



# PROGRESS TOWARD VIRAL HEPATITIS ELIMINATION IN CANADA

## 2025 REPORT

ACTION HEPATITIS CANADA



ACTION HÉPATITES CANADA

Prepared by

**Action Hepatitis Canada**

[www.actionhepatitiscanada.ca](http://www.actionhepatitiscanada.ca)

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Finally, we wish to acknowledge the people in Canada who are affected by viral hepatitis, who are represented in the statistics and figures within this report. You are not just numbers to us. You are our family, friends, colleagues, and clients, and we stand alongside you in advocating for an equitable approach to viral hepatitis elimination.

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## **LAND ACKNOWLEDGMENT**

Action Hepatitis Canada represents member organizations from across Turtle Island, the lands and unceded territories of many different Indigenous groups and communities who have respected and cared for this land since time immemorial.

As people committed to addressing ongoing injustices and health inequities, we must recognize that many of these harms are the result of the history of colonization and its ongoing impacts, including practices and institutions that must be dismantled and reshaped to respect Indigenous People and Indigenous ways of knowing and being.

We recommit together to repairing harms and working towards a more just future for all.

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## **ACTION HEPATITIS CANADA MEMBER ORGANIZATIONS AS OF MAY 2025**

### **Steering Committee Organizations**

AIDS Committee of Newfoundland and Labrador (ACNL)  
BC Hepatitis Network  
Blood Ties Four Directions Centre (YT)  
Canadian Association of Hepatology Nurses (CAHN)  
CATIE  
Centre associatif polyvalent d'aide hépatite C (CAPAHC)  
Hep NS  
HIV Legal Network  
Manitoba Harm Reduction Network (MHRN)  
PAN  
R.E.C.A.P. Health Services (NB)  
Substance User Network of the Atlantic Region (SUNAR)

### **Member Organizations**

AIDS Coalition of Nova Scotia (ACNS)  
AIDS Committee of North Bay & Area (ON)  
AIDS Committee of York Region  
AIDS New Brunswick  
Alberta Hepatitis Elimination Network (AHEN)  
All Nations Hope Network (Saskatchewan)  
Ally Centre of Cape Breton  
ANKORS (BC)  
Atlantic Interdisciplinary Research Network for Social and Behavioural Issues in Hepatitis C and HIV/AIDS (AIRN)  
Avenue B (formerly AIDS Saint John)  
AVI Health and Community Services  
CAAN  
Calgary Liver Unit, Viral Hepatitis Clinic  
Canadian AIDS Society  
Canadian Association of Nurses in HIV/AIDS Care  
Canadian Association of People Who Use Drugs (CAPUD)  
Canadian Refugee Health Network  
Canadian Society for International Health (CSIH)  
Carefirst Family Health Team  
Central Toronto Community Health Centre (Queen West CHC and Shout)  
Community-Based Research Centre (CBRC)  
Cool Aid Community Health Centre  
Coopérative de solidarité SABSA  
CUPS Clinic (Calgary)  
Dr. Peter Centre  
Dopamine (Montreal)  
Elevate NWO  
Ensemble (Moncton)

Gay Men's Sexual Health Alliance (GMSH)  
GEIPSI (QC)  
Gilbert Centre  
Healing Our Nations  
Hépatites Ressources  
Liver Canada  
Lookout Society  
Lower Mainland Purpose Society  
Mainline Needle Exchange (Halifax)  
Manitoba Hepatitis C Support Community Inc.  
Northern Healthy Connections Society (NS)  
Northreach Society (AB)  
North Lambton Community Health Centre  
Nova Scotia Hemophilia Society  
Nova Scotia Sexual Health Centres (Sexual Health Centre Lunenburg County, Halifax Sexual Health Centre, Sheet Harbour Sexual Health Centre)  
Oahas  
Pewaseskwan (the Indigenous Wellness Research Group) - University of Saskatchewan  
PEERS Alliance (PEI)  
Pender Hep C Support Society  
PEI Native Council  
Phoenix Society  
Prairie Harm Reduction  
Prisoners' HIV/AIDS Support Action Network (PASAN)  
Programme National de Mentorat sur le VIH-Sida et Hépatites Virales, CHUM UHRESS Saint-Luc  
Realize  
Sanguen Health Centre  
Sandy Hill Community Health Centre – Oasis Program  
Saskatchewan Infectious Disease Care Network  
Shining Mountains Living Community Services (Alberta)  
Sidaction Mauricie  
St. Stephen's Community House, Corner Drop-In  
Street Health Centre Kingston  
Timmons Liver Health Team  
Toronto Community Hep C Program (South Riverdale Community Health Centre, Regent Park Community Health Centre, Sherbourne Health Centre)  
Unlocking the Gates Services Society (BC)  
Vancouver Island Persons Living with HIV/AIDS Society (VPWAS)  
Viral Hepatitis Care Network – VIRCAN  
Wellness Within (NS)

## TABLE OF CONTENTS

Abbreviations	1
Context: Why Viral Hepatitis Matters	2
Viral Hepatitis Elimination Targets	5
Who is Disproportionately Impacted?	6
Metrics to Measure Our Progress	7
TLDR - Key Takeaways	9
Bright Spots	10
National Progress	11
Federal Recommendations	12
Provincial/Territorial/Jurisdictional Progress Reports	
Alberta	13
British Columbia	14
Manitoba	15
New Brunswick	16
Newfoundland and Labrador	17
Nova Scotia	18
Ontario	19
Prince Edward Island	20
Quebec	21
Saskatchewan	22
Northwest Territories	23
Nunavut	24
Yukon	25
Corrections: Federal	26
Corrections: Provincial	27
Emerging Priority Population: Women	28
Point-of-Care and Dried Blood Spot Testing	29
Data Gaps and Report Limitations	30
Monitoring and Evaluation Methodology	
New Cases Metric	31
Planning Metric	32
Testing Metric	33
Testing-To-Treatment Link Metric	36
Treatment Uptake Metric	38
Prevention Metric	41
References	44

## ABBREVIATIONS

AHC	Action Hepatitis Canada
B	birth
CBO	community-based organization
CTFPHC	Canadian Task Force on Preventive Health Care
CTS	consumption and treatment services
DAA	direct-acting antiviral(s)
DBS	dried blood spot
gbMSM	gay, bisexual, and other men who have sex with men
HBV	hepatitis B virus
HCV	hepatitis C virus
HDV	hepatitis delta (D) virus
LAM	lamivudine
NACI	National Advisory Committee on Immunization
NSP	needle syringe program
OAT	opioid agonist therapy
OPS/SCS	overdose prevention site/supervised consumption site
PHAC	Public Health Agency of Canada
PLHBV	people living with hepatitis B
PLHCV	people living with hepatitis C
POC	point-of-care
P/T	provincial/territorial
PWAI	people who are incarcerated
PWID/PWUD	people who inject drugs/people who use drugs
RNA	ribonucleic acid
STBBI	sexually transmitted and blood-borne infections
WHO	World Health Organization
WUD	women who use drugs

# Context: Why Viral Hepatitis Elimination Matters

## ABOUT VIRAL HEPATITIS

- Hepatitis B virus (HBV) and hepatitis C virus (HCV) are liver infections. They are two of the leading causes of liver disease and transplantation and two of the most burdensome infectious diseases in Canada.<sup>1</sup>
- An estimated 214,000 people in Canada are living with chronic HCV,<sup>2</sup> and 262,000 with chronic HBV.<sup>2</sup>
- Symptoms may be delayed for decades, so many people who are infected are unaware, even while liver damage is occurring. The only way to confirm a chronic HBV or HCV infection is through a blood test.
- Untreated, viral hepatitis can cause **liver damage, cancer**, and even **death**.
- **An estimated 24 people die each week in Canada from viral hepatitis.** (see page 11)

## BUT VIRAL HEPATITIS ELIMINATION IS WITHIN CANADA'S REACH

- Since 2015, hepatitis C is **curable** with highly effective treatments of daily pills for 8 or 12 weeks, with few or no side effects.
- Hepatitis B is a **vaccine-preventable** infection and, while there is no cure yet, there are treatments to manage the disease and prevent advanced liver disease, and reduce cancer.
- With these medical advancements, what is needed now are **policies** that support **easy** and **equitable** access to **prevention, testing, treatment, and care**.

## HEALTH EQUITY

- While Canada's public health care system was founded on principles of fairness and equality, today there are many health inequities experienced by people across Canada. These are reflected among people affected by viral hepatitis.
- These include structural or geographic inequities, such as reduced access to prevention, testing, and treatment in rural and remote areas of Canada or between provincial and territorial boundaries.
- These inequities also result in some groups of people having higher rates of new viral hepatitis infections and higher prevalence of viral hepatitis compared to the overall population.

“No one should be left behind. We must ensure that everyone, regardless of their background or circumstances, has access to hepatitis diagnosis and treatment.

- World Health Organization

*Without addressing the inequities in healthcare access for remote and rural areas of Canada, and without working in true partnership with Indigenous communities to embed their priorities into health services and create culturally safe healthcare, there will remain considerable barriers to achieving viral hepatitis elimination.*

## CANADA'S PROMISE

- In May 2016, at the World Health Organization (WHO) Sixty-ninth World Health Assembly, the first-ever *Global Viral Hepatitis Strategy (2016-2021)*<sup>3</sup> was endorsed by the 194 Member States. **The strategy aimed to eliminate viral hepatitis as a public health threat by 2030.** The *Global Viral Hepatitis Strategy (2022-2030)* was then adopted to renew this commitment.<sup>4</sup>
- As a Member State, Canada signed on to this strategy and endorsed the targets contained within it. The WHO strategy includes specific targets, and all countries were tasked with developing a National Action Plan to meet these targets. The Public Health Agency of Canada (PHAC) responded by publishing the *Pan-Canadian framework for action to reduce the health impact of Sexually Transmitted and Blood-Borne Infections (STBBI)*<sup>5</sup> in 2018 and the *Government of Canada five-year action plan on STBBI*<sup>6</sup> in 2019, which was renewed and revised in 2024.<sup>7</sup>

## THE ROLE OF THE PROVINCES & TERRITORIES (P/Ts)

- PHAC's *Framework for Action* and *Action Plan* replicate the WHO targets for viral elimination by 2030, and were endorsed by all Canadian provinces and territories.
- As the provision of health care is under provincial and territorial jurisdiction, it is their governments' responsibility to create and implement their own viral hepatitis elimination strategies.

## THE IMPORTANCE OF PREVENTION

Viral hepatitis prevention is an area where some provinces and territories are making **policy choices that directly conflict with the abundance of evidence** available to them:

- We know that up to 90% of new HCV cases occur among people who share drug-use equipment. Yet, multiple provinces have stopped or restricted funding for the distribution of new equipment, closed supervised consumption sites, and/or returned to 1:1 needle exchange models.
- We know that the criminalization of drug use has led to an over-representation of people who use drugs being incarcerated. Yet, not one province or territory provides a needle and syringe program (NSP) or supervised consumption site in P/T carceral settings.
- We know that children born in Canada are being diagnosed with hepatitis B as adolescents, which could have been prevented if they were vaccinated at birth.<sup>8</sup> Yet, Canada's vaccination recommendations still do not align with the WHO recommendation of the first dose being administered at birth, and five provinces continue to use school-based HBV vaccination schedules.

This report shows that in 2023, just two P/Ts achieved the 2025 target for new infections of HCV, and six achieved the 2025 target for HBV. If we want to achieve the elimination targets by 2030, we need to get serious about viral hepatitis prevention policy.

***It's great that we can cure HCV and treat HBV,  
but it's still even better to prevent it in the first place.***

## A NOTE ABOUT HEPATITIS DELTA (HDV)

- Some people with hepatitis B may also have hepatitis D.
- People with both HBV and HDV infection are at higher risk of liver damage, including cirrhosis and liver cancer.
- HDV often goes undetected.
- An HDV treatment is newly approved for use in Canada and is currently being reviewed by Canada's Drug Agency (CDA) for reimbursement recommendation.
- Testing people with chronic HBV for HDV will allow us to detect HDV infections earlier and improve the care of those living with HDV.
- Eliminating HBV will also eliminate HDV, and HBV vaccination also protects against HDV infections.

