RETHINKING VIRAL HEPATITIS PREVENTION

Confronting Systems That Create Risk

ACTION HEPATITIS CANADA

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A 2026 report and recommendations for policymakers, prepared by Action Hepatitis Canada.

ACKNOWLEDGEMENTS

This report is produced by Action Hepatitis Canada and made possible with funding from AbbVie Corporation, Cepheid, Gilead Sciences Canada Inc., GSK Canada, and Hbc Care. The contents of this report do not necessarily reflect the views of funders.

We would like to thank the Canadian Network on Hepatitis C and the Canadian HBV Network for their continued work in supporting viral hepatitis elimination efforts across Canada. We would also like to thank the Action Hepatitis Canada member organizations we work with and for, specifically those who contributed to this report: CAAN, CATIE, Cool Aid Community Health Centre, Dr. Peter Centre, Edmonton Liver Clinic, HIV Legal Network, Manitoba Harm Reduction Network, PAN, PASAN, RECAP Clinic, Substance User Network of the Atlantic Region (SUNAR), Vircan.

We are grateful to the clients and peers of RECAP and the Manitoba Harm Reduction Network for sharing their experiences with us.

Finally, we wish to acknowledge the people affected by viral hepatitis and represented in the statistics and figures within this report. You are not just numbers to us. You are our family, friends, and colleagues, and we stand alongside you on the journey toward eliminating viral hepatitis as a public health threat in Canada by 2030.

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LAND ACKNOWLEDGEMENT

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

CITATION

Action Hepatitis Canada. Rethinking Viral Hepatitis Prevention: Confronting Systems That Create Risk. May 2026. Available at: https://www.actionhepatitiscanada.ca/RethinkingPrevention

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About This Report

Canada has committed to eliminating viral hepatitis as a public health threat by 2030. The tools to achieve this exist: hepatitis C is curable, and effective prevention strategies are well established. Hepatitis B is manageable and vaccine-preventable.

While science has opened the door to eliminating viral hepatitis, infrastructure determines who gets to walk through it. In Canada, hepatitis C continues to disproportionately affect people who use drugs, particularly those navigating unstable housing, criminalization, and other systemic barriers to care. These patterns are not solely indicative of individual behaviour; they are a direct reflection of environments that either offer or deny access to prevention, treatment, support, and care.

This report gives particular attention to hepatitis C because reducing new infections remains Canada's weakest viral hepatitis elimination metric. It focuses on strengthening prevention infrastructure in the environments where exposure currently occurs. Broader strategies aimed at supporting people with substance use disorder are important components of public health policy but operate through different structures and systems and are outside the scope of this analysis.

Throughout this report, we use language that reflects how hepatitis C transmission occurs in practice. Rather than focusing on individual behaviours or "risk groups," we examine how policies, institutional practices, and service gaps create inequities in the availability of prevention tools and in where transmission continues to occur. Populations do not inherently carry risk; risk is produced in environments shaped by policy choices. This shift helps identify where action is most likely to reduce new infections.

This report is intended for policymakers, public health leaders, healthcare providers, community organizations, and advocates working across sectors. Drawing on national consultation, policy analysis, community expertise, and implementation research, this report applies a practical systems lens to the elimination of viral hepatitis. It explores how corrections, healthcare, housing, harm-reduction infrastructure, and enforcement policies interact, sometimes reinforcing risk and sometimes reducing it. It highlights examples of alignment that improve continuity of care, prevent new infections, and strengthen community wellbeing.

Finally, viral hepatitis elimination is not only a public health target. It is also a matter of rights, equity, and government accountability. Where governments know that preventable transmission is concentrated in specific environments, they have a responsibility to ensure that prevention, testing, treatment, vaccination, and continuity of care are meaningfully accessible in those settings.

