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HIV, viral hepatitis and sexually transmissible infections in Australia Annual surveillance report 2025

Hepatitis B

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Annual surveillance report 2025

Kirby Institute, UNSW Sydney

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in collaboration with networks in surveillance for HIV, viral hepatitis and sexually transmissible infections

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Hepatitis B

We recognise communities and individuals impacted by and at risk of HIV, hepatitis B, hepatitis C, and sexually transmissible infections. These people and communities are crucial stakeholders in the work we do, with invaluable contributions and lived experiences. We acknowledge and affirm their crucial role in the development of this report, and public health surveillance more broadly. This report aims to ensure that ongoing and emerging public health threats and inequities are apparent, and that high quality data are available to inform appropriate public health responses to address these issues. We also acknowledge the ongoing negative impacts stigma and societal discrimination play in perpetuating inequity, and support principles of empowerment, community ownership, and partnership.

The years for comparison in this report are for the 10-year period from 2015 to 2024. Many indicators in the report were affected by the COVID-19-related impacts on travel and access to health care, particularly testing and treatment. These impacts are acknowledged in figures and text throughout the report.

We acknowledge the late Dr Nicholas Medland for his significant contribution to HIV and STI surveillance and research in Australia and throughout the region. He generously provided his time and expertise whenever asked, and his commitment to public health will have a lasting impact. We pay tribute to his memory and legacy. Vale Nick.

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1 Summary data

Hepatitis B notifications

- In 2024, there were a total of 5594 hepatitis B notifications in Australia, with 2582 (46%) among females, 2994 (54%) among males, and 18 (<1%) notifications for whom sex was not reported.
- The hepatitis B notification rate declined by 23% between 2015 and 2024, from 26.2 to 20.2 per 100 000. Overall declines were likely attributable in part to the impact of hepatitis B vaccination. The sharp decline in notification rates between 2019 and 2021, followed by a slight increase between 2021 and 2024, was likely due in part to the impacts of the COVID-19 pandemic, particularly the impact on testing uptake, international travel, and migration.
- Compared to other age groups, the hepatitis B notification rate in 2024 was highest among those aged 30 to 39 years (38.6 per 100 000), 40 to 49 years (34.5 per 100 000), and 50 to 59 years (27.1 per 100 000). The rate declined considerably among younger age groups between 2015 and 2024 — down 60% among people under 20 years (from 4.1 to 1.6 per 100 000), 51% among those aged 20 to 29 years (from 40.9 to 20.1 per 100 000), and 30% among those aged 30 to 39 years (from 55.0 to 38.6 per 100 000). Little change was seen among those aged 40 years and older. The overall trends by age group during 2015–2019 likely reflect the impact of hepatitis B vaccination programs, while the declines from 2020 onwards also reflect the COVID19 pandemic and related disruptions.
- The hepatitis B notification rate among Aboriginal and Torres Strait Islander peoples is based on data from five jurisdictions (Australian Capital Territory, Northern Territory, Queensland, South Australia, and Western Australia), where Aboriginal and Torres Strait Islander status was reported for at least half of all hepatitis B notifications for each of the five years (2020–2024).
- The hepatitis B notification rate among Aboriginal and Torres Strait Islander peoples declined by 32% between 2020 and 2024, from 34.6 to 23.6 per 100 000. The rate was higher compared with nonIndigenous people in 2024 (17.1 per 100 000).

Testing and care

- According to modelled estimates, in 2024, an estimated 67% (153 286) of people living with chronic hepatitis B in Australia had been diagnosed, and of those, an estimated 28% (63 444) were receiving regular clinical care.
- Best practice indicates that all people diagnosed with chronic hepatitis B require regular monitoring to assess the stage and progression of their liver disease and to facilitate the commencement of treatment as needed.
- Treatment for hepatitis B is recommended for patients who meet specific criteria for treatment based on age, viral load, liver function tests, liver fibrosis stage and family history. In 2024, 13% (28 805) of people living with chronic hepatitis B were estimated to be receiving antiviral therapy. It is estimated a further 38 959 treatment-eligible people living with hepatitis B did not receive antiviral treatment.

Prevention

- In 2024, hepatitis B vaccination coverage among infants reached 95.2% for Aboriginal and Torres Strait Islander infants and 94.8% for non-Indigenous infants by 24 months of age, meeting the national target of 95%. Coverage at 12 months was lower, at 89.3% and 92.2% respectively. Overall vaccination coverage has declined since 2020, and work is ongoing to investigate barriers to achieving higher rates.

2 Interpretation

Hepatitis B among adolescents and adults in Australia is transmitted through a variety of pathways, including injection drug use and sexual contact. Most people living with chronic hepatitis B in Australia were born overseas and acquired hepatitis B at birth or in early childhood. Therefore, hepatitis B notifications reflect trends in both the incidence of new infections and testing for those with chronic infections. Between 2020 and 2021, there were reductions in testing, diagnosis, and monitoring of hepatitis B, likely due to the ongoing COVID-19 pandemic. This change represents reduced progress toward Australia's Fourth National Hepatitis B Strategy targets for diagnosis, linkage to care, and treatment.

Between 2015 and 2024, hepatitis B notification rates declined among younger age groups (under 40 years) that are most likely to have benefited from the introduction of universal vaccination of infants in 2000 (1990 in the Northern Territory) and adolescent catch-up programs from 1998 (with variations by jurisdiction when school-based vaccination programs were introduced). Vaccination programs introduced in countries that many Australian migrants emigrate from also have led to lower hepatitis B prevalence among recent migrants to Australia. Other strategies to prevent vertical transmission of hepatitis B including maternal screening and treatment, and hepatitis B Immunoglobulin (HBIG) injection for infants born to women with hepatitis B, are also likely to have contributed to this decline.

Between 2017 and 2024 there was a decline in hepatitis B vaccination rates, likely impacting the progress towards the elimination of vertical transmission and has the potential to increase hepatitis B transmission over the coming decades.

Given the high proportion of hepatitis B notifications without a reported Aboriginal and Torres Strait Islander status, the actual hepatitis B-related burden of disease among Aboriginal and Torres Strait Islander peoples may be higher than what is currently reported. Improved completeness of Aboriginal and Torres Strait Islander status collected during pathology testing is essential to more accurately understand the true impact of hepatitis B on Aboriginal and Torres Strait Islander communities.

3 Hepatitis B notifications

This section focuses on people notified with hepatitis B infection in Australia. There were 5594 hepatitis B notifications in Australia in 2024 with the vast majority (99%, 5518) reported as unspecified (without evidence of recent infection), and only 76 (1%) were reported as newly acquired. Of all hepatitis B notifications, 144 (3%) were among Aboriginal and Torres Strait Islander peoples, 3443 (62%) were among non-Indigenous people, and there were a further 2007 (36%) notifications for which Aboriginal and Torres Strait Islander status was not reported. In 2024, half (54%, 2994) of hepatitis B notifications were among males, 57% (3173) were among people aged 40 years and above, and 83% (4621) were among people residing in major cities (Table 1).

