Queensland Health

Queensland Hepatitis C Plan

2030

Queensland Government

Contents

Director-General's Statement

Queensland Health is committed to working towards the virtual elimination of hepatitis C transmissions in Australia by 2030 through a comprehensive approach to prevention, testing and treatment.

The availability of direct acting antiviral medications that can cure 95 per cent of people with chronic hepatitis C has been a significant development in recent years. Increased access to testing and treatment has been integral to reducing hepatitis C prevalence over time. The challenge looking forward, will be ensuring that barriers and gaps that still exist in the system don't leave priority populations and affected communities behind.

We recognise that many people who need treatment may have more complex issues - comorbidities, experiencing homelessness, a history of incarceration or other competing health and social priorities. We need to look for opportunities to provide models of service delivery that can reach and engage people in various settings.

This Plan acknowledges the current provision of quality hepatitis C prevention, testing and treatment services within Queensland Health, the private sector and community-based organisations across Queensland.

As community ownership is essential to our efforts, Queensland Health is committed to supporting strong relationships between partner agencies in order to achieve the goal of the virtual elimination of hepatitis C transmission.

The Plan covers the period to 2030 and is framed around the five inter-related pillars of prevention, testing, person-centred treatment and care, stigma and discrimination and governance, research, surveillance and monitoring.

By continuing to work together we can achieve the Plan's goals to:

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

Dr David Rosengren
Director-General
Queensland Health

First Nations Acknowledgment Statement

Queensland Health respectfully acknowledges the Traditional and Cultural Custodians of the lands, waters and seas across Queensland. We pay our respects to Elders past and present, while recognising the role of current and future leaders in shaping a better health system.

We value the culture, traditions and contributions that the Aboriginal and Torres Strait Islander peoples have made to our communities and recognise that our collective responsibility as government, communities and individuals is to ensure equity and equality, recognition and advancement of Aboriginal and Torres Strait Islander peoples in Queensland in every aspect of our society.

Queensland Health acknowledges the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples and supports the cultural knowledge, determination and commitment of Aboriginal and Torres Strait Islander communities in caring for their health and wellbeing.

Artwork produced for Queensland Health by Gilimbaa

Acknowledgement of lived and living experience

Queensland Health acknowledges the individual and collective expertise of people with a lived and living experience of hepatitis C. We recognise their vital contribution for the purpose of learning and growing together to achieve better outcomes for all.

Alignment with human rights

Human rights are fundamental to the blood borne virus and sexually transmissible infections (BBVSTI) response in Queensland and grounded in the recognition all people have the right to health, dignity, and an adequate standard of living. This encompasses the right to comprehensive and inclusive healthcare, education, and respect for sexual rights. Sexual rights outline all people have a right to relationships which are safe, pleasurable, free from coercion, stigma, discrimination, and violence. This extends to recognising the presence or absence of BBVSTIs should not determine someone's overall health, wellbeing, or self-worth.

About this Plan

The *Queensland Hepatitis C Plan 2030* (the Plan) is one in a suite providing a coordinated response to sexually transmissible infections (STIs) and blood borne viruses (BBVs) in Queensland. These are:

- Queensland HIV Plan 2030
- Queensland Hepatitis B Plan 2030
- Queensland Hepatitis C Plan 2030
- Queensland Sexually Transmissible Infections Plan 2030
- Queensland Syphilis Action Plan 2023-2028

This suite of plans are companion documents to the Queensland Sexual Health Framework which adopts the vision of HEALTHQ32 to improve the health and wellbeing of all Queenslanders by supporting responsive sexual health services, targeted health promotion and prevention activities, and ensuring priority populations have equitable access to prevention, testing, treatment and care. This Plan supports Public Health 2032, a vision for public health services in Queensland.

This Plan aligns with the aims of the First Nations First Strategy 2032. Queensland Health is committed to closing the gap in inequalities that exist between First Nations and non-First Nations Australians. This includes addressing the disproportionate burden of BBVSTIs experienced by First Nations peoples in Queensland.

The *Queensland Hepatitis C Plan 2030* builds on the successes of the previous *Queensland Hepatitis C Action Plan 2019-2022* and outlines the new and refocused strategic directions needed to meet Queensland's commitment to the elimination of hepatitis C as a public health threat by 2030. In 2024 the Sexual Health Ministerial Advisory Committee (SHMAC) hosted a roundtable discussion which brought together key stakeholders in the viral hepatitis field and informed the development of this Plan.

The *Queensland Hepatitis C Plan 2030* aligns with the priorities of the *Sixth National Hepatitis C Strategy 2025–2030* (not released at time of publication) and sets out Queensland's approach to eliminating new hepatitis C infections, improving hepatitis C treatment uptake, and eliminating hepatitis C-related disparities.

Queensland Health will undertake a mid-point review in 2028 to assess progress against the 2027 and 2030 targets. This will enable strategic directions to be redefined as needed, ongoing and emerging challenges to be addressed, and new evidence-based interventions to be accommodated.

Introduction

Since it was first identified in 1990, hepatitis C has affected the lives of millions of people throughout the world. Today, through a robust partnership approach between community organisations, people with lived experience, affected communities, government, primary care and research bodies, Queensland has the opportunity to eliminate hepatitis C as a public health threat by 2030.

Hepatitis C is a blood borne virus that, if left untreated, can lead to liver fibrosis, cirrhosis and cancer. The rollout of Direct Acting Antiviral (DAA) medication on the Pharmaceutical Benefits Scheme (PBS) in March 2016 has resulted in significant numbers of people being cured of their infection and reducing their likelihood of developing liver disease. However, successful hepatitis C cure does not confer immunity against future infection which means effective prevention strategies including community and peer delivered education, access to needle and syringe programs (NSPs) and pathways for non-judgemental testing and re-treatment need to be maintained to reduce the risk of re-infection.

Inequities in the social determinants of health are significant drivers and contributors to hepatitis C related health disparities and highlight the need to focus not only on hepatitis C prevention and treatment efforts, but also on the ways processes, programs and policies affect priority populations. This Plan additionally acknowledges the disparate outcomes associated with barriers to health care access and services experienced by disadvantaged population groups, such as people living with mental illness and people experiencing housing instability, substance use and stigma and discrimination.