## THIS PROGRESS REPORT

- The metrics and recommendations in this report reflect the WHO targets included in the *Framework for Action and Action Plan*, as well as the priority actions from the *Blueprint to inform hepatitis C elimination efforts in Canada*.<sup>9</sup> The *Blueprint* is a document for provincial/territorial policymakers to guide them in priorities for action and measuring their progress toward global HCV elimination goals. HBV and HDV metrics were developed in consultation with the Canadian HBV Network.
- This report also reflects the perspective of the community-based organizations that comprise the membership of Action Hepatitis Canada (AHC), prioritizing the policy changes our membership believes will have the greatest impact.



# Viral Hepatitis Elimination Targets

Within the WHO's Global Viral Hepatitis Strategy (2016-2021),<sup>3</sup> and echoed in PHAC's *Framework for Action*<sup>5</sup> and *Action Plan*,<sup>6,7</sup> there are several targets that collectively will lead to and/or define our success at eliminating viral hepatitis as a public health threat.

The original hepatitis elimination goals were relative changes from a 2015 baseline measured in percentages. In 2022, WHO provided absolute targets for countries to validate elimination.<sup>4</sup>

## GLOBAL TARGETS

Original Relative Targets for 2030	Updated Absolute Targets for 2030	Interim Targets for 2025
90% reduction in new cases of chronic HBV and HCV infections	≤ 2 new HBV cases per 100,000 population, ≤ 5 new HCV cases per 100,000	≤ 11 new HBV cases per 100,000, ≤ 13 new cases of HCV per 100,000
65% reduction in HBV and HCV deaths per year	≤ 4 HBV-related deaths per 100,000, ≤ 2 HCV-related deaths per 100,000	≤ 7 HBV-related deaths per 100,000, ≤ 3 HCV-related deaths per 100,000
90% of HBV and HCV infections diagnosed	unchanged	60% of HBV and HCV infections diagnosed
80% of HBV patients receiving treatment and HCV patients cured	unchanged	50% of HBV patients receiving treatment and HCV patients cured

The WHO guidance does not include targets related to HDV. However, since the hepatitis delta virus can only survive in people who have HBV, eliminating HBV will also eliminate HDV.

# Who is disproportionately impacted?

There are many groups of people who face barriers including discrimination, racism, and structural exclusion in Canada, and in our healthcare system specifically.

**When we use the term priority populations for viral hepatitis, we are explicitly referring to groups or communities that bear a disproportionate burden of this particular disease.** This is in addition to the structural racism, classism, ableism, sexism, or additional forms of discrimination that other identities may encounter in accessing viral hepatitis care. We also recognize that these many identities intersect and overlap, and the harms and risks can be compounded when they do.

The five priority populations and one age cohort identified for hepatitis C in the *Blueprint to inform hepatitis C elimination efforts in Canada* are:



People who are incarcerated (PWAI)



People who use drugs (PWUD)



Indigenous people



Gay, Bisexual, and other Men Who Have Sex With Men (gbMSM)



Newcomers and Immigrants from Countries with High Prevalence Rates of HCV



People born between 1945-1975

The majority of cases of HBV in Canada are among newcomers and immigrants from countries where HBV is prevalent.

HBV shares many of the same transmission paths as HCV, so the risk of exposure is higher in most of the same priority populations as those identified for HCV, though the ratios are certainly different.

“The challenges faced by Indigenous populations residing in urban, rural, and remote areas are distinct, particularly concerning access to culturally appropriate testing, treatment and wrap-around care services. I believe one of the greatest barriers to Indigenous people seeking and accessing services related to Hep C is the lack of dedicated funding and people who can provide wrap-around care in the community.

- Carrielynn Lund

“While no one should ever have to be in the correctional system to access their right to health care, for many their incarceration may present an opportunity to access services including prevention, screening, early intervention, and treatment programs. This will improve both individual and public health outcomes.

- *Prison Health is Public Health, the Right to Hepatitis C Prevention, Diagnosis, and Care in Canada's Correctional Settings.*<sup>10</sup>

# Metrics to Measure our Progress

While this report does not evaluate all the targets set in the various strategies and blueprints, we have selected these six metrics based on the availability of data and the centrality of the target to the overall elimination goals.

The selection of different metrics could produce different results, bringing jurisdictions closer to 2030 goals or highlighting key areas that are not on track. Regular assessment and refinement of the monitoring and evaluation methodologies is important.



## Metric 1: Decrease in New Cases of HBV and HCV

One of the global targets for viral hepatitis elimination is a maximum rate of new cases of chronic viral hepatitis: 11 per 100,000 for HBV by 2025, and two by 2030, and a rate of 13 per 100,000 for HCV by 2025, and five by 2030.



## Metric 2: Elimination Plan or Strategy in Place

Each province and territory in Canada must create and implement its own strategy toward viral hepatitis elimination that incorporates viral hepatitis impact and service coverage targets or goals.



## Metric 3: Testing for HBV, HCV, and HDV

This metric evaluates the implementation by government of four testing strategies that have been recommended to improve the rate of viral hepatitis diagnosis. To reach elimination targets through a health equity lens, parity of access to testing modalities is needed across all jurisdictions.

i. The *Blueprint* recommends automatically testing samples that are positive for HCV antibodies to confirm if active infection is present. This is known as **HCV RNA reflex testing**. This testing intervention simplifies the process for patients receiving their HCV diagnosis and reduces costs to the health care system.

ii. In March 2025, the Society of Obstetricians and Gynaecologists of Canada (SOGC) released *Clinical Consensus Statement No. 458: Hepatitis C Virus in Pregnancy*, providing updated guidelines for prenatal testing that will add **HCV prenatal testing** to the existing recommendation of HBV and HIV testing.<sup>11</sup>

iii. The Canadian Task Force on Preventive Health Care (CTFPHC) has not developed national screening guidelines for HBV. However, new guidelines from the United States recommend **universal one-time screening for chronic hepatitis B infections in all adults**, with consent.<sup>12</sup>

iv. *The management of chronic hepatitis B: guideline update from the Canadian Association for the Study of the Liver and Association of Medical Microbiology and Infectious Disease Canada*<sup>13</sup> recommends that all samples that are positive for **chronic HBV, also called HBV surface antigen (HBsAg), be automatically tested for HDV**.



#### **Metric 4: Access to HCV and HBV Treatment Following Diagnosis**

i. For HCV, the *Blueprint* recommends the use of ‘test-and-treat strategies’ where providers can initiate treatment on the same day they diagnose a patient, rather than processes that require 3+ appointments. This metric evaluates whether direct-acting antivirals (DAA) treatment reimbursement criteria and policies support this strategy.

ii. For HBV, the *CASL/AMMI Guidelines* make recommendations for first-line therapies.<sup>13</sup> This metric evaluates the accessibility of these first-line therapies on publicly-funded drug plans.



#### **Metric 5: Annual HCV Treatment Prescribing Counts**

Modelling has been done to determine how many people living with HCV would need to start treatment each year so that 80% have received treatment by 2030 (a WHO elimination target). This metric compares the number of people who started treatment each year from 2015-2024 against the annual treatment start target to determine if treatment uptake is on track.



#### **Metric 6: Prevention Measures**

Both HCV and HBV are preventable, but so far, only HBV has a vaccine.

i. The provision of new drug use equipment prevents viral hepatitis infection and other STBBIs. This metric determines whether new drug use equipment is publicly funded and distributed through community channels. **New drug use equipment distribution should support safer injecting, smoking, and snorting practices, in adequate amounts and through accessible channels, with consideration for geographical equity.**<sup>14</sup> This was measured through community reporting and perception on whether the funded supplies match the need (either in type or amount of equipment) and whether they were equitably available geographically, with a focus on the provincial governments’ role rather than local program-level decisions.

ii. The WHO indicates that the most effective way to prevent chronic HBV infection is to universally administer the first **HBV vaccine dose at or near the time of birth**. This is because up to 95% of babies and children exposed to HBV will develop a chronic infection, which poses significant health risks and could require lifelong treatment. Despite this, HBV vaccination policies across Canada vary from birth to grade seven.

iii. With childhood vaccination programs in place since the 1990s, the majority of new cases are reported among the cohort of adults who are too old to have benefited or otherwise missed these vaccinations. For this reason, the United States has recently adopted a “catch-up” recommendation of **HBV vaccination for all adults aged 19-59**, in addition to the birth dose vaccination policy.<sup>15</sup>

# TL;DR

1. Canada is on track with most WHO 2025 interim targets as measured, except for the prevention of new infections. Significant progress has been made or is underway in removing barriers to viral hepatitis treatment. Our interest now lies specifically in making sure prevention, diagnosis, and linkage to care are addressed through a health equity lens.
2. At the P/T level and with the epidemiologic data available, seven of ten provinces are still on track to meet HCV elimination goals. Three are still not: Manitoba, Ontario, and Quebec. With new data, we are pleased to note that the Yukon is also on track to meet HCV elimination goals.
3. We do not have the right P/T data for HBV to determine if progress toward elimination goals is on track.

## Key Takeaways



### Provinces and prisons need to get serious about prevention

**While many provinces and the federal prison system have made great progress in removing barriers to HCV treatment, their prevention policies are undermining these efforts.** Viral hepatitis prevention is an area where some jurisdictions are making **policy choices that directly conflict with the abundance of evidence** available to them:

- Harm reduction is HCV prevention, with adequate coverage of new drug use equipment and OAT preventing up to 74% of new HCV infections.<sup>9</sup>
- Hepatitis B is preventable with birth-dose vaccination and adult catch-up vaccination, including among immigrants and newcomers.
- A new study has shown every \$1 spent on scaling up NSPs in federal prisons would save \$2 in treating infections related to drug use.<sup>16</sup>



### Testing policy needs to catch up with testing technology

Two point-of-care tests for HCV antibody are approved for use in Canada, and one rapid test to confirm infection. These tests should allow patients who are at risk of loss to follow up to be diagnosed and start treatment on the same day. **To fully benefit from these new technologies, provinces and territories need policies that integrate these testing technologies into data collection and reimbursement systems, as well as public funding models.**



### Federal action is needed to support linkage to treatment

**HCV treatment numbers in many provinces have been stagnant or falling since peaking in 2018.** Community-based organizations are best positioned to help link people who are often structurally excluded from mainstream healthcare settings to treatment and care for viral hepatitis (and other STBBI). Multi-year funding for linkage-to-care staff across the country is needed to reach elimination targets in an equitable way.



### Federal accountability is needed to achieve elimination

**Canada's STBBI Action Plan still doesn't include any targets**, despite the original 2019 version promising that setting targets would be one of the first steps. The 2024 update was also released with no domestic or interim elimination targets or targeted outcomes for each of the listed actions. How are we meant to measure progress without targets?

# BRIGHT SPOTS



## Good things are happening!



### Planning

**Prince Edward Island** has led the country since 2018 with their 10-year Hepatitis C Elimination Plan.

**Newfoundland** is currently in the final approval stages of their Hepatitis C Elimination Plan, co-created with government and community. Meanwhile, **Ontario** and **British Columbia** Ministries of Health participated in the development of these provinces' elimination roadmaps. **Manitoba** updated the HCV treatment protocol in 2024 to be elimination-oriented, removing barriers to treatment access and creating opportunity for decentralizing treatment.



### Point-of-Care and Dried Blood Spot Testing

**Ontario** leads the country in the provision of HCV antibody testing, providing no-cost POC and DBS testing and supplies through Ontario Hepatitis C Teams.<sup>17</sup> (Next steps would be that results are captured in provincial database and RNA POC testing is adopted.)

The Public Health **Ontario** (PHO) laboratory also accepts the submission of DBS results for the purposes of hepatitis C virus RNA detection, as do **New Brunswick** and **British Columbia**, filling a testing gap, particularly in rural and remote areas.



### HCV Treatment

**Saskatchewan** dropped all requirements for treatment in 2024, making reimbursement approval automatic and removing co-pays.

**British Columbia, Newfoundland, Nova Scotia, Ontario, Prince Edward Island, and Quebec** have also removed approval requirements for HCV treatment or created online same-day approval mechanisms, helping reduce the number of people lost to care.



### HCV Treatment Access in Corrections

**British Columbia** leads the country in person-centred STBBI care in correctional settings with guidelines for HCV and STBBI testing co-created with PWAI through the STBBI Pathways project. BC PharmaCare created "Plan Z" to remove the barrier of PWAI needing to file taxes in order to have drug plan coverage.

Through a collaborative process, HCV training has been implemented across **Ontario's** provincial correctional facilities. PWAI can now request HCV testing and treatment while in custody. To ensure continuity of care for those who leave custody before completing treatment, transitional planning includes providing the remaining monthly dispense of medication and linking individuals with community-based treatment resources.

