectives and targets and eliminate both hepatitis B and C in Australia by 2030. 2. Reduce stigma in community and healthcare settings to enable access to testing, treatment, and support without fear of discrimination. 3. Ensure equitable, culturally sensitive healthcare for hepatitis B and C through collaboration with community leaders.
Audience:	Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.
Responsibility:	PHAA Health Promotion Special Interest Group
Contact:	Professor Muhammad Aziz Rahman, Convenor Health Promotion SIG
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PHAA affirms the following principles:

1. Effective national responses to hepatitis B and C require the involvement of priority populations, commitment to human rights, ensuring access to quality care, promotion of prevention, harm reduction and health equity. Additionally, national responses must address stigma, educate individuals, communities and healthcare settings, and encourage individuals to seek testing, treatment, and support without fear of discrimination. All responses must have a commitment to shared responsibility among governments, healthcare providers, community organisations, affected communities, and individuals, supported by evidence-based policy and partnerships. [1,2]
2. Chronic hepatitis B and hepatitis C should continue to be recognised as major public health issues, with continued commitment towards disease elimination in Australia by 2030. [2]
3. Improved awareness and education of viral hepatitis among communities, priority populations and healthcare professionals is essential to encourage prevention, testing, treatment and care for those living with viral hepatitis. This includes addressing barriers such as language and cultural attitudes in culturally and linguistically diverse (CALD) communities (hepatitis B) and reducing misinformation and social stigma around hepatitis C and injectable drug use that can prevent individuals from seeking testing, treatment, and care. [3]
4. Legal, regulatory, and policy barriers affect priority populations at risk of viral hepatitis, including by negatively influencing their health-seeking behaviours. These barriers should be addressed through collaboration with government and non-government organisations to change the policy focus of drug use and addiction from a law enforcement issue to a health issue.[4]
5. Policies for hepatitis B and C should be integrated with broader public health initiatives, such as prison health reform and housing affordability programs, to ensure comprehensive care and improve health outcomes for vulnerable populations, including those experiencing homelessness who are disproportionately affected by chronic viral hepatitis.[5]
6. The COVID-19 pandemic (2019–2021) disrupted hepatitis B and C testing, diagnosis, treatment, and monitoring due to healthcare resource reallocation and lockdowns. Surveillance programs were delayed, and patient access to care declined.[6,7] Australia needs a resilient healthcare system with contingency plans to maintain essential hepatitis B and C services during future emergencies, such as pandemics or climate change related disruptions.[6,7]
7. Healthcare policies should mandate regular blood-borne virus (BBV) testing for all healthcare workers and students undertaking clinical placements to protect patient safety and minimise transmission risks.[8] Following the CDNA National Guidelines,[8] this testing should occur at least once every three years to effectively reduce the risk of inadvertent transmission to clients.

PHAA notes the following evidence:

Hepatitis B

8. Hepatitis B is a vaccine-preventable, blood borne virus and sexually transmissible infection that can cause liver inflammation and liver disease.[1,2]

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9. By the end of 2023, an estimated 219,800 people were living with chronic hepatitis B in Australia. Of these, approximately 69% (151,161 individuals) had been diagnosed, and 24% (53,765 individuals) were receiving regular clinical care, such as viral load monitoring or antiviral therapy. [7]

10. Hepatitis B disproportionately impacts a number of key populations, priority groups and settings. Among the total people living with chronic Hepatitis B, about three-quarters (70%) were born overseas, 23% were Australian-born non-Indigenous people, 7% were Aboriginal and Torres Strait Islander people and 3% of all people with hepatitis B were gay and bisexual men.[1]

11. 20-30% of people with untreated chronic hepatitis B will develop advanced liver disease, which can lead to complications including liver failure, liver cancer and death. In 2023, there was an estimated 460 deaths in Australia due to complications from chronic Hepatitis B.[7]

12. The hepatitis B notification rate declined by 33% between 2013 and 2022, from 28.8 to 19.3 per 100,000. Declines between 2019 and 2021, followed by a slight increase in 2022 were likely attributable in part to vaccination, as well as COVID-19 impacts on migration, healthcare access and testing, and travel in 2020.[7]

13. Early detection and prolonged, adequate suppression of viral replication are essential goals for the management of chronic hepatitis B. People living with hepatitis B typically require lifelong management, involving 6-monthly clinical assessments including blood tests to identify changes in liver function. In addition, annual tests are suggested to detect liver scarring, along with liver ultrasounds and blood tests for liver cancer where clinically indicated. Antiviral treatment is often used to manage advancing chronic hepatitis B and may be required lifelong, depending on clinical assessment.[9]

14. Hepatitis B is a preventable disease, with vaccination being the most effective form of protection. In the absence of immunisation, transmission risk can be reduced by using proven prevention measures. These include practicing safe sex by using condoms, covering cuts and open wounds with waterproof dressings, avoiding the sharing of personal items such as toothbrushes and razors, and ensuring body art is done only at registered piercing and tattoo studios that follow appropriate infection control and sterilisation procedures. Wearing gloves when providing first aid is also recommended to prevent potential exposure to bloodborne viruses.[10]

15. Affected communities, especially communities with high rates of people born overseas and Aboriginal and Torres Strait Islander communities should be actively engaged and supported in addressing hepatitis B. Policies should prioritise culturally appropriate care, reducing health disparities and stigma, ensuring that care is accessible to all and promoting healthy behaviours. Collaborating with community leaders and groups will ensure that health initiatives are relevant, effective, and accessible to those most at risk.[11]

Hepatitis C

16. Hepatitis C is a blood borne virus that can cause liver inflammation and liver disease, and there is no vaccination available.[12]

17. Of the 68,890 people living with chronic hepatitis C at the end of 2023 in Australia, an estimated 57,900 (84%) had been diagnosed, and 52,110 (90% of those diagnosed) had their hepatitis C diagnosis confirmed with a Ribonucleic Acid (RNA) test.[7] In 2022, there were 6,728 hepatitis C notifications (meaning cases reported to public health authorities) in Australia, and over two-thirds (4,659, 68%) of the new notifications were among males.