This Plan will build on the progress and successes of previous action plans which include:

- achieving treatment coverage of 55 per cent of people estimated to be living with chronic hepatitis C in Queensland in 2022
- hepatitis C RNA prevalence (measure of chronic infection) among people who inject drugs in Queensland reducing from 21 per cent in 2018 to 10 per cent in 2022
- providing 1454 episodes of hepatitis C treatment in Queensland prisons in 2022
- utilisation of hepatitis C rapid point of care testing (POCT) in Queensland correctional settings and community settings across the state
- establishing hepatitis C test and treat programs in probation and parole settings
- increasing the proportion of Needle and Syringe Program (NSP) clients who report ever having treatment for hepatitis C from 33 per cent in 2016 to 61 per cent in 2022
- Distributing 11.6 million needles and syringes across Queensland in 2022–2023
- 930 community pharmacies participating in the Pharmacy NSP.

Guiding principles

The Queensland Hepatitis C Plan 2030 is underpinned by the Guiding Principles of the draft *Sixth National Hepatitis C Strategy 2025–2030*:

- Partnership
- Person-centred response
- Meaningful involvement of priority populations
- Health equity
- Human rights
- Health promotion
- Prevention
- Access and quality health service
- Harm reduction
- Commitment to evidence-informed policy and programs

Priority areas

- Enabling **self-determination and empowerment** of priority populations in their engagements with the healthcare system
- Fostering **collaboration and partnerships** between government, primary healthcare providers, people with lived experience and priority settings to promote harm reduction and person-centred care to priority populations
- Supporting **simplified testing and treatment pathways**, including the integration of point-of-care testing and peer workers into models of care
- **Enhancing surveillance** to provide meaningful insights into gaps in care delivery, prioritise and target interventions and measure their effectiveness.

Hepatitis C in Queensland

Hepatitis C is the most frequently reported blood borne virus in Queensland, with 2093 cases notified in 2023. Compared with the previous 5-year average, there was a 20 per cent increase in newly acquired hepatitis C notifications and a six per cent decrease in unspecified[1] hepatitis c notifications in 2023. An increase in notifications of newly acquired hepatitis C is partially due to increased testing within correctional settings which provides information on testing history and allows confirmation of infections acquired within 24 months prior to the diagnosis.

Of the 2093 hepatitis C diagnoses in 2023, 76 per cent were in males. In 2023 there was an overall four per cent increase in notifications in males, but a 14 per cent decrease in females. Fifty-five per cent of the total hepatitis C notifications were in those aged between 20 and 39 years, with a further 25 per cent of notifications in those aged 50 years or older.

First Nations people are over-represented in hepatitis C notifications in 2023 accounting for 26 per cent of all hepatitis C notifications and 40 per cent of notifications within correctional settings. Correctional settings accounted for 39 per cent of the total hepatitis C notifications and 75 per cent of newly acquired hepatitis C notifications. There was a 30 per cent increase in hepatitis C notifications in correctional settings in 2023 compared with the 5-year average. In non-correctional settings, there was a 13 per cent reduction in notifications when compared with the 5-year average.

Data for 2020–2022 should be interpreted with caution due to the impact the COVID-19 pandemic had on disease transmission and testing.

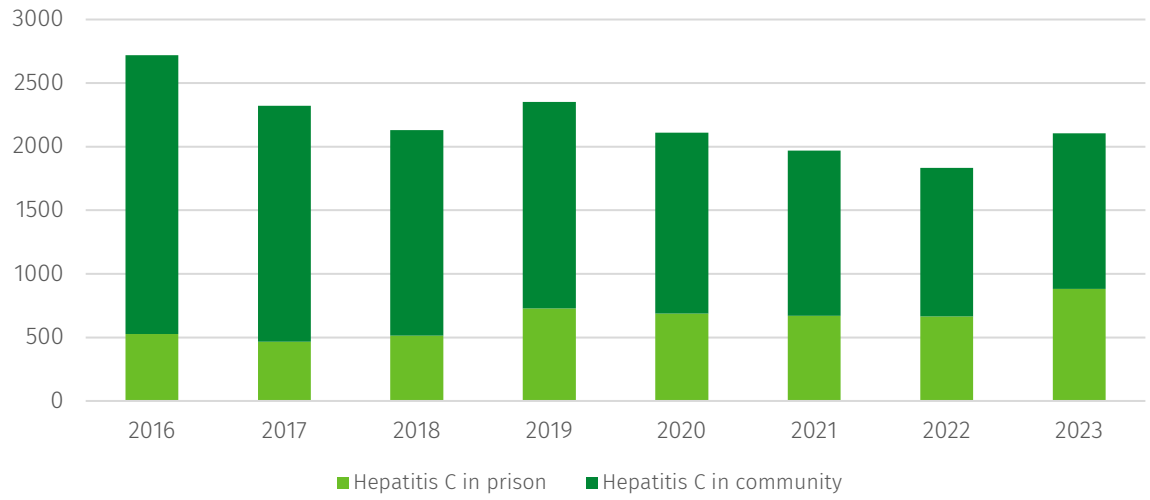


Figure 1. Notifications of hepatitis C in Queensland, by setting (prison vs community), 2016-2023 (Queensland Notifiable Conditions System, 2024)

1 Unspecified hepatitis C notifications are notifications of unknown duration which don't meet the criteria of newly acquired

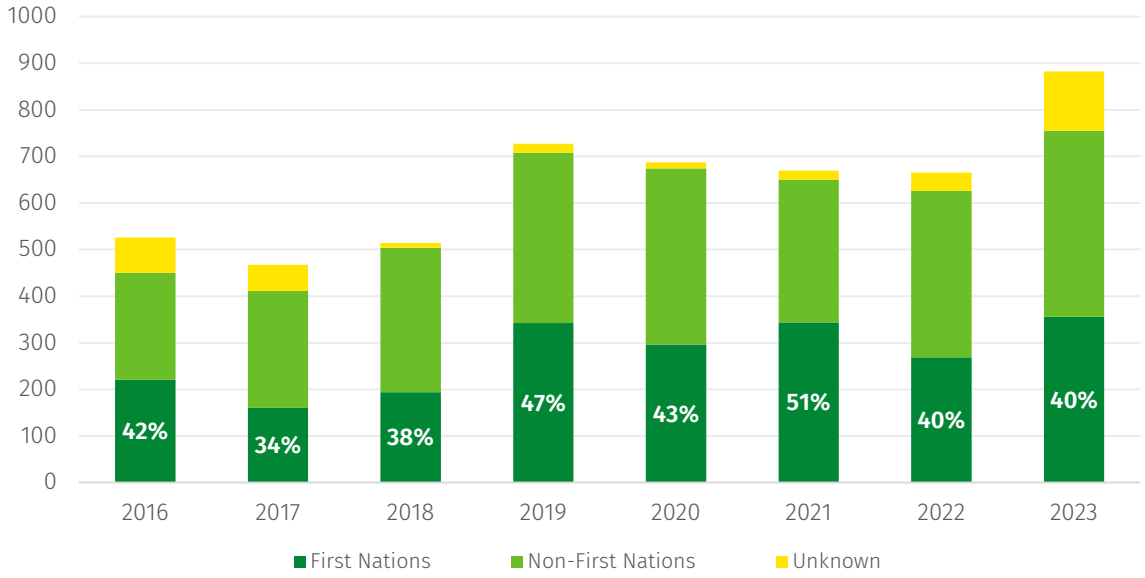


Figure 2. Notifications of hepatitis C in prisons, by First Nations status, 2016–2023 (Queensland Notifiable Conditions System, 2024)

Treatment uptake

By the end of 2023, a total of 24,185 Queenslanders were treated with DAAs for chronic hepatitis C with the majority being cured.