Table 1 Table 1 Characteristics of hepatitis B notifications, 2015 – 2024

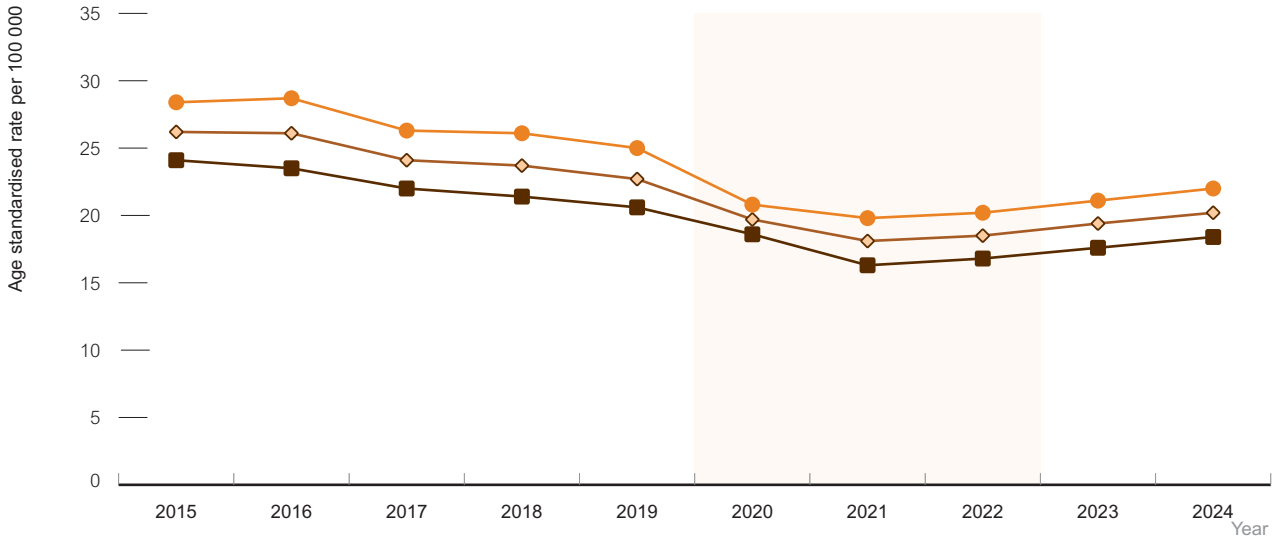
	Year of diagnosis									
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Characteristic										
Total cases	6220	6271	5941	5909	5770	5042	4649	4909	5277	5594
Newly acquired[a]	148	169	147	139	166	127	82	62	95	76
Sex										
Female	2884	2855	2738	2700	2643	2406	2132	2258	2436	2582
Male	3318	3390	3186	3187	3107	2622	2505	2633	2831	2994
Not reported	18	26	17	22	20	14	12	18	10	18
Age group (years)										
<20	232	255	170	145	163	94	69	85	104	89
20–29	1422	1273	1195	1134	984	725	599	601	639	766
30–39	1848	1984	1820	1797	1843	1532	1309	1322	1406	1566
40–49	1177	1182	1104	1223	1136	1011	1072	1048	1173	1214
50–59	869	848	831	784	767	818	768	828	841	874
60–69	475	472	566	573	618	606	548	661	720	689
70+	193	255	254	253	259	254	284	364	394	396
Not reported	4	2	1	0	0	2	0	0	0	0
Aboriginal and Torres Strait Islander status										
Aboriginal and/or Torres Strait Islander	255	194	176	173	155	177	163	112	138	144
Non-Indigenous	3300	3727	3772	3850	3627	3017	2790	2921	3490	3443
Not reported	2665	2350	1993	1886	1988	1848	1696	1876	1649	2007
Area of residence										
Major cities	5226	5367	5057	4992	4900	4243	3830	4163	4362	4621
Regional	704	674	618	633	626	585	606	578	700	720
Remote	173	102	120	107	97	114	119	73	97	108
Not reported	117	128	146	177	147	100	94	95	118	145
State/Territory										
ACT	82	89	87	82	83	79	66	88	83	91
NSW	2216	2216	2209	2332	2146	1932	1697	2000	1945	2098
NT	161	109	101	85	83	92	32	45	94	118
QLD	1029	1047	905	851	944	838	753	800	1017	950
SA	341	318	296	274	309	266	200	192	238	263
TAS	41	40	43	43	67	57	75	64	49	56
VIC	1777	1792	1764	1746	1687	1263	1293	1337	1374	1481
WA	573	660	536	496	451	515	533	383	477	537

a Newly acquired hepatitis B is defined as newly diagnosed hepatitis B infection with evidence of acquisition in the two years before diagnosis. Enhanced surveillance procedures related to hepatitis B vary by state/territory. The total number of cases reported here is likely to be an underestimation of the true number of newly acquired infections. Case counts for individual years are subject to revision due to ongoing data updates. All data reported in this analysis were extracted in May 2025.

Source: Australian National Notifiable Diseases Surveillance System.

The hepatitis B notification rate in Australia declined by 23%, from 26.2 per 100 000 in 2015 to 20.2 per 100 000 in 2024. The sharp decline in notification rates between 2019 and 2021, followed by a slight increase between 2021 and 2024, was likely due in part to the impacts of the COVID-19 pandemic, in particular the impact on testing uptake, international travel, and migration. The overall decline since 2015 was likely due to hepatitis B vaccination programs in Australia and overseas [1], and occurred only in those aged under 40 years (see Figure 2). Notification rates have been consistently higher among males than females, and were 22.0 and 18.4 per 100 000 in 2024, respectively (Figure 1).

Figure 1 Hepatitis B notification rate per 100 000 population by gender, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Female	24.1	23.5	22.0	21.4	20.6	18.6	16.3	16.8	17.6	18.4
Male	28.4	28.7	26.3	26.1	25.0	20.8	19.8	20.2	21.1	22.0
Total	26.2	26.1	24.1	23.7	22.7	19.7	18.1	18.5	19.4	20.2

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

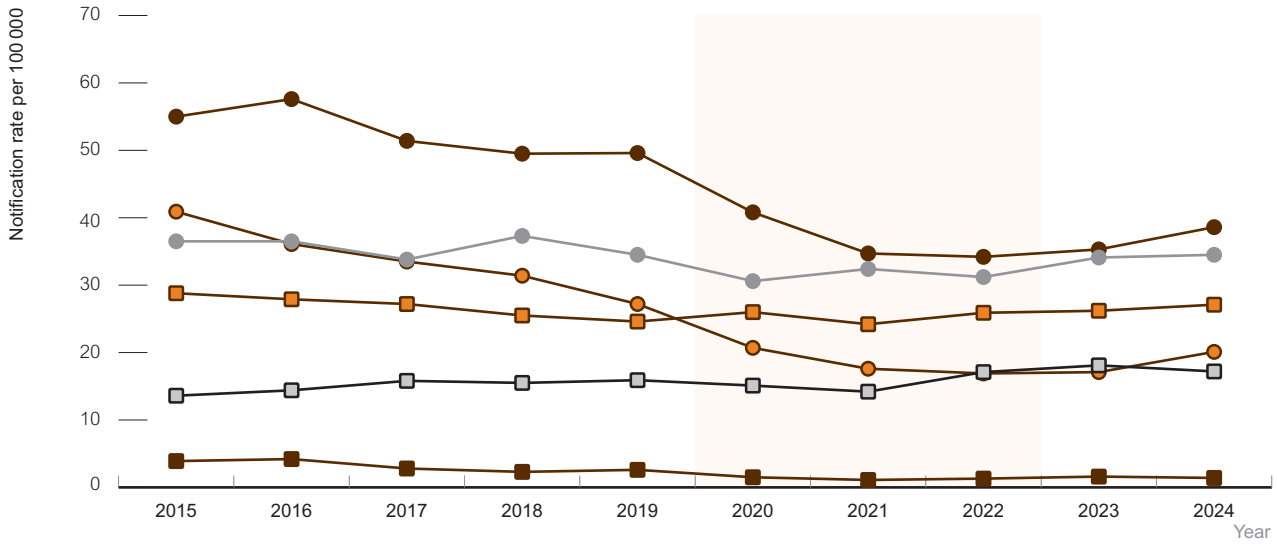
Source: Australian National Notifiable Diseases Surveillance System & The Australian Bureau of Statistics.

What does this mean?

The rate of hepatitis B diagnoses has declined since 2015. Males are diagnosed slightly more often than females.

In 2024, the highest notification rates were seen among those aged 30 to 39 years (38.6 per 100 000), 40 to 49 years (34.5 per 100 000), and 50 to 59 years (27.1 per 100 000). Between 2015 and 2024, hepatitis B notification rates declined overall, driven by declines among younger age groups. A decline of 51% was seen among those aged 20 to 29 years (from 40.9 to 20.1 per 100 000), 60% among those aged under 20 years (from 4.1 to 1.6 per 100 000) and 40% among those aged 30 to 39 years (from 55.0 to 38.6 per 100 000) (Figure 2). In the same period, the notification rate fluctuated among those aged 40 to 49 years (34.5 per 100 000 in 2024) and those aged 50 to 59 years (27.1 per 100 000). Among those aged 60 years and older, the notification rate increased by 26% from 13.6 per 100 000 in 2015 to 17.2 per 100 000 in 2022. The greater declines seen among the younger age groups are likely due to hepatitis B immunisation, introduced nationally for infants in Australia in 2000, and in many countries with high migration to Australia in the 1990s (Figure 2). Detailed breakdowns of notification rates by gender and age are available on the Kirby Institute data site.