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The Elimination Gap

ABOUT HEPATITIS B & C

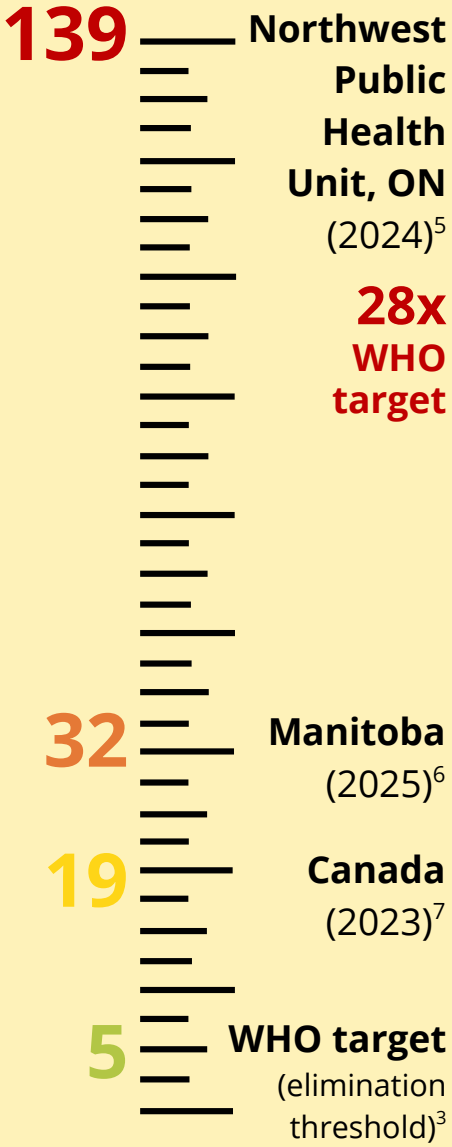
- Hepatitis B virus (HBV) and hepatitis C virus (HCV) are liver infections.
- Transmission most commonly occurs through blood-to-blood contact with infected blood.
- Symptoms may be delayed for decades, so many people who are infected are unaware, even while liver damage is occurring. The only way to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

PROGRESS, AND WHERE IT HAS STALLED

- Canada endorsed the World Health Organization's *Global Health Sector Strategy on Viral Hepatitis* in 2016, committing to **eliminate viral hepatitis as a public health threat by 2030**.[3]
- Canada has made meaningful progress on several elimination targets through **expanded access to curative HCV treatment** and **improved testing**, reflecting our collective efforts toward elimination.[4]
- However, **a key metric for ending viral hepatitis as a public health threat — new cases — remains off track**.[2,4]
- While many provinces and the federal prison system have made great progress in removing barriers to HCV treatment, several have recently repealed prevention policies, undermining these efforts.

Canada's HCV Elimination Gap

Newly diagnosed cases per 100,000 population



Reducing new infections must become central to Canada's HCV response if elimination is to remain achievable.

Treatment cures hepatitis C, but elimination requires both treatment and prevention. When the environments where transmission occurs remain unchanged, reinfection can continue to drive new cases.

HCV clusters can signal future HIV outbreaks

Patterns in HCV transmission can serve as an early warning signal for broader risk of blood-borne infections.

In several jurisdictions, clusters of HCV infections have preceded increases in HIV transmission where prevention systems were not reaching people consistently. Recent increases in HIV diagnoses in a region in Manitoba where safer drug-use equipment distribution was banned municipally illustrate how quickly transmission can accelerate when prevention environments weaken.

WHAT THE DATA SHOWS ABOUT HCV TRANSMISSION

- In Canada, approximately **85% of new HCV infections occur through sharing or reuse of drug-use equipment**.[8]
- This statistic is often used to describe *who* is at risk, but it is more useful for understanding *where* prevention systems are failing people.
- Research increasingly shows that HCV risk is shaped not only by individual behaviours but by broader economic, social, and policy **environments** that influence access to safer drug use equipment, healthcare, and stable living conditions.[9]
- **Reinfection** is part of this same picture. When HCV continues to circulate within a community environment, people can be exposed again even after successful treatment.

Elimination benefits entire communities

Reducing HCV transmission strengthens public health for everyone. When fewer people are exposed to HCV, the risk of infection after unexpected blood-to-blood contact, including accidental community exposures, becomes much lower.

This means HCV elimination improves safety not only in settings where transmission risk is highest, but across communities as a whole.

Closing the elimination gap will require strengthening prevention, testing, treatment, and care in the environments where transmission is occurring, not just identifying the populations most affected.

A Note About Hepatitis B

- While this report is focused on reducing HCV transmission, HBV remains an important part of the viral hepatitis landscape in Canada.
- Unlike HCV, HBV is not yet curable, but it is **preventable through vaccination** and manageable with long-term treatment.
- HBV is transmitted through blood and certain body fluids, including during birth, through sexual contact, and through blood-to-blood exposure. Most people with HBV are infected at birth or as young infants from contact with infected blood or body fluids, highlighting the importance of testing and vaccination.
- Because transmission can occur in a number of healthcare, household, and community exposure settings, **vaccination is the most effective prevention strategy**.