In 2016, 6705 Queenslanders initiated DAA treatment. Treatment uptake has slowed since then as shown in Figure 2. There was an 8.5 per cent increase in treatment episodes in 2023.

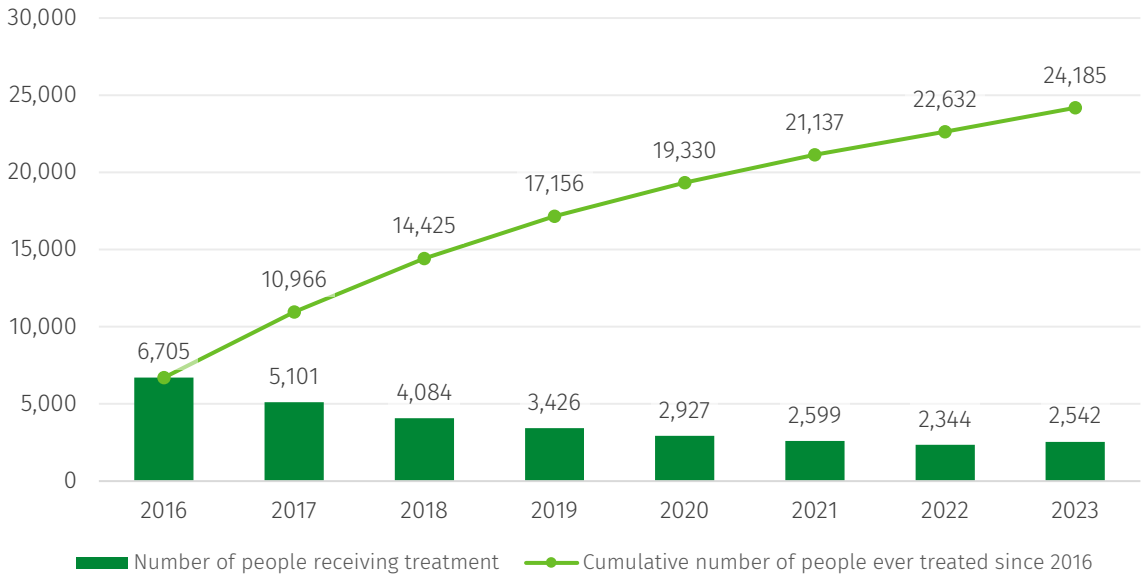


Figure 3. Uptake of direct acting antiviral treatment for hepatitis C in Queensland, 2016-2023 (prepared by Public Health Intelligence Branch Queensland Health from PBS data, 2024)

Hepatitis C care cascade

The hepatitis C care cascade (Figure 4) estimates the number of people living with hepatitis C in Queensland (13,260), the number diagnosed at the end of 2023 (12,030) and the number of people diagnosed with hepatitis C that were confirmed by RNA testing (10,820). At the end of 2023, it is estimated that 91 per cent of people living with hepatitis C had been diagnosed and 90 per cent of these people had confirmatory RNA testing.

Between 2016 and 2023 a total of 24,185 Queenslanders had been treated for hepatitis C and of these 22,822 had been cured. Hepatitis C treatment coverage as at the end of 2023 is 67 per cent.

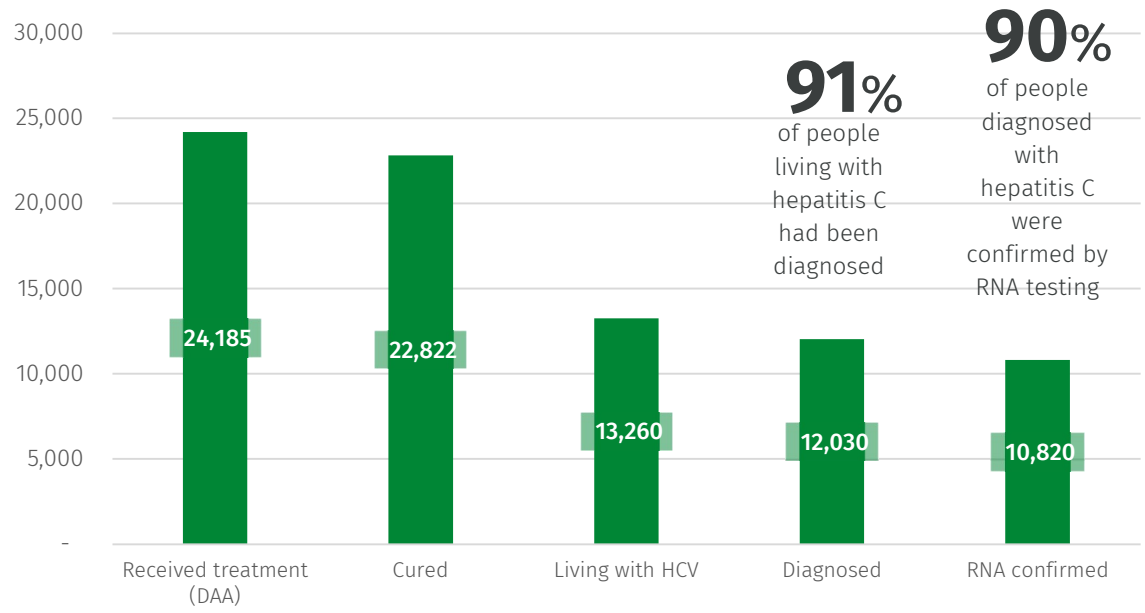


Figure 4. Hepatitis C care cascade in Queensland 2023 (prepared by Public Health Intelligence Branch Queensland Health from Kirby Institute data, 2024)