Figure 2 Hepatitis B notification rate per 100 000 population by age group, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
<20	3.9	4.2	2.8	2.3	2.6	1.5	1.1	1.3	1.6	1.4
20–29	40.9	36.1	33.5	31.4	27.2	20.7	17.6	16.9	17.1	20.1
30–39	55.0	57.6	51.4	49.5	49.6	40.8	34.7	34.2	35.3	38.6
40–49	36.5	36.5	33.8	37.3	34.5	30.6	32.4	31.2	34.1	34.5
50–59	28.8	27.9	27.2	25.5	24.6	26.0	24.2	25.9	26.2	27.1
60+	13.6	14.4	15.8	15.5	15.9	15.1	14.2	17.1	18.1	17.2

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

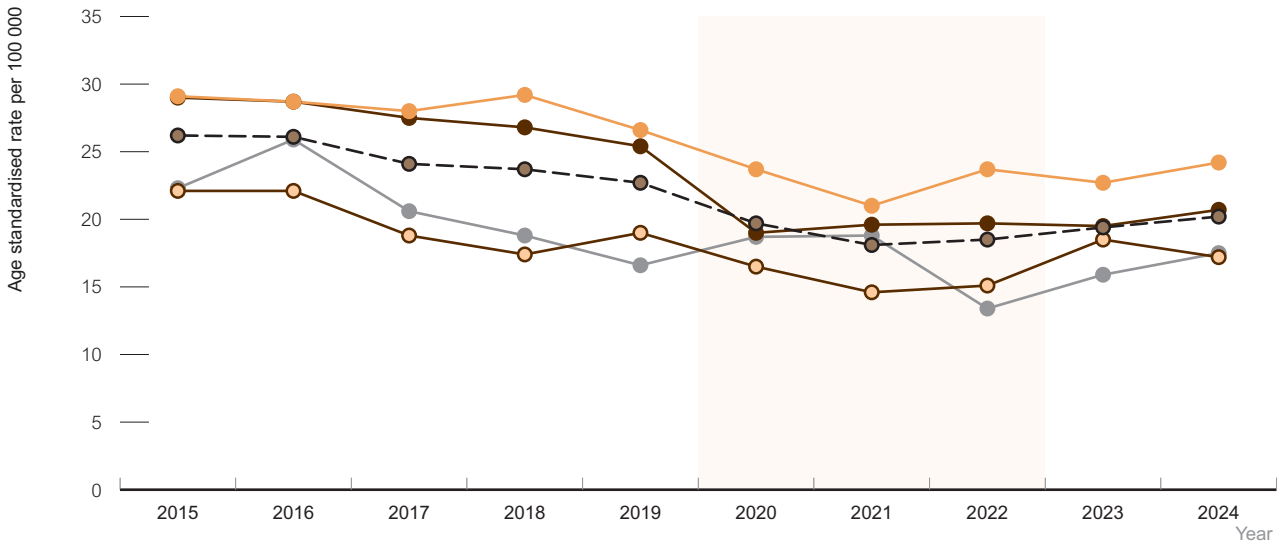
Source: Australian National Notifiable Diseases Surveillance System & The Australian Bureau of Statistics.

What does this mean?

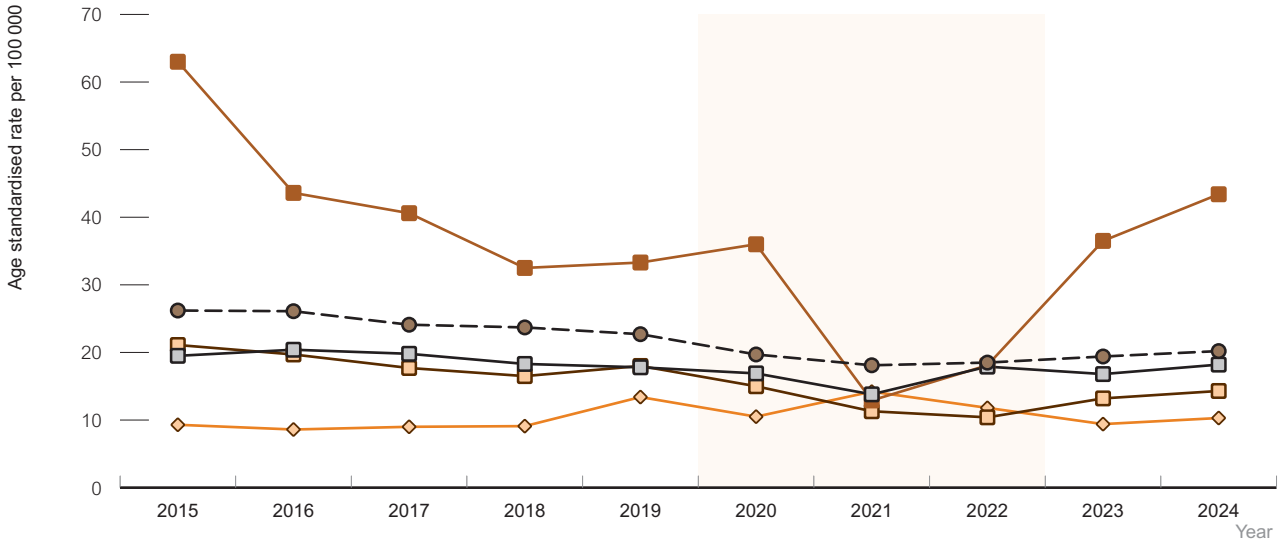
Since 2015, hepatitis B diagnoses have decreased across all age groups under 40 years, especially for people aged under 30 years.

The hepatitis B notification rate declined in every state and territory between 2015 and 2024 apart from Tasmania (11% increase, though noting low case numbers). The greatest declines were observed in South Australia (32%), the Northern Territory (31%), Victoria (29%), and Western Australia (22%). In 2024, the highest notification rates were observed in the Northern Territory (43.4 per 100 000), New South Wales (24.2 per 100 000), and Victoria (20.7 per 100 000) (Figure 3). These jurisdictions are estimated to have the highest prevalence of hepatitis B, due to the geographic distribution of priority populations such as those born overseas and Aboriginal and Torres Strait Islander people [2].

Figure 3 Hepatitis B notification rate per 100 000 population by state/territory, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
NSW	29.1	28.7	28.0	29.2	26.6	23.7	21.0	23.7	22.7	24.2
QLD	22.1	22.1	18.8	17.4	19.0	16.5	14.6	15.1	18.5	17.2
VIC	29.0	28.7	27.5	26.8	25.4	19.0	19.6	19.7	19.5	20.7
WA	22.3	25.9	20.6	18.8	16.6	18.7	18.8	13.4	15.9	17.5
Australia	26.2	26.1	24.1	23.7	22.7	19.7	18.1	18.5	19.4	20.2



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
ACT	19.5	20.4	19.8	18.3	17.8	16.9	13.8	17.9	16.8	18.2
NT	63.0	43.6	40.6	32.5	33.3	36.0	12.9	18.1	36.5	43.4
SA	21.1	19.7	17.7	16.5	18.0	15.0	11.3	10.4	13.2	14.3
TAS	9.3	8.6	9.0	9.1	13.4	10.5	14.2	11.8	9.4	10.3
Australia	26.2	26.1	24.1	23.7	22.7	19.7	18.1	18.5	19.4	20.2