HBV VACCINATION POLICY

The World Health Organization recommends **vaccinating all babies** against HBV within 24 hours of birth. However, in Canada, five provinces (Saskatchewan, Manitoba, Ontario, Nova Scotia, and Newfoundland and Labrador) rely on school-based vaccination programs during adolescence. **This has proven to be a policy failure that allows infants to acquire lifelong HBV infections.**[10]

Gaps also remain among individuals who did not receive childhood immunizations through earlier provincial programs, necessitating catch-up vaccination policies for adolescents and adults who were not previously immunized.

Currently, HBV vaccination coverage for adults is a policy patchwork varying from jurisdiction to jurisdiction, but many provincial policies offer HBV catch-up vaccines to a list of populations at higher risk, including people who use drugs and people who are incarcerated.

HBV SCREENING POLICY RECOMMENDATIONS

In addition, *The Management of Chronic Hepatitis B: 2025 Guidelines Update from the Canadian Association for the Study of the Liver and Association of Medical Microbiology and Infectious Disease Canada*[11] recommends **universal one-time screening for HBV** and **reflex testing for Hepatitis Delta (HDV)**. HDV infections can only take hold in a person living with HBV, and it is the most severe form of viral hepatitis in humans, with 2-3x the rate of progression to liver cancer and cirrhosis, making early detection key.

Like HCV prevention tools, HBV vaccination is most effective when it is consistently available in healthcare and community settings where exposure risks occur. Ensuring consistent access to HBV vaccination, testing, and treatment remains an important opportunity to strengthen Canada's prevention infrastructure.

From Risk Groups to Risk Environments

REFRAMING HOW HCV RISK IS UNDERSTOOD

Public health discussions about HCV and other sexually transmitted and blood-borne infections (STBBI) have often focused on "risk groups" or "high-risk behaviours." These terms are intended to help target prevention and care. But they can unintentionally centre individuals as the source of risk, rather than the broader social, structural, and environmental factors that shape exposure and vulnerability.

The phrase "high-risk behaviour" subtly places the emphasis on what someone *did or is going to do* rather than on what made that situation more likely in the first place.

In reality, HCV and STBBI transmission follows patterns in access (or lack of access) to safer drug-use equipment, testing, treatment, stable living environments, and culturally-safe, supportive care. When infections concentrate in particular communities, this reflects how prevention systems are working, not simply personal choices.

RISK, SET, AND SETTING

One framework that helps explain this more clearly is the concept of risk, set, and setting, developed by Dr. Norman Zinberg in his 1984 book *Drug, Set, and Setting*.[12]

Zinberg gave academic grounding to something harm reduction advocates had long understood: health outcomes are shaped not only by drugs or behaviours but by the circumstances surrounding them.

The framework highlights three interacting elements:

- **Risk:** the drug or activity itself and its potential for harm or transmission.
- **Set:** the personal circumstances someone brings into a situation, including health status, trauma history, income stability, and emotional wellbeing.
- **Setting:** the physical, social, and policy environment in which an activity takes place.

Together, these factors shape whether exposure becomes likely or avoidable.

When people have access to safer drug-use equipment, testing, treatment, and stable places to live, transmission drops. When they are navigating criminalization, stigma, housing instability, or fragmented services, the likelihood of exposure increases.

When the focus stays on populations rather than environments, the conditions that shape transmission risk can remain invisible.

From "priority populations" to priority environments

People who use drugs are frequently identified as a priority population for HCV prevention. But drug use itself does not cause transmission.

Hepatitis C spreads through blood-to-blood contact, most often when drug-use equipment previously used by someone with the virus is reused. Environments where safer drug-use equipment, testing, treatment, and supportive services are difficult to access make this kind of exposure far more likely.

This shifts the question from who is at risk to where risk is being produced.

How HCV Risk Environments Took Hold

The environments in which HCV transmission occurs today developed over decades through policy choices, institutional practices, and the stories we tell ourselves and each other about drug use, poverty, mental health, and "public order."

