



UNSW
Kirby Institute

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



Hepatitis C



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HIV, viral hepatitis and sexually transmissible infections in Australia

Annual surveillance report 2025

Kirby Institute, UNSW Sydney

Prepared by:

Jonathan King
Jisoo Amy Kwon
Richard Gray
Hamish McManus
Skye McGregor

Other contributors:

- Australian Government Department of Health, Disability and Ageing
- State/territory health departments
- Brynley Hull, Aditi Dey, National Centre for Immunisation Research and Surveillance
- Gladymar Perez Chacon, Hamish McManus, Cassandra Bull, Ela Naruka, Jackie Thomas, Behzad Hajarzadeh, Htein Linn Aung, Heather Valerio, Gregory Dore, Lisa Maher, Bradley Mathers, Sue Heard, Curtis Chan, Kathy Petoumenos, Nicholas Medland, The Kirby Institute, UNSW Sydney
- Anh Nguyen, Jennifer MacLachlan, Nicole Romero, Benjamin Cowie, WHO Collaborating Centre for Viral Hepatitis, Victorian Infectious Diseases Reference Laboratory, The Doherty Institute
- Anna Wilkinson, Jason Asselin, Michael Traeger, Mark Stoové, Margaret Hellard, Burnet Institute
- Wing-Yee Lo, Australia and New Zealand Liver and Intestinal Transplant Registry
- Timothy Broady, Centre for Social Research in Health, UNSW Sydney
- Monica Lahra, WHO Collaborating Centre for STI and AMR Microbiology, NSW Health Pathology
- John Didlick, Hepatitis Australia

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

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Design il Razzo, Email: admin@ilrazzo.com.au

Kirby Institute UNSW Sydney NSW 2052

Telephone: 02 9385 0900 (International +61 2 9385 0900)

Email: info@kirby.unsw.edu.au

Hepatitis C

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 from 2015 to 2024. Data with which to assess progress towards national and global hepatitis C elimination targets are presented in Australia's progress towards hepatitis C elimination: annual report 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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Abbreviations

ABS	Australian Bureau of Statistics
ACCESS	Australian Collaboration for Coordinated Enhanced Sentinel Surveillance
ANSPS	Australian Needle Syringe Program Survey
DAA	interferon-free direct-acting antiviral therapy

1 Summary data

Hepatitis C notifications

- In 2024, there were 7281 hepatitis C notifications in Australia. Of these, 70% (5130) were among males, 47% (3428) were among people aged 25 to 44 years, and 58% (4208) were among people residing in major cities.
- The hepatitis C notification rate declined by 39% between 2015 and 2024, from 43.2 to 26.3 per 100 000 population. Notification rates declined among all age groups except those aged 65 years and older, for whom the rate increased by 75%.
- Among the age group most likely to have acquired hepatitis C recently, people aged 15 to 24 years, the notification rate declined by 39% between 2015 and 2024, from 36.8 to 22.3 per 100 000.
- Over this period, the notification rate among females aged 18-24 years declined by 64% (from 25.0 to 8.9 per 100 000), while the rate among males aged 18-24 years declined by 28% (from 48.1 to 34.7 per 100 000).
- Between 2020 and 2024, among Aboriginal and Torres Strait Islander people aged 15 to 24 years, the notification rate declined by 19% from 266.4 to 216.5 per 100 000. In 2024 among people aged 15 to 24 years, the notification rate among Aboriginal and Torres Strait Islander peoples was more than eleven times as high as among non-Indigenous people (216.5 and 18.9 per 100 000, respectively).

Testing

- Among people who inject drugs and attend clinics in the Australian Collaboration for Coordinated Enhanced Sentinel Surveillance (ACCESS), the proportion who received a hepatitis C test in the past 12 months fluctuated between 49% and 61% and was 52% in 2024. However, a decline in the number of people attending clinics in the ACCESS network since the start of the COVID-19 pandemic means that overall testing numbers in this group declined from 2020.
- Data from the Australian Needle Syringe Program Survey (ANSPS) indicate that in 2024, about half (49%) of survey respondents reported a hepatitis C antibody test in the previous 12 months, a decline from proportions in 2015 to 2019 (range: 53% to 55%). Since the beginning of the COVID-19 pandemic in 2020, the proportion reporting a hepatitis C antibody test among this cohort has remained stable between 47% and 49%.

Incidence, prevalence, and morbidity

- Between 2015 and 2024, among people living with chronic hepatitis C as well as those cured, the estimated number with hepatitis C-related cirrhosis increased by 52% (from 18 730 to 28 440). In this period, there was a 36% decrease in the estimated number of people living with hepatitis C and with associated cirrhosis, from 17 090 to 10 990.
- According to modelled estimates, between 2015 and 2024, incident hepatitis C infections decreased by 75% from 5 530 to 1 370. In the same period, among incident infections, the proportion of reinfections increased from 0% to 61%, while the proportion of primary incident infections decreased from 100% to 39%.
- Between 2015 and 2024, among people tested at ACCESS primary care sites with high caseloads of people with a history of injection drug use, there were 135 seroconversions during 395.9 person-years at risk. Over this period, hepatitis C incidence within this cohort decreased from 0.7 to 0.2 new infections per 100 person-years.
- Among ANSPS participants, hepatitis C RNA prevalence (an indicator current hepatitis C infection), was 8% in 2024, down from 55% in 2015.
- Between 2015 and 2024, the number of people receiving liver transplants due to hepatitis C-related cirrhosis and hepatitis C-related hepatocellular carcinoma reduced by 88% and 59%, respectively.
- The estimated number of hepatitis C-related deaths (among people living with hepatitis C and people cured of hepatitis C) decreased by 22% from 730 in 2015 to 570 in 2024.
- Of the estimated 62 880 people living with chronic hepatitis C at the end of 2024, an estimated 55 610 (88%) had been diagnosed, and 41 710 (75% of those diagnosed) had their hepatitis C diagnosis confirmed with an RNA test.

Treatment

- According to modelled estimates, of the 67 970 people living with chronic hepatitis C at the start of 2024 (end of 2023), 5240 people (8%) received initial hepatitis C treatment during 2024 and 4920 (94% of those treated) were cured. A further 3 026 people (4%) received retreatment, of whom 1860 (61%) received treatment following reinfection with 1 750 people cured of their reinfection.
- Among participants in the ANSPS in 2024 with a self-reported history of chronic hepatitis C, 78% reported ever receiving hepatitis C treatment, an increase from 11% in 2015 and the highest proportion over the reporting period.

Injecting risk behaviour

- The reuse of needles and syringes that have been used by others (receptive syringe sharing) by people who inject drugs is a major risk factor for transmission of hepatitis C. The proportion of ANSPS respondents who reported receptive syringe sharing in the past month generally stable between 2015 and 2024 and was 19% in 2024.

2 Interpretation

Overall, the number of hepatitis C notifications in Australia has declined since 2016 when subsidised interferon-free direct-acting antiviral (DAA) therapy became available through the Pharmaceutical Benefits Scheme. This highly curative therapy has also resulted in a marked decline in the prevalence of people living with hepatitis C. Among people who inject drugs participating in the Australian Needle Syringe Program Survey (ANSPS), hepatitis C RNA prevalence declined from 55% in 2015 to 8% in 2024. This major decline in prevalence is contributing to reduced community hepatitis C transmission, and a decline in the burden of disease among people who inject drugs.

Among people who inject drugs participating in the ANSPS and with a history hepatitis C, the proportion who also report receiving treatment in their lifetime increased from 11% in 2015 to 78% in 2024, the highest proportion on record. Strategies are needed to further raise awareness among the wider community and health sector about the need for testing and availability of highly curative hepatitis C treatments to eliminate hepatitis C as a public health threat by 2030, in line with Australian Government and World Health Organization targets. Although 111 184 people have received highly curative DAA therapies, the number of people initiating therapy each year has steeply declined since 2016. Efforts must be redoubled to support all people with chronic hepatitis C to achieve a cure through DAA therapy.

Hepatitis C notification rates remain more than seven times as high among Aboriginal and Torres Strait Islander peoples compared with non-Indigenous people, suggesting higher rates of injection drug use and/or less harm reduction coverage. Given the high proportion of hepatitis C notifications without a reported Aboriginal and Torres Strait Islander status, the actual hepatitis C-related burden of disease among Aboriginal and Torres Strait Islander peoples may be even higher. Better capture of Aboriginal and Torres Strait Islander status among notifications data is required to better measure the true impact of hepatitis C on Aboriginal and Torres Strait Islander communities.

Further, there is hyper-incarceration of Aboriginal and Torres Strait Islander peoples where access to evidence-based harm-reduction strategies is substantially limited. Therefore, there is a need to expand harm reduction strategies in prison settings, including the implementation of needle and syringe programs. More broadly, there is a need for harm reduction programs that are culturally safe, appropriate, and co-designed with Aboriginal and Torres Strait Islander communities both inside and outside prison environments.

3 Hepatitis C notifications

This section focuses on people notified with hepatitis C in Australia. There were 7281 hepatitis C notifications in Australia in 2024. In 2024, 5130 (70%) hepatitis C notifications were among males, 3428 (47%) were among people aged 25 to 44 years, and 4208 (58%) were among people residing in major cities. By Aboriginal and Torres Strait Islander status, 1527 (21%) notifications occurred among Aboriginal and Torres Strait Islander peoples, 3943 (54%) were among non-Indigenous people, and 1811 (25%) were among people for whom Aboriginal and Torres Strait Islander status was not reported. Aboriginal and Torres Strait Islander peoples comprise an estimated 3.8% of the Australian population ⁽¹⁾ meaning these notifications reflect a disproportionately high burden of disease (Table 1).

Table 1 Characteristics of new hepatitis C notifications, 2015 – 2024

Characteristic	Year of diagnosis									
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Total cases	10 245	12 552	10 410	9 535	9 120	8 021	7 498	6 738	7 655	7 281
Gender										
Female	3 452	4 173	3 285	2 989	2 824	2 488	2 376	2 061	2 104	2 121
Male	6 763	8 351	7 102	6 516	6 268	5 517	5 105	4 671	5 525	5 130
Not reported	30	28	23	30	28	16	17	6	26	30
Age group										
0–14	43	36	32	30	40	56	33	28	29	19
15–24	1 162	1 164	1 115	950	1 079	947	774	674	887	775
25–34	2 628	2 850	2 476	2 191	2 145	1 950	1 815	1 514	2 005	1 831
35–44	2 506	3 168	2 534	2 387	2 123	1 830	1 678	1 489	1 610	1 597
45–54	2 106	2 735	2 210	1 967	1 781	1 510	1 397	1 244	1 304	1 222
55–64	1 453	2 081	1 610	1 483	1 407	1 244	1 196	1 135	1 083	1 038
65+	344	517	432	525	545	483	605	653	735	797
Not reported	3	1	1	2	0	1	0	1	2	2
Aboriginal and Torres Strait Islander status										
Aboriginal and/or Torres Strait Islander	1 332	1 595	1 619	1 515	1 581	1 346	1 456	1 235	1 747	1 527
Non-Indigenous	4 906	5 993	5 533	5 253	4 817	4 021	3 933	3 509	4 121	3 943
Not reported	4 007	4 964	3 258	2 767	2 722	2 654	2 109	1 994	1 787	1 811
Area of residence										
Major cities	6 138	7 467	6 037	5 476	5 121	4 536	4 242	3 929	4 284	4 208
Regional	3 401	4 153	3 559	3 056	3 016	2 653	2 608	2 225	2 660	2 393
Remote	256	263	238	227	196	157	182	141	171	145
Not reported	450	669	576	776	787	675	466	443	540	535
State/Territory										
ACT	189	183	141	139	134	137	107	97	111	117
NSW	3 228	5 003	3 928	3 593	3 297	2 946	2 516	2 463	2 614	2 568
NT	200	194	151	147	133	104	105	77	97	82
QLD	2 508	2 747	2 346	2 132	2 361	2 154	2 081	1 764	2 256	2 000
SA	533	543	482	430	357	295	238	219	270	241
TAS	264	257	232	189	166	134	175	113	113	117
VIC	2 192	2 402	1 930	1 897	1 688	1 329	1 266	1 205	1 282	1 205
WA	1 131	1 223	1 200	1 008	984	922	1 010	800	912	951

Source: Australian National Notifiable Disease Surveillance System.

There was a 39% decrease in the hepatitis C notification rate, from 43.2 per 100 000 population in 2015, to 26.3 per 100 000 in 2024 (Figure 1). Notification rates have been decreasing among both males and females since 2015 despite an increase in 2016. The increase in 2016 likely reflected the increase in testing associated with government-funded direct-acting antiviral (DAA) treatments becoming available on the PBS in March 2016 ⁽²⁾. In 2016, the rapid uptake of treatment and cure among people living with hepatitis C coincided with a steady reduction in notification rates.