# NATIONAL PROGRESS



## CURRENT STATUS: LIKELY ON TRACK FOR BOTH HBV AND HCV

The Public Health Agency of Canada (PHAC) has reported the following national progress toward our WHO targets.<sup>2</sup>

Estimated # of PLHCV (2021): **214,000**

Estimated # of PLHBV (2021): **262,000**

**21.0**  
HCV

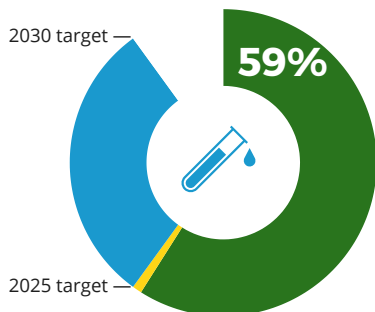
**New cases, 2021**  
(rate per 100,000)  
2025 target: 13 | 2030 target: 5

**HBV**

**New cases, 2021 not available**  
(rate per 100,000)  
2025 target: 11 | 2030 target: 2

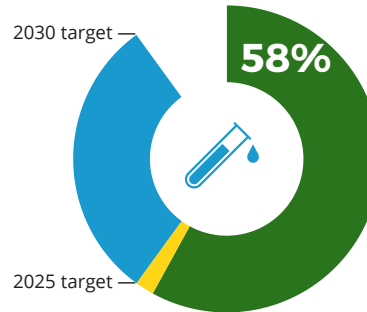
**8200** Estimated new infections, 2021  
(that's almost 1 per hour)

### HCV Diagnosis



**As of 2021, 59% of people who have chronic HCV in Canada were diagnosed.**  
2025 target: 60%  
2030 target: 90%

### HBV Diagnosis



**As of 2021, 58% of people who have chronic HBV in Canada were diagnosed.**  
2025 target: 60%  
2030 target: 90%



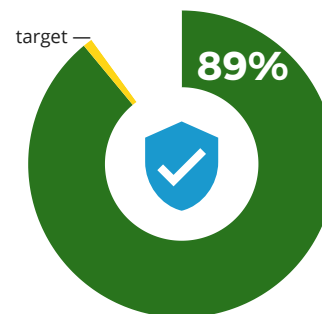
**2 in 5** people were **unaware** of their chronic viral hepatitis infection and could benefit from testing and treatment.

### HCV Treatment

Between 2012 and 2021, an estimated **108,000 people** with chronic HCV received treatment.

Between 2015 and 2021, more people were treated and cured each year than there were new infections.

### HBV Prevention



**As of 2021, 89% of 14-year-olds had received one or more doses of the hepatitis B vaccine.**  
2025 target: 90%  
2030 target: 90%

### Mortality

**972** known deaths attributed to HCV, 2021  
Rate of 3 per 100,000  
2025 target: ≤ 3 | 2030 target: ≤ 2

**274** known deaths attributed to HBV, 2021  
Rate of 1 per 100,000  
2025 target: ≤ 7 | 2030 target: ≤ 4

**As of 2021, and with the data available, Canada has achieved the 2025 mortality targets.**

**Notes:** The COVID-19 pandemic resulted in decreased testing, treatment, and care services for HBV and HCV. Also, potential underreporting of viral hepatitis as a cause on death certification is likely.



# FEDERAL ROLE AND RECOMMENDATIONS



## Federal Leadership Needed

While most people living with viral hepatitis receive health coverage through their province or territory, three priority populations receive their health coverage from the federal government: Indigenous people, those in federal prisons, and refugee claimants. The federal government also has an important role in health funding, data collection, and public health guidance.



### Planning

The national *STBBI Action Plan* was renewed in 2024 in consultation with stakeholders. However, the plan does not include any targets to measure progress toward the 2030 WHO goals.



### Screening Guidelines

Canadian Task Force on Preventive Health (CTFPHC) National screening guidelines for HCV remain risk-based, despite all evidence that risk-based guidelines are not effective.<sup>18, 19</sup> CTFPHC have no national guidelines for HBV.



### Testing-to-Treatment Link

HCV treatment numbers in many provinces have been stagnant or falling since peaking in 2018. Community-based organizations are best positioned to help link people who are often structurally excluded from mainstream healthcare settings to treatment and care for viral hepatitis (and other STBBI), with adequate funding to do so.



### Prevention

The federal government can and should provide funding and policy to support the further expansion of harm reduction programs in all Canadian jurisdictions, including federal correctional facilities, and encourage NACI to prioritize HBV birth dose vaccination recommendation.

## RECOMMENDED NEXT STEPS

- Develop targets for viral hepatitis as part of the national *STBBI Action Plan*, using a health equity lens, to measure progress in elimination of viral hepatitis.
- Provide multi-year funding to community-based organizations supporting priority populations for STBBI prevention and linkage-to-care programming in all Canadian jurisdictions.
- Update HCV screening guidelines and create HBV screening guidelines to provide rights- and evidence-based guidance.
- Prioritize HBV birth dose vaccination recommendations.
- Fund and increase efforts to collect updated HBV and HCV prevalence estimates for all Canadian provinces and territories.



# ALBERTA

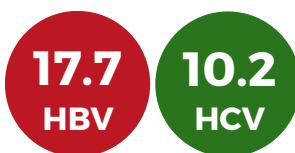


## CURRENT STATUS: ON TRACK FOR HCV, UNKNOWN FOR HBV



### New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV  
2030 target: 2 HBV, 5 HCV  
2019 rates: 17.0 HBV, 30.4 HCV



Estimated # of PLHCV (2015):  
**24,983**

Estimated # of PLHBV:  
**unknown**



### Planning

- Alberta Health developing updated STBBI framework that will include HCV and HBV



### Testing

- HCV RNA reflex testing implemented
- HCV prenatal testing implemented
- HBV universal one-time testing for all adults not implemented
- HDV reflex testing not implemented



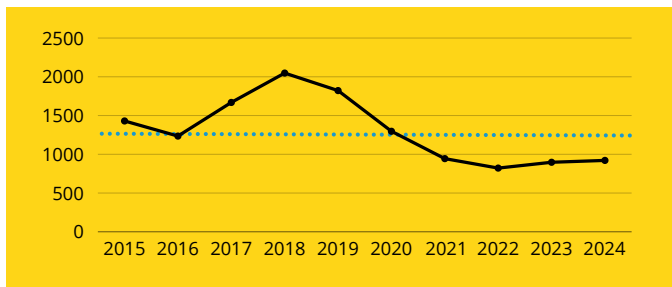
### Testing-to-Treatment Link

- HCV 1-day starts not possible  
Faxed approval forms take 1-3 days  
Blue Cross coverage costs and wait times a barrier
- 1st line recommended antivirals for HBV are on public formulary, but requires Blue Cross coverage, cost-prohibitive for some



### HCV Treatment

- Annual target: 1249



### Prevention

- New drug use equipment publicly funded and distributed through community channels, though not adequate in amount or accessibility to meet community needs
- Birth dose HBV vaccination not implemented  
1st dose offered at age 2 months
- Universal HBV vaccination for adults not recommended or publicly funded

### New HCV cases to HCV Tx starts (2023)

**479**

**897**

## PROGRESS

- ✓ Some improvements to HCV treatment access in provincial corrections.
- ✓ New HBV Primary Care Screening, Testing, and Monitoring Pathway in development.

## RECOMMENDATIONS

- Develop a viral hepatitis elimination strategy with testing and treatment targets.
- Remove reimbursement barriers to HBV and HCV treatment, including HCV reinfections.
- Ensure drug use equipment distribution matches the needs of the community in type, amount, and accessibility. Monitor and report.
- Implement universal HBV screening and “catch-up” vaccination for adults, and HBV vaccination for all babies at birth.

# BRITISH COLUMBIA

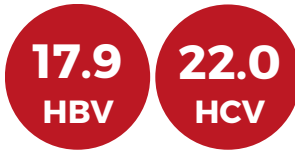


**CURRENT STATUS: ON TRACK FOR HCV, UNKNOWN FOR HBV**



## New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV  
 2030 target: 2 HBV, 5 HCV  
 2019 rates: 21.9 HBV, 37.7 HCV



Estimated # of PLHCV (2015):  
**28,607**

Estimated # of PLHBV:  
**unknown**



## Planning

- Ministry of Health funded consultation to develop the BC Viral Hepatitis Elimination Roadmap



## Testing

- HCV RNA reflex testing implemented
- HCV prenatal testing in process
- HBV universal one-time testing for all adults not implemented
- HDV reflex testing not implemented



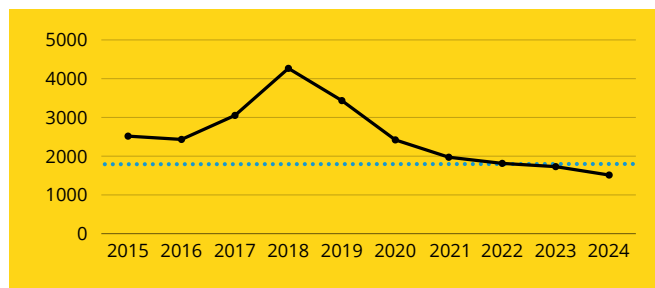
## Testing-to-Treatment Link

- HCV 1-day starts possible with Fibrosan  
 Fibrosis stage test still required
- 1st line recommended antivirals for HBV only available if LAM fails, and subject to annual deductible



## HCV Treatment

- Annual target: 1788



## Prevention

- New drug use equipment publicly funded and distributed through community channels, though not geographically equitable or adequate to meet community needs
- Birth dose HBV vaccination not implemented  
 1st dose offered at age 2 months
- Universal HBV vaccination for adults not recommended or publicly funded

New HCV cases to HCV Tx starts (2023)  
**1210**      **1730**

## PROGRESS

- ✓ Created online same-day approval for DAA reimbursement requests.
- ✓ Consistent, data-driven improvements, including Canada's first comprehensive viral hepatitis testing guidelines which include birth cohort HCV screening, access to HCV treatment in correctional settings, and allowing DBS test results for confirmation of chronic HCV.

## RECOMMENDATIONS

- Implement recommendations from BC Viral Hepatitis Elimination Roadmap.
- Ensure drug use equipment distribution matches the needs of the community geographically. Monitor and report.
- Implement universal HBV screening and "catch-up" vaccination for adults, and HBV vaccination for all babies at birth.

# MANITOBA

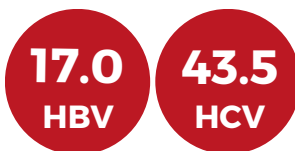


**CURRENT STATUS: NOT ON TRACK FOR HCV, UNKNOWN FOR HBV**



## New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV  
2030 target: 2 HBV, 5 HCV  
2019 rates: 21.0 HBV, 55.1 HCV



Estimated # of  
PLHCV (2015):

**8715**

Estimated # of  
PLHBV:

**unknown**

New HCV cases to HCV Tx starts  
(2023)

**631**

**217**



## Planning

- Updated HCV treatment protocol is elimination- and public health-oriented.



## Testing

- HCV antigen reflex testing implemented
- HCV prenatal testing not implemented
- HBV universal one-time testing for all adults not implemented
- HDV reflex testing not implemented



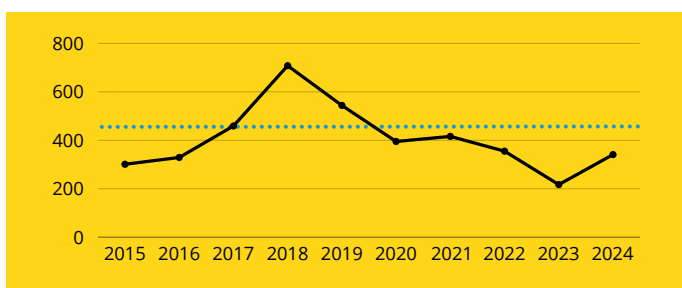
## Testing-to-Treatment Link

- HCV 1-day starts not possible  
Faxed approval form takes 2-14 days
- 1st line recommended antivirals for HBV are on public formulary



## HCV Treatment

- Annual target: 436



## Prevention

- New drug use equipment publicly funded and distributed through community channels, though not geographically equitable to meet community needs
- Birth dose HBV vaccination not implemented  
1st dose offered at age 11
- Universal HBV vaccination for adults not recommended or publicly funded

## PROGRESS

- ✓ Strong harm reduction network with relationships with health units.
- ✓ Updated HCV treatment protocol to broaden treatment access, remove barriers, and encourage treatment of all chronic HCV infections, including reinfections.
- ✓ Program being developed to decentralize HCV treatment and care.