How societies understand the root causes of social issues shapes the responses that seem appropriate. When we tell ourselves that harms are caused mainly by bad choices or bad behaviour, punishment and exclusion can feel justified. When harms are understood as resulting from social and structural conditions, then prevention, care, and supportive environments become clearer and more achievable responses.

Structural stigma both shaped and was reinforced by these response choices over time, influencing whose health was prioritized, which risks were tolerated, and which responses were socially and politically appropriate.

There are three main factors that show up repeatedly in that history:

MORALISM

- Responses to drug use and poverty have often been framed as matters of personal responsibility rather than public health. That framing influenced where services were located, how they were delivered, and who they were meant for.
- In Canada and other countries with colonial histories, drug policies have additionally been shaped by **racial bias**, influencing which communities and substances were seen as threats. Early legislation, such as **the Opium Act**,[13] reflected these assumptions and helped establish policy directions that **prioritized control and punishment over prevention and care**.
- These approaches continued through later enforcement eras, including the War on Drugs, which **expanded criminalization without reducing drug use** and contributed to service environments where prevention tools were unevenly available.[14]
- Together, moral framing and racialized policy histories shaped prevention systems that developed unevenly across regions and settings, leaving some communities with less consistent access to health-supporting options and greater exposure to criminalization that continues to influence risk environments today.

VISIBILITY MANAGEMENT BIAS

- Public policy has often focused on the **visibility** of social issues like homelessness, encampments, public drug use, discarded drug-use equipment, and mental health episodes, rather than on their **underlying causes**.
- This means that choices about where to place shelters, how to conduct policing, and what services to offer have been influenced by **concerns about visibility** and neighbourhood impact. These decisions influence where prevention infrastructure exists, and where it does not.
- When services are designed primarily to manage visibility, access becomes uneven by design.

FRAGMENTED SERVICE SYSTEMS

- Health, housing, mental health, addictions care, the justice system, corrections, and income supports did not develop as a coordinated system. They grew separately, under different mandates, funding structures, and governmental jurisdictions.
- People often move between these systems during periods of instability, but the systems themselves are not built to follow them. Each transition can interrupt access to essential tools for disease prevention, including testing, treatment, safer equipment, or continuity of care.
- This lack of cohesion means that breaks in service are all too common and built into the design of how these services operate. Together, these patterns helped shape the environments in which HCV transmission now occurs.

DESIGN BARRIERS: THE GAP BETWEEN ACCESS ON PAPER AND REALITY

Another pattern appears consistently across jurisdictions: services may exist in theory but be incredibly challenging to access in practice.

Waitlists, limited hours, staffing shortages, strict eligibility requirements, and convoluted intake processes make it difficult for people to get the help they need.

For instance:

- Harm reduction services might only be available Monday through Friday, leaving evenings and weekends devoid of support when it is often needed most.
- Treatment pathways might require navigating multiple appointments or specialist referrals.
- Staffing issues can pause or limit programs.
- Long waitlists for housing, mental health, or addictions services are a frequent problem.
- People in Ontario provincial carceral settings may be sharing nail clippers with their entire range, exposing them to blood from over 200 other people.

People often have to navigate complex systems during crises, even though many are managing physical, cognitive, neurological, or mental health challenges that make this navigation especially difficult.

Research suggests that approximately half of the people accessing homelessness services in Canada are living with a brain injury.[15] This has important implications for homelessness systems design, and, given the high intersection of homelessness and STBBI, is a consideration in our prevention, testing, and treatment systems as well. Some acquired brain injuries are linked to overdose and other drug-related harms,[16] underscoring the need for low-barrier prevention, testing, and treatment access. When access depends on attending multiple appointments, managing referrals, or onerous intake processes, programs are difficult to use even when they technically exist.

In several jurisdictions, abstinence-focused policy approaches have been introduced in contexts where voluntary treatment services are still hard to access due to waitlists, staffing shortages, or geographic gaps. This further limits access to care.

Where HCV Risk is Produced Today

Rates of hepatitis C transmission are not evenly distributed across Canada.

Though overall rates of HCV are slightly declining, the highest rates continue to be reported in parts of Saskatchewan, Manitoba, and Northern Ontario, reflecting longstanding differences in access to prevention infrastructure, testing, treatment, and culturally appropriate care. These regional patterns also overlap with jurisdictions where Indigenous communities represent a larger proportion of the population and where colonial policy environments continue to shape access to health services.