Figure 1 Hepatitis C notification rate per 100 000 population by sex, 2015 – 2024



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

Source: Australian National Notifiable Disease Surveillance System.



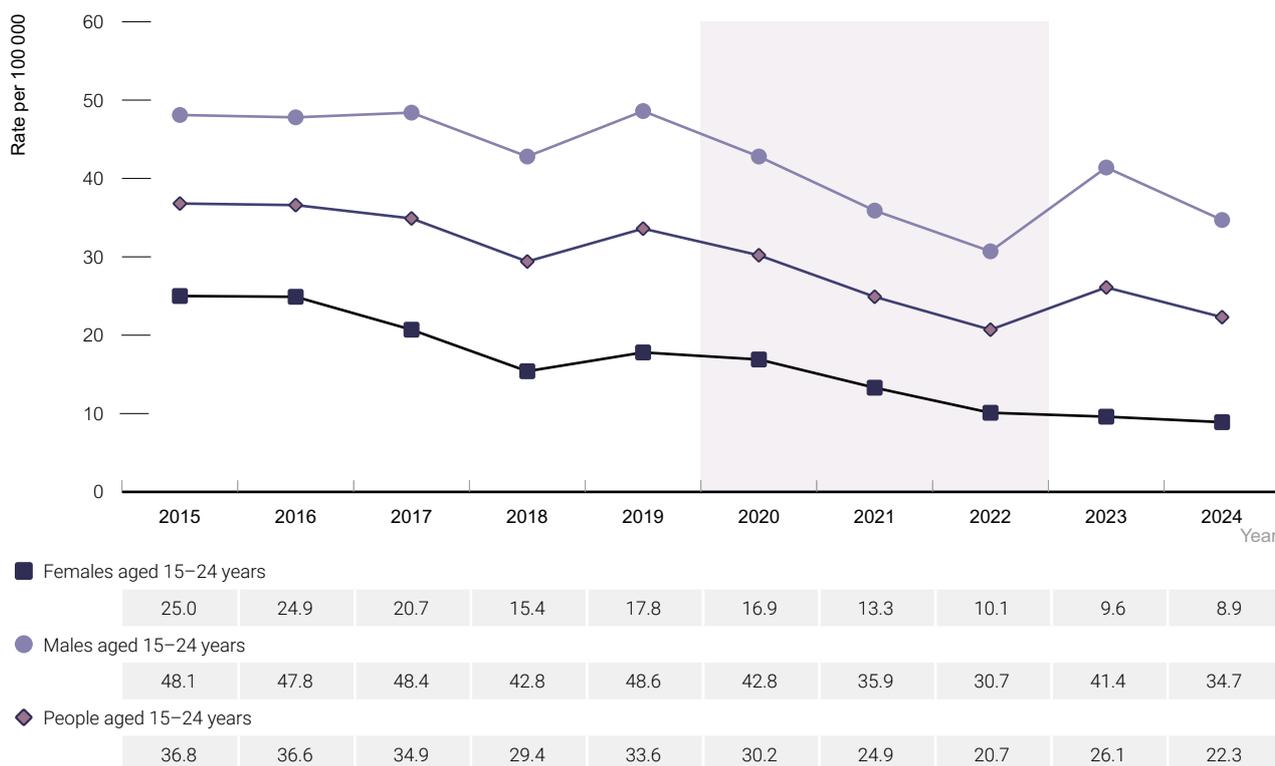
What does this mean?

The number of new hepatitis diagnoses has reduced since 2016.

Hepatitis C notification rates declined among all age groups between 2015 and 2024 apart from among those aged 65 years and older, for whom the notification rate increased by 75%, from 9.5 to 16.7 per 100 000. The greatest decline in the notification rate was recorded among those aged 35 to 44 years (by 47%, from 77.6 to 41.1 per 100 000). Greater declines were seen among women compared with men. For detailed breakdown of notification rates by age and sex, please see the [Kirby Institute data site](#).

Compared with older age-groups, most primary hepatitis C infections (initial infections) among those aged 15 to 24 years are more recently acquired⁽³⁾. Therefore, trends in the notification rates among those aged 15–24 years are used here as a proxy for trends in the incidence of hepatitis C infection. There was a 39% decline in the notification rate among this group between 2015 and 2024 from 36.8 to 22.3 per 100 000. The notification rate among females declined by 64% from 25.0 per 100 000 in 2015 to 8.9 per 100 000 in 2024. By comparison, the rate among males declined to a lesser extent (28%), from 48.1 per 100 000 in 2015 to 34.7 per 100 000 in 2024 (Figure 2). The greater decline in the notification rate among women compared with men in the same age group could be attributed to an increase in prison testing and/or more rapid declines in the at-risk population among women. It should be noted, notification rates reflect only diagnosed and reported cases, whereas modelled estimates of hepatitis C incidence account for undiagnosed infections and delays in diagnosis, and therefore provide a more complete picture of true transmission trends. For modelled incidence estimates see [Hepatitis C incidence](#).

Figure 2 Hepatitis C notification rate per 100 000 population among people aged 15 to 24 years by sex, 2015 – 2024



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

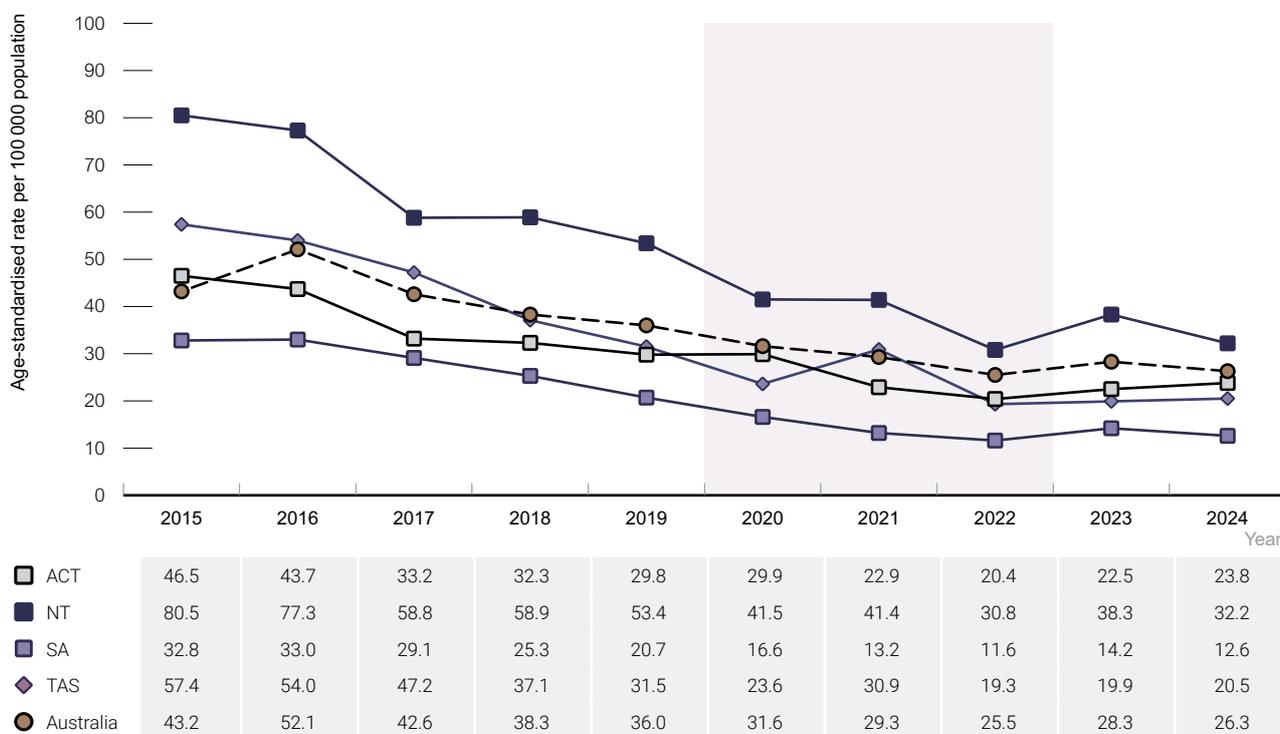
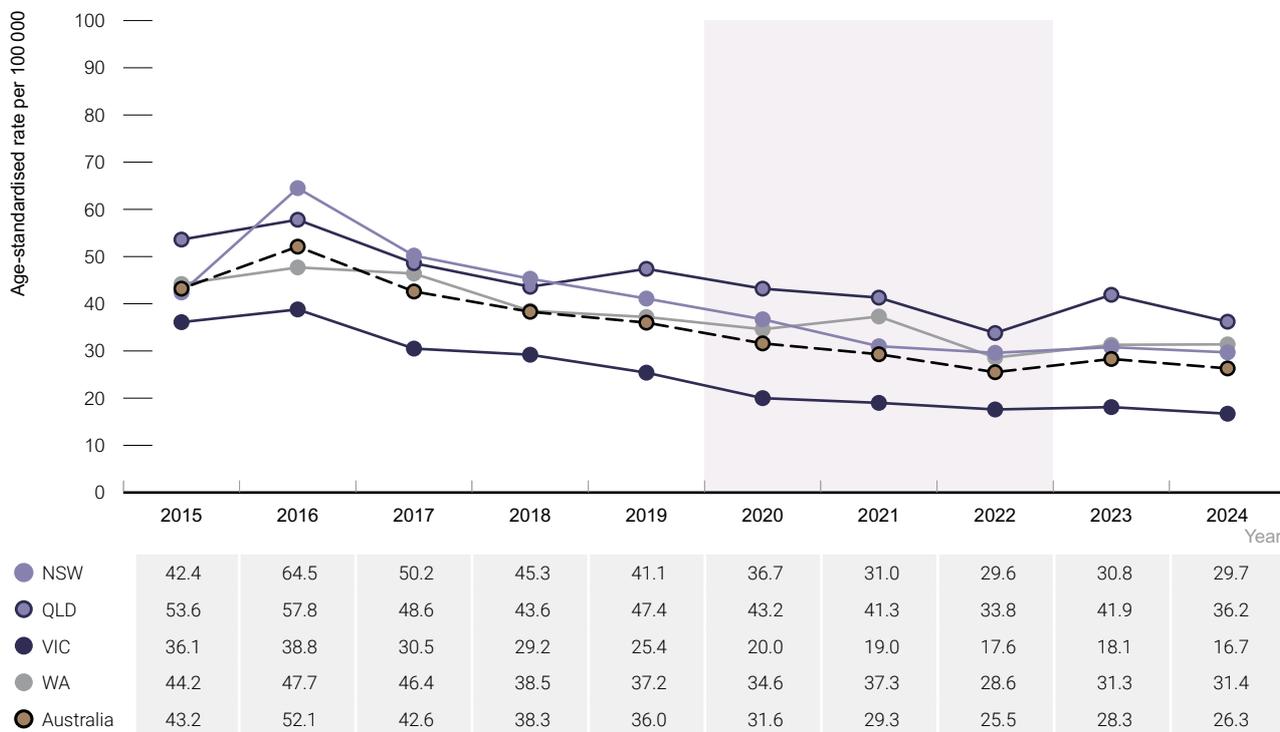
Source: Australian National Notifiable Disease Surveillance System.

What does this mean?

The rate of hepatitis C diagnoses among young people has declined since 2015.

In 2024, hepatitis C notification rates were highest in Queensland at 36.2 per 100 000, followed by the Northern Territory at 32.2 per 100 000, and Western Australia at 31.4 per 100 000 (Figure 3). Between 2015 and 2024, all states and territories saw a reduction in notification rates, ranging from a 64% reduction in Tasmania, to a 29% reduction in Western Australia.