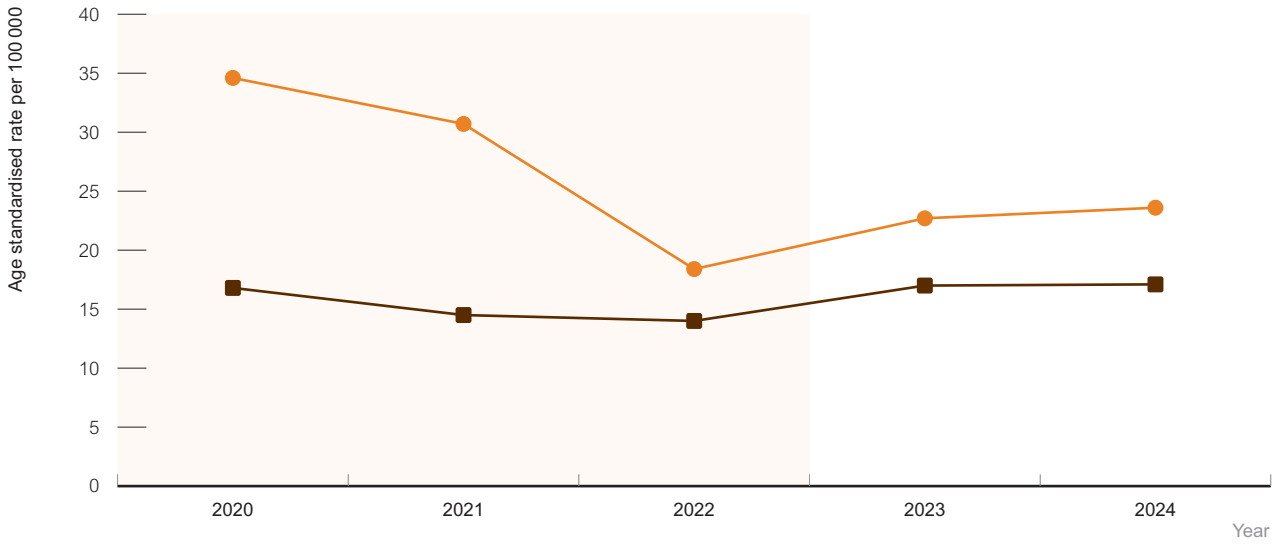
Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: Australian National Notifiable Diseases Surveillance System & The Australian Bureau of Statistics.

The hepatitis B notification rate among Aboriginal and Torres Strait Islander peoples is based on data from five jurisdictions (Australian Capital Territory, Northern Territory, Queensland, South Australia, and Western Australia), where Aboriginal and Torres Strait Islander status was reported for at least half of all hepatitis B notifications for each of the five years (2020 – 2024). Approximately 50% of Aboriginal and Torres Strait Islander peoples reside in these jurisdictions, so it is important to note that the notification rates presented below are not necessarily nationally representative.

In 2024, the hepatitis B notification rate was 40% higher among Aboriginal and Torres Strait Islander peoples (23.6 per 100 000) compared with non-Indigenous people (17.1 per 100 000) (Figure 4). Among Aboriginal and Torres Strait Islander peoples in the reported jurisdictions, the notification rate declined by 32% from 34.6 per 100 000 in 2020 to 23.6 per 100 000 in 2024. Over the same period the hepatitis B notification rate among non-Indigenous people fluctuated and was 17.1 per 100 000 in 2024. For further information on hepatitis B notification rates by Aboriginal and Torres Strait Islander status and age, please refer to the Kirby Institute data site and the *Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander peoples: Annual surveillance report 2025* [3].

Figure 4 Hepatitis B notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, 2020 – 2024



	2020	2021	2022	2023	2024
Aboriginal and Torres Strait Islander	34.6	30.7	18.4	22.7	23.6
Non-Indigenous	16.8	14.5	14.0	17.0	17.1

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

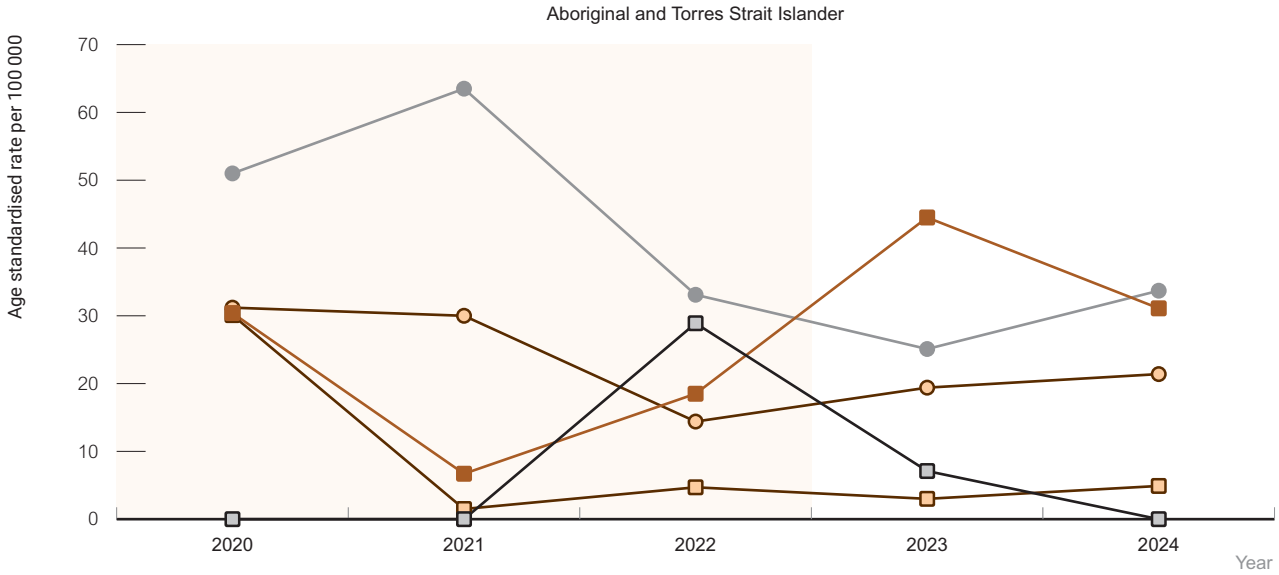
Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, and Western Australia) & The Australian Bureau of Statistics.

What does this mean?

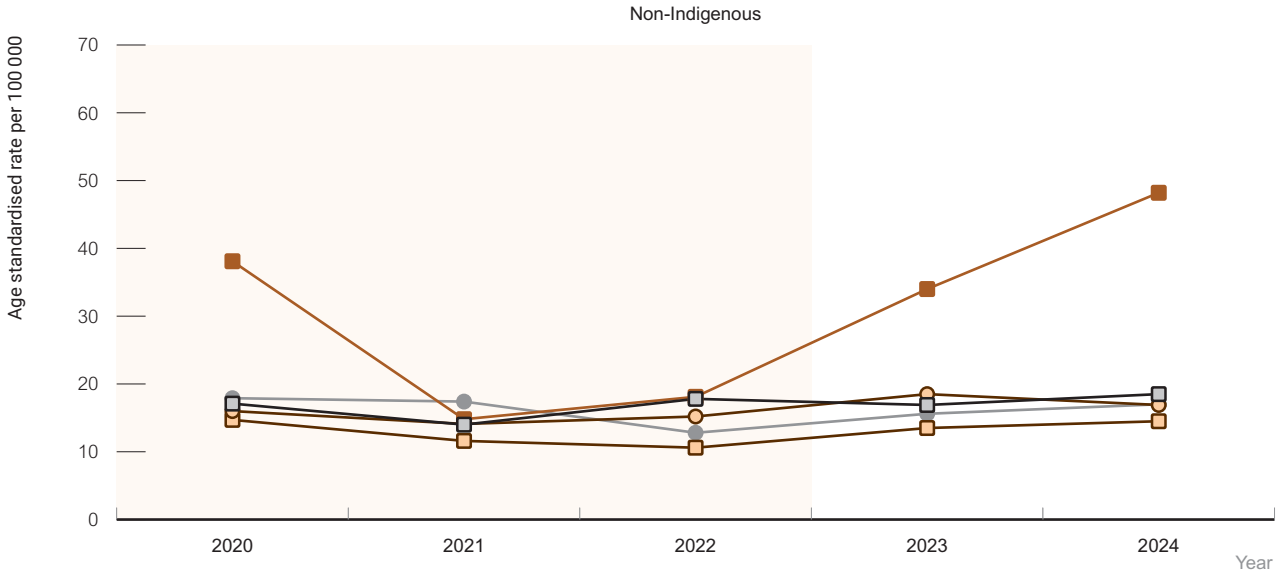
The Hepatitis B diagnosis rate has declined since 2020 among both among Aboriginal and Torres Strait Islander peoples and non-Indigenous people.