## RECOMMENDATIONS

- Set annual provincial targets for viral hepatitis testing and treatment.
- Continue to decentralize HCV treatment and care beyond specialists to allow for community-based treatment starts.
- Implement HBV vaccination at birth for all babies, and universal HBV screening and vaccination for adults.

# NEW BRUNSWICK



**CURRENT STATUS: ON TRACK FOR HCV, UNKNOWN FOR HBV**



## New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV

2030 target: 2 HBV, 5 HCV

2019 rates: 8.0 HBV, 32.7 HCV

12.5  
HBV

25.3  
HCV

Estimated # of  
PLHCV (2015):

2559

Estimated # of  
PLHBV:

unknown



## Planning

- Ministry of Health will soon release an updated STBBI Action Plan and HCV Elimination Plan



## Testing

- HCV RNA reflex testing implemented
- HCV prenatal testing not implemented
- HBV universal one-time testing for all adults not implemented
- HDV reflex testing not implemented



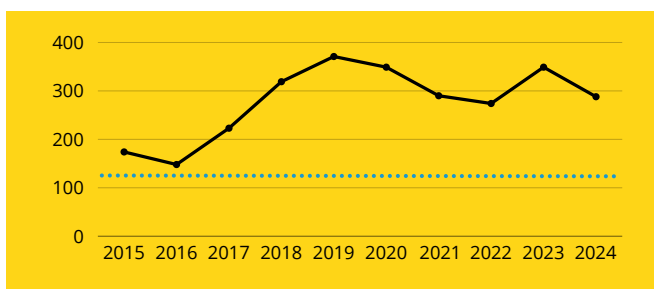
## Testing-to-Treatment Link

- HCV 1-day starts not possible  
Reflex RNA results take 1-2 weeks, faxed approval form takes 2-5 days
- 1st line recommended antivirals for HBV are on public formulary



## HCV Treatment

- Annual target: 128



## Prevention

- New drug use equipment publicly funded and distributed through community channels, though not adequate to meet community needs and not geographically equitable
- Birth dose HBV vaccination implemented
- Universal HBV vaccination for adults not recommended or publicly funded

New HCV cases to HCV Tx starts  
(2023)

211

349

## PROGRESS


- ✓ Currently developing an HCV elimination strategy as part of an updated STBBI plan.
- ✓ Removed unnecessary genotype and fibrosis test requirements for HCV treatment reimbursement.

## RECOMMENDATIONS

- Set annual provincial targets for viral hepatitis testing and treatment.
- Ensure drug use equipment distribution matches the needs of the community in type, amount, and geographical accessibility. Monitor and report.
- Fund POC testing and accept results for treatment reimbursement, and /or streamline laboratory testing for quicker results.
- Implement HBV screening and "catch-up" vaccination for adults.

# NEWFOUNDLAND & LABRADOR

**CURRENT STATUS: ON TRACK FOR HCV, UNKNOWN FOR HBV**


 **New case rates per 100,000 (2023)**  
 2025 target: 11 HBV, 13 HCV  
 2030 target: 2 HBV, 5 HCV  
 2019 rates: 1.9 HBV, 36.1 HCV

3.7  
HBV

30.3  
HCV

**Estimated # of PLHCV (2015):**  
**664**


**Estimated # of PLHBV:**  
**unknown**

 **Planning**

- The new Newfoundland HCV elimination strategy, co-led by community, is pending government approval

**New HCV cases to HCV Tx starts (2023)**


163
140

 **Testing**

- HCV RNA reflex testing implemented
- HCV prenatal testing implemented
- HBV universal one-time testing for all adults not implemented
- HDV reflex testing not implemented

**PROGRESS**

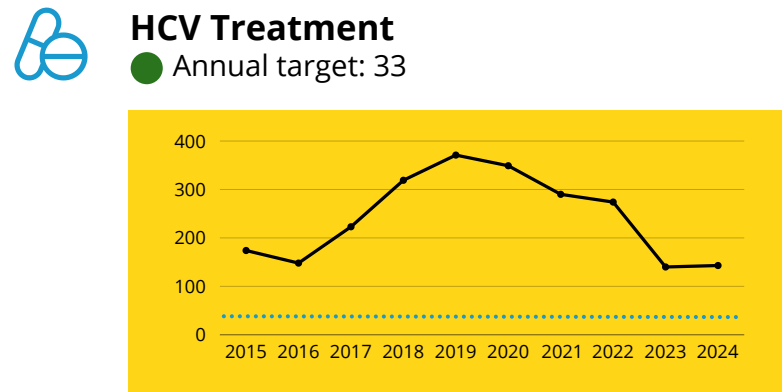
- ✓ Developed an HCV elimination strategy, co-led by community.
- ✓ Created a mechanism for same-day starts.
- ✓ Made HCV treatment available in correctional settings.


 **Testing-to-Treatment Link**

- HCV 1-day starts possible
- 1st line recommended antivirals for HBV only available if LAM fails

**RECOMMENDATIONS**

- Set annual targets for viral hepatitis testing and treatment.
- Continue efforts to decentralize HCV treatment and care.
- Implement HBV vaccination at birth for all babies, and universal HBV screening and “catch-up” vaccination for adults.



 **Prevention**

- New drug use equipment publicly funded and distributed through community channels, including mailout program for rural and remote; budget regularly increased to reflect community needs
- Birth dose HBV vaccination not implemented 1st dose offered at age 11
- Universal HBV vaccination for adults not recommended or publicly funded

# NOVA SCOTIA

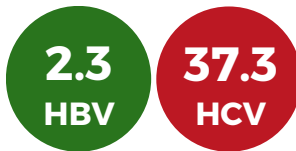


**CURRENT STATUS: ON TRACK FOR HCV, UNKNOWN FOR HBV**



## New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV  
 2030 target: 2 HBV, 5 HCV  
 2019 rates: 2.3 HBV, 33.1 HCV



Estimated # of PLHCV (2015):

**4411**

Estimated # of PLHBV:

**unknown**



## Planning

- No elimination plan or strategy in place

New HCV cases to HCV Tx starts (2023)

**395**

**604**



## Testing

- HCV RNA reflex testing implemented
- HCV prenatal testing not implemented
- HBV universal one-time testing for all adults not implemented
- HDV reflex testing not implemented

## PROGRESS

- ✓ Code implemented to remove approval requirement for DAA reimbursement.
- ✓ Removed unnecessary testing requirements for reimbursement.



## Testing-to-Treatment Link

- HCV 1-day starts almost possible  
All barriers removed except POC RNA test for approval
- 1st line recommended antivirals for HBV are on public formulary

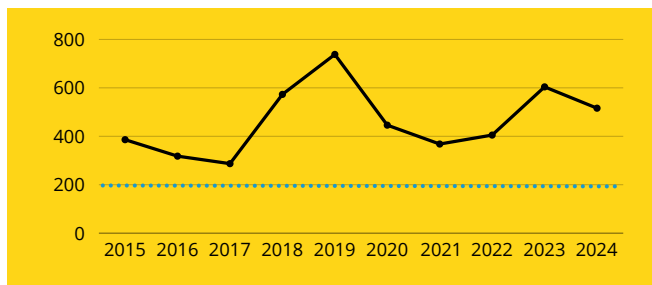
## RECOMMENDATIONS

- Develop an elimination strategy with annual provincial targets for viral hepatitis testing and treatment.
- Ensure drug use equipment distribution matches the needs of the community in both type and amount. Monitor and report.
- Implement universal HCV prenatal testing.
- Implement HBV vaccination at birth for all babies, and universal HBV screening and "catch-up" vaccination for adults.



## HCV Treatment

- Annual target: 221



## Prevention

- New drug use equipment publicly funded and distributed through community channels, though funding has not kept up with increased demand and costs to meet community needs
- Birth dose HBV vaccination not implemented  
1st dose offered at age 12
- Universal HBV vaccination for adults not recommended or publicly funded

# ONTARIO

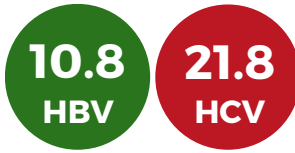


**CURRENT STATUS: NOT ON TRACK FOR HCV, UNKNOWN FOR HBV**



## New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV  
2030 target: 2 HBV, 5 HCV  
2019 rates: 13.5 HBV, 33.4 HCV



Estimated # of PLHCV (2015):  
**119,104**

Estimated # of PLHBV:  
**unknown**



## Planning

- Ministry of Health participated in an ex-officio capacity in the development of the *Ontario Roadmap to HCV Elimination* and is a partner and funder in implementation.



## Testing

- HCV RNA reflex testing implemented
- HCV prenatal testing not implemented
- HBV universal one-time testing for all adults not implemented
- HDV reflex testing not implemented



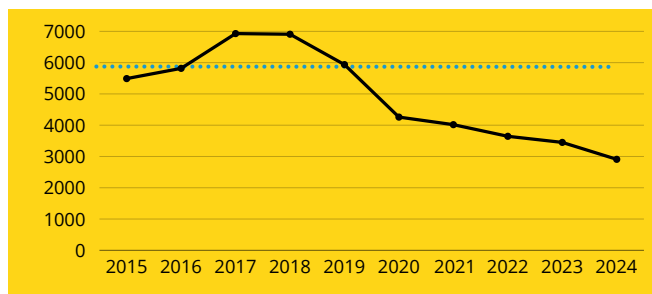
## Testing-to-Treatment Link

- HCV 1-day starts possible
- 1st line recommended antivirals for HBV are on public formulary



## HCV Treatment

- Annual target: 5955



## Prevention

- New drug use equipment publicly funded and distributed through community channels, though access varies; some CTS closed, and new HART Hubs not offering drug use equipment distribution
- Birth dose HBV vaccination not implemented 1st dose offered at age 12
- Universal HBV vaccination for adults not recommended or publicly funded

New HCV cases to HCV Tx starts (2023)  
**3400**      **3450**

## PROGRESS

- ✓ Leading the country in policies that support integration of POC and DBS tests.
- ✓ Data-driven HCV policy improvements, including removal of 6-month confirmatory testing requirement, RNA reflex testing, and improved testing and treatment access in correctional settings.

## RECOMMENDATIONS

- Set annual viral hepatitis testing and treatment targets.
- Ensure drug use equipment distribution matches the needs of the community in amount and accessibility. Monitor and report.
- Develop and implement broader screening guidelines to capture new cases and link them to care.
- Implement HBV vaccination at birth for all babies, and universal HBV screening and "catch-up" vaccination for adults.



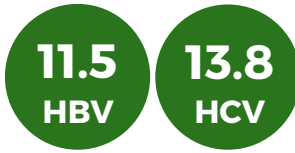
# PRINCE EDWARD ISLAND

**CURRENT STATUS: ON TRACK FOR HCV, UNKNOWN FOR HBV**



## New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV  
 2030 target: 2 HBV, 5 HCV  
 2019 rates: 15.4 HBV, 33.4 HCV



Estimated # of  
 PLHCV (2015):

**624**

Estimated # of  
 PLHBV:

**unknown**



## Planning

- PEI 10-year hepatitis C management and treatment strategy in place since 2018



## Testing

- HCV RNA reflex testing implemented
- HCV prenatal testing partially implemented
- HBV universal one-time testing for all adults not implemented
- HDV reflex testing not implemented



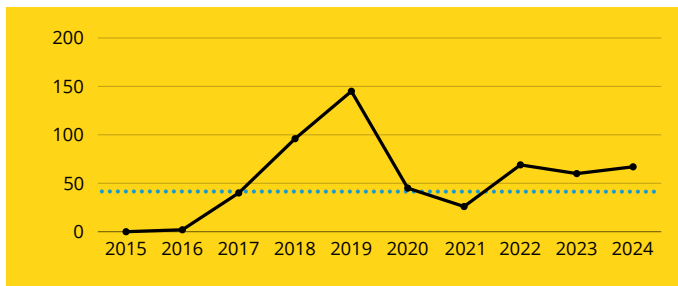
## Testing-to-Treatment Link

- HCV 1-day starts possible
- 1st line recommended antivirals for HBV are on public formulary



## HCV Treatment

- Annual target: 31



## Prevention

- New drug use equipment publicly funded and distributed through community channels, though type, amount and accessibility not adequate to meet community needs
- Birth dose HBV vaccination not implemented 1st dose offered at age 2 months
- Universal HBV vaccination for adults not recommended or publicly funded

New HCV cases to HCV Tx starts  
 (2023)

**24**

**60**

## PROGRESS

- ✓ Widespread rollout and adoption of dried blood spot testing provincially.
- ✓ New liver clinic providing care to all HBV patients in the province.
- ✓ Dedicated HCV prescribers in OAT, addiction, and correctional facilities.