A study on the epidemiology of HCV in the prairie provinces shows that expanded access to direct-acting antiviral treatment significantly increased testing and treatment uptake but was not sufficient on its own to reduce transmission rates.[17] These findings reinforce the importance of sustained investment in prevention infrastructure alongside treatment scale-up.

POLICY ENVIRONMENTS, INSTITUTIONAL SETTINGS, AND SOCIAL ENVIRONMENTS

- HCV transmission does not occur randomly. It follows predictable patterns based on the infrastructure of prevention tools, healthcare access or lack thereof, and social supports.
- Sociologist Dr. Tim Rhodes expanded on Dr. Zinberg's idea about how risk, set, and setting affect health. He showed that the risk of getting HCV is influenced by various social, physical, economic, and policy factors, which impact how easily people can access prevention and treatment options.[9]
- Across Canada, several policy, institutional, and social environments consistently shape whether exposure is more likely or less likely, and where prevention, testing, and treatment can have the greatest impact.
- The six environments described below are not intended to be an exhaustive list of settings in which HCV transmission risk can emerge. Instead, they identify several key settings where prevention systems shape access to safer equipment, testing, and treatment. In practice, these environments frequently overlap, and broader structural forces, including racism and poverty, influence how risk is produced across multiple settings at once.
- Importantly, across these environments, the highest-risk moments are often points of transition: arrest, release, hospital discharge, shelter entry or exit, treatment intake or discharge, housing loss, or movement between communities. Prevention infrastructure must therefore be designed around continuity, not just program availability.

Policy environments shape where risk concentrates. Institutional settings shape how transmission occurs. Social environments shape who is most affected within the same spaces.

- Colonial policy environments
- Criminalization policy environments
- Carceral settings
- Healthcare settings
- Shelter systems
- Gendered relationship environments

Colonial Policy Environments

Indigenous people are disproportionately affected by HCV in Canada.[8]

In 2023, for example, the rate of new HCV diagnoses in First Nations communities in Saskatchewan (101.2 cases per 100,000) was about three times higher than the overall rate in Saskatchewan (32.3 cases per 100,000 population) and five times higher than the rate in Canada (19.4 cases per 100,000 population).[18] This pattern reflects the ongoing impacts of colonial policies that continue to shape access to housing, healthcare, and harm reduction services.

Colonial displacement, the legacy of residential schools, child welfare involvement, and jurisdictional gaps between federal and provincial health systems have created persistent barriers to prevention services and continuity of care. These barriers are especially visible in northern, rural, and remote communities, where access to testing, treatment, and safer drug-use equipment may be limited or inconsistent.

Indigenous people are also overrepresented in several of the service environments discussed in this report, including carceral settings and homelessness services. In 2023, Indigenous people represented 32% of the federal prison population, while making up just 5% of the total adult population, and Indigenous women represented roughly half of all women detained in federal prisons.[19]

Reducing HCV transmission requires strengthening access to prevention, testing, and treatment in Indigenous communities and supporting Indigenous-led health services that are designed to meet community needs.

The Health Canada Task Force on Substance Use found that “immediate, comprehensive policy change is needed to redress the historical and ongoing harms to First Nations, Inuit, and Métis people, families, and communities.”[20]

> The mass incarceration of Indigenous people is a direct continuation of colonial laws and policies that have displaced, criminalized, and marginalized Indigenous communities for generations. Harm reduction must address these systemic harms by supporting Indigenous-led, culturally grounded approaches that restore power, self-determination, and wellness for First Nations, Inuit, and Métis people, both in prison and in the community.
>
> *- Trevor Stratton, Indigenous Leadership Policy Manager, CAAN Communities, Alliances & Networks*

Criminalization Policy Environments

Drug criminalization does not simply punish drug use after the fact. It shapes where, how, and under what conditions drug use occurs. By forcing people into rushed, hidden, surveilled, or unstable settings, criminalization undermines access to safer drug-use equipment, trusted outreach, testing, and treatment. This policy environment influences transmission patterns even when prevention programs exist elsewhere in the health system.

Drug criminalization policies also shape HCV risk indirectly by increasing exposure to correctional settings and disrupting continuity of care.