Higher rates of newly diagnosed hepatitis B among Aboriginal and Torres Strait Islander populations compared to the non-Indigenous population reflects the higher prevalence of chronic hepatitis B among Aboriginal and Torres Strait Islander peoples. This relates to historical vertical and early childhood transmission, particularly in the pre-vaccine era, with some additional infections through sexual and blood contact in adolescence and adulthood [4]. Aboriginal and Torres Strait Islander peoples also have higher rates of risk factors for adult hepatitis B acquisition which reflect ongoing consequences of colonisation and the Stolen Generation. However, it should be acknowledged that among the jurisdictions reported, the gap between the Aboriginal and Torres Strait Islander notification rate and the non-Indigenous notification rate in 2024 has reduced since 2020. This trend may be partly due to high hepatitis B vaccination rates among Aboriginal and Torres Strait Islander peoples (See Hepatitis B prevention). In the Northern Territory, the Hep B PAST Study, may have increased the number of hepatitis B notifications over the reporting period. Between 2020 and 2024 hepatitis B notification rates fluctuated in every reported state and territory (Figure 5).

Figure 5 Hepatitis B notification rate per 100 000 by state/territory and Aboriginal and Torres Strait Islander status, 2020 – 2024



	2020	2021	2022	2023	2024
ACT	0.0	0.0	28.9	7.1	0.0
NT	30.4	6.7	18.5	44.5	31.1
QLD	31.2	30.0	14.4	19.4	21.4
SA	30.1	1.5	4.7	3.0	4.9
WA	51.0	63.5	33.1	25.1	33.7



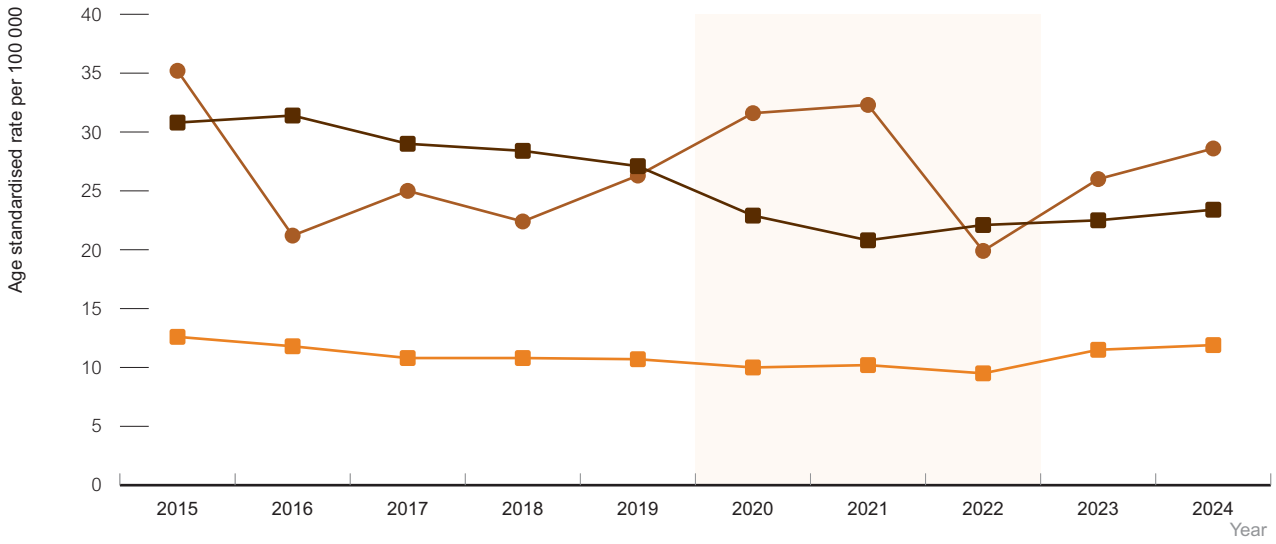
	2020	2021	2022	2023	2024
ACT	17.1	14.0	17.8	16.9	18.5
NT	38.1	14.8	18.1	34.0	48.2
QLD	16.0	14.1	15.2	18.5	16.9
SA	14.7	11.6	10.6	13.5	14.5
WA	17.9	17.4	12.8	15.6	17.0

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: Australian National Notifiable Diseases Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for ≥50% of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, Tasmania, and Western Australia) & The Australian Bureau of Statistics.

Hepatitis B notification rates were higher in 2024 among people residing in major cities (23.4 per 100 000) and remote areas (28.6 per 100 000) than in regional areas (11.9 per 100 000). Between 2015 and 2024, the hepatitis B notification rate declined by 19% in remote areas, 24% in major cities, and remained stable in regional areas (Figure 6). The differing rates in decline may relate to a combination of the variation in levels of overseas immigration between areas and the implementation of Australian hepatitis B immunisation programs (see Figure 10). These patterns were similar among males and females, with notification rates lowest in regional areas for both genders. Due to small numbers of hepatitis B notifications by Aboriginal and Torres Strait Islander status and region of residence, trends over time should be interpreted with caution. For breakdowns of notification rates by gender and remoteness area please see the Kirby Institute data site.

Figure 6 Hepatitis B notification rate per 100 000 population by region of residence, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Major cities	30.8	31.4	29.0	28.4	27.1	22.9	20.8	22.1	22.5	23.4
Regional	12.6	11.8	10.8	10.8	10.7	10.0	10.2	9.5	11.5	11.9
Remote	35.2	21.2	25.0	22.4	26.3	31.6	32.3	19.9	26.0	28.6

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: Australian National Notifiable Diseases Surveillance System.

4 Number of people living with hepatitis B and prevalence

Number of people living with hepatitis B

Estimates included in this report are derived using a mathematical model for the natural history of hepatitis B in Australia. To ensure estimates most accurately reflect the current epidemiology and clinical pattern of chronic hepatitis B in Australia, data inputs and assumptions are updated annually to incorporate new information. For this reason, historical indicator estimates provided in this report may differ from those in previous reports. These data as well as more detailed data relating to hepatitis B are generated and published by the WHO Collaborating Centre for Viral Hepatitis at the Doherty Institute as part of the National Surveillance for Hepatitis B Indicators Project and the Viral Hepatitis Mapping Project.

At the end of 2024, there were an estimated 227 571 people living with chronic hepatitis B in Australia. Of those, an estimated 166 056 (73%) were born overseas, 32 510 (14%) were Australian-born non-Indigenous people, and 14 928 (7%) were Aboriginal and/or Torres Strait Islander people (Table 2). People born in Southeast Asia and Northeast Asia, together with Aboriginal and Torres Strait Islander peoples, represent 10% of the Australian population [4], but account for more than half of all people living with chronic hepatitis B in Australia. The estimated proportion of people living with hepatitis B was also higher among people who inject drugs (6065, 3% of people living with chronic hepatitis B) and gay and bisexual men (8012, 4% of people living with chronic hepatitis B). Prevalence estimates among overseas-born Australians largely mirror the prevalence in their regions of origin, which is particularly high in parts of the Asia–Pacific. (Figure 7).