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

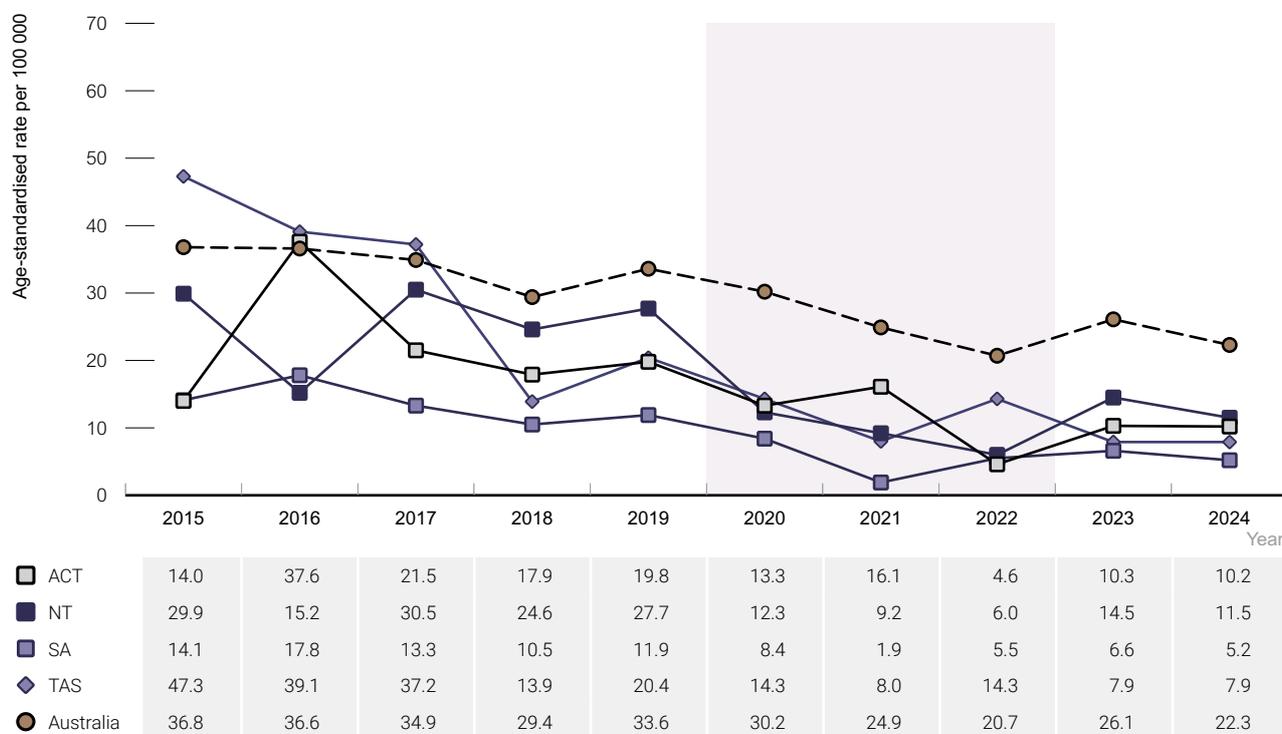
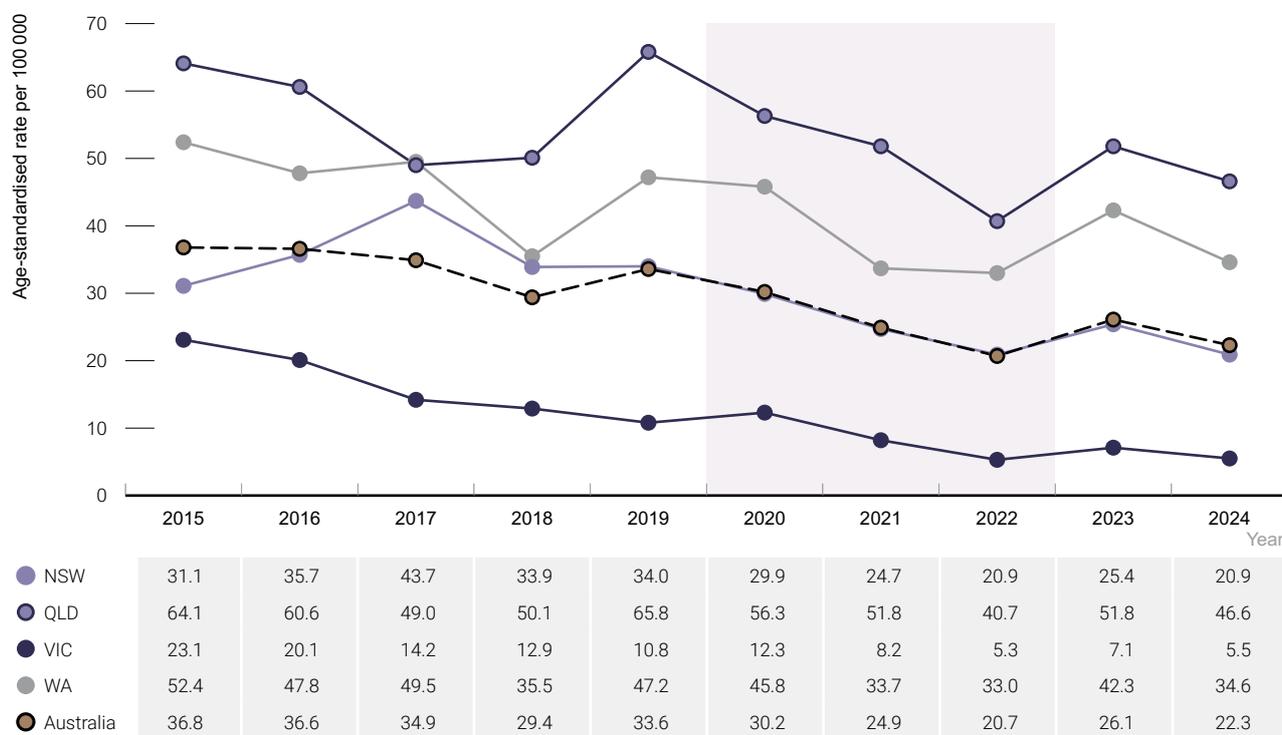


Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: Australian National Notifiable Disease Surveillance System.

Hepatitis C notification rates among people aged 15 to 24 years declined in every state and territory between 2015 and 2024. In this period, the largest declines were in Tasmania (83%) and Victoria (76%) (Figure 4).

Figure 4 Hepatitis C notification rate per 100 000 population among people 15 to 24 years of age, by state/territory, 2015 – 2024



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

Source: Australian National Notifiable Disease Surveillance System.

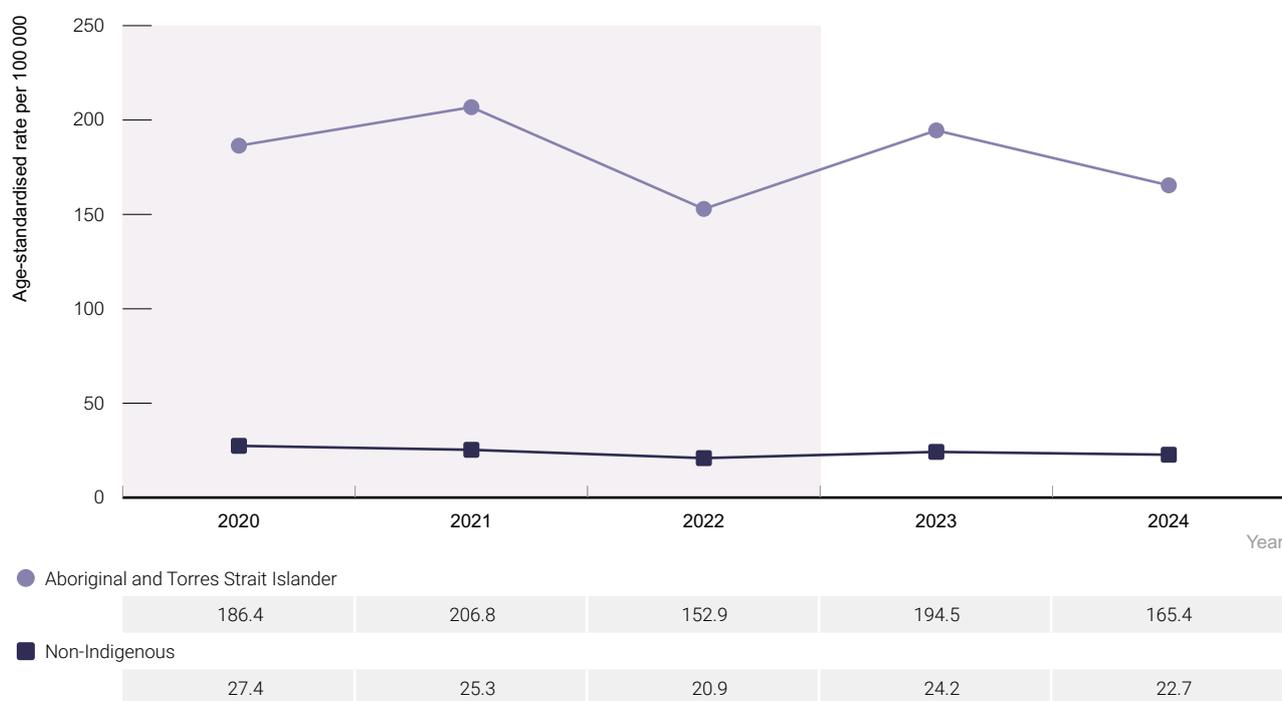
Aboriginal and Torres Strait Islander peoples

Hepatitis C notification rates among Aboriginal and Torres Strait Islander peoples are based on data from five jurisdictions (the Northern Territory, Queensland, South Australia, Tasmania, and Western Australia) where Aboriginal and Torres Strait Islander status was $\geq 50\%$ complete for all hepatitis C notifications for each of the five years (2020 – 2024).

Around half (49%) of Aboriginal and Torres Strait Islander peoples reside in these jurisdictions so notification rates may not be nationally representative. Incomplete information on Aboriginal and Torres Strait Islander status can underestimate the true extent of these infections among Aboriginal and Torres Strait Islander peoples and notification rates may not reflect national trends. The 2021 Census data from the Australian Bureau of Statistics recorded a larger than expected increase in the number of people self-identifying as Aboriginal and/or Torres Strait Islander. This increase was unlikely due to demographic changes (such as from births, death or migration). Because of this change, trends in hepatitis C notification rates should be interpreted with caution. Further details can be found on the [ABS website](#).

Based on the data from these five jurisdictions, the hepatitis C notification rate among Aboriginal and Torres Strait Islander peoples declined by 11% between 2020 and 2024 from 186.4 to 165.4 per 100 000 (Figure 5). In 2024, the age-standardised hepatitis C notification rate was more than seven times as high among Aboriginal and Torres Strait Islander peoples (165.5 per 100 000) compared with non-Indigenous people (22.7 per 100 000).

Figure 5 Hepatitis C notification rate per 100 000 population by Aboriginal and Torres Strait Islander status, 2020 – 2024



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

Source: Australian National Notifiable Disease Surveillance System. Includes jurisdictions in which Indigenous status was reported for $\geq 50\%$ of notifications for each year Northern Territory, Queensland, South Australia, Tasmania, and Western Australia).

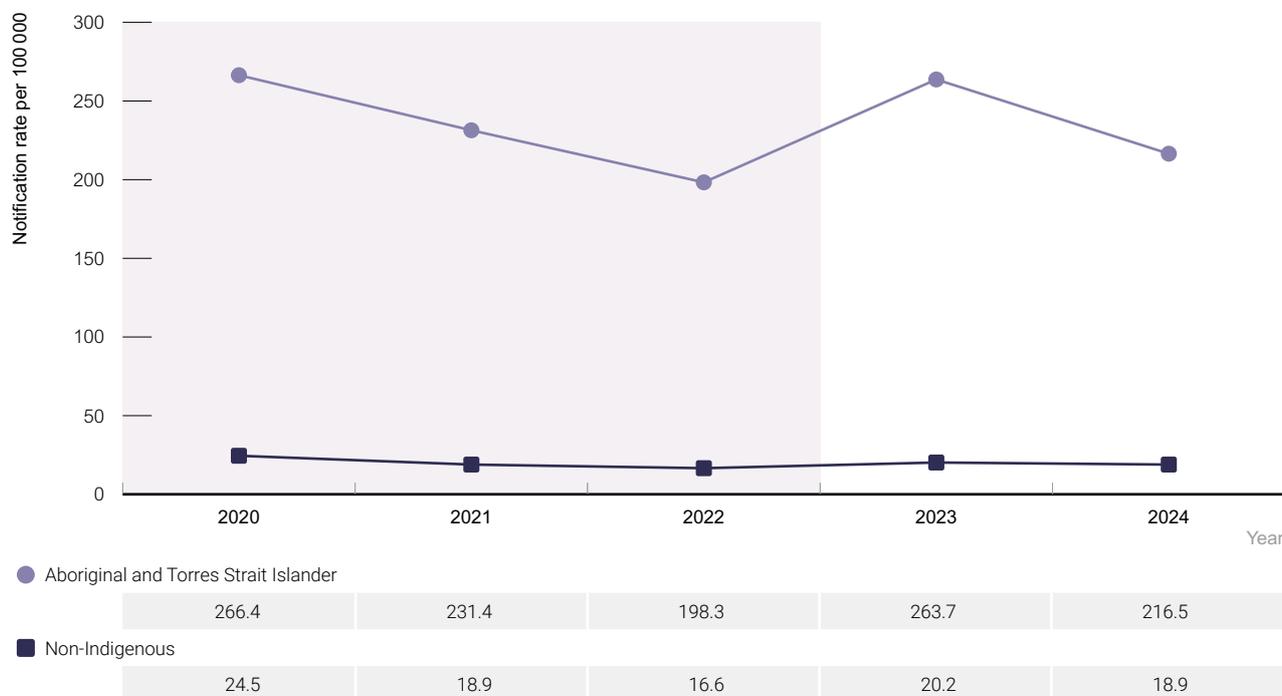


What does this mean?