Arrest, detention, and short custodial stays can interrupt treatment, separate people from community-based supports, and reduce access to prevention tools. Criminalization can also discourage people from accessing health services due to fear of surveillance or legal consequences.

JAIL EXPANSION

Plans to significantly expand jail capacity in Ontario, framed as a response to overcrowding, illustrate how governments often respond to the consequences of carceral policy by building more custodial space rather than reducing the policy drivers of incarceration, remand, and associated health risks.[21]

A RETURN TO ABSTINENCE-BASED POLICY

In several jurisdictions, recent policies have placed increased emphasis on abstinence-based responses to drug use while limiting access to harm reduction services and prevention tools. For example, in Alberta and Ontario, supervised consumption sites have been defunded and forced to close.[22, 23] In Ontario, they are being replaced with recovery- and treatment-based Homelessness & Addiction Recovery Treatment (HART) Hubs. These have been slow to open, creating service gaps, and they are prohibited from providing the harm reduction services that communities rely on.[24] Gaps in service limit access to safer drug-use equipment, testing referrals, and connections to treatment, particularly in communities where alternative services are not available, and are expected to result in rising rates of HCV transmission.

Increasingly, drug-use policy has emphasized abstinence-based "recovery" as a primary response framework. While recovery supports are important and may benefit some people, they cannot substitute for disease prevention infrastructure. Framing abstinence as the central solution to drug use can shift attention away from harm prevention infrastructure and from the structural conditions that shape exposure risk.

> Despite substantial scientific evidence, Needle and Syringe Program scale-up continues to be hindered by restrictive global, regional, and country policies, entrenched stigma and discrimination, and chronic underfunding. The consequences of inaction are devastating: new blood-borne virus infections, outbreaks and uncontained epidemics, preventable deaths, and widening health inequities.
>
> *- Addressing policy barriers to scaling up needle and syringe programmes: a global call to action, The Lancet Global Health*[25]

United Nations Issues Stern Warning to Canada

A March 2026 report from the **United Nations Human Rights Committee** reinforces the importance of understanding drug use and homelessness through a public health and human rights lens.[26] In its review of Canada's implementation of the *International Covenant on Civil and Political Rights*, the Committee expressed concern about legal frameworks that permit detention based solely on drug use, the criminalization of drug consumption in public spaces, and inadequate access to healthcare in detention settings. The Committee recommended that responses to drug use be grounded primarily in public health, harm reduction, and human rights considerations rather than punitive approaches.

The Committee also emphasized that the right to life includes positive obligations on governments to ensure access to essential health care and to address conditions such as homelessness and the drug toxicity crisis. These findings reinforce the importance of prevention infrastructure as part of Canada's broader human rights commitments.

> The closure of 16 sites in 2025 and the defunding of 8 remaining supervised consumption services (SCS) less than one year later represents a systematic dismantling of the provincial network of publicly funded, evidence-based SCS, which have played a critical role in addressing the ongoing drug toxicity crisis in communities across Ontario since 2017.
>
> *- What the Evidence Says about Defunding Ontario's Remaining Supervised Consumption Sites, March 2026*[27]

> Adequate distribution of harm reduction equipment and access to harm reduction services is essential for the prevention of new hepatitis C infections.
>
> *- Public Health Ontario*[28]

Carceral Settings

- Correctional services in Canada are operated by both the federal and provincial/territorial (P/T) governments.
- Sentences of two years or more are served in institutions run by the federal government and those with a sentence of two years less a day fall under P/T jurisdiction.
- While a very limited and flawed Prison Needle Exchange Program is in place in 14 of the 43 federal institutions, no province or territory has implemented a program to provide safer drug use supplies.[29]

A new study has shown that every $1 spent on scaling up needle and syringe programs in federal prisons would save $2 in treating infections related to hepatitis C and injection-related infections.[30]

People who are incarcerated are 40 times more likely to be exposed to HCV than Canada's general population,[31] making carceral settings the most obvious example of a physical risk environment.

Many people enter jail or prison already living with HCV but without access to treatment. Others lose access to HCV treatment medications started in the community. Access to testing is inconsistent. Access to safer drug-use equipment is extremely limited or unavailable in most prisons and jails. Access to various opioid agonist therapies is becoming more restricted.[32] This recent policy change is expected to weaken patient autonomy and trust, reduce retention on opioid agonist therapy, and erode the highly effective strategies that have sustained low prevalence of HIV and HCV in Canadian federal prisons.[32]

In addition, people who are released from incarceration often face barriers to accessing health care in the community. Whatever policy approach a government takes on addiction, preventing communicable disease remains a core responsibility within places of detention and during transition back to the community. The delivery of HCV care to people in carceral settings in Canada is essential to HCV elimination.