Table 2 Estimated number of people living with chronic hepatitis B and estimated prevalence by region of birth, 2024

Population	People living with chronic hepatitis B	Proportion of all people living with chronic hepatitis B	Hepatitis B prevalence
Total	227 571	100%	0.80%
Other Australian-born non-Indigenous[a]	32 510	14.30%	0.20%
Born in Northeast Asia	54 153	23.80%	4.90%
Born in Southeast Asia	52 275	22.90%	3.90%
Born in Sub-Saharan Africa	11 330	5.00%	2.40%
Other regions of birth	47 083	21.20%	0.80%
Aboriginal and/or Torres Strait Islander people	14 928	6.50%	1.40%
People who inject drugs	6 065	2.70%	2.40%
Gay and bisexual men[b]	8 012	3.50%	2.10%

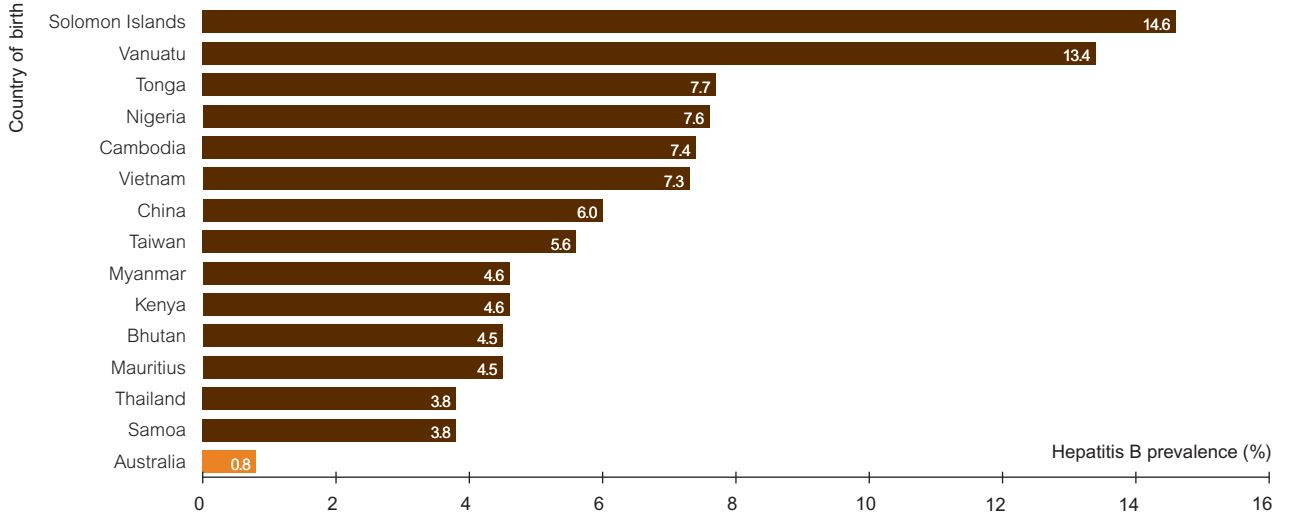
Note: Although people may belong to more than one subgroup, they are allocated only one in the model, due to lack of data about overlapping risks. Estimates are for Australian-born non-Indigenous people due to prioritisation of country of birth and Aboriginal and Torres Strait Islander status as risk factors. Estimates for this population based on sexual behaviour data from the Second Australian Study of Health and Relationships.

a Estimates are for Australian-born non-Indigenous people due to prioritisation of country of birth and Aboriginal and Torres Strait Islander status as risk factors.

b Estimates for this population based on sexual behaviour data from the Second Australian Study of Health and Relationships.

Source: National Surveillance for Hepatitis B Indicators Project, WHO Collaborating Centre for Viral Hepatitis, Doherty Institute.

Figure 7 Estimated prevalence of chronic hepatitis B infection among Australians born overseas by country of birth, 2024

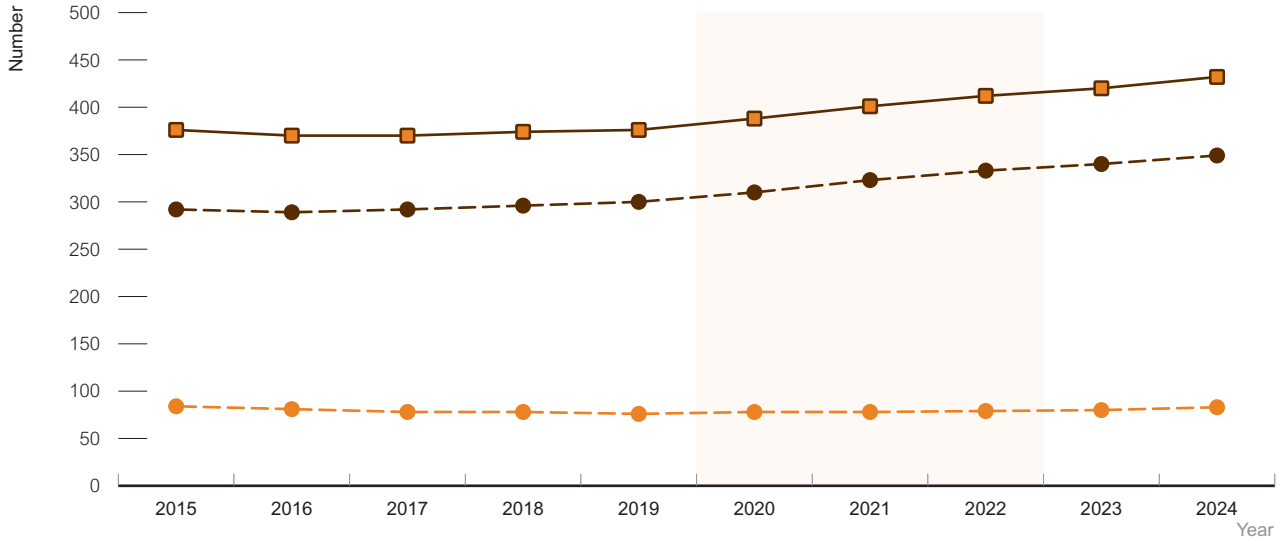


Source: Adjusted Australian antenatal prevalence data [5,6], international population seroprevalence data [7,8], generated by the National Viral Hepatitis Mapping Project, WHO Collaborating Centre for Viral Hepatitis, Doherty Institute.

Hepatitis B morbidity

The total number of estimated attributable deaths has changed over time, decreasing during the mid-2000s due to the introduction of effective antiviral treatment and the resulting reduction in mortality associated with chronic hepatitis B among people at greatest risk of adverse outcomes. In recent years, the number of deaths has plateaued and even begun to increase rather than continue declining, partly due to population ageing, population growth, and insufficient increases in treatment uptake. There were an estimated 432 deaths attributable to chronic hepatitis B in 2024, with most deaths attributed to hepatocellular carcinoma (349 deaths), compared with decompensated cirrhosis (83 deaths) (Figure 8).

Figure 8 Estimated number of deaths due to chronic hepatitis B, 2015 – 2024



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Deaths due to decompensated cirrhosis	84	81	78	78	76	78	78	79	80	83
Deaths due to hepatocellular carcinoma	292	289	292	296	300	310	323	333	340	349
Total deaths	376	370	370	374	376	388	401	412	420	432

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: National Viral Hepatitis Mapping Project, WHO Collaborating Centre for Viral Hepatitis, Doherty Institute.

There is no comprehensive registry of advanced liver disease related to hepatitis B in Australia. One indicator of the extent of liver disease caused by hepatitis B is the number of liver transplants due to chronic hepatitis B infection. Of the 223 liver transplants in 2024, seven (3%) were attributable to chronic hepatitis B infection. Many factors influence the selection of candidates for transplant, and the numbers may not necessarily reflect the overall morbidity and mortality attributable to individual causes of liver disease. For detailed information relating to chronic hepatitis B among liver transplant patients, please see the Kirby Institute data site.