The rate of new diagnoses among Aboriginal and Torres Strait Islander peoples has declined since 2020 but remains higher than among non-Indigenous people.

Between 2020 and 2024, among Aboriginal and Torres Strait Islander people aged 15 to 24 years, the hepatitis C notification rate declined by 19% from 266.4 to 216.5 per 100 000. In the same period, among non-Indigenous people aged 15 to 24 years, the notification rate declined by 23% from 24.5 to 18.9 per 100 000. The hepatitis C notification rate among Aboriginal and Torres Strait Islander peoples aged 15 to 24 years was more than 11 times as high as among non-Indigenous people aged 15 to 24 years (216.5 vs 18.9 per 100 000) (Figure 6).

Figure 6 Hepatitis C notification rate among people aged 15 to 24 years by Aboriginal and Torres Strait Islander status per 100 000 population, 2020 – 2024

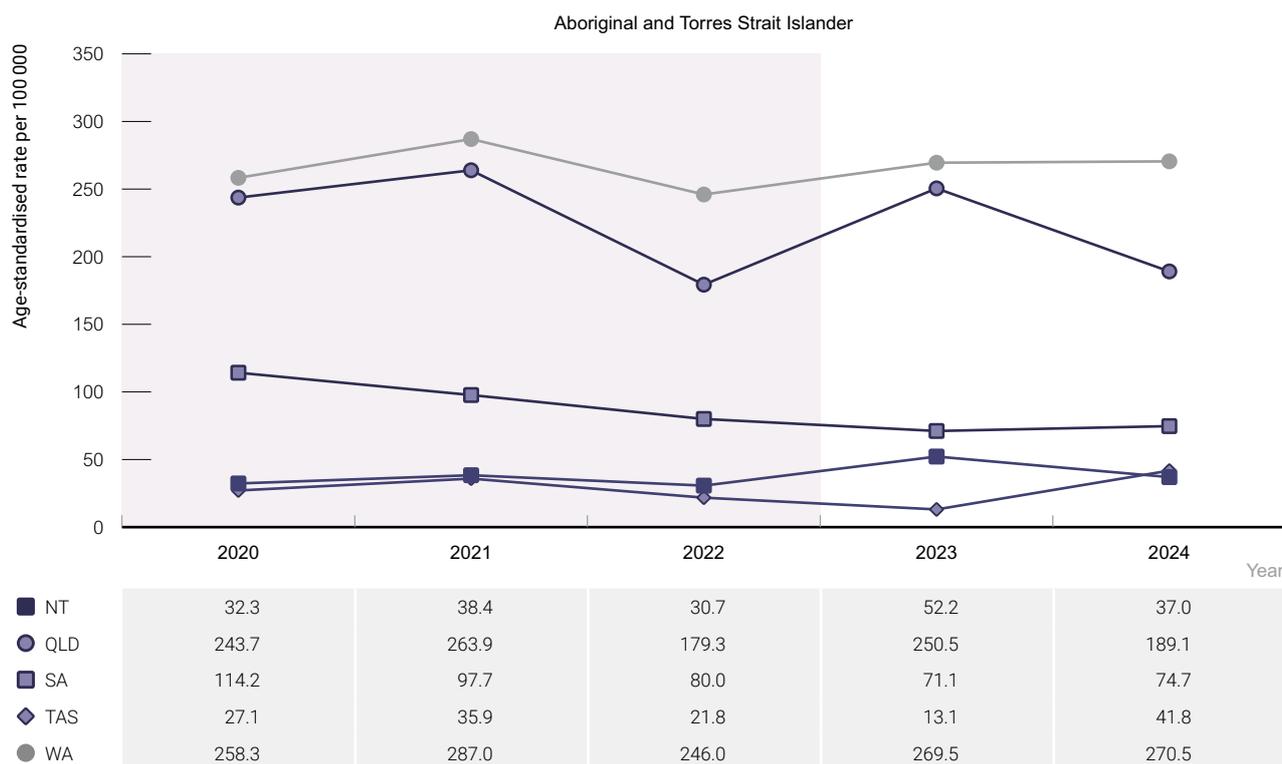


Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: Australian National Notifiable Disease Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year (Australian Capital Territory, Northern Territory, Queensland, South Australia, and Western Australia).

The hepatitis C notification rate in 2024 among Aboriginal and Torres Strait Islander peoples was highest in Western Australia (270.5 per 100 000), followed by Queensland (189.1 per 100 000), then South Australia (74.7 per 100 000). In Queensland and South Australia, the hepatitis C notification rate declined between 2020 and 2024 among Aboriginal and Torres Strait Islander peoples. In Western Australia, the hepatitis C notification rate among Aboriginal and Torres Strait Islander peoples fluctuated in the same period, while the rate increased in the Northern Territory and Tasmania (Figure 7). In the same period, the hepatitis C notification rate among non-Indigenous people declined in every reported state and territory. See *Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people: annual surveillance report 2025* for further detail ⁽⁴⁾.

Figure 7 Hepatitis C notification rate per 100 000 population by Aboriginal and Torres Strait Islander status and state/territory, 2020 – 2024



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

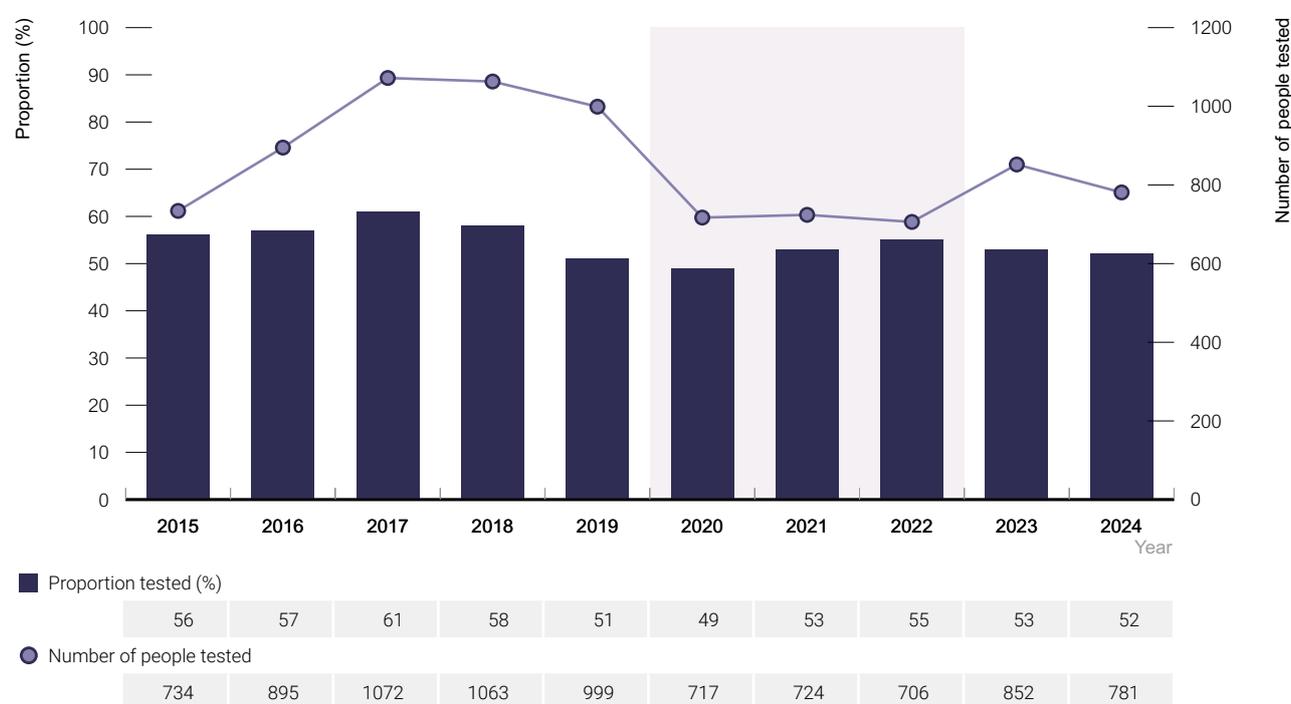
Source: Australian National Notifiable Disease Surveillance System. Includes jurisdictions in which Aboriginal and Torres Strait Islander status was reported for $\geq 50\%$ of notifications for each year (Northern Territory, Queensland, South Australia, Tasmania, and Western Australia).

4 Hepatitis C testing

Sentinel surveillance of hepatitis C testing is conducted by the Australian Collaboration for Coordinated Enhanced Sentinel Surveillance (ACCESS) and includes general primary care sites specialising in the health of people who inject drugs, sexual health clinics, and primary care clinics specialising in the health of gay and bisexual men and other men who have sex with men. According to Medicare data, national hepatitis C testing rates showed a decline between 2019 and 2021 as a consequence of the COVID-19 pandemic related restrictions ⁽⁵⁾.

Among people who inject drugs attending one of the sexual health clinics in ACCESS, the proportion who received a hepatitis C test in the past 12 months fluctuated between 2015 and 2024 and was 52% in 2024 (Figure 8). Over the same period, the number of hepatitis tests undertaken by people who inject drugs attending one of the sexual health clinics in ACCESS fluctuated between 2015 (734 people tested) and 2024 (781 people tested). A decline in the number of ACCESS clinic attendees since the start of the COVID-19 pandemic means that the number of people tested has reduced since 2019. Trends over time should be interpreted with caution (Figure 8).

Figure 8 Number and proportion of people who inject drugs attending a sexual health clinic in the ACCESS network who had a hepatitis C test in the past 12 months, 2015 – 2024

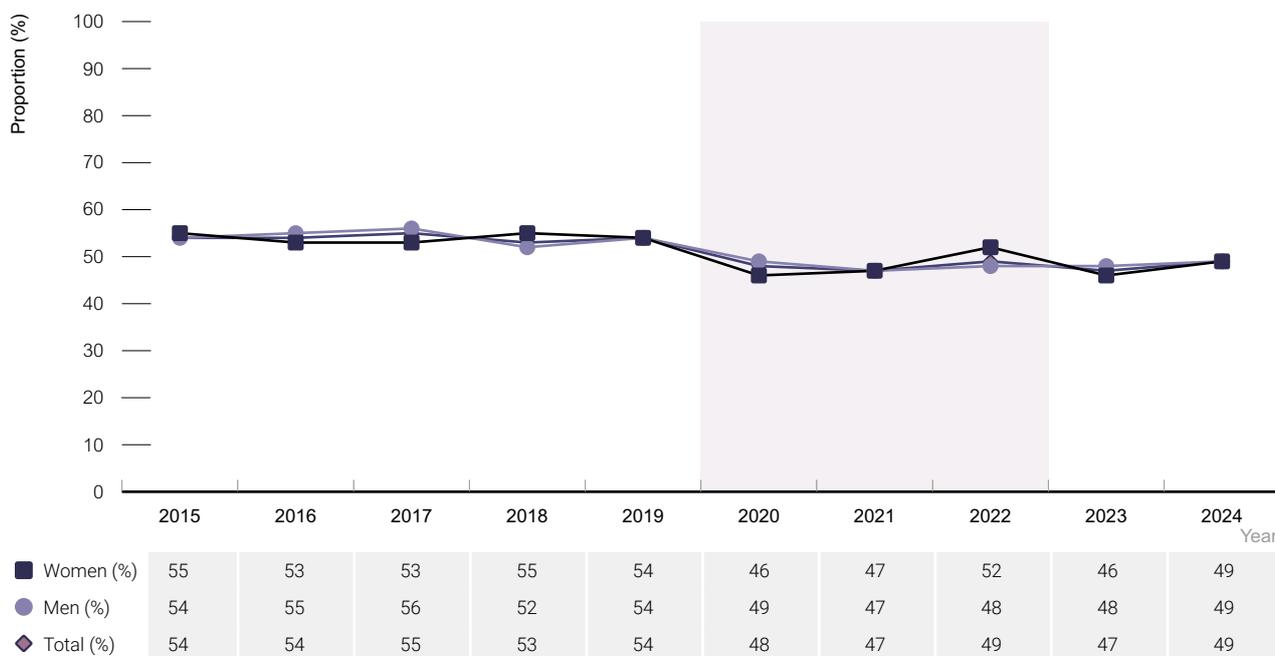


Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022. Of clinics enrolled in ACCESS, injection drug use status could be identified for analysis only among Sexual Health Clinics.

Source: ACCESS; see [Methodology](#) for detail.