18. Hepatitis C disproportionately impacts a number of key populations, priority groups and settings.[7] The most affected populations include people who inject drugs, people who are incarcerated and Aboriginal

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and Torres Strait Islander people.

19. In 2023, the age-standardised hepatitis C notification rate for Aboriginal and Torres Strait Islander people was more than six times greater compared with non-Indigenous people (165.5 vs 25.7 per 100 000 populations).[13]

20. The primary route of transmission is injecting drug use, specifically receptive needle and syringe sharing (when an individual injects with a needle or syringe previously used by another person). Other routes include failure of infection control procedures during medical/dental procedures, vertical transmission (from mothers to babies), unsterile piercings and tattoos. [7,18] Transmission through sex is rare, but the risk is higher among men who have sex with men. [7,18]

21. Hepatitis C causes both acute and chronic infection, with around 70–80% of acute cases progressing to chronic infection if left untreated, increasing the long-term risk of cirrhosis and liver cancer. Between 2017 and 2023, total new hepatitis C infections in Australia declined by 61%, from 4,470 to 1,740 annually, while the proportion of reinfections rose from 30% to 52%, highlighting the need for sustained harm reduction and prevention efforts among high-risk groups. Despite an overall 26% reduction in hepatitis C-related deaths since 2015 from 720 to 530 deaths in 2023, the estimated number of people with hepatitis C-related cirrhosis has increased by 47% from 18,660 to 27,420, underlining the ongoing burden of disease.[7]

22. Hepatitis C infections are commonly occurring co-infections amongst people with human immunodeficiency virus (HIV) or people with hepatitis B. HIV/hepatitis C coinfected patients have a more rapid progression to cirrhosis and its complications than patients with only hepatitis C infection.[14] Similarly, people with HIV/ hepatitis C or hepatitis B/ hepatitis C co-infections face higher risk of chronic liver disease and death than those without HIV infection.[15] Therefore, the Gastroenterology Society of Australia recommends that people with HIV are tested annually for hepatitis C with anti- hepatitis C antibody (Ab) or hepatitis C RNA tests.[16]

23. People with chronic hepatitis C require treatment.[3] Following Pharmaceutical Benefits Scheme listing of highly effective, tolerable direct acting antiviral (DAA) treatments in 2016, there has been a significant increase in treatment uptake. Between 2016 and the end of 2023, 105,940 individuals had been treated for hepatitis C (first treatment), including 5,499 people initiating treatment in 2023. Treatment of a person in prison who has hepatitis C is highly cost-effective and should therefore be dealt with as a priority within the prison budget. [9]

24. Harm reduction and demand reduction are the primary prevention strategies for people who inject drugs. The risk of transmission should be actively reduced through education and targeted prevention programs, including diagnostic testing of high-risk populations, [11] needle and syringe programs (NSPs) and evidence-based opioid treatment programs (OTP). Other measures include standard infection control procedures, safe sex practices, and strong regulation of blood safety and healthcare quality. [17,18]

25. Similar to Hepatitis B, affected communities and individuals should be actively engaged and supported, with policies and laws formulated to encourage healthy behaviours. Support for CALD communities should also be strengthened by working with community groups and leaders.[12]

26. Stigma and discrimination against people with hepatitis B or C exist between the people living with hepatitis B and C themselves, within the health service, among the broader community and in policy and legislation.[19,20] Specifically, stigma and discrimination disproportionately affect vulnerable and marginalised groups who have particular characteristics (sexuality and sexual behaviour, gender identity and expression and intersex status; race, ethnicity, CALD background, migrant, refugee or

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visa status; past, present or perceived use of drugs; and engagement in sex work).[20] Stigma and discrimination may impede access to health services for people living with and/or at risk of viral hepatitis.

Sustainable Development

27. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goal 3 – Good Health and Wellbeing.

PHAA seeks the following actions:

28. The speedy passage and full implementation of the Fourth National Hepatitis B [9] and the Sixth National Hepatitis C [11] Strategies, with adequate resourcing, are critical to achieving their 2030 objectives and targets. This includes addressing health inequities, reducing stigma and discrimination, and ensuring culturally appropriate care for affected communities through collaboration with community leaders and groups.
29. Integration of hepatitis B and C policies with other public health policies, including prison health reform, is essential.
30. Reducing stigma and improving health literacy in community and healthcare settings is crucial for effective prevention, care, and treatment of hepatitis B and C, and encourages individuals to seek testing, treatment, and support without fear of discrimination.

PHAA resolves to:

31. Advocate for the above steps to be taken based on the principles in this position statement.

First adopted 2002, revised 2005, 2008, 2011, 2014, 2017, 2020, 2023 and 2025

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