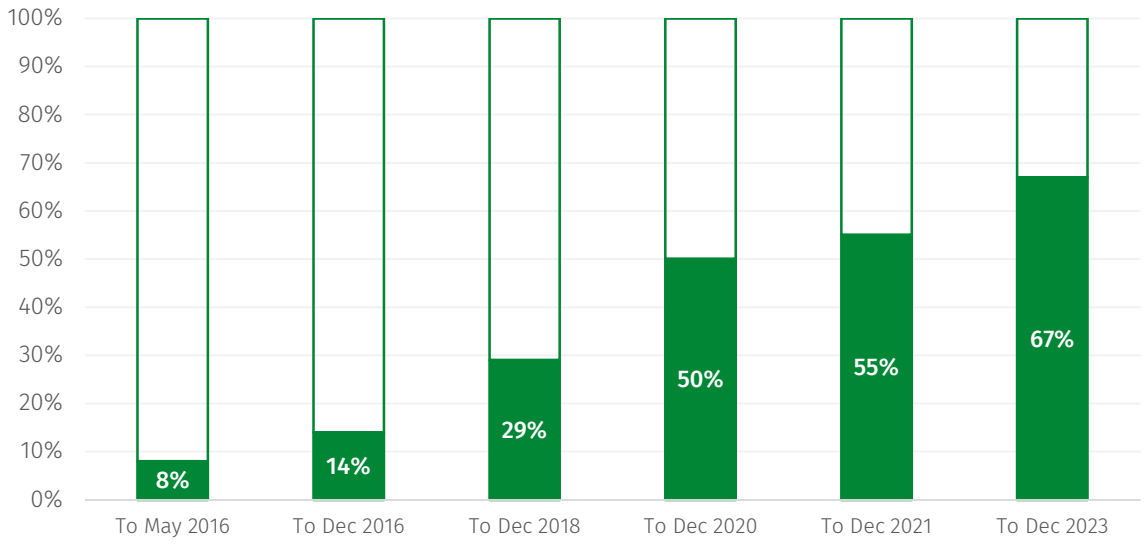


Figure 5. Hepatitis C treatment coverage in Queensland, cumulative starting March 2016 (from UNSW Kirby Institute, Monitoring hepatitis C treatment uptake in Australia, July 2016-July 2024)

Priority populations

Hepatitis C disproportionately impacts several key populations, including:

- people who inject drugs
- people in custodial settings
- First Nations peoples
- people who experience homelessness
- people living with mental health issues
- people with long-standing undiagnosed infection related to historical risk factors
- gay, bisexual and other men who have sex with men (GBMSM)
- sex workers
- people from culturally and linguistically diverse (CALD) backgrounds.

People may identify with more than one priority population. Policies and programs need to engage with priority populations in a meaningful way that embraces diversity in cultural, sexual and gender identities.

Priority settings

Priority settings provide an opportunity to engage with priority populations and other people who may be at risk of hepatitis C transmission. These include:

- custodial settings
- community corrections settings (probation and parole)
- primary healthcare settings
- sexual health clinics
- Aboriginal and Torres Strait Islander Community Controlled Health Services
- needle and syringe programs
- drug and alcohol services
- mental health services
- homelessness services and support services for people experiencing homelessness
- community-based organisations and non-government organisations who work with priority populations
- antenatal services
- multicultural community and health services including refugee health services
- emergency departments and urgent care clinics
- infectious diseases clinics.

Providing access to hepatitis C prevention, testing and treatment in a trusted setting such as through peer education or community-led testing and treatment programs for affected community and priority sub-populations is a priority. Engaging with people with lived experience in the design of service delivery will lead to the development of more effective models.

Queensland Hepatitis C Plan 2030

By 2030, hepatitis C will be eliminated as a public health threat[2] in Queensland and every person with hepatitis C will have access to treatment and care, live free from stigma and discrimination, and can achieve their full potential for health and wellbeing across their lifespan.

This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, geographic location, visa status or socioeconomic circumstance.

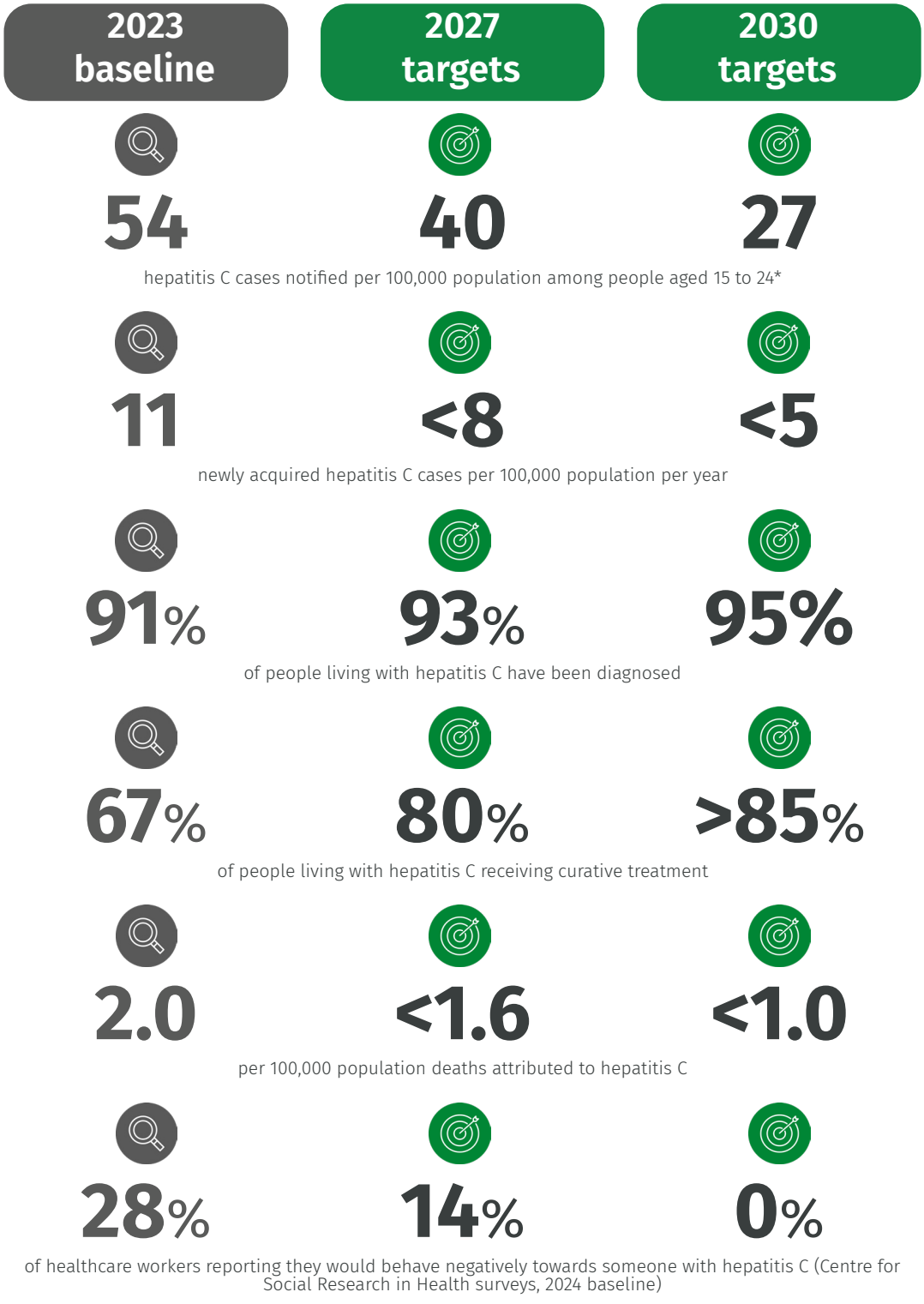
Queensland Health, Hospital and Health Services (HHSs), primary care services, community-controlled health services, non-government organisations, communities and affected populations collaborate to plan and lead the response to hepatitis C in Queensland.