Data from the annual ANSPS provide insights into the demographic characteristics and risk behaviours of laboratory confirmed and self-reported bloodborne virus prevalence, including hepatitis C antibody and RNA prevalence, among people who inject drugs attending needle and syringe programs throughout Australia. Prior to the start of the COVID-19 pandemic, the proportion of ANSPS respondents reporting a hepatitis C test in the previous 12 months fluctuated between 53% and 55%. Between 2020 and 2024 the proportion tested was lower compared to previous years but remained stable between 47% and 49% (49% overall in 2024; 49% among men and 49% among women) (Figure 9).

Figure 9 Proportion of people who inject drugs attending needle and syringe programs who reported a hepatitis C antibody test in the past 12 months by sex, 2015 – 2024



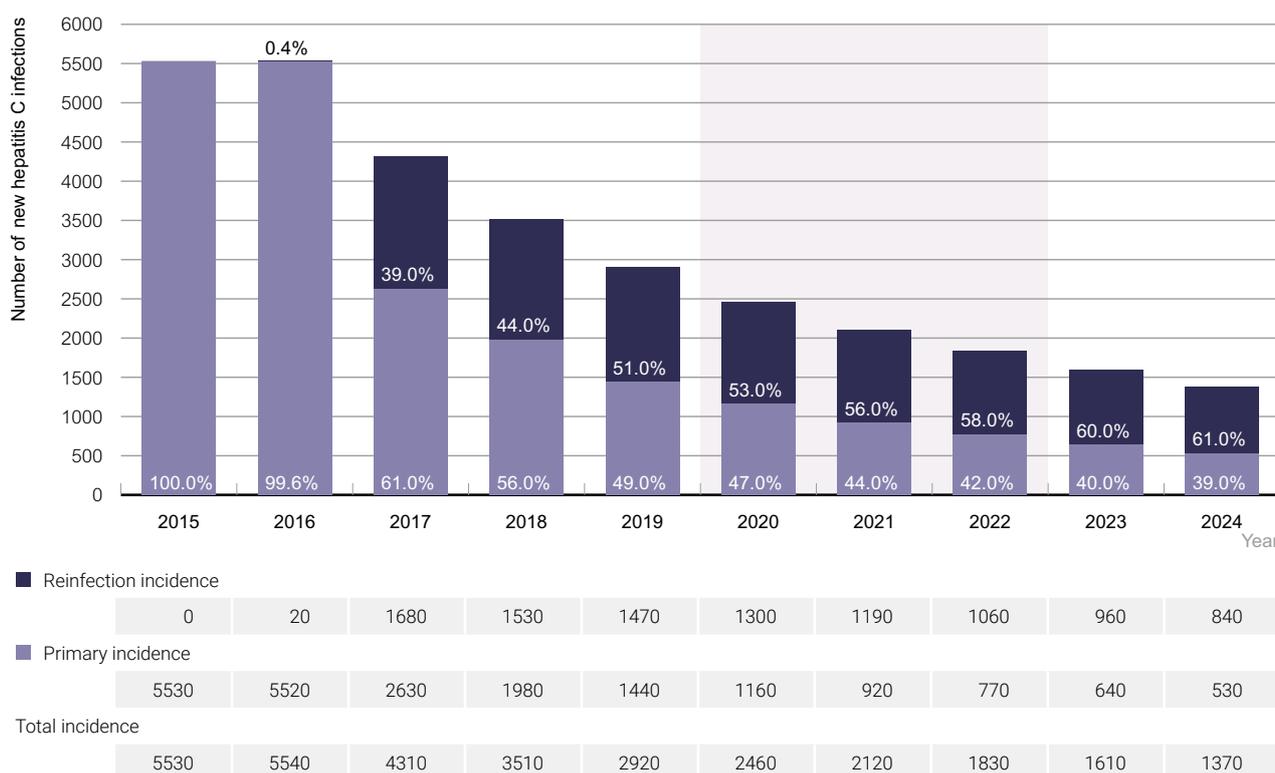
Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: Australian Needle Syringe Program Survey; see [Methodology](#) for detail.

5 Hepatitis C incidence

Hepatitis C incidence reflects new transmissions and serves as a key indicator for monitoring the effectiveness of prevention programs and progress towards national and global hepatitis C elimination targets. In the absence of empirical data, mathematical modelling is used to estimate national hepatitis C incidence. Between 2015 and 2024, the estimated number of new hepatitis C infections declined by 75%, from 5 530 to 1 370 (Figure 10). During this period, the estimated proportion of reinfections among all hepatitis C cases increased from 0% to 61%, while the proportion of primary infections decreased from 100% to 39%.

Figure 10 Estimated hepatitis C incidence by reinfection status, 2017 – 2024



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

Source: See [Methodology](#) for details of mathematical modelling used to generate estimates.



What does this mean?

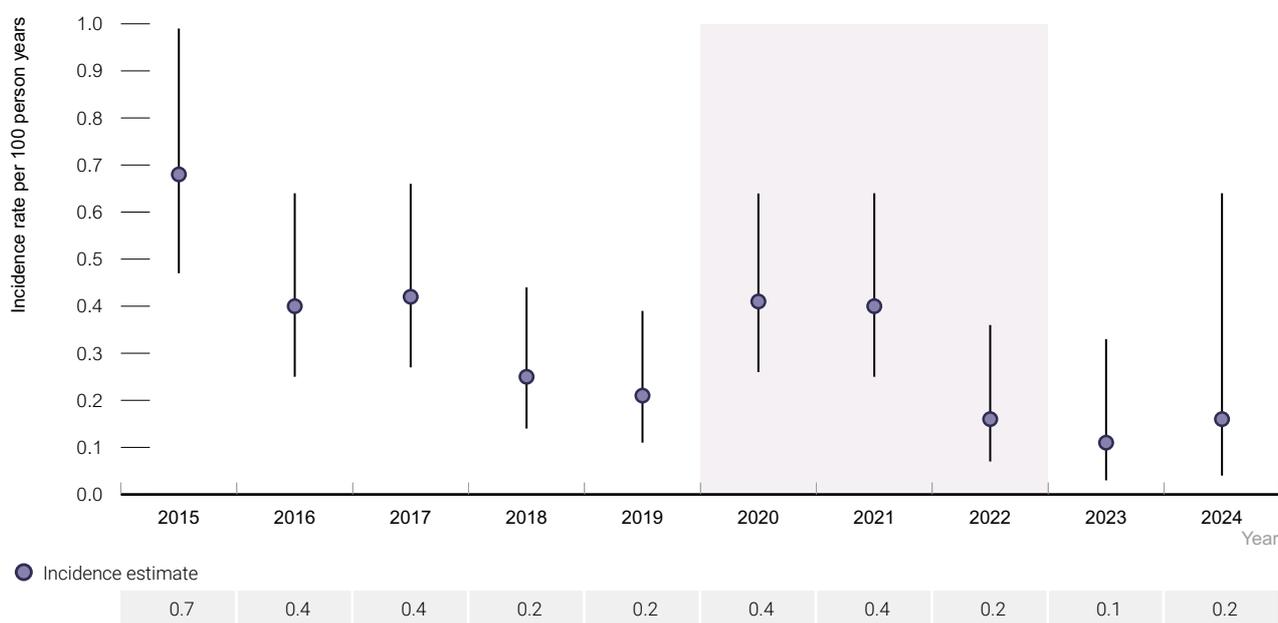
The estimated number of new infections every year is steadily declining, but a increasing proportion of new infections are among people becoming reinfected with hepatitis C.

Hepatitis C incidence estimates for priority populations are calculated using sentinel surveillance data from the ACCESS network are presented below.

For the years 2015 to 2024, 13 050 people who initially tested hepatitis C antibody-negative and attended one of 18 ACCESS primary care sites with high caseloads of people with a history of injecting drug use had at least one repeat test. Among this hepatitis C incidence cohort, 135 seroconversions to hepatitis C antibody positive were documented during 39 592 person-years at risk. Hepatitis C incidence declined from 0.7 to 0.2 new infections per 100 person-years over this period (Figure 11).

In the same period, among 8836 HIV positive gay and bisexual men attending one of 23 ACCESS primary care sites or sexual health clinics who had at least one repeat hepatitis C test, regardless of injection drug use, there were 220 seroconversions during 49 537 person-years at risk. Among this population, between 2015 and 2024, hepatitis C incidence declined from 1.0 to 0.3 new infections per 100 person-years (Figure 13). Note that individuals and tests are included from 2009 to create at-risk (HCV antibody negative on first observed test) cohort for incidence analysis.

Figure 11 Incidence of hepatitis C infection at ACCESS primary care clinics, 2015 – 2024



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

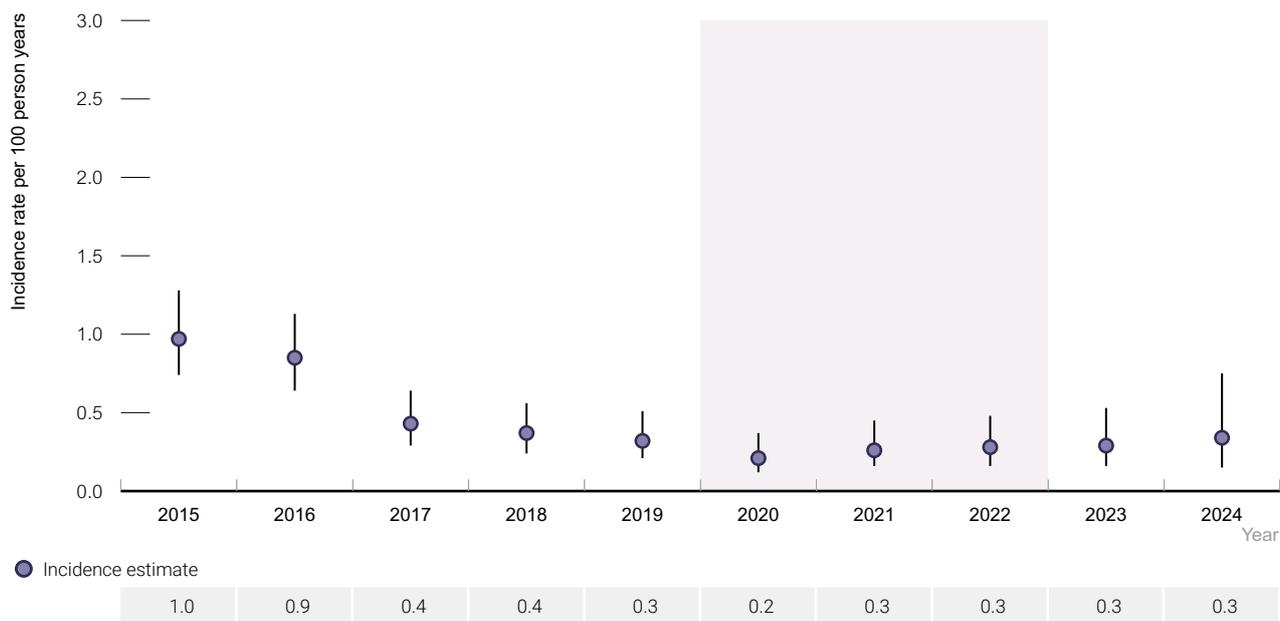
Source: ACCESS; see [Methodology](#) for detail.



What does this mean?

The number of new hepatitis C infections among people attending ACCESS primary care clinics has declined considerably since 2015.

Figure 12 Incidence of hepatitis C infection among HIV-positive gay and bisexual men attending ACCESS sexual health and primary care clinics, 2015 – 2024



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

Source: ACCESS; see [Methodology](#) for detail.



What does this mean?