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

> Oh, God, yeah. If I had been offered Hep C treatment inside, I would've done it for sure. That would have been the perfect time.
> *- Molly, Nova Scotia*

Healthcare Settings

Hospitals, emergency departments, and addictions treatment programs are often key points of contact for people who are not connected to primary care. These encounters create important opportunities for testing, vaccination, treatment initiation, and referrals to community-based services, especially with the help of peer navigators. However, many of these opportunities are still missed, and routine viral hepatitis screening has not yet been consistently integrated across these settings in many parts of Canada.

Transitions between care settings are a particularly important gap. People may be discharged from hospital or addictions treatment without prescriptions filled, follow-up appointments scheduled, or connections to community services confirmed. In some cases, HCV treatment that was started in the community is interrupted during hospital stays because medications are not included on hospital formularies. When housing instability or drug use is present, these breaks in continuity make treatment completion significantly harder.

Experiences of stigma and racism within healthcare settings also affect whether people are able to access care in the first place.[33] Some patients report leaving care early, being discharged without stable supports in place, or avoiding services altogether because previous encounters felt unsafe or dismissive. These experiences shape whether healthcare settings function as effective prevention environments.

Improving hepatitis outcomes does not always require new services. It often requires strengthening transitions between existing services and ensuring that routine encounters with the healthcare system consistently support testing, treatment continuity, and follow-up.

> I've been there and been in, like, serious pain. We don't really go to the hospital to hang out and have fun. But they think we're just there seeking drugs or whatever. So even when I know that I got an infection, I don't want to go to the hospital because I know that the judgment is there. (...) I'm not just a junkie. But also, my addiction didn't happen over night and my recovery isn't going to happen overnight.
> *- Renee, New Brunswick*

> For Indigenous women, racism within the health care system is a huge barrier for us. It's one of the biggest deterrents. We are not believed. We are surveilled. We are seen as less than human and less worthy of care, love, and support.
> *- Denise Baldwin, Indigenous Harm Reduction Network*

Shelter and Supportive Housing Settings

People experiencing homelessness or fleeing violence often rely on shelter systems, outreach services, and drop-in programs as their primary points of contact with care. These settings can support prevention and testing when services are integrated. Without that integration, access becomes inconsistent.

In some shelters, restrictive rules or abstinence-based approaches can create additional barriers for people who use drugs, leading some to avoid services altogether or cycle in and out of unstable settings. People also report using drugs to stay awake or remain alert when they do not feel safe enough to sleep, particularly in crowded or unpredictable environments.

In practice, some shelter environments can come to resemble extensions of the carceral system, with surveillance, control-focused rules, and limited autonomy shaped by ideology, underfunding, staffing pressures, or risk-management requirements. When shelter systems are not designed and adequately resourced to centre safety, dignity, and harm reduction principles, they can unintentionally increase exposure to the very risks they are meant to reduce.

THE NEED FOR LOW-BARRIER VAW SHELTERS

"Violence against Women (VAW) is the "most pervasive health risk to women and gender-diverse people in Canada." Indigenous women, racialized women, women living with disabilities, 2SLGBTQ+ individuals, women living with HIV, and women who use drugs are disproportionately exposed to VAW, and thus to its severe physical and mental harms. Globally, women who use drugs — who may have multiple, intersecting identities — experience rates of VAW up to 24 times higher than women who do not use drugs. Yet those who use drugs are often barred from VAW shelters, vital spaces free from violence with links to otherwise inaccessible health services.

Over the past decade, there has been a shift toward low-barrier models in VAW shelters, emphasizing harm reduction. Even so, gaps persist. Some provincial and territorial policies continue to permit service access refusals based on drug use. Even when access is granted in principle, punitive shelter rules, stigmatizing encounters with staff, encounters with police and child welfare authorities, and uneven harm reduction services bar meaningful access in practice."