## RECOMMENDATIONS

- Continue expanding HCV strategy to include HBV.
- Ensure drug use equipment distribution to the needs of the community in both type and amount. Monitor and report.
- Continue expanding funded POC testing options.
- Implement universal HBV screening and "catch-up" vaccination for adults, and vaccination at birth for all babies.



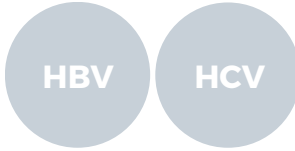


## CURRENT STATUS: NOT ON TRACK FOR HCV, UNKNOWN FOR HBV



### New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV  
 2030 target: 2 HBV, 5 HCV  
 2019 rates: 12.1 HBV, 12.8 HCV



Estimated # of  
 PLHCV (2015):  
**49,794**

Estimated # of  
 PLHBV:  
**unknown**



### Planning

- Ministry of Health declined to participate in the development of *Élimination de l'hépatite C. Feuille de route Québec*



### Testing

- HCV RNA reflex testing not implemented
- HCV prenatal testing not implemented
- HBV universal one-time testing for all adults not implemented
- HDV reflex DNA testing not implemented



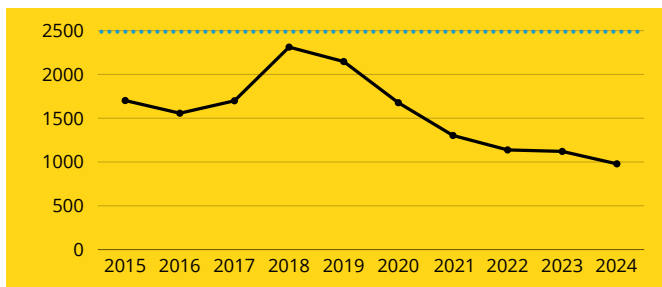
### Testing-to-Treatment Link

- HCV 1-day starts almost possible
- All barriers removed except POC RNA test for approval
- 1st line recommended antivirals for HBV are on public formulary



### HCV Treatment

- Annual target: 2490



### Prevention

- New drug use equipment publicly funded and distributed through community channels, though not in adequate amount to meet community needs
- Birth dose HBV vaccination not implemented 1st dose offered at age 2 months
- Universal HBV vaccination for adults not recommended or publicly funded

New HCV cases to HCV Tx starts (2023)  
**unknown 1121**

### PROGRESS

- ✓ No restrictions on who can prescribe or submit for DAA reimbursement, automatic approvals.

### RECOMMENDATIONS

- Endorse and implement *Élimination de l'hépatite C. Feuille de route Québec* when completed.
- Ensure drug use equipment distribution matches the needs of the community in amount and accessibility. Monitor and report.
- Implement HCV RNA reflex testing and universal HCV prenatal testing.
- Implement universal HBV screening and "catch-up" vaccination for adults, and HBV vaccination at birth for all babies.

# SASKATCHEWAN

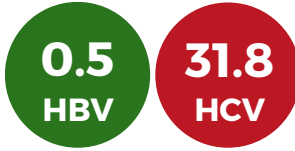


**CURRENT STATUS: ON TRACK FOR HCV, UNKNOWN FOR HBV**



## New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV  
2030 target: 2 HBV, 5 HCV  
2019 rates: 10.7 HBV, 52.5 HCV



Estimated # of PLHCV (2015):

**6467**

Estimated # of PLHBV:

**unknown**

New HCV cases to HCV Tx starts (2023)

**401**

**960**



## Planning

- No elimination plan or strategy in place



## Testing

- HCV RNA reflex testing implemented
- HCV prenatal testing implemented
- HBV universal one-time testing for all adults not implemented
- HDV reflex testing not implemented



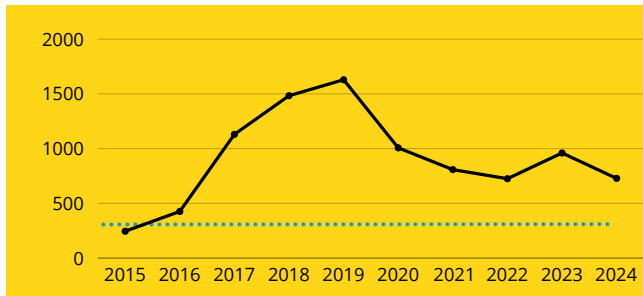
## Testing-to-Treatment Link

- HCV 1-day starts possible
- 1st line recommended antivirals for HBV are on public formulary



## HCV Treatment

- Annual target: 323



## Prevention

- Some new drug use equipment publicly funded, though not meeting community needs in type, distribution model, amount, or accessibility. Harm reduction education defunded.
- Birth dose HBV vaccination not implemented  
1st dose offered at age 11
- Universal HBV vaccination for adults not recommended or publicly funded

## PROGRESS

- ✓ Automatic approval for DAA reimbursements, and co-pay removed.
- ✓ HCV treatment numbers have stayed above target since 2016.

## RECOMMENDATIONS

- Develop an elimination plan that includes targets.
- Ensure drug use equipment distribution matches the needs of the community in type and amount, in evidence-based models, and reinstate harm reduction education. Monitor and report.
- Implement HBV vaccination at birth for all babies, and universal HBV screening and "catch-up" vaccination for adults.

# NORTHWEST TERRITORIES



## CURRENT STATUS: UNKNOWN



### New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV

2030 target: 2 HBV, 5 HCV

2019 rates: 6.7 HBV, 8.9 HCV

HBV

HCV

Estimated # of  
PLHCV (2015):

**778**

Estimated # of  
PLHBV:

**unknown**

New HCV cases to HCV Tx starts  
(2023)

**unknown unknown**



### Planning

- Elimination plan or strategy unknown



### Testing

- HCV RNA reflex testing policy unknown
- HCV prenatal testing policy unknown
- HBV universal one-time testing for all adults not implemented
- HDV reflex DNA testing policy unknown



### Testing-to-Treatment Link

- HCV 1-day starts not quite possible  
Faxed approval forms take 1-3 days
- 1st line recommended antivirals for HBV are on public formulary



### HCV Treatment

- Annual target: 39

Annual treatment count data not available



### Prevention

- Status of new drug use equipment publicly funded and distributed through community channels unknown
- Birth dose HBV vaccination implemented
- Universal HBV vaccination for adults not recommended or publicly funded

## RECOMMENDATIONS

- Develop an elimination plan that includes targets, in consultation with priority populations and using a health equity lens.
- Ensure drug use equipment distribution matches the needs of the community in type, amount, and availability.
- Implement universal HBV screening and “catch-up” vaccination for adults.
- Collect and share data that allows for monitoring of progress toward elimination targets.



## CURRENT STATUS: UNKNOWN



### New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV

2030 target: 2 HBV, 5 HCV

2019 rates: 10.4 HBV, 5.2 HCV

HBV

HCV

Estimated # of  
PLHCV (2015):

**243**

Estimated # of  
PLHBV:

**unknown**

New HCV cases to HCV Tx starts  
(2023)

**unknown unknown**



### Planning

- Elimination plan or strategy unknown



### Testing

- HCV RNA reflex testing implemented
- HCV prenatal testing policy unknown
- HBV universal one-time testing for all adults not implemented
- HDV reflex DNA testing policy unknown



### Testing-to-Treatment Link

- HCV 1-day starts not quite possible  
Faxed approval forms take 1-3 days
- 1st line recommended antivirals for HBV are on public formulary



### HCV Treatment

- Annual target: 12

Annual treatment count data not available



### Prevention

- Status of new drug use equipment publicly funded and distributed through community channels unknown
- Birth dose HBV vaccination implemented
- Universal HBV vaccination for adults not recommended or publicly funded

## RECOMMENDATIONS

- Develop an elimination plan that includes targets, in consultation with priority populations and using a health equity lens.
- Ensure drug use equipment distribution matches the needs of the community in type, amount, and availability.
- Implement universal HBV screening and “catch-up” vaccination for adults.
- Collect and share data that allows for monitoring of progress toward elimination targets.

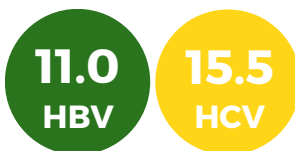


## CURRENT STATUS: ON TRACK FOR HCV, UNKNOWN FOR HBV



### New case rates per 100,000 (2023)

2025 target: 11 HBV, 13 HCV  
 2030 target: 2 HBV, 5 HCV  
 2019 rates: 5.0 HBV, 33.8 HCV



Estimated # of  
 PLHCV (2018):

**423**

Estimated # of  
 PLHBV:

**unknown**

New HCV cases to HCV Tx starts  
 (2023)

**7**

**14**



### Planning

- No elimination plan or strategy in place



### Testing

- HCV RNA reflex testing implemented
- HCV prenatal testing implemented
- HBV universal one-time testing for all adults not implemented
- HDV reflex testing not implemented



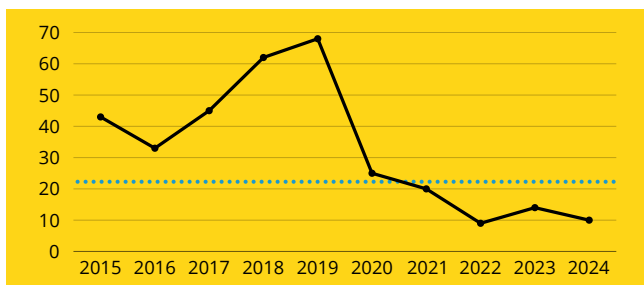
### Testing-to-Treatment Link

- HCV 1-day starts not quite possible  
 Faxed approval form takes 1-3 days
- 1st line recommended antivirals for HBV are on public formulary



### HCV Treatment

- Annual target: 21



### Prevention

- New drug use equipment publicly funded and distributed through community channels in adequate amounts and types but with geographical inequities
- Birth dose HBV vaccination not implemented  
 1st dose offered at age 2 months
- Universal HBV vaccination for adults not recommended or publicly funded

## PROGRESS

- ✓ HCV prenatal testing implemented
- ✓ Currently undertaking database and EMR improvements to follow up on previous untreated HCV cases and identify barriers to care

## RECOMMENDATIONS

- Develop an elimination plan that includes targets.
- Develop a treatment pathway that allows people to start treatment in their own community rather than requiring them to come to Whitehorse for an in-person appointment with a visiting specialist.
- Fund POC testing and accept results for treatment reimbursement.
- Implement universal HBV screening and "catch-up" vaccination for adults and HBV vaccination at birth for all babies.

# CORRECTIONS: FEDERAL

## CURRENT STATUS: UNKNOWN FOR HCV AND HBV

- Supervision of custody for people with a sentence of two years or more is the responsibility of the federal government. The Correctional Service of Canada (CSC) runs the 43 federal prisons and is responsible for all policies related to, and the provision or delivery of, health care in these facilities.
- Given the close relationship between **imprisonment, injection drug use, and HCV**, people who are incarcerated and living with HCV are likely one of the most marginalized patient groups affected by HCV. They are also **less likely to access health services in any other setting** and face higher risk of HCV infection, occurring both in prison and in the community following release.<sup>20</sup>
- **The delivery of viral hepatitis care, to people who are incarcerated in Canada—including prevention—is essential to viral hepatitis elimination.**<sup>20</sup>
- CSC representatives presented data at the BCCSU Conference in 2023 that suggested prevalence among PWAI by CSC was going down. However, that data is not publicly available, and the lack of transparency in testing and treatment progress and the lack of reinfection/prevention strategy is of ongoing concern.



### HCV Testing Policy

- Opt-in testing offered at admission and available on demand during incarceration
- No recent reporting on # and proportion of those receiving an HCV test at admission



### HCV Treatment Access

- Everyone eligible, regardless of disease stage
- No reporting on # and proportion of those offered treatment.