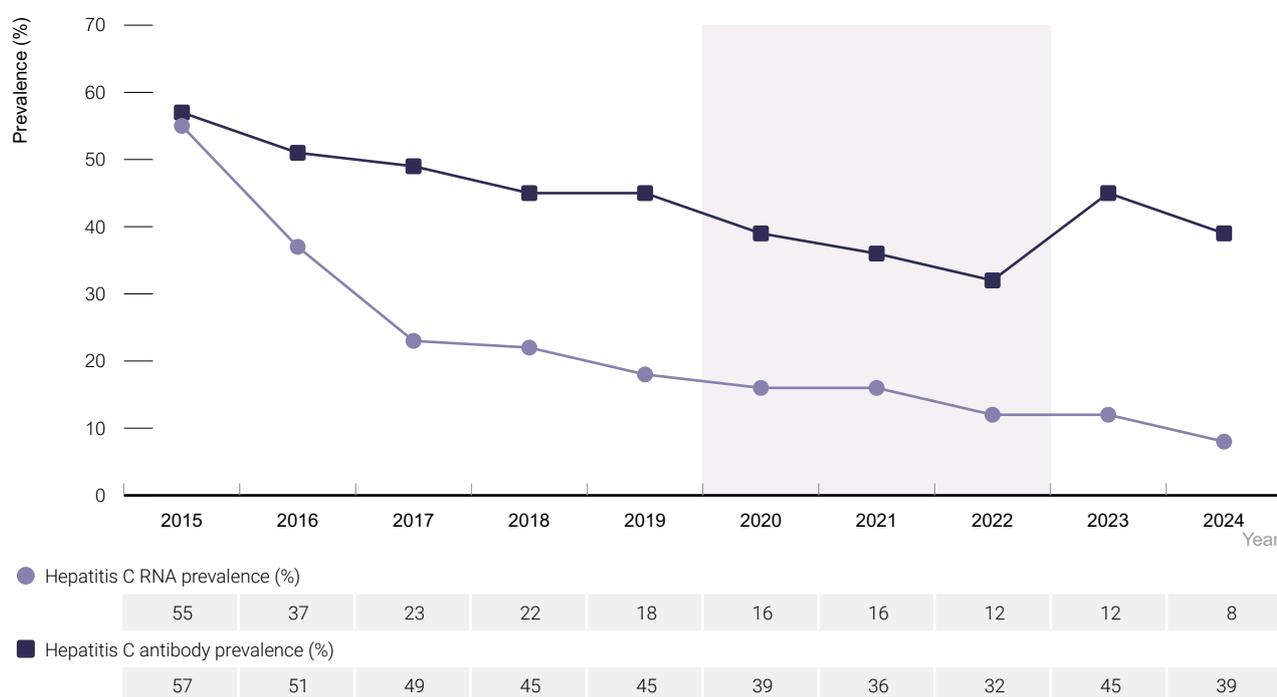
The number of new hepatitis C infections among gay and bisexual men attending ACCESS sexual health and primary care clinics has declined considerably since 2015.

6 Hepatitis C prevalence

Australia's hepatitis C epidemic affects people across age groups and sociodemographic backgrounds. Key populations include people with a history of injecting drugs, people with a history of incarceration, people from high-prevalence countries (where the prevalence of hepatitis C is higher than 3.5%), and Aboriginal and Torres Strait Islander peoples. Among ANSPS participants, hepatitis C antibody prevalence declined steadily from 57% in 2015 to 32% in 2022 but then increased to 39% in 2024 (Figure 13).

By comparison, greater declines were seen in hepatitis C RNA prevalence, reflecting the reduced level of current infection among people with hepatitis C antibodies since the widespread availability of DAA therapy ⁽⁶⁾. Hepatitis C RNA prevalence declined from 55% in 2015 to 8% in 2024, representing a large decline in the prevalence of active hepatitis C infection among participants of the ANSPS (Figure 13).

Figure 13 Hepatitis C antibody and RNA prevalence among people attending needle and syringe programs, 2015 – 2024



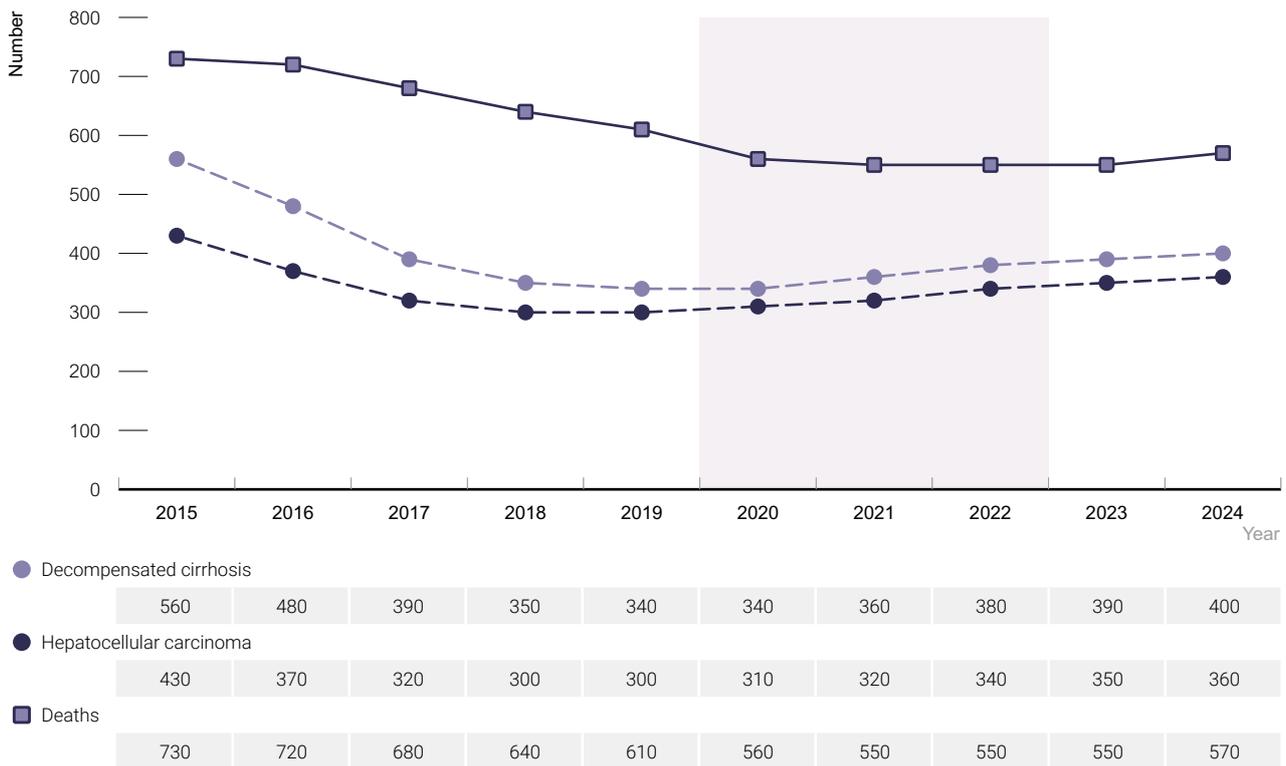
Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022. RNA testing commenced 2015. Data is weighted for gender and HCV Ab status from 2015-2019. Data from 2020 onwards are not weighted.

Source: Australian Needle Syringe Program Survey; see [Methodology](#) for detail.

7 Hepatitis C morbidity and mortality

In lieu of empirical mortality and morbidity data, estimates are based on mathematical modelling ^(7,8). Among people who were living with chronic hepatitis C as well as those who have been cured, the estimated number of new cases of hepatitis C-related decompensated cirrhosis declined by 29% from 560 in 2015 to 400 in 2024 (Figure 14). The estimated number of new cases of hepatitis C-related hepatocellular carcinoma declined by 16% between 2015 and 2024 from 430 to 360. The estimated number of hepatitis C related deaths (including viraemic and cured cases) declined by 22% from 730 in 2015 to 570 in 2024 (Figure 14).

Figure 14 Estimated number of incident cases of hepatitis C-related decompensated cirrhosis, hepatocellular carcinoma, and deaths, 2015 – 2024

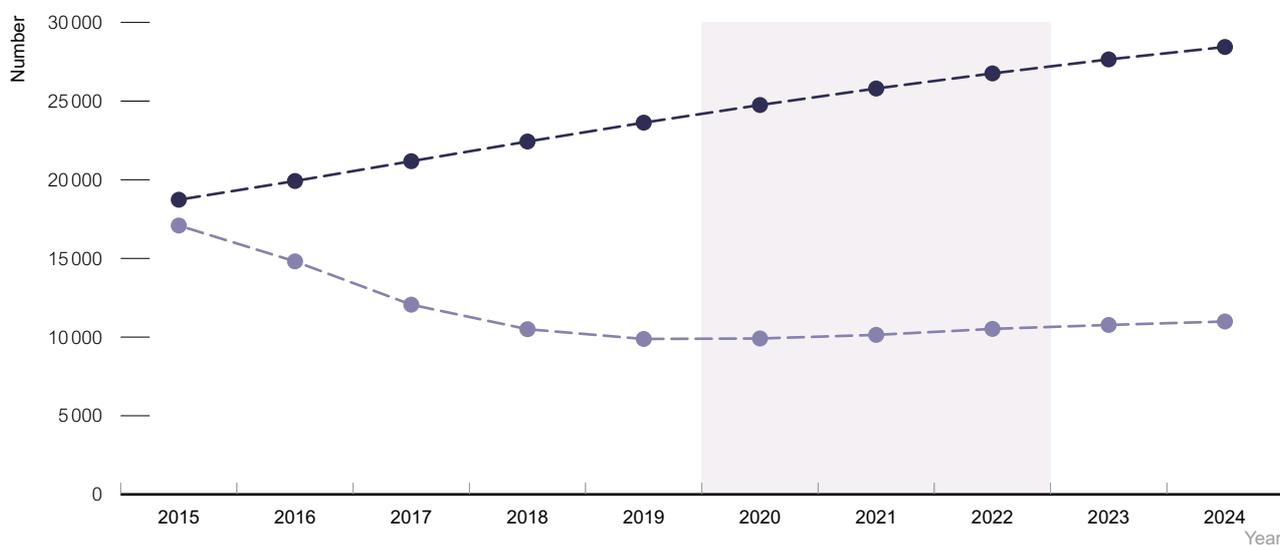


Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022. Includes people with chronic hepatitis C infection and those who have been cured of infection but still have hepatitis C-related severe fibrosis or cirrhosis.

Source: See [Methodology](#) for detail.

People cured of chronic hepatitis C are included as they may still develop morbidity after being cured. Among people who were living with chronic hepatitis C as well as those who have been cured, between 2015 and 2024, the estimated number with hepatitis C-related cirrhosis increased by 52% (from 18 730 to 28 440). Removing those who have been cured, the estimated number of people living with chronic hepatitis C who had hepatitis C-related cirrhosis declined by 36% between 2015 and 2024 from 17 090 to 10 990 (Figure 15).

Figure 15 Estimated number of people with hepatitis C-related cirrhosis, 2015 – 2024



■ Cirrhosis - people living with chronic hepatitis C	17 090	14 810	12 060	10 500	9 880	9 910	10 140	10 520	10 770	10 990
■ Cirrhosis - people living with chronic hepatitis C and those who have been cured	18 730	19 920	21 180	22 430	23 630	24 750	25 800	26 760	27 650	28 440

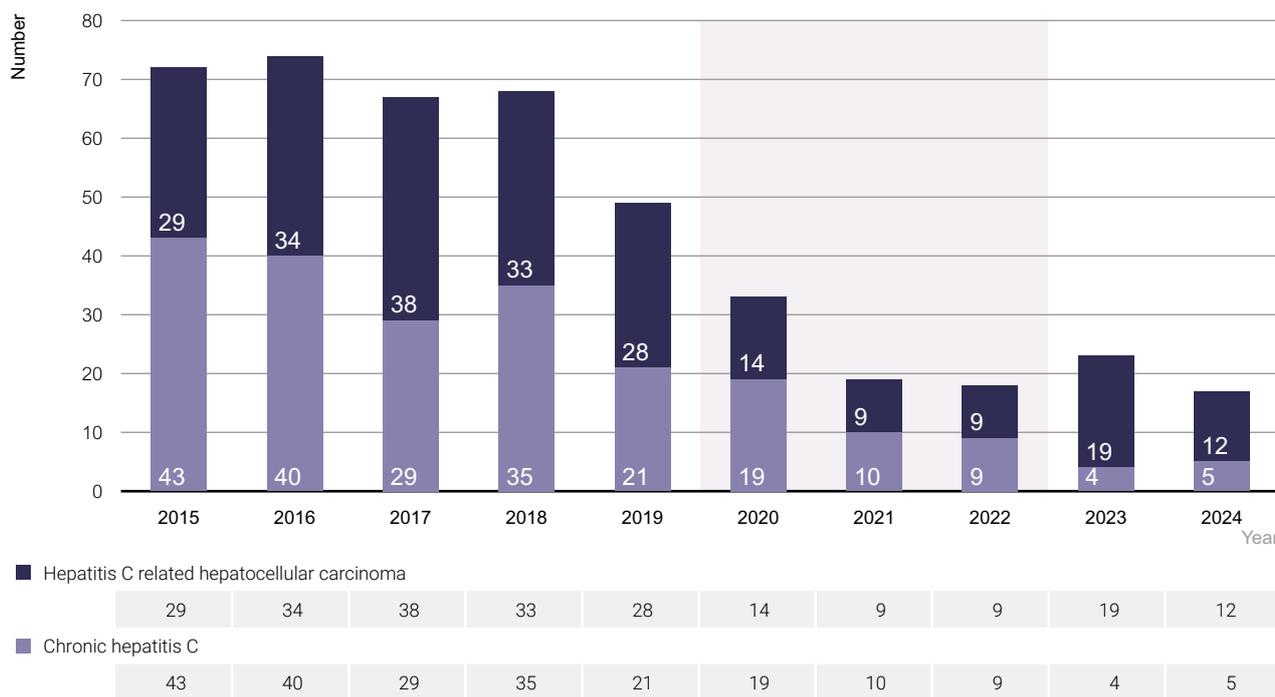
Note: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022.