5 Hepatitis B testing and care

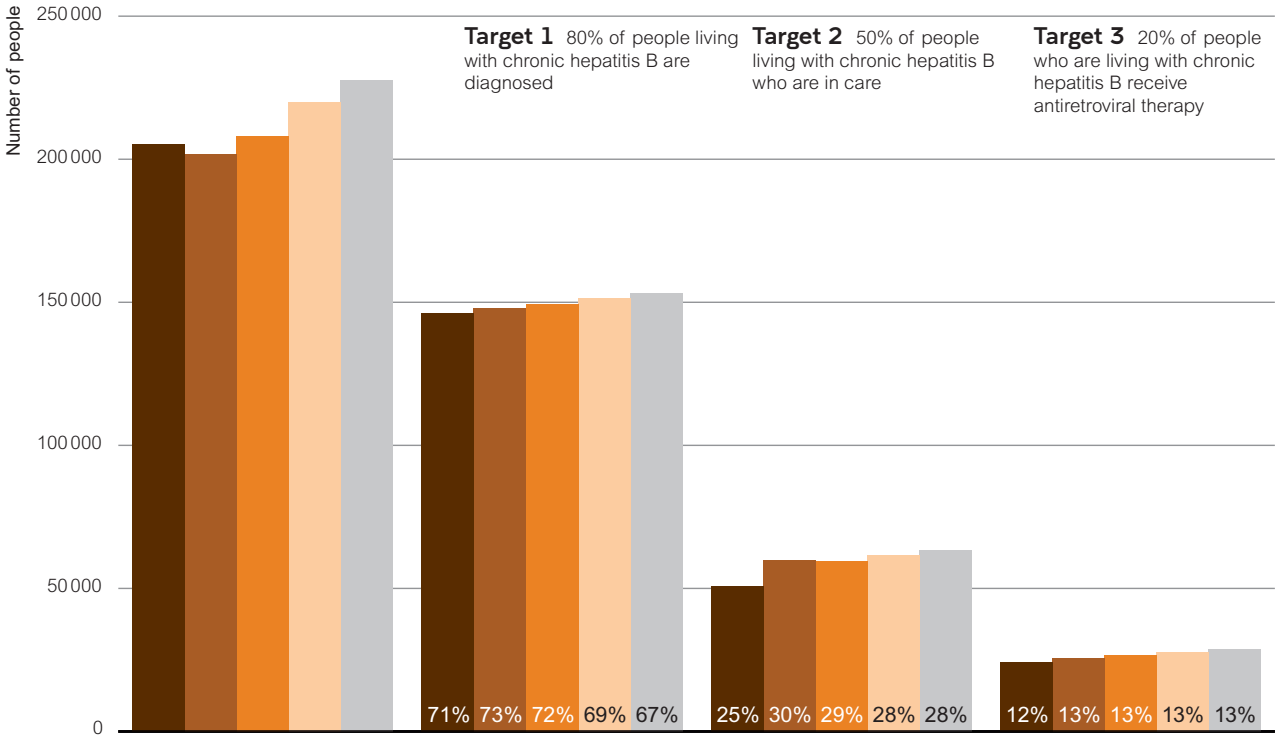
The hepatitis B diagnosis and care cascade

This section includes the hepatitis B diagnosis and care cascade, which estimates the number of people living with chronic hepatitis B infection in Australia, number diagnosed, number retained in care and number receiving antiviral treatment.

These estimates are produced by the WHO Collaborating Centre for Viral Hepatitis at the Doherty Institute and are intended to support improvements in the delivery of services to people with hepatitis B infection. Proportions of people in each stage of the cascade in Australia were estimated using mathematical modelling, notifications, and Medicare data. The approach was informed by recommendations from a national stakeholder reference group (see Methodology for further detail).

At the end of 2024, an estimated 227 571 people were living with chronic hepatitis B in Australia. Of those, an estimated 153 286 (67%) were diagnosed, 63 444 (28% of those living with chronic infection) received care (viral load monitoring or received antiviral therapy), and 28 805 (13% of those living with chronic infection) received antiviral therapy (Figure 9). It is estimated a further 38 959 treatment-eligible people living with hepatitis B did not receive antiviral treatment (for data please refer to the *National Surveillance for Hepatitis B Indicators Project Report*).

Figure 9 The hepatitis B diagnosis and care cascade, 2020 – 2024



	Living with hepatitis B infection	Diagnosed with hepatitis B infection	Receiving care	Received treatment
2020	205 264	146 254	50 978	24 300
2021	201 991	147 886	60 073	25 724
2022	208 155	149 267	59 517	26 617
2023	220 092	151 355	61 536	27 641
2024	227 571	153 286	63 444	28 805

Note: Due to updated modelling methods, estimates may be different from figures presented in previous years of reporting.

Source: National Surveillance for Hepatitis B Indicators Project, WHO Collaborating Centre for Viral Hepatitis, Doherty Institute.

Hepatitis B treatment

While treatment for hepatitis B is not curative, it can reduce morbidity and mortality associated with infection. Treatment controls viral replication and resulting liver damage, which profoundly reduces progression to advanced liver disease and hepatocellular carcinoma. In general, people who are chronically infected but do not have any signs of significant viral replication or active liver damage do not need treatment. However, it is important to closely monitor liver health with regular (at least annual) liver function tests, liver fibrosis assessment, and quantitative viral DNA tests. Treatment for hepatitis B should be considered for people with elevated hepatitis B viral load, abnormal liver function tests, or significant liver fibrosis.

From the start of 2020 to the end of 2024, there was a 19% increase in the number of people who were dispensed hepatitis B antiviral treatment, from 24 300 to 28 805 (see Figure 9). However, the population of people living with chronic hepatitis B increased in the reporting period (see The hepatitis B diagnosis and care cascade), and the proportion of people on treatment remains substantially below the target level. Treatment for hepatitis B in Australia is most commonly first line antiviral monotherapy; data regarding hepatitis B treatment by drug class is available in the *National Surveillance for Hepatitis B Indicators Report 2024*.

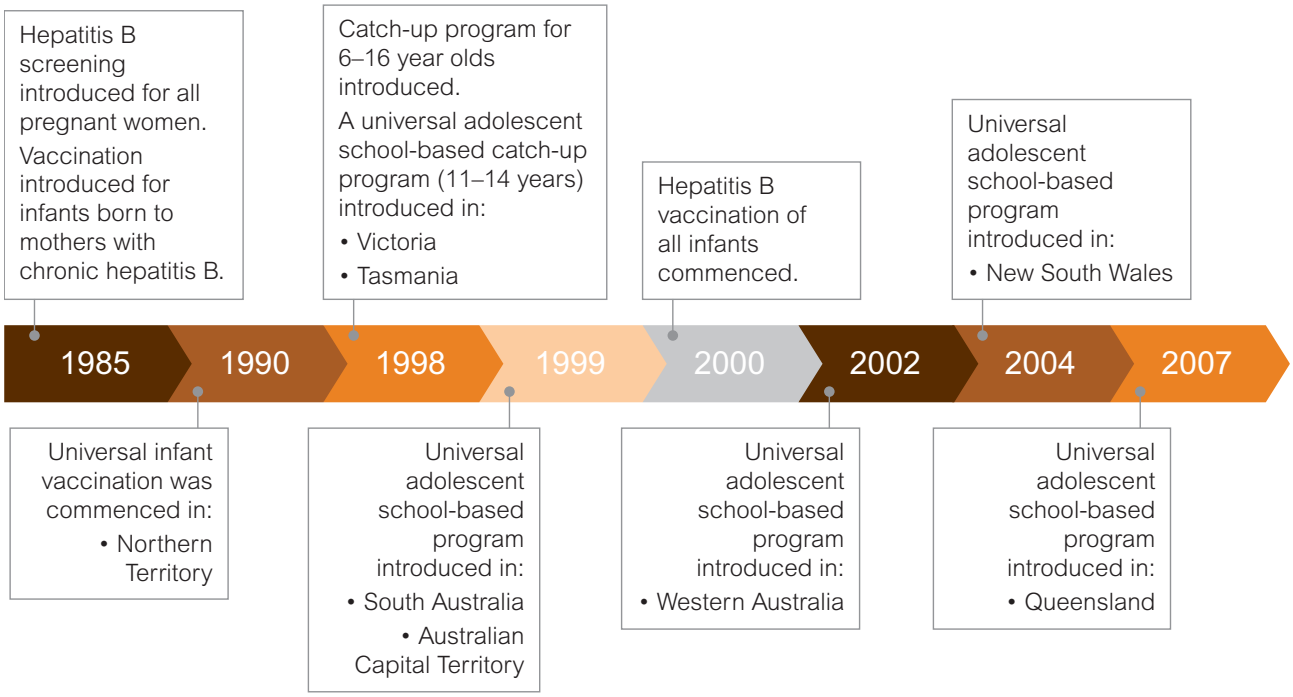
6 Hepatitis B prevention

Vaccination is the cornerstone of hepatitis B primary prevention. Other strategies to protect people from acquiring hepatitis B infection include use of sterile needles and syringes and ancillary equipment among people who inject drugs, condom use, universal precautions in healthcare settings, interventions for pregnant women living with chronic hepatitis B and their babies, and screening of blood donors [9]. Secondary prevention strategies to reduce the risk of progression to hepatocellular carcinoma include improving access to diagnosis, monitoring, and antiviral treatment for those with evidence of active liver disease.