CSC reports only the % of people who have cleared their infection of those who completed treatment. This is a metric of little value that simply confirms the efficacy of DAAs, despite stating a commitment to WHO elimination targets in the same report.<sup>21</sup>



### Prevention

- **Education:** Comprehensive STBBI education not provided for PWAI, correctional officers, and healthcare staff
- **PNEP:** Needle exchange available in only 12 of 43 institutions; model lacks confidentiality
- **OPS:** Overdose Prevention Site available in 4 of 43 institutions
- **OAT:** Opioid Agonist Therapy is available in all institutions, both as maintenance and new start prescriptions
- **HBV Vaccine:** All PWAI are offered an HBV vaccine (as per NACI recommendation)<sup>22</sup>

“Every dollar invested in the current PNEP or its expansion is estimated to save \$2 in costs for treating hepatitis C and injection-related infections. This study adds to the growing body of evidence supporting PNEPs as effective harm reduction strategies that are also cost-saving.

- Dr. Nadine Kronfli, citing a new 2024 study<sup>16</sup>

## RECOMMENDATIONS

- Implement Prison Needle Exchange Programs (PNEP) across all correctional centres using a model with multiple distribution channels for accessibility and anonymity.
- Implement Overdose Prevention Sites (OPS) across all correctional centres.
- Begin reporting HCV testing and treatment uptake.
- Provide comprehensive STBBI education for all PWAI, correctional officers, and healthcare staff.



# CORRECTIONS: PROVINCIAL

## CURRENT STATUS: NOT ON TRACK

- The Ministry for Public Safety and Solicitor General (or equivalent) in each province or territory runs the provincial and territorial correctional facilities. It is responsible for the supervision of custody for those sentenced to less than two years and people held on pretrial remand or awaiting sentencing.
- **Continuity of HCV care upon release is a major challenge** for correctional systems globally, with calls to streamline the provision of health care in corrections with health care in the community.<sup>23</sup>
- In provinces that have transferred the responsibility for the provision of health care from **corrections authorities to local health authorities, improvements in health care have been reported.**<sup>24</sup>
- Viral hepatitis (and other STBBI) screening, treatment, and care **need to occur both in the community and in corrections in order to decrease transmission.**
- When the same standard of health care, including prevention measures such as harm reduction, is not available to people in correctional facilities as in the community, it is a **contravention of the UN Standard Minimum Rules for the Treatment of Prisoners** (Nelson Mandela Rules).<sup>25</sup>

**Table 3.** Review of provincial/territorial policies related to viral hepatitis, 2025

	MOH responsible for health care services in corrections	Access to HCV testing and treatment equivalent to access in community	Reporting on # and proportion of PWAI being tested and treated	Linkage to care at release for PWAI who are HCV+ but tx not completed	NSP for disease prevention	OAT (maintenance & new start prescriptions) available to all PWAI	HBV vaccination offered universally to PWAI and staff
AB	yes	partial*	no	yes**	no	yes	no
BC	yes	yes	yes	yes	no	yes	yes
MB	no	no	no	no	no	Maintenance	yes
NB	no	yes	no	no	no	Maintenance	no
NL	yes	yes	yes	yes	no	yes	no
NS	yes	yes	no	no	no	Maintenance	yes
ON	no	no	no	yes	no	Maintenance	no
PE	no	yes	no	unknown	no	unknown	unknown
QC	yes	no	no	unknown	no	yes	yes
SK	no	yes	no	no	no	Maintenance	no
NT	unknown	unknown	unknown	unknown	no	unknown	unknown
NU	unknown	unknown	unknown	unknown	no	unknown	unknown
YT	no	yes	no	yes	no	yes	yes

\*Eligibility restrictions removed, other than requirement for sentence to be at least 24 weeks

\*\* Pilot

“Only those who come into the facility with a current prescription get access to OAT. This is a huge problem, of course, because people are suffering and it is unnecessary. We have a whole building of people sharing OAT, finding ways to pay for these meds, often owing money or favours. It keeps the cycle going. There just needs to be accessible treatment.

- Provincial corrections social worker

## RECOMMENDATIONS

- Offer universal opt-out STBBI testing in all correctional centres, with informed consent, and report on uptake.
- Offer treatment and/or linkage to care on release to everyone diagnosed with active HCV and report on uptake.
- Implement Needle Syringe Programs (NSP) across all correctional centres using a model with that provides accessibility and anonymity.
- Provide OAT initiation, maintenance, and continuity upon release.
- Provide at least 30 days of pharmacare/drug plan coverage at release to allow for continuity of treatments, including OAT.
- Provide HBV vaccinations.

# POINT-OF-CARE and DRIED BLOOD SPOT TESTING



## Point-Of-Care (POC) Testing

- Providing effective links from testing to treatment in an equitable way, especially among priority populations, remains a challenge.
- One solution is POC tests, especially those that non-healthcare professionals can administer in non-traditional settings, like pharmacies, supervised consumption sites, prisons, and mobile outreach services.
- POC tests provide results at the site where samples are collected, meaning **results can be provided same-day**, usually within minutes. This can help increase the number of people who are aware of their status.
- Two POC tests came to the Canadian market in the last few months: a second option for rapid HCV antibody tests, and the first HCV RNA confirmatory test.
- **To fully benefit from these new technologies, P/Ts need policies that support new platforms (including public funding), allow health services to capture and action results, integrate data, and support reimbursement.**<sup>26</sup>

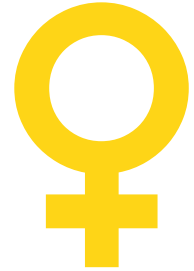
## Dried Blood Spot (DBS) Testing

- While Dried Blood Spot (DBS) tests do not have the benefit of providing quick results on-site like POC tests, they do allow for non-healthcare professionals to collect samples in non-traditional settings.
- The ease of sample collecting and the stability of the collected sample (they do not need to be refrigerated) make DBS tests a useful tool, especially in rural and remote communities where transportation of blood samples to a lab may otherwise be challenging.
- DBS tests provide unique opportunities to improve health equity in HCV diagnosis and linkage to care in certain settings, reaching people who have previously not been tested.
- Importantly, DBS tests are useful in situations where it is only feasible to collect one blood sample for both antibody and confirmatory RNA testing.
- Prince Edward Island, British Columbia, and Ontario have policies that allow DBS tests to be submitted for reimbursement for HCV treatment province-wide, removing the need for confirmatory blood draws by a clinician.
- **To fully benefit from DBS testing, all P/Ts need to begin processing DBS tests in their labs and accept DBS results for treatment reimbursement.**<sup>27</sup>



# EMERGING PRIORITY POPULATION: WOMEN

- **HCV is on the rise** in women, pregnant people, and their newborns.<sup>28</sup>
- This increase is likely related to the rising number of women who use drugs (WUD): WUD face higher risks of acquiring viral hepatitis and HIV than their male counterparts.<sup>29, 30</sup>
- WUD have less control over access to drugs and injecting equipment, less access to harm reduction and treatment services, and are more likely than men to be “second on the needle” (i.e. they inject after, and often are injected by, a male partner).<sup>29-31</sup>
- Despite the gendered dynamics of injection drug use being well documented, gender responsive harm reduction services are very limited.<sup>32</sup>



## Prenatal Screening

- **New guidelines** from the Society of Obstetricians and Gynaecologists of Canada (SOGC) were published in 2025 and recommend adding HCV to HBV and HIV in prenatal screening.<sup>11</sup>
- In addition, DAA treatments for HCV were approved for use with children from three years of age in 2022.<sup>33</sup>
- **Universally offering screening of HCV among people who are pregnant has the potential to eliminate vertical (birthing parent-to-child) transmission.**
- Although most P/Ts have implemented universal HBV prenatal screening, reflex HBV DNA testing and linkage to care in pregnancy is not consistent. Some women with high HBV DNA may benefit from treatment in pregnancy to reduce risk of vertical transmission.

### However, HCV prenatal screening is not enough:

- Not all women become pregnant.
- Not all people who are pregnant seek or are able to access prenatal care—especially those who have had negative experiences with mainstream healthcare, including WUD.<sup>29, 34</sup>
- Whether it is still practice or not, it is a commonly held belief in many marginalized populations that being identified as a WUD during prenatal care can result in babies being apprehended.<sup>34, 35</sup>
- Addressing the structural causes of increased risk for HCV infection requires gender responsive harm reduction programs and services to help prevent the spread of viral hepatitis and other STBBIs.<sup>29, 31, 32</sup>

“With a gender lens, we see women and gender diverse people who use drugs are inadequately served. Commitment to ‘see’ and meet the harm reduction needs of women and gender diverse people must be redoubled in all countries.

- Women and Harm Reduction International Network

# LIMITATIONS and DATA GAPS



## Prevalence and Treatment Data

- As has been the case since the first progress report in 2021, it was difficult to determine what the annual HCV treatment initiation target for each province and territory should be, as there are few recently published sub-national prevalence estimates.
- Similarly for HBV, we are unable to measure progress on elimination targets without prevalence estimates at the P/T level.
- HCV and HBV prevalence estimates should be updated urgently for all provinces and territories.
- Treatment data for most P/Ts is not only not available to Action Hepatitis Canada and researchers for free, it is also not provided to PHAC or to most P/T public health teams. The data that is available for HCV is expensive and is modelled, and credible data for HBV treatment does not seem to be available, even for purchase.
- Reliable, accessible data on treatment numbers for both HCV and HBV are needed to monitor progress toward the 2030 elimination target.

## Health Equity Data

- The care cascades that are available, both nationally and provincially, do not use an intersectional approach, nor are there metrics provided to measure our frameworks from a health equity perspective. More work needs to be done in this area to help us all measure barriers for priority populations and more specifically, where those priority populations intersect.

**HOW WILL WE KNOW IF WE HAVE ELIMINATED VIRAL  
HEPATITIS IN 2030 WITHOUT ACCURATE DATA?**

# Monitoring & Evaluation Methodology



## Metric 1: Decrease in new cases of HCV and HBV

### Rationale:

One of the original global targets for viral hepatitis elimination was a 30% reduction in new cases of chronic viral HCV and HBV infections by 2020 and a 90% reduction in new cases by 2030. In 2023, this target was updated to absolute targets as rates per 100,000 population. These targets are five new cases of HCV annually per 100,000 and just two new cases of HBV annually per 100,000.

Target rates for 2025 provided by the WHO are 13 for HCV and 11 for HBV.

### Monitoring & Evaluation Methodology:

Similar to PHAC, we use new *reported* cases as a proxy for new cases. We reviewed the reports of new cases (reported as both number of cases and rates per 100,000) of HCV and HBV in 2023 for each province and territory. We have listed 2019 rates in the table as well as a comparison.<sup>36</sup>

If rates are at or below the 2025 target, we list them as green. If rates are above but close to the 2025 target, we list them as yellow. If rates are far above 2025 target, we list them as red.

**Table 4.** Review of provincial/territorial reports of new cases of both HCV and HBV, 2019 and 2023

	HCV Rate 2019	HCV Rate 2023	HCV Cases 2023	HBV Rate 2019	HBV Rate 2023	HBV Cases 2023	Source
<b>2025/2030 Target</b>	13/5			11/2			
<b>AB</b>	30.4	10.2	479	17.0	17.7	832	37
<b>BC</b>	37.7	22.0	1210	21.9	17.9	982	38
<b>MB</b>	55.1	43.5	631	21.0	17.0	246	39
<b>NB</b>	32.7	25.3	211	8.0	12.5	105	40
<b>NL</b>	36.1	30.3	163	1.9	3.7	20	41
<b>NS</b>	33.1	37.3	395	2.3	2.3	24	42
<b>ON</b>	33.4	21.8	3400	13.5	10.8	1686	43
<b>PE</b>	33.4	13.5	24	2.5	11.5	22	44
<b>QC</b>	12.8	Unknown	Unknown	12.1	Unknown	Unknown	
<b>SK</b>	52.5	31.8	401	10.7	0.5	6	45
<b>NT</b>	8.9	Unknown	Unknown	6.7	Unknown	Unknown	
<b>NU</b>	5.2	Unknown	Unknown	10.4	Unknown	Unknown	
<b>YT</b>	33.8	15.5	7	5.0	11.0	5	46



## Metric 2: Elimination Plan or Strategy in Place

### Rationale:

Each province and territory in Canada must create and implement its own strategy toward viral hepatitis elimination that includes and evaluates progress on targets for prevention, testing, and treatment of viral hepatitis cases.

### Monitoring & Evaluation Methodology:

We reviewed provincial and territorial Ministry of Health websites and asked staff within each provincial and territorial Ministry of Health if they have a current strategy or action plan, either for STBBIs or for viral hepatitis specifically. If so, we also evaluated whether they included any goals or targets to measure viral hepatitis prevention, testing, and treatment targets or goals oriented toward WHO, PHAC, or *Blueprint* elimination targets.