Source: See [Methodology](#) for detail.

There is no comprehensive registry of advanced illness related to hepatitis C in Australia. One indicator of the extent of illness caused by hepatitis C is the number of liver transplants due to chronic infection. Of the 223 liver transplants in 2024, 17 (8%) were attributable to chronic hepatitis C infection or hepatitis C related hepatocellular carcinoma.

The number of people having liver transplants in Australia due to hepatitis C related cirrhosis reduced by 88% between 2015 and 2024 from 43 (20% of all liver transplants) to 5 (2% of all transplants). The number of liver transplants attributed to hepatitis C-related hepatocellular carcinoma has reduced by 59% from 29 (13% of all liver transplants) in 2015 to 12 (5% of all liver transplants) in 2024 (Figure 16). 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 but suggest a major impact of direct-acting antiviral therapy. For detailed information relating to chronic hepatitis C among liver transplant patients, please see the [Kirby Institute data site](#).

Figure 16 Number of liver transplants due to chronic hepatitis C and hepatitis C related hepatocellular carcinoma, 2015 – 2024



Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022. Only includes people aged 16 years and over.
 Source: Australian and New Zealand liver Transplant Registry; see [Methodology](#) for detail.

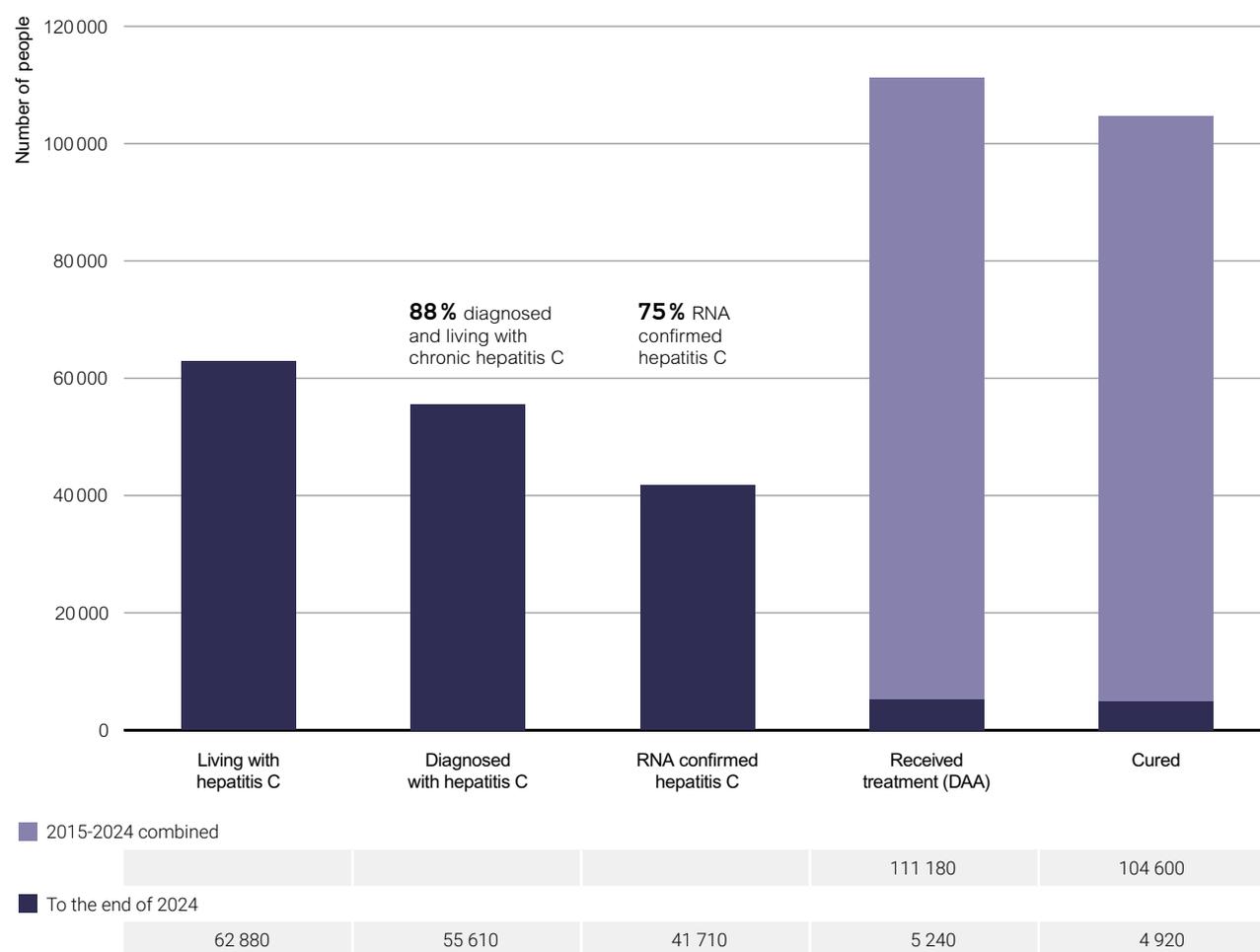
8 Hepatitis C diagnosis and care cascade

Methods used to generate cascade estimates are regularly revised to reflect the best and most current research available. Therefore, the following estimates may differ to same-year estimates presented in previous reporting.

This section includes the hepatitis C diagnosis and care cascade, with estimates of the number of people living with chronic hepatitis C in Australia, the number and proportion of people who have been diagnosed, and the number who received antiviral treatment. These estimates are used to support and inform the delivery of services to people living with chronic hepatitis C infection, from diagnosis of chronic hepatitis C to initiation of antiviral therapy and cure. Using available data and accounting for uncertainties, the number and proportions of people in each stage of the cascade in Australia were estimated (Figure 17, Figure 18, Table 2).

At the end of 2024, an estimated 62 880 people were living with chronic hepatitis C in Australia, down from 162 590 at the end of 2015. Of those living with chronic hepatitis C at the end of 2024, an estimated 88% (55 610 people) were diagnosed up from 80% (129 710 people) in 2015. Including all years between 2015 and 2024, an estimated 75% of those diagnosed also had an RNA test to confirm their chronic hepatitis C infection (41 710 people in 2024; Figure 17, Table 2). Due to changes in methodology, the estimated proportion of people who had an RNA test to confirm their hepatitis C status has changed. For further details, please see the [Methodology](#) chapter.

Figure 17 The hepatitis C diagnosis and care cascade, 2024

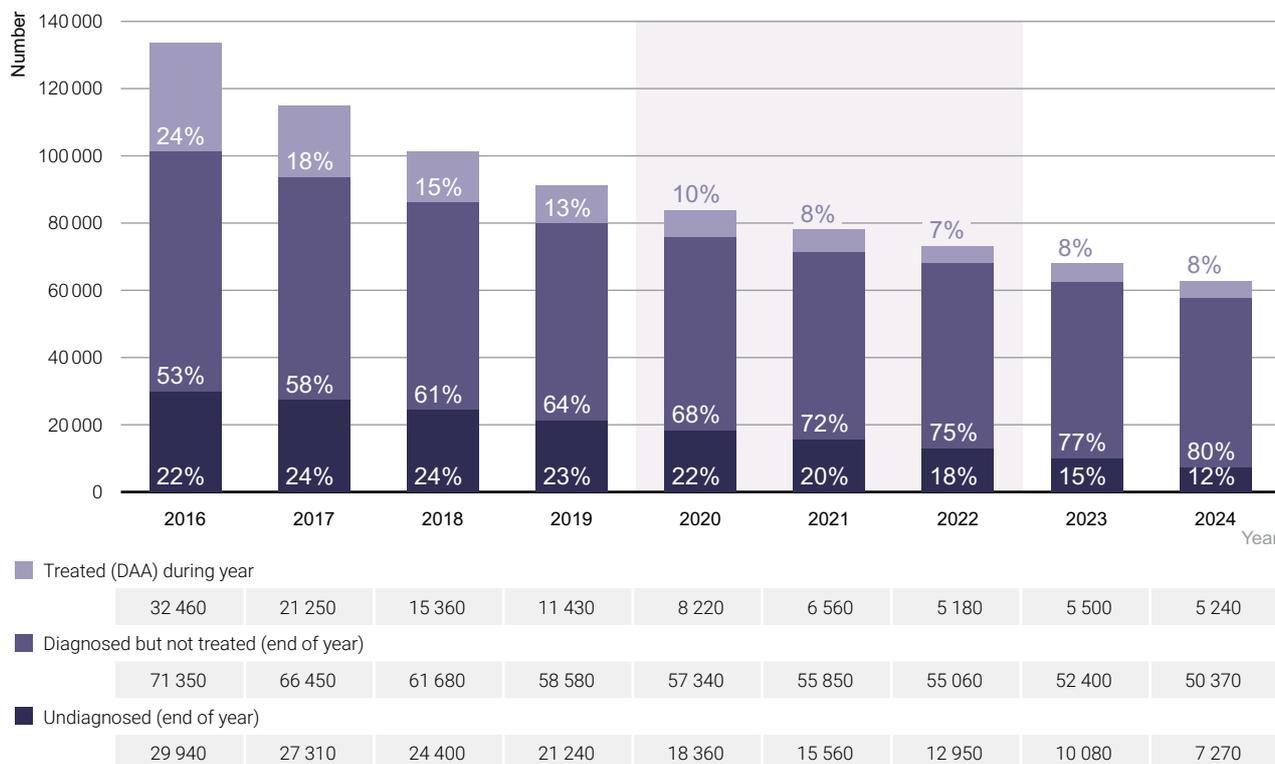


Source: See [Methodology](#) for details of mathematical modelling used to generate estimates.

Of the 67 970 people living with chronic hepatitis C at the start of 2024 (end of 2023), 8% (5 240 people) received hepatitis C DAA treatment in 2024, down from 16% (21 250 people) in 2017 (end of 2016). In 2024, 94% of people who had received treatment were cured of hepatitis C, with 4 920 people cured in 2024 (Table 2). The Australian Government has committed to the World Health Organization targets of 90% of people living with chronic hepatitis C infection to be diagnosed, with 85% cured by 2030. For estimates over a greater range of years, please see the [Kirby Institute data site](#).

Further details are provided in the [Methodology](#) section.

Figure 18 The hepatitis C diagnosis and care cascade gaps, 2016 – 2024



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

Source: See [Methodology](#) for details of mathematical modelling used to generate estimates.



What does this mean?

The number of people living with hepatitis C is steadily reducing and the proportion of people who know their hepatitis C status is increasing. However, the proportion of people with hepatitis C who are on treatment is reducing.

Table 2 The hepatitis C diagnosis and care cascade estimates, 2015 – 2024

Year	Living with chronic hepatitis C (end of year)	Diagnosed with chronic hepatitis C (end of year) (% ^a)	RNA confirmed hepatitis C (end of year) (% ^b)	Received DAA hepatitis C treatment (during the year) (% ^c)	Received DAA following hepatitis C reinfection	Cured of hepatitis C (during the year) (% ^d)	Cured of hepatitis C reinfections (during the year)
2015	162 590	129 710 (80%)	97 280 (75%)	0 (0%)			
2016	133 750	103 810 (78%)	77 860 (75%)	32 460 (20%)		30 630 (94%)	
2017	115 010	87 700 (76%)	65 770 (75%)	21 250 (16%)	20	19 950 (94%)	20
2018	101 430	77 030 (76%)	57 780 (75%)	15 360 (13%)	520	14 420 (94%)	490
2019	91 260	70 020 (77%)	52 510 (75%)	11 430 (11%)	910	10 750 (94%)	850
2020	83 920	65 550 (78%)	49 170 (75%)	8 220 (9%)	1 250	7 720 (94%)	1 170
2021	77 970	62 420 (80%)	46 810 (75%)	6 560 (8%)	1 280	6 170 (94%)	1 210
2022	73 180	60 230 (82%)	45 170 (75%)	5 180 (7%)	1 360	4 860 (94%)	1 280
2023	67 970	57 890 (85%)	43 420 (75%)	5 500 (8%)	1 820	5 170 (94%)	1 710
2024	62 880	55 610 (88%)	41 710 (75%)	5 240 (8%)	1 860	4 920 (94%)	1 750