Hepatitis B vaccination

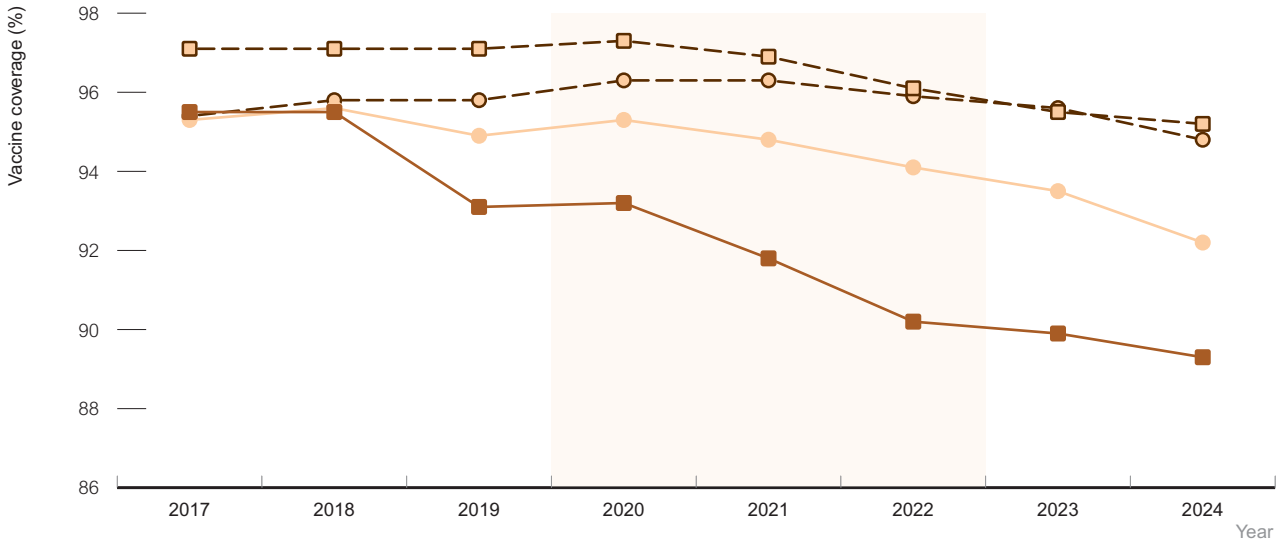
Patterns of hepatitis B infection in Australia should be interpreted with knowledge of the history of hepatitis B immunisation programs. In the Northern Territory, hepatitis B screening was introduced for all pregnant women and vaccination to infants born to mothers living with chronic infection in 1985; universal infant vaccination was implemented in 1990, and a catch-up program for children aged 6 to 16 years was introduced in 1998. In other states and territories, hepatitis B vaccination of all infants commenced in 2000, and a universal adolescent (children aged 11 to 14 years) school-based hepatitis B vaccination catch-up program commenced in 1998 in Victoria and Tasmania, in 1999 in South Australia and the Australian Capital Territory, in 2002 in Western Australia, in 2004 in New South Wales, and in 2007 in Queensland (Figure 10) [10].

Figure 10 Roll-out of hepatitis B vaccination in Australia, by year



Between 2017 and 2024, hepatitis B vaccination coverage rates for non-Indigenous children aged 12 months declined from 95.5% to 92.2% (Figure 11). Among Aboriginal and Torres Strait Islander children aged 12 months, the vaccination coverage rate declined from 95.5% in 2017 to 89.3% in 2024. Among Aboriginal and Torres Strait Islander children aged 24 months, vaccination coverage rates remained over 95% between 2017 and 2024, reaching 95.2% in 2024. Among non-Indigenous children aged 24 months, the vaccination coverage rate dropped below 95% for the first time over the reporting period in 2024 (94.8%) Overall vaccination coverage rates have declined since 2020. The National Vaccination Insights Project has been established to gain insights into barriers to completing vaccination schedules and inform the development of strategies to improve vaccination uptake.

Figure 11 Hepatitis B vaccination coverage estimates at 12 and 24 months by Aboriginal and Torres Strait Islander status, 2017 – 2024



	2017	2018	2019	2020	2021	2022	2023	2024
Aboriginal and Torres Strait Islander 12 months (%)	95.5	95.5	93.1	93.2	91.8	90.2	89.9	89.3
Aboriginal and Torres Strait Islander 24 months (%)	97.1	97.1	97.1	97.3	96.9	96.1	95.5	95.2
Non-Indigenous 12 months (%)	95.3	95.6	94.9	95.3	94.8	94.1	93.5	92.2
Non-Indigenous 24 months (%)	95.4	95.8	95.8	96.3	96.3	95.9	95.6	94.8

Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: National Centre for Immunisation Research and Surveillance Australia; see Methodology for detail.

What does this mean?

The hepatitis B vaccination rate has declined since 2017, particularly among infants aged 12 months.

References

1. MacLachlan J, Allard N, Carville K, Haynes K, Cowie B. Mapping progress in chronic hepatitis B: geographic variation in prevalence, diagnosis, monitoring and treatment, 2013-15. Aust N Z J Public Health. 2018 Feb;42(1):1. doi:10.1111/1753-6405.12693 PubMed PMID: 28712127.
2. MacLachlan J, Purcell I, Mondel A, Cowie B. Viral Hepatitis Mapping Project: Hepatitis C National Report 2023–2024 [Internet]. Darlinghurst NSW Australia: ASHM; 2025. Report No. Available from: https://ashm.org.au/vh-mapping-project/
3. Naruka E, Miller A, Thomas J, McGregor S, Monaghan R. Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people Annual Surveillance Report 2025. Sydney, Australia: Kirby Institute, UNSW Sydney; 2025. Report No.
4. Graham S, MacLachlan JH, Gunaratnam P, Cowie BC. Chronic hepatitis B prevalence in Australian Aboriginal and Torres Strait Islander people before and after implementing a universal vaccination program: a systematic review and meta-analysis. Sex Health. 2019 Jun;16(3):3. doi:10.1071/SH18150 PubMed PMID: 31141676.
5. Reekie J, Gidding HF, Kaldor JM, Liu B. Country of birth and other factors associated with hepatitis B prevalence in a population with high levels of immigration. Journal of Gastroenterology and Hepatology. 2013 Sep;28(9):9.
6. He WQ, Duong MC, Gidding H, MacLachlan J, Wood J, Kaldor JM, et al. Trends in chronic hepatitis B prevalence in Australian women by country of birth, 2000 to 2016. Journal of Viral Hepatitis. 2020;27(1):1. doi:10.1111/jvh.13202
7. Schweitzer A. Worldwide prevalence of chronic hepatitis B virus infection: estimations based on a systematic review of data published between 1965 and 2013. The Lancet. 2015;online.
8. Kowdley KV, Wang CC, Welch S, Roberts H, Brosgart CL. Prevalence of chronic hepatitis B among foreign-born persons living in the United States by country of origin. Hepatology. 2012 Aug;56(2):2. doi:10.1002/hep.24804
9. World Health Organization. Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. Geneva: WHO; 2015. Report No.
10. National Centre for Immunisation Research and Surveillance. Significant events in hepatitis B vaccination practice in Australia. Sydney: NCIRS; 2015. Report No.