**Table 5.** Review of provincial/territorial policies regarding viral hepatitis elimination, 2025

	Most recent policy including viral hepatitis elimination goals or targets	Year released
<b>AB</b>	Alberta Health and STBBI Action Team developing updated STBBI framework to include HCV/HBV <span style="float: right;">●</span>	TBD
<b>BC</b>	Ministry of Health funding consultations for the development of the BC Viral Hepatitis Elimination Roadmap <span style="float: right;">●</span>	TBD
<b>MB</b>	Updated HCV treatment protocol is elimination- and public health-oriented. <span style="float: right;">●</span>	2024
<b>NB</b>	Ministry of Health will soon release an HCV Elimination Plan <span style="float: right;">●</span>	TBD
<b>NL</b>	HCV Elimination Strategy complete and pending government approval <span style="float: right;">●</span>	2025
<b>NS</b>	None <span style="float: right;">●</span>	-
<b>ON</b>	Ministry of Health participated in an ex-officio capacity in the development of Ontario's Roadmap to Hepatitis C Elimination, and participating in the implementation as partner and funder. <span style="float: right;">●</span>	2023
<b>PE</b>	PEI 10-year hepatitis C management and treatment strategy <span style="float: right;">●</span>	2018
<b>QC</b>	Ministry of Health declined to be involved in the development of <i>Élimination de l'hépatite C. Feuille de route Québec</i> <span style="float: right;">●</span>	-
<b>SK</b>	None <span style="float: right;">●</span>	-
<b>NT</b>	Unknown <span style="float: right;">●</span>	-
<b>NU</b>	Unknown <span style="float: right;">●</span>	-
<b>YT</b>	None <span style="float: right;">●</span>	-



## **Metric 3: Testing For HCV and HBV**

### **i. Is HCV RNA or Antigen Reflex Testing Implemented?**

#### **Rationale:**

- **1 out of every 3** Canadians who have been diagnosed as HCV antibody positive has never received an HCV RNA test<sup>9</sup> to confirm if they actually have a chronic infection.
- Automatically reflexing on positive HCV antibody tests to the HCV RNA or antigen test is cost-effective and favoured by both patients and healthcare providers.<sup>9</sup>
- HCV RNA or antigen reflex testing has now been routinely implemented across most laboratories in Canada.

The *Blueprint to inform hepatitis C elimination efforts in Canada* recommends implementing HCV RNA reflex testing across all laboratories in Canada to ensure everyone moves through the HCV care cascade efficiently.

#### **Monitoring & Evaluation Methodology:**

An environmental scan on laboratory testing for HCV in Canada was conducted to determine the most recent or up-to-date HCV testing algorithms in each province and territory.

### **ii. Is HCV Prenatal Testing Implemented?**

#### **Rationale:**

- HCV is on the rise in pregnant people and their newborn babies.<sup>28</sup>
- Guidelines released in early 2025 from the Society of Obstetricians and Gynaecologists of Canada (SOGC) recommend adding HCV to prenatal screening panel.<sup>11</sup>
- Treatment of young children is now possible, as DAA treatments for HCV were approved for use with children from three years of age in 2022.<sup>33</sup>
- Universal screening of HCV among people who are pregnant has the potential to eliminate vertical (birthing parent-to-child) transmission.

#### **Monitoring & Evaluation Methodology:**

An environmental scan was conducted to determine which provincial and territorial governments have implemented HCV prenatal testing policies.

**Table 6.** Review of provincial/territorial implementation of HCV RNA and antigen reflex testing policy, and HCV Prenatal testing policy, 2025

	<b>HCV reflex RNA or antigen testing implemented?</b>	<b>HCV prenatal testing implemented?</b>
<b>AB</b>	● Yes	● Yes
<b>BC</b>	● Yes	● In process
<b>MB</b>	● Yes	● No
<b>NB</b>	● Yes	● No
<b>NL</b>	● Yes	● Yes
<b>NS</b>	● Yes	● No
<b>ON</b>	● Yes	● No
<b>PE</b>	● Yes	● No
<b>QC</b>	● No	● No
<b>SK</b>	● Yes	● Yes
<b>NT</b>	unknown	● No
<b>NU</b>	● Yes	● No
<b>YT</b>	● Yes	● Yes

### iii. Is One-Time HBV Testing for Adults Implemented?

**Rationale:**

- The Canadian Task Force on Preventive Health Care (CTFPHC) has not developed national screening guidelines for HBV. However, new guidelines from the United States recommend universal one-time screening for chronic hepatitis B infections in all adults, with consent.<sup>12</sup>
- The new US screening guidelines have been found to increase screening rates in primary clinics without increasing clinical burden while also removing the stigma of asking about risk factors.<sup>47</sup>

**Monitoring & Evaluation Methodology:**

An environmental scan was conducted to determine which provincial and territorial governments have implemented universal one-time HBV testing for adults.

No provinces or territories were found to have either of these policies in place, and there is no guidance from the CTFPHC on evidence-based HBV screening. HBV screening continues to be a patchwork of risk-based factors that differ from jurisdiction to jurisdiction.

#### **iv. Is Reflex HDV Testing Implemented?**

##### **Rationale:**

- Chronic hepatitis delta virus (HDV) is only found in people who have chronic hepatitis B. It is considered to be the most deadly of the hepatitis viruses because it progresses very quickly.
- A new treatment is now approved for use in Canada and is currently being reviewed by CDA for reimbursement recommendations, and early detection and treatment initiation are important to stop the progression of liver damage.
- The 2025 CASL/AMMI *Guidelines* recommend that all confirmed chronically infected samples (hepatitis B surface antigen positive) undergo reflex testing for HDV.<sup>13</sup>

##### **Monitoring & Evaluation Methodology:**

An environmental scan was conducted to determine which provincial and territorial governments have implemented HDV reflex testing.

No provinces or territories were found to have this policy in place.



## **Metric 4: Access to HCV and HBV Treatment Following Diagnosis**

### **i. Are One-Day HCV Treatment Starts Possible?**

#### **Rationale:**

- The HCV testing process is itself a barrier.
- In most settings, it requires three visits: screening for the antibody, RNA testing to confirm that the infection is still active, and receiving and discussing the results.
- Up to **three out of four people in priority populations are lost to care during this process.**<sup>9</sup>

**Simpler testing technology and approval policies would improve progression through the cascade of care to treatment and aid elimination efforts.**

Expediting linkage to care and treatment initiation, as suggested in the *Blueprint*, could close gaps in the cascade of care for HCV. To expedite linkage to care, "test-and-treat strategies," where treatment providers are able to initiate HCV treatment on the same day that they test and diagnose a patient, must be implemented in our efforts toward elimination.

#### **Monitoring & Evaluation Methodology:**

To determine the ability of treatment providers across Canada to initiate HCV treatment on the same day that a patient receives an HCV diagnosis, a review of the criteria for reimbursement of DAAs in the ten provincial, three territorial, and one federal publicly-funded drug plans was conducted.<sup>48</sup> Attempts to verify data were made with Ministry of Health staff in each province and territory between February and April of 2025 and are the source for any differences between the study cited and Table 7. Data for the "eligible prescribers" column in Table 7 comes from a 2023 study by Mandel et al.<sup>49</sup>

### **ii. Are 1st-line Recommended Antivirals for HBV Publicly Funded?**

#### **Rationale:**

The CASL/AMMI *Guidelines* make recommendations for first-line therapies for the management of chronic hepatitis B. This metric evaluates the accessibility of these first-line therapies on publicly-funded drug plans.

#### **Monitoring & Evaluation Methodology:**

To determine the ability of treatment providers across Canada to initiate 1st-line recommended therapies, a review of the criteria for reimbursement in the ten provincial and three territorial publicly-funded drug plans was conducted.

Restrictions detected included the requirement for the patient to have tried and failed with a non-recommended therapy such as lamivudine (LAM) before the first-line therapy would be reimbursed, and co-pays and deductibles in some jurisdictions that can make accessing treatment cost prohibitive.



**Table 7.** Matrix of HCV treatment reimbursement approval policies for Canadian publicly-funded drug plans, 2025

Public Drug Plan	POC HCV RNA test can be used for DAA approval	HCV genotype test required	Fibrosis stage required	2 HCV RNA+ tests required	Wait time and method for DAA approval	Eligible prescribers	Treatment for reinfection
Alberta	Unknown	No	No	No	Faxed form 1-3 days	Specialists + non-specialists w/ training on a restricted prescriber list	Considered case-by-case
British Columbia	Unknown	No	Yes	No	Online same day	Specialists + non-specialists w/ training on a restricted prescriber list	Yes
Manitoba	Unknown	No	No	No	Faxed form 2-14 days	Restricted prescriber list	Yes
New Brunswick	Unknown	No	No	No	Faxed form 2-5 days	Specialists + non-specialists w/ training on a restricted prescriber list	Yes
Newfoundland & Labrador	Yes	No	No	No	Faxed form same day	No specific restrictions	Yes
Nova Scotia	Unknown	No	No	No	Approval not required	Specialists + non-specialists w/ training on a restricted prescriber list	Yes
Ontario	Yes	No	No	No*	Approval not required	Specialists + non-specialists with training	Yes, with special access form
Prince Edward Island	Yes	No	No	No	Approval not required	No specific restrictions	Yes
Quebec	Unknown	No	No	No	Online Same day	No specific restrictions	Yes
Saskatchewan	Yes	No	No	No	Approval not required	Specialists + non-specialists w/ training on a restricted prescriber list	Yes, with special access form
Northwest Territories	Unknown	No	No	No	Faxed form 1-3 days	Unknown	Unknown
Nunavut	Unknown	No	No	No	Faxed form 1-3 days	Unknown	Unknown
Yukon	Unknown	No	No	No	Faxed form 1-3 days	Specialists + other prescribers with specialist	Yes
People with FN Status (NIHB)	Unknown	No	No	No	Faxed form 1 day	No specific restrictions	Yes

- Policy facilitates 1-day HCV treatment
- Policy may limit 1-day HCV treatment
- Policy limits 1-day HCV treatment

\*No longer required as there are other options provided for proving chronicity.

**Table 8.** Matrix of HBV 1st-line therapy reimbursement approval policies in Canadian publicly-funded drug plans, 2025

<b>1st-line recommended oral HBV treatment on public formulary? (ETV, TAF, TDF, Peg-IFN)</b>		
<b>AB</b>	yes, with non-group Blue Cross annual premiums (ETV, TDF, Peg-IFN)	●
<b>BC</b>	yes, with annual deductible (ETV, TDF) and only if failed LAM	●
<b>MB</b>	yes (ETV, TDF)	●
<b>NB</b>	yes (ETV, TDF)	●
<b>NL</b>	yes (ETV, TDF), only if failed LAM	●
<b>NS</b>	yes (ETV, TDF)	●
<b>ON</b>	yes (ETV, TDF)	●
<b>PE</b>	yes (ETV, TDF)	●
<b>QC</b>	yes (ETV, TDF; TAF in rare exceptions)	●
<b>SK</b>	yes (ETV, TDF)	●
<b>NT</b>	yes (ETV, TDF)	●
<b>NU</b>	yes (ETV, TDF)	●
<b>YT</b>	yes (ETV, TDF)	●



### **Metric 5: Annual HCV Treatment Prescribing Counts**

**Rationale:**

In order to achieve the HCV treatment coverage goals set out by the WHO, modelling has been done to determine how many people living with HCV would need to start treatment each year in Canada so that 80% of all people living with HCV in 2015 have received treatment by 2030.

To evaluate progress towards this goal, we looked at how many people started HCV treatment each year and compared this to the modelled annual treatment targets that have been set to determine whether treatment uptake is on track.

**Monitoring & Evaluation Methodology:**

Data on total HCV patient estimates per year from each province in Canada were licensed from IQVIA®<sup>50</sup> with the exception of 2023 data, which came from a recent PHAC Hepatitis C treatment trends report.<sup>51</sup> The HCV patient estimates from IQVIA® are based on projected numbers from anonymized patient prescription data. For all years except 2023, they only include prescriptions for DAAs, not interferon or ribavirin. While the projected patient data from IQVIA® is not an exact count of HCV patients treated in each province per year, it is within an acceptable range. It is believed to accurately represent the trends and patterns in HCV treatment uptake at a provincial level.

Yukon and PEI data for all years were provided directly by Ministry of Health staff and are not modelled.