Goals

- Eliminate hepatitis C as a public health threat by 2030
- Reduce mortality and morbidity related to hepatitis C
- Reduce the negative impact of health inequities, stigma, discrimination, and legal and human rights issues experienced by people living with or affected by hepatitis C.

2 The World Health Organisation defines the elimination of hepatitis C as a public health threat as a 90 per cent reduction of new chronic cases by 2030 (from 2015 baseline)

Targets



**The hepatitis C notification rate among people aged 15 to 24 has been used as a proxy for the overall incidence of hepatitis C infection, as most primary hepatitis C infections among this age group are considered as recently acquired.*

Pillar 1: Prevention

The Queensland Needle and Syringe Program (QNSP) which commenced in 1988 is a critical prevention program providing people who inject drugs with sterile injecting equipment, peer support, harm reduction education, and healthcare navigation. People in custodial settings experience increased risk of infection as evidence-based prevention methods such as condoms and NSPs are not currently available (at the time of publication) in Queensland correctional centres. This Plan prioritises harm reduction to prevent hepatitis C transmission and injecting related infections among people who inject drugs, including continuing to advocate to government for the implementation of needle and syringe programs in correctional settings.

In 2022, the hepatitis C notification rate among First Nations peoples in Queensland was six times higher than among non-First Nations people[3]. The over-representation of First Nations peoples in correctional settings is a contributing factor to these rates. Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) are key services to provide hepatitis C education, prevention, testing and treatment. This Plan supports programs designed by First Nations peoples for their communities and recognises the crucial role of the Aboriginal and Torres Strait Islander Health workforce in delivering these programs.

Priority actions

1.1 Enhance needle and syringe and opioid dependence treatment programs

- Distribute a range of sterile injecting equipment via primary and secondary sites, community pharmacies and vending machines, and provide information on harm reduction appropriate to the needs of people who inject drugs
- Improve access to initiatives such as opioid agonist treatment (OAT), take-home naloxone and other drug treatment services to reduce overdose, injecting related risks and hepatitis C transmission
- Reduce wait times to access OAT and improve retention on OAT to reduce relapse and hepatitis C reinfection
- Collect and report on the Queensland Needle and Syringe Program Minimum Data Set and participate in the annual Australian Needle and Syringe Program Survey
- Support opportunities to embed NSP points of access across a range of settings to reach priority populations as well as exploring additional distribution methods.

3 King, J., McManus, H., Kwon, J., Gray, R., & McGregor, S. (2023). HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2023. Kirby Institute, UNSW Sydney. https://doi.org/10.26190/f5ph-f972

1.2 Partner with First Nations communities to address health inequities

- Improve culturally appropriate access and uptake of harm reduction services such as NSPs and OAT for First Nations peoples
- Support partnerships between HHSs, NGOs, ATSICCHOs and custodial settings to ensure continuity of hepatitis C care across services
- Support the Aboriginal and Torres Strait Islander workforce to provide harm reduction through education and program delivery
- Endorse the findings from the University of Queensland '*Enhancing harm reduction services for Aboriginal and Torres Strait Islander people who inject drugs through improved engagement*' study funded by the Sexual Health Research Fund.

1.3 Prevention measures in correctional settings

- Facilitate opportunities for evidence-based prevention, including developing options for addressing and assessing barriers to the provision of NSPs in custodial settings in partnership with Queensland Corrective Services, the Office for Prisoner Health and Wellbeing (OPHW) and other key stakeholders
- Improve access to treatment and reduce wait times for treatment in correctional settings to enhance 'treatment as prevention' outcomes
- Support the uptake of harm reduction services such as NSPs and OAT for people upon release from custody
- Support correctional settings to provide education on Hepatitis C and other blood borne virus prevention, including to corrections staff.

1.4 Health promotion and prevention across priority populations

- Support and strengthen peer-led community initiatives to improve understanding of hepatitis C and transmission risks
- Sustain engagement and testing for GBMSM and sex workers at routine BBVSTI screening
- Include regular clinician targeted hepatitis C messaging through a range of communication channels used by primary care
- Develop and implement hepatitis C co-designed and targeted prevention and education programs with a focus on reducing transmission and re-infection risks
- Support funded programs to expand place-based, targeted engagement of priority populations
- Integrate hepatitis C awareness in liver health promotion activities and initiatives.

Pillar 2: Testing

Hepatitis C testing and treatment pathways will be supported across a range of settings including general practice, mental health and alcohol and other drug (MHAOD) settings, emergency departments, custodial and community corrections settings, ATSICCHOs, needle and syringe programs, homelessness services and sexual health services. Testing in custodial and community corrections settings in Queensland is prioritised to diagnose and treat newly acquired hepatitis C infections to reduce incidence and prevalence. Queensland Health will continue to support the work being undertaken by MHAOD services to improve pathways for hepatitis C testing and treatment as part of the *'Hepatitis C Easy to Test Easy to Treat' Multimorbidity Quality Improvement Strategy 2024*.

Innovative testing models such as rapid point of care testing (POCT) are a highly accepted form of testing for people affected by hepatitis C particularly in NSPs, prisons, watch houses and MHAOD settings. POCT is well suited to mobile and outreach testing models which are encouraged as a way to effectively reach people from priority populations who may not engage with more traditional healthcare services.

Including peers in service delivery can increase uptake of hepatitis C prevention, testing and treatment and ensure appropriate engagement for affected communities.