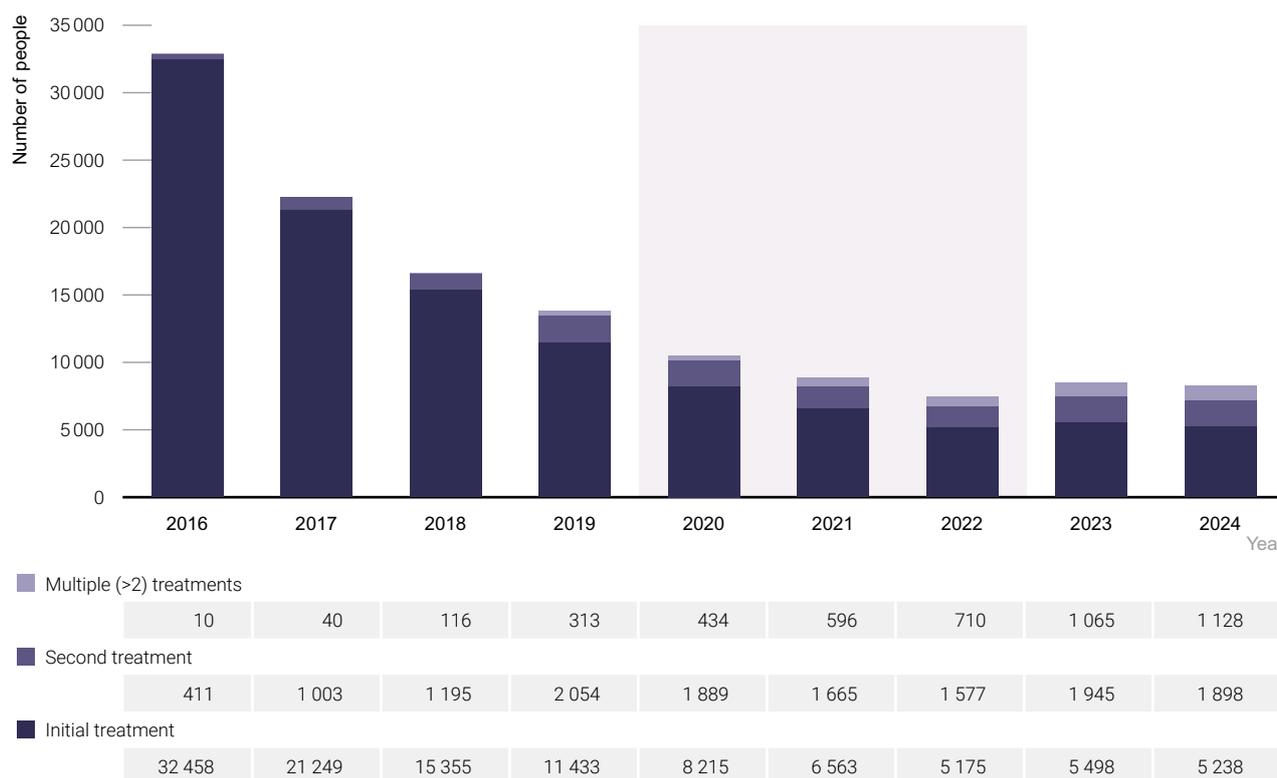
Notes: a The proportion diagnosed is the number of people diagnosed divided by the number of people living with chronic hepatitis C;
b The proportion of RNA confirmed hepatitis C is the number of people with RNA confirmed hepatitis C divided by the number of people diagnosed with hepatitis C;
c The proportion for diagnosed and received treatment is the number of people treated with DAA therapy over the given year divided by the number of people with hepatitis C at the start of the given year;
d The proportion cured of hepatitis C is the number of people cured of hepatitis C divided by the number of people who received hepatitis C treatment.

Source: See [Methodology](#) for details of mathematical modelling used to generate estimates.

9 Hepatitis C treatment

Subsidised interferon-free DAA regimens became available in Australia from March 2016. High levels of DAA treatment coverage have been associated with population-level declines in hepatitis viraemia ⁽⁶⁾. The World Health Organization has set the target of 90% of people living with hepatitis C treated by 2030 ⁽⁹⁾. Since March 2016, DAA treatment initiations (the number of people commencing a course of therapy) per year have declined from 32 458 in 2016 to 5 238 in 2024 (Figure 19). Over this period the number of people receiving at least one additional course of therapy increased from 10 in 2016 to 1 128 in 2024. Between March 2016 and the end of 2024, 111 184 people received PBS-subsidised DAA treatment and an estimated 99 680 were cured (Figure 19, see Figure 17). This means that during this period, 66% of all people living with HCV at the start of 2016 (162 590 people), have received treatment with 94% of those cured (104 600 people) (See Figure 17).

Figure 19 The number of people living with hepatitis C who received treatment, 2016 – 2024



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

Source: Pharmaceutical Benefits Scheme.

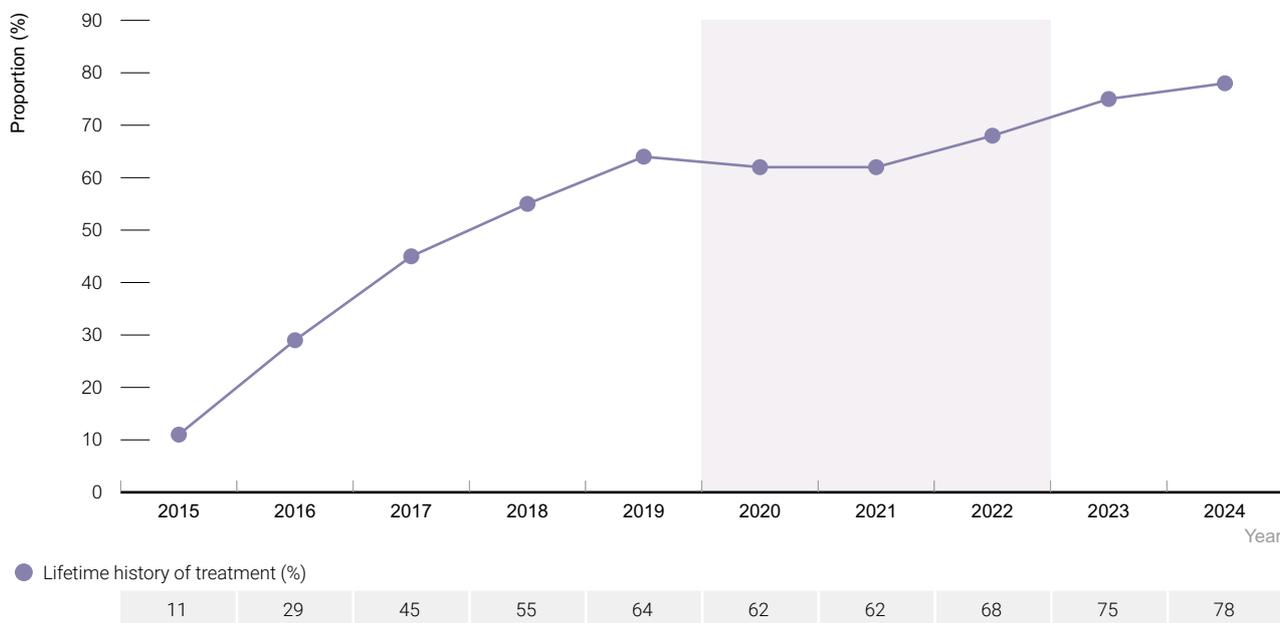
Table 3 Number of people with chronic hepatitis C infection initiating direct-acting antiviral therapy by state/territory, 2024

State/Territory	Number initiating direct-acting antiviral therapy in 2024
Australian Capital Territory	60
New South Wales	1940
Northern Territory	30
Queensland	1400
South Australia	230
Tasmania	80
Victoria	900
Western Australia	600
Australia	5240

Source: Pharmaceutical Benefits Scheme

Data from the ANSPS indicate that among respondents with self-reported chronic hepatitis C in 2024, 78% reported ever having received hepatitis C treatment, the highest in the reporting period, and an increase from 11% in 2015 (Figure 20). This increase reflects improved access through subsidised interferon-free direct-acting antiviral regimens from March 2016⁽⁸⁾. Please refer to the *Australian NSP Survey 30 Year National Data Report 2020 – 2024: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees* for more information .

Figure 20 Proportion of hepatitis C antibody positive people seen at needle and syringe programs with a lifetime history of hepatitis C treatment, 2015 – 2024



Notes: The shaded section of the chart indicates the years most affected by the COVID-19 pandemic, 2020 – 2022. Denominator for lifetime history of treatment is restricted to people with hepatitis C antibody positive serology and excludes people who self-reported spontaneous clearance; excludes people who reported treatment induced clearance >12 months previously.

Source: Australian Needle Syringe Program Survey; see [Methodology](#) for detail.



What does this mean?

The proportion of people using needle and syringe programs who have ever had hepatitis C treatment has increased considerably since 2015.

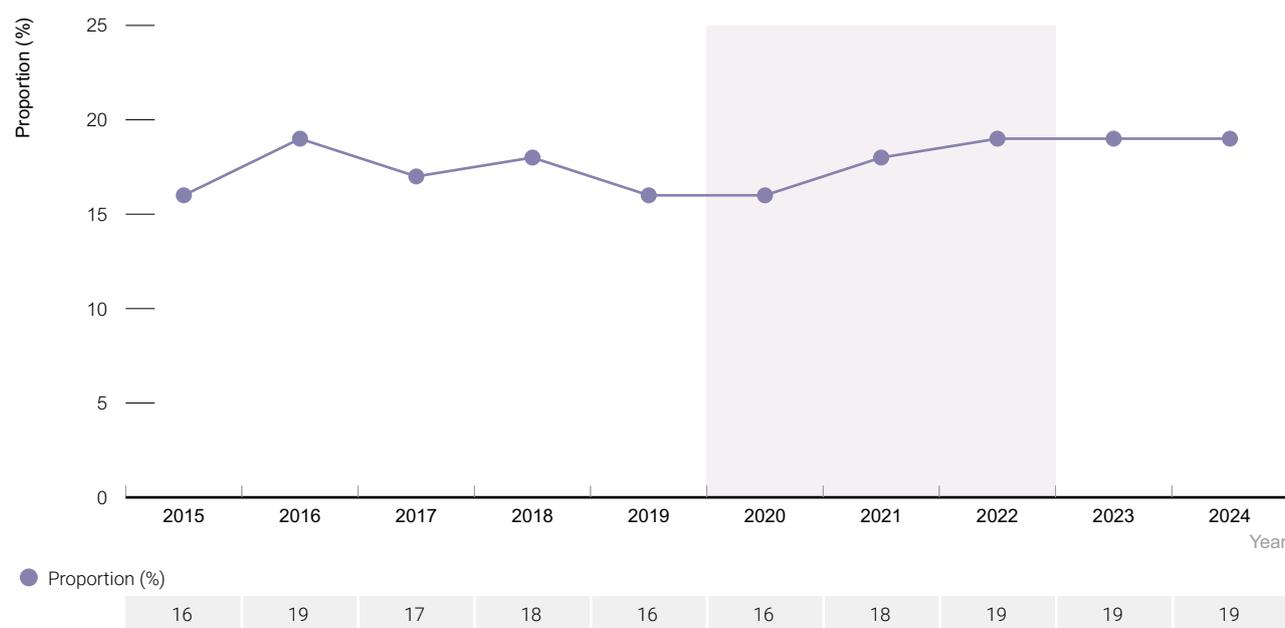
10 Hepatitis C prevention

The reuse of needles and syringes that have been used by others (receptive syringe sharing) is a major risk factor for the transmission of hepatitis C and other bloodborne viruses among people who inject drugs. In 2022, among participants in the *Australian hepatitis and risk survey in prisons (AusHep)*, 26% reported sharing needles/syringes when in prison compared with 21% when outside prison. Harm reduction strategies, in community and prison settings, such as needle and syringe programs and medication assisted treatment/therapy as well as safer injecting facilities, community education and peer-led interventions can reduce injecting risk behaviour and therefore reduce hepatitis C transmission⁽¹⁰⁻¹²⁾. Opioid agonist therapy has been shown to reduce the incidence of hepatitis C and HIV among people who inject drugs⁽¹³⁻¹⁵⁾. Health promotion is important to enhance the effectiveness of harm reduction strategies and to support people who inject drugs to implement safer injecting practices. Mathematical modelling suggests improving access to diagnosis and antiviral treatment and engagement in regular ongoing liver cancer monitoring for all people with cirrhosis, even when cured of hepatitis C infection, can lead to reductions in hepatitis C incidence⁽¹⁶⁾.

Injecting risk behaviour

Data from the ANSPS indicate that the prevalence of receptive syringe sharing has been generally stable over the past 10 years (2015 – 2024). In 2024, 19% of people attending needle and syringe programs reported receptive syringe sharing in the last month (Figure 21).

Figure 21 Proportion of people seen at needle and syringe programs reporting receptive syringe sharing in the past month, 2015 – 2024



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

Source: Australian Needle Syringe Program Survey; see [Methodology](#) for detail.

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