Modelled targets for the annual number of HCV treatments required each year to be 'on track' to reach HCV elimination targets by 2030 were obtained from the most recently available published estimates.<sup>46, 52</sup>

In order to set a treatment initiation target for each jurisdiction, the most recent estimate of the number of people living with HCV (PLHCV) for that jurisdiction was taken, multiplied by the 80% treatment target, then divided by sixteen (for the years 2015-2030, as 2015 is the baseline year for WHO targets). These targets may underestimate the number of treatment initiations required each year to reach the 2030 elimination goals; however, given the paucity of data, they are the most relevant indicator that can currently be provided.

**Table 9.** Estimated prevalence of HCV, HBV, annual HCV treatment targets, and projected annual HCV patient treatment (DAAs) counts for Canadian provinces, 2015-2024

	Estimated burden of HCV	Annual treatment target	Estimated burden of HBV	Total Patients									
				2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
AB	24983	1249	unknown	1430	1235	1669	2048	1822	1297	944	822	897	921
BC	28607	1788	unknown	2517	2432	3052	4266	3434	2420	1973	1814	1730	1513
MB	8715	436	unknown	301	329	459	708	544	395	416	355	217	341
NB	2559	128	unknown	174	148	223	319	371	349	290	274	349	288
NL	664	33	unknown	50	70	50	85	112	78	156	106	140	143
NS	4411	221	unknown	386	318	287	573	738	446	368	405	604	516
ON	119104	5955	unknown	5490	5817	6929	6908	5937	4259	4017	3645	3450	2909
PE	624	31	unknown	0	1	40	96	181	62	26	69	60	67
QC	49794	2490	unknown	1702	1557	1699	2312	2147	1677	1303	1138	1121	979
SK	6467	323	unknown	245	426	1130	1483	1629	1007	808	725	960	728
NT	778	39	unknown	-	-	-	-	-	-	-	-	-	-
NU	243	12	unknown	-	-	-	-	-	-	-	-	-	-
YT	423	21	unknown	43	33	45	62	68	25	20	9	14	10



## Metric 6: Prevention Measures

### i. Coverage of New Drug Use Equipment Distributed

#### Rationale:

- PWUD are a priority population for HCV prevention interventions.
- The highest rates of new HCV infections in Canada are found among PWID. These account for up to **85%** of all new hepatitis C infections.<sup>9</sup>
- HCV is preventable with evidence-based, WHO-recommended, and cost-effective interventions such as needle and syringe programs (NSP) and opioid agonist therapy (OAT). Combined, these interventions reduce the risk of hepatitis C infection by up to **74%**.<sup>9</sup>
- HBV is also transmissible through the same pathways as HCV, so this is also an effective HBV prevention strategy.
- New drug use equipment distribution should support safer injecting, smoking, and snorting practices, in adequate amounts and through accessible channels, with consideration for geographical equity.<sup>14</sup>

### Harm reduction is by far the most effective prevention strategy for hepatitis C.

#### Monitoring & Evaluation Methodology:

Previous editions of this progress report used a metric of “coverage of needles and syringes distributed per person who injects drugs.” Unfortunately, while this is a metric with targets in the *Global Health Sector Strategy* and the *Blueprint*, only British Columbia tracks and reports both the number of PWID estimated in the province and the number of new needles and syringes distributed. This metric also did not capture prevention through drug equipment other than needles and syringes, and did not account for geographic equity within a jurisdiction.

For this 2025 Progress Report, we are using two measures:

1. Does the province or territory fund the distribution of new drug use equipment and harm reduction education?
2. Do the community-based organizations (CBOs) working in that province or territory perceive the funded distribution to meet the needs of the community in quantity and type (supporting safer injecting, smoking, and snorting practices), and is access equitable? Is safer drug use education funded? (As reported by AHC member organizations in each province and territory, with a focus on disease prevention and provincial-level policy, not overdose prevention or CBO distribution model choices for the purposes of this metric.)

**Table 10.** Coverage of funded drug use equipment distribution by province and territory, 2025

<b>P/T</b>	<b>Is drug use equipment distribution publicly funded?</b>	<b>Community perspective on whether distribution is adequate in quantity and type, and equitably accessible</b>
<b>AB</b>	Yes	CBOs limit distribution due to budget constraints, and note that access is not equitable in smaller communities. ●
<b>BC</b>	Yes	CBO equipment orders are filled in full, but hammer pipes are not covered. Supplies are readily accessible in urban centres, but not in rural or suburban areas. ●
<b>MB</b>	Yes	CBO equipment orders are filled in full even though regional health authorities indicate they are over budget. Distribution efforts are made in both large and smaller centres and in rural communities, though accessibility is limited in some rural areas due to lack of funding. ●
<b>NB</b>	Yes	CBO equipment orders are filled in full (though some CBOs enforce daily limits). Vending machine program in some urban areas, but coverage is very limited in some rural areas. ●
<b>NL</b>	Yes	Budget has doubled in last two years to meet demand and is reviewed quarterly to ensure demand is met. Large network of distributors and a mail-out program to meet the needs in rural communities. ●
<b>NS</b>	Yes	Network of distribution sites and outreach provides good coverage and all requested supply types are covered, but provincial funding has not been increased to meet increasing demand and rising costs of supplies to meet the needs of the community. ●
<b>ON</b>	Yes	CBOs report adequate funding to fill their equipment orders and all types of safer use equipment is funded. Consumption and Treatment Services (CTS) sites have recently been defunded and/or closed across Ontario, replaced by HART hubs that do not distribute harm reduction supplies, creating gaps in this prevention service. ●
<b>PE</b>	Yes	Budget has been increased, providing better access and availability to new supplies, but capacity to meet the need in both rural and urban communities is not adequate. ●
<b>QC</b>	Yes	There is a robust network of CBOs distributing across the province, however CBO equipment orders are reportedly adjusted by public health in the online system to reflect lower amounts of equipment requested, resulting in an inadequate amount of supplies to meet the needs of the community. ●
<b>SK</b>	Yes	While new needles are still funded, funding is restricted to a 1:1 needle exchange model. Pipes are not funded, and supervised consumption sites and safer drug use education are not funded. CBOs report that funded services do not meet the needs of the community in type, amount, or availability. ●
<b>NT</b>	Not available	
<b>NU</b>	Not available	
<b>YT</b>	Yes	CBO equipment orders are filled in full and types of equipment funded meet the need of the community, however geographical coverage gaps are significant outside of Whitehorse. ●

## ii. Is Birth Dose HBV Vaccination Implemented?

### Rationale:

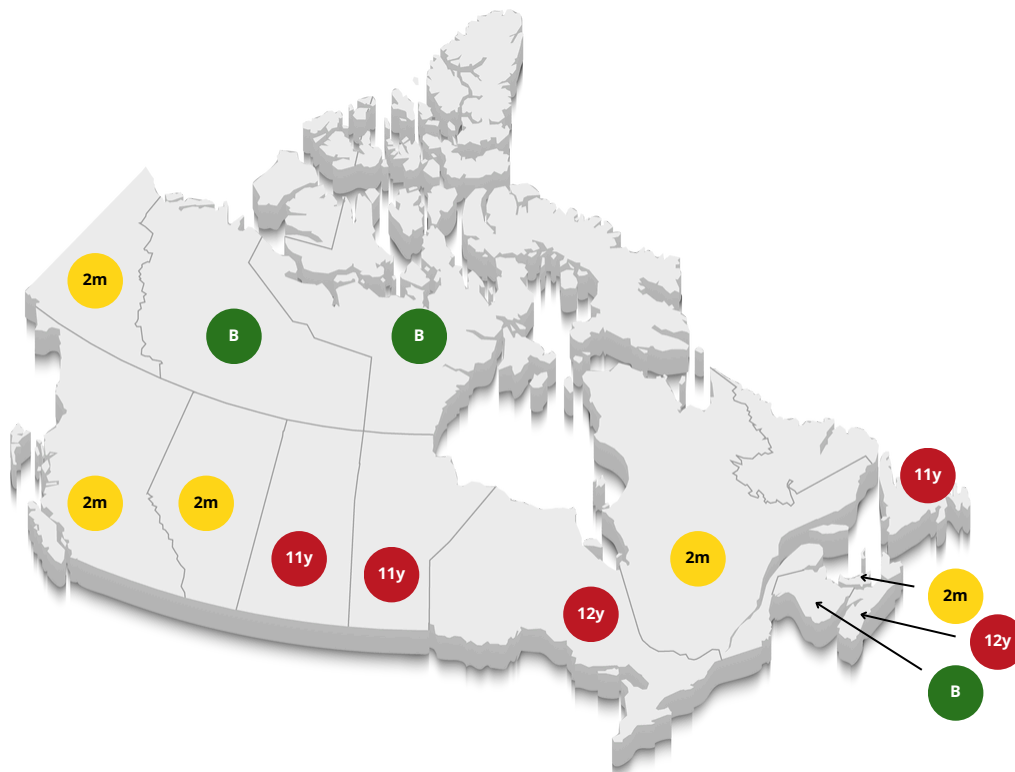
- Hepatitis B is **completely preventable**, and preventing HBV infections is an effective and important cancer prevention tool.
- The WHO recommends that all infants receive the first dose of HBV vaccine within 24 hours of birth.<sup>53</sup> Despite these recommendations, Canadian provinces and territories offer the HBV vaccine at varying ages, from birth to 12 years.
- Caregivers who know the risks and can pay out-of-pocket or have private coverage often obtain infant HBV vaccination, but many either are not aware or do not have the resources to do so.
- Infant vaccination is especially important as **over 90% of infants who become infected will develop chronic hepatitis B**, compared to 5% of adults. (95% of healthy adults will clear a hepatitis B infection spontaneously.)
- Chronic hepatitis B is a lifelong disease that requires treatment and monitoring by specialists due to the many health complications but may not be available to all where they live, creating further inequity. Birth dose vaccination prevents this.

**Implementing birth-dose vaccination across Canada is the #1 way to bring the number of new infections in children to zero.**

### Monitoring & Evaluation Methodology:

A review was conducted to determine the age at which the first HBV vaccine dose is universally offered in each province and territory.

**Figure 1.** Age at which HBV vaccine dose 1 is universally offered across Canada, 2025



## Is universal adult HBV vaccination recommended and publicly funded?

### Rationale:

- With childhood vaccination programs in place since the 1990s, the majority of new cases are reported among the cohort of adults who are too old to have benefitted from these programs or otherwise missed these vaccinations, perhaps due to immigrating to Canada from a country where HBV is prevalent without being vaccinated in their country of birth.
- For this reason, the United States has newly adopted a recommendation of HBV vaccination for all adults aged 19-59, in addition to the birth dose vaccination policy.<sup>14</sup>

### Monitoring & Evaluation Methodology:

We reviewed the vaccination policies in each province and territory to determine if adult HBV vaccination policies recommended universal adult vaccination, and if so, if the vaccination was publicly funded.

Provinces and territories all have risk-based policies, and no provinces or territories were found to recommend and publicly fund universal HBV vaccinations for adults.



## Provincial Corrections

1. Is the Ministry of Health responsible for healthcare services in corrections?
2. Is access to HCV testing and treatment equivalent to access in the community, or are there additional restrictions related to length of stay or remand status, etc.?
3. Does the Ministry report on the number and proportion of PWAI being tested and treated?
4. Is linkage to care made at release for PWAI who are known to be HCV positive, but treatment has not been completed?
5. Is a Needle Syringe Program (NSP) implemented as disease prevention?
6. Is OAT available to all PWAI (both maintenance and new start prescriptions)?
7. Is HBV vaccination offered universally to PWAI (and staff)?

### Rationale:

1. Having the Ministry of Health responsible for healthcare services in corrections is associated with improved healthcare access and outcomes.<sup>19</sup>
2. When the same standard of health care is not available to people in correctional facilities as in the community, it is a contravention of the UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules).<sup>20</sup>
3. Reporting on testing and treatment numbers provides important data to inform policy choices and also provides accountability for the implementation of stated policies.
4. Many provinces cite short stays as the reason to not initiate HCV treatment.<sup>15</sup>
5. NSPs are an important disease prevention tool, including preventing reinfection.
6. OAT availability again speaks to the compliance with the Nelson Mandela Rules, referenced above.
7. NACI recommends HBV vaccination for all PWAI and corrections staff.<sup>17</sup>

### Monitoring & Evaluation Methodology:

We reviewed the policies in each province and territory to complete Table 3 on page 27 and, where possible, verified the data with ministry staff.



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