Priority actions

2.1 Supporting point of care testing

- Support the roll-out of POCT for hepatitis C antibodies and RNA in key settings with particular attention to tailoring testing depending on lower or higher hepatitis C prevalence in the population/settings
- Support the sharing of testing flowcharts, guidelines and support tools across diverse settings to allow for new sites to commence testing and provide multiple points of testing access for community members
- Support Aboriginal and Torres Strait Islander Health Workers and Health Practitioners to complete blood borne virus training including hepatitis C point of care training
- Explore the implementation of programs that incorporate diverse testing options, such as dried blood spot testing and self-testing, within models of care specifically designed to meet the needs of key populations/settings
- Explore options for recording point of care testing results within notification and clinical systems to avoid duplication of testing across services
- Support the establishment of governance of point of care testing programs to maintain quality assurance and confidence in the program including the establishment of a streamlined coordinated processes to report and share results to enable continuity of care, support appropriate clinical management and improve surveillance accuracy.

2.2 Strengthen testing pathways via Mental Health Alcohol and Other Drug (MHAOD) services

- Support pathways for in-house testing and treatment as part of usual care across all MHAOD services
- Support MHAOD services to undertake regular testing and linkage to care as well as exploring high intensity testing weeks
- Explore the implementation of a 12 monthly reminder/recall system for people on OAT who have identified risks that may lead to hepatitis C infection
- Promote the implementation of the Queensland MHAOD Multimorbidity Hepatitis C Quality Improvement Strategy and data collection tools.

2.3 Embed hepatitis C testing across diverse settings

- Support opportunities to embed testing across a range of settings to reach priority populations including people with historic risk who remain undiagnosed
- Improve knowledge of and utilisation of reflex RNA testing on all positive antibody tests including appropriate collection of blood tubes and ordering of tests
- Support laboratory implementation of automatic reflex RNA testing following all hepatitis C positive antibody tests to support timely diagnosis of chronic infection
- Support risk-based testing as part of routine First Nations people's healthcare
- Consider incentives for higher risk population groups to test, treat, and refer contacts
- Support outreach models of care and mobile testing models and share experiences across the state
- Include hepatitis C testing for GBMSM who have injecting and other blood to blood transmission risk factors
- Implement activities to increase testing amongst culturally and linguistically diverse communities across key settings including targeted point of care testing (recognising different risk factors including medical procedures performed overseas)
- Support hepatitis C testing being embedded within a suite of tests for blood-borne pathogens including tests for HIV, hepatitis B and syphilis including for women contemplating pregnancy or seeking antenatal care
- Offer HCV testing as part of blood borne virus screening to people entering correctional settings upon entry and every 6 to 12 months
- Promote healthcare workforce education inclusive of integrating reflex RNA testing within the cascade of care to improve testing and diagnosis
- Support health promotion campaigns to encourage on-going engagement with regular testing amongst priority populations.

2.4 Supporting primary health care

- Promote simplified testing and linkage to care flowcharts for primary care
- Promote awareness that complete testing for chronic hepatitis C includes an RNA test and reduce the repeating of antibody tests where a positive antibody is already recorded
- Support initiatives to improve screening and accessibility of hepatitis C testing data in General Practice settings and ATSICCHOs e.g., case finding and clinical auditing quality

improvement projects, system enhancements to clinical software to ensure that all positive results are followed up and people are offered treatment

- Support systems to seek patient consent to upload hepatitis C point of care testing results to electronic health records.

2.5 Peer workforce development

- Support and build capacity of a peer workforce to promote prevention, testing and treatment services
- Support peer led prevention and testing service models
- Improve opportunities for peer training and mentorship to improve access and engagement in care by people living with hepatitis C

2.6 Advocacy to support testing equity and accessibility

- Advocate for equity for Medicare ineligible people to accessing hepatitis testing
- Advocate for change in Medicare billing processes to enable a complete testing episode and contemporary testing practices.

2.7 Contemporary testing practices

- Update surveillance case definitions to focus on identifying current (rather than past) infections to provide meaningful surveillance data and inform testing strategies
- Support upcoming hepatitis C testing technologies and strategies with focus on linkage to care.

Photo: Kombi Clinic team (Photographer: Connor Ashleigh)

Pillar 3: Person-centred treatment and care

Queensland Health acknowledges that person-centred and non-discriminatory services are crucial to engaging people living with hepatitis C in treatment and care. This Plan aims to improve the accessibility of treatment in diverse settings including outreach locations via support for mobile clinic collaborations, high intensity testing events, a peer workforce, and nurse-led models of care. Many clients who are yet to access hepatitis C treatment may require additional support to build trust and ongoing connection with services.

Queensland Health will work to improve notification follow up and explore ways to facilitate improved linkage into care.

People cured of hepatitis C, but still living with cirrhosis, continue to experience increased risk of morbidity and mortality beyond cure. Services need to be flexibly delivered to meet the needs of people affected by hepatitis C to manage cirrhosis after treatment completion.

Priority actions

3.1 Reduce barriers to treatment initiation and completion

- Monitor time from testing to treatment across services to reduce barriers to same-day or next day treatment models especially in high volume services such as correctional settings
- Explore and enhance nurse-led models of care (eg nurse navigators), telehealth and other remote prescribing methods to improve access to care in outreach, rural, regional and remote settings
- Encourage prescribers to prepare the prescription as a Reg 49 script, ensuring complete supply at time of initial script (8-12 weeks)
- Ensure prisoners are released with the full course of their prescribed hepatitis C treatment to ensure continuity of treatment and successful treatment outcomes
- Ensure all clinicians and service providers are aware of the Close the Gap (CTG) funding for these medicines
- Improve continuity of care for people diagnosed in custody and accessing treatment or post-cure testing on release in the community
- Increase the accessibility of treatment by supporting programs which cover co-payment costs for clients where cost is a barrier
- Support clients with treatment readiness by encouraging a holistic person-centred approach which addresses social determinants of health
- Involve people with lived experience to improve treatment pathways and engagement
- Enhance support for all MHAOD doctors and nurse practitioners to initiate and provide hepatitis treatment and care within their clinics

- Support advocacy efforts to reform state and/or Commonwealth funding to provide access to DAAs for long-term inpatients in mental health facilities and people who use drugs who are admitted to hospital for long periods to treat complex conditions
- Explore the establishment of a hepatitis C Community of Practice for clinicians and program managers to support innovations in treatment pathways and models of care.

3.2 Improve notification driven linkage to care

- Improve notification follow-up, treatment initiation recording and enable the notification of reinfections
- Support the statewide work of the Hepatitis C Hub based at West Moreton Public Health Unit to improve active public health follow up of hepatitis C cases through case investigation and enhanced surveillance
- Investigate improved integration of pathology results into electronic medical records.

3.3 Post-cure management and connection to care

- Improve access to specialist care for marginalised people from priority populations who face significant challenges in managing their health care due to chronic hepatitis related liver complications, stigma and discrimination
- Ensure accessible pathways for people with cirrhosis to receive appropriate management including monitoring for liver cancer
- Ensure people with continuing risk of hepatitis C have access to RNA testing and treatment for re-infection.

Photo: Hepatitis Queensland

Pillar 4: Stigma and discrimination

Almost three quarters of people living with hepatitis C in Australia report experiencing stigma and discrimination[4]. Evidence supports the need to address individual, interpersonal, and structural stigma as an integral part of elimination efforts. Queensland Health will continue investment in healthcare professional and community awareness and education to reduce stigma and discrimination against people who inject drugs and people affected by hepatitis C including those people who have experienced incarceration, homelessness and mental health issues. This Plan will involve community organisations and people with lived experience in the development and delivery of workforce and health promotion campaigns to ensure effective messaging and to normalise testing for people at risk of hepatitis C and promote access to treatment and care.

Priority actions

4.1 Reduce hepatitis C-related stigma and discrimination

- Improve data collection tools to monitor stigma and discrimination
- Advocate for policy change to enable people affected by hepatitis C to access harm reduction, testing and treatment in non-judgemental settings involving peers wherever possible
- Advocate for an end to laws, regulation and policies that result in hepatitis C-related stigma and discrimination
- Promote education and training on stigma and discrimination for staff in priority settings other than healthcare settings, including custodial settings, and for police and other frontline workers.

4.2 Reduce hepatitis C-related stigma and discrimination in healthcare settings

- Promote peer led education and training for healthcare professionals on stigma, discrimination, and bias toward populations who experience risk for hepatitis C, including people who inject drugs and people in contact with custodial settings
- Deliver and evaluate the BBV stigma education and training module (developed in 2024 and available on iLearn)
- Establish a culturally responsive workforce by ensuring there is an organisational commitment to cultural awareness and safety and establishing mechanisms to recognise, address, and prevent racism at the individual and organisational levels.

4 Broady T, Brener L, Hopwood M, Cama E, Treloar, C. (2020). Stigma Indicators Monitoring Project: Summary Report. Phase Two. Sydney: UNSW Centre for Social Research in Health

4.3 Design stigma reduction communication with affected communities

- Implement targeted communication campaigns and health promotion activities to reduce stigma experienced by priority populations through collaboration with community-based organisations
- Involve peers, people from First Nations and CALD backgrounds and relevant communities in the co-design and delivery of communications campaigns and health promotion activities.

Photo: Queensland Injectors Health Network

Pillar 5: Governance, research, surveillance and monitoring

The Hepatitis C Plan 2030 will utilise the strong evidence base provided by national research and surveillance bodies who inform the hepatitis C response in Australia. Queensland Health remains committed to working closely with national research centres leading this work including the Kirby Institute, Burnet Institute and Doherty Institute.

Queensland Health will ensure high quality data and surveillance systems are continuously improved to support data completeness, comparability and utility essential for strategic planning and program improvement.

To strengthen governance and support the monitoring of progress against the priority actions, Queensland Health will establish strategic, tactical and operational governance and advisory frameworks which include key stakeholder representatives including sexual health services, MHAOD, primary healthcare providers, community organisations, research bodies and the Department of Health.

Priority actions

5.1 Support research

- Work with Queensland and national research partners to support hepatitis C related research which includes and is informed by people with lived experience
- Support translation of research findings into program and service implementation
- Actively identify research priorities and identify and source funding to facilitate local research in Queensland.

5.2 Enhance surveillance data

- Identify and resolve gaps in surveillance data for measuring and monitoring the implementation of this Plan including by exploring new dashboard and reporting formats
- Improve completeness of data on First nations status, language spoken and country of birth
- Ensure data and research findings are regularly communicated back to affected communities and stakeholders with particular focus upon principles of Indigenous data sovereignty and data governance[5]

5 This includes First Nations peoples having the right to exercise ownership and control over Indigenous data across all phases of the lifecycle, including creation, collection, access, interpretation, management, dissemination and reuse

- Support the work of Public Health Units and epidemiologists to improve active public health follow up and collection of enhanced data of hepatitis C cases, to monitor trends and identify, prevent or control clusters or outbreaks
- Support the introduction and continued capacity building of the new hepatitis C case definition to accurately capture reinfections.

5.3 Strengthen governance and monitoring

- Provide opportunities for the hepatitis C workforce across Queensland to meet and share learnings such as the annual ASHM Hepatitis C and Prison forum and the Queensland Needle and Syringe Program annual forum
- Maintain active engagement with the BBVSTI Committee and the Queensland Sexual Health Clinical Network by providing updates against this Plan
- Conduct a mid-term review of the Hepatitis C Plan in 2028 to report on progress of actions, review priority actions and progress against elimination targets.

Indicators

	Indicator	Data Source	Frequency
Pillar 1 Prevention	Amount of sterile injecting equipment distributed	Queensland Needle and Syringe Program, Department of Health	Annual
	Proportion of people who inject drugs reporting re-use of a needle previously used by someone else	Australian Needle and Syringe Program Survey, The Kirby Institute	Annual
	Number of people receiving OAT (inclusion of First Nations status data for future reporting) and coverage across settings including prisons	National Opioid Pharmacotherapy Statistics Annual Data	Annual
	Percentage of people who inject drugs in prison who are on OAT and number of people on the waitlist for OAT in prison	AusHep Study, The Kirby Institute	Annual
	Assess progress on implementing harm reduction initiatives in correctional settings	Office of Prisoner Health and Wellbeing and Communicable Diseases Branch, Department of Health	Annual
Pillar 2 Testing	Number of hepatitis C tests undertaken including point of care tests	Public Health Intelligence Branch, Department of Health, The Kirby Institute	Annual
	Number of staff trained to deliver point of care tests including Aboriginal and Torres Strait Islander Health Workers and Practitioners	HHS and NGO data, The Kirby Institute	Annual
	Proportion of PWID in Queensland who have been tested for hepatitis C RNA in their lifetime and in the previous 12 months	Australian Needle and Syringe Program Survey, The Kirby Institute	Annual
	People in prison who report ever being tested for hepatitis C	AusHep Study, National Prisons Hepatitis Network, The Kirby Institute	Annual
	People in prison who report being tested for hepatitis C in the last year	AusHep Study, National Prisons Hepatitis Network, The Kirby Institute	Annual
	People in prison living with hepatitis C who report ever being tested	AusHep Study, National Prisons Hepatitis Network, The Kirby Institute	Annual

	Indicator	Data Source	Frequency
Pillar 3 Person-centred treatment and care	The proportion of people living with chronic hepatitis C receiving treatment	Kirby Institute Annual Surveillance report	Annual
	Number of episodes of treatment provided in correctional settings (including first treatment and re-treatment)	Prison Health Service data reported to Office of Prisoner Health and Wellbeing	Annual
	Number of episodes of treatment provided in mental health and drug and alcohol settings	MHAOD Hepatitis C Cascade of Care Dashboard	Annual
	Total number of people initiating treatment – annually and cumulative from 2016	Public Health Intelligence Branch, Department of Health. Data sourced from the PBS	Annual
	Hepatitis C RNA prevalence amongst people who inject drugs	Australian Needle and Syringe Program Survey, The Kirby Institute	Annual
	Reduction in liver cirrhosis and HCC amongst patients with hepatitis C	Queensland Hospital Liver Clinic data	Annual
	Reduce hepatitis C attributable mortality to <1.6 deaths per 100,000 population per year (2027) and <1.0 death per 100,000 population (2030)	The Kirby Institute	Annual
Pillar 4 Stigma and discrimination	Number of hepatitis C initiatives delivered and evaluated which provided education about hepatitis C risks, testing, treatment and hepatitis C-related stigma and discrimination	Funded service provider reports: ASHM, Hepatitis Queensland, QuIHN, ECCQ, HHS service delivery reports where available.	Annual
	Number of hepatitis C education sessions delivered for health workforce in Queensland (and attendance numbers)	ASHM, Hepatitis Queensland and QuIHN	Annual
	Number of people completing the online BBV stigma and discrimination learning module	Communicable Diseases Branch, Department of Health.	Annual
	National Stigma Indicators Monitoring Project – explore opportunities to access Queensland-specific data from this dataset	UNSW Centre for Social Research in Health	As reported

	Indicator	Data Source	Frequency
Pillar 5 Governance, research, surveillance and monitoring	Weekly, quarterly, year-to-date and annual reporting of hepatitis C notifications	Public Health Intelligence Branch, Department of Health	Weekly, quarterly, annual
	Monitor the incidence of hepatitis C per 100,000 population and cases per 100 people who inject drugs per year	Public Health Intelligence Branch, Department of Health	Weekly, quarterly, annual
	Number and type of research activities undertaken including peer led and co-designed research with affected communities.	Queensland Sexual Health Research Fund, Kirby Institute UNSW, Burnet Institute, The W3 Project La Trobe University Australian Research Centre in Sex, Health and Society (ARCSHS)	Annual
	Establish a robust surveillance system in Queensland to monitor effectiveness of strategies and overarching policy.	Public Health Intelligence Branch, Queensland Health	

Hepatitis C in Queensland 2030 - Plan on a page

By 2030, hepatitis C will be eliminated as a public health threat in Queensland and every person with hepatitis C will have access to treatment and care, live free from stigma and discrimination, and can achieve their full potential for health and wellbeing across their lifespan.

Priority settings

- Custodial settings
- Community corrections settings (probation and parole)
- Primary healthcare settings
- Sexual health clinics
- Aboriginal and Torres Strait Islander Community Controlled Health Services
- Needle and syringe programs
- Drug and alcohol services
- Mental health services
- Homelessness services and support services for people experiencing homelessness
- Community-based organisations and non-government organisations who work with priority populations
- Antenatal services
- Multicultural community and health services including refugee health services
- Emergency departments and urgent care clinics
- Infectious diseases clinics

Priority populations

- People who inject drugs
- People in custodial settings
- First Nations peoples
- People who experience homelessness
- People living with mental health issues
- People with long-standing undiagnosed infection related to historical risk factors
- Gay, bisexual, and other men who have sex with men
- Sex workers
- People from culturally and linguistically diverse backgrounds

Targets 2027

40
hepatitis C cases notified per 100,000 population among people aged 15 to 24

<8
newly acquired hepatitis C cases per 100,000 population per year

93%
of people living with hepatitis C have been diagnosed

80%
of people living with hepatitis C receiving curative treatment

<1.6
per 100,000 population deaths attributed to hepatitis C

14%
of healthcare workers reporting they would behave negatively towards someone with hepatitis C (Centre for Social Research in Health Surveys)

Targets 2030

27
hepatitis C cases notified per 100,000 population among people aged 15 to 24

<5
newly acquired hepatitis C cases per 100,000 population per year

95%
of people living with hepatitis C have been diagnosed

>85%
of people living with hepatitis C receiving curative treatment

<1.0
per 100,000 population deaths attributed to hepatitis C

0%
of healthcare workers reporting they would behave negatively towards someone with hepatitis C (Centre for Social Research in Health Surveys)

Pillar 1 Prevention

Priority actions

- **1.1** Enhance needle and syringe and OAT programs
- **1.2** Partner with First Nations communities to address health inequities
- **1.3** Prevention measures in correctional settings
- **1.4** Health promotion and prevention across priority populations

Pillar 2 Testing

Priority actions

- **2.1** Supporting point of care testing (POCT)
- **2.2** Strengthen test pathways in mental health alcohol & other drug services
- **2.3** Embed hepatitis C testing across diverse settings
- **2.4** Supporting primary health care
- **2.5** Peer workforce development
- **2.6** Advocacy to support testing equity and accessibility
- **2.7** Contemporary testing practices

Pillar 3 Person-centred treatment and care

Priority actions

- **3.1** Reduce barriers to treatment initiation and completion
- **3.2** Improve notification driven linkage to care
- **3.3** Post-cure management and connection to care

Pillar 4 Stigma and discrimination

Priority actions

- **4.1** Reduce hepatitis C-related stigma and discrimination
- **4.2** Reduce hepatitis C-related stigma and discrimination in healthcare settings
- **4.3** Design stigma reduction communication with affected communities

Pillar 5 Governance, research, surveillance and monitoring

Priority actions

- **5.1** Support research
- **5.2** Enhance surveillance data
- **5.3** Strengthen governance and monitoring

Queensland Government

Abbreviations

Acronym	Definition
ATSICCHOs	Aboriginal and Torres Strait Islander Community Controlled Health Organisations
BBV	Blood borne virus
CALD	Culturally and linguistically diverse
DAA	Direct-acting antiviral
HHSs	Hospital and Health Services
MHAOD	Mental Health, Alcohol and Other Drugs
NGO	Non-government Organisation
NSP	Needle and syringe program
OAT	Opioid Agonist Treatment
OPHW	Office of Prisoner Health and Wellbeing
PWID	People who inject drugs
POCT	Point of Care Testing
RNA	Ribonucleic acid
STI	Sexually transmissible infection

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