- from Towards Access for All: Best & Promising Practices from Low-Barrier, Harm Reduction Shelters in Canada, HIV Legal Network, 2024.[34]

Gendered and Relational Environments

HCV is on the rise in women, pregnant people, and their newborns.[35]

- Women who use drugs face higher risks of acquiring viral hepatitis and HIV than their male counterparts.[36]
- They 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).[37]
- Despite the gendered dynamics of injection drug use being well documented, gender responsive harm reduction services are very limited.[38]

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 STBBI. This requires services that recognize how gender, safety, caregiving, and relationships shape prevention options in practice.[37]

Prevention Infrastructure That Reduces Risk

Harm reduction is HCV prevention, with adequate coverage of safer drug-use equipment and opioid agonist therapy preventing up to 74% of new HCV infections in Canada.[8]

Needle and syringe programs, supervised consumption services, outreach teams, peer-led distribution networks, and safer supply programs are all evidence-based best practices that reduce exposure risk and connect people to testing and treatment.

Policy decisions can also reduce risk: stable operating funding for harm reduction services, rural delivery supports, transportation supports, discharge planning standards, low-barrier shelter programs, adequate income supports, adequate affordable and supportive housing options, and evidence-based drug policy all promote safety and wellbeing.

Access to HCV prevention tools is shaped not only by the presence of programs but also by how those programs are funded, distributed, and integrated across systems. Policies that support flexible service delivery models, continuity of care across institutional transitions, and prevention access in rural and remote communities can significantly reduce transmission risk environments.

Harm reduction is a radical act of love, compassion, and justice.

HARM REDUCTION AS RELATIONAL CARE

Harm reduction began as a community response to prevent HIV and HCV transmission when formal systems were not yet responding.[39]

From the beginning, it was grounded in relationships, trust, and the belief that people deserve tools to protect their health, whether or not they wish or are able to stop using drugs.[40]

Peer-led distribution, outreach-based care, and community-run services remain central to this work today. These approaches recognize that prevention happens through connection as much as through equipment.

Harm reduction services are often the first place people access testing, treatment referrals, and primary healthcare after long periods without support. Strengthening these services strengthens the entire prevention system.

RURAL AND REMOTE PREVENTION ENVIRONMENTS

Access to HCV prevention tools varies significantly outside large urban centres.

In rural and remote communities, services may operate fewer hours, cover larger geographic areas, require long-distance travel, or be nonexistent. Concerns about privacy and stigma can also make it harder to access supplies locally. These conditions can reduce consistent access to sterile equipment, testing, and treatment, even where programs technically exist.

Strengthening prevention in rural and remote communities is an essential part of reducing new infections nationally.

Expanding prevention in rural and remote communities

Newfoundland and Labrador has introduced a province-wide mail distribution program that provides safer drug-use supplies at no cost to residents across the province.[41]

Programs like this reduce travel barriers, improve privacy, and make prevention tools available in communities where in-person services are nonexistent or may not operate daily. Approaches that adapt distribution to geography help ensure prevention systems reach people wherever they live.

Where safer drug-use equipment is consistently accessible locally, and without barriers, transmission decreases.

Harm reduction services are also one of the most consistent entry points into healthcare for people who are not well served by traditional systems. Strengthening this infrastructure strengthens prevention.

PHARMACIES AS PREVENTION INFRASTRUCTURE

Pharmacy-based access to testing, prescribing, and prevention supplies can significantly expand reach, particularly in smaller communities and during transitions between institutional settings. Because pharmacy staff are at the intersection of accessibility and healthcare delivery, they are well-positioned to expand access to equitable care.[42]

Mainline's Brown Bag Program

Mainline Needle Exchange in Halifax, NS has teamed up with more than 100 pharmacies across the province "to make safer use more accessible at times when we are closed or between our outreach runs to smaller communities. Just ask a pharmacist for a brown bag and they will be glad to help."[43]

Recommendations

1. **Strengthen and protect community-led prevention infrastructure through sustained federal partnerships.** Targeted, multi-year investments through Indigenous Services Canada and the Public Health Agency of Canada are needed to support Indigenous-led and community-based HCV (and other STBBI) prevention initiatives in regions with the highest transmission rates. Protecting the Community Action Fund and Harm Reduction Fund will sustain trusted outreach relationships, improve early testing and treatment connections, and reduce pressure on acute care and crisis-response systems.

2. **Ensure consistent access to harm reduction supplies and prevention services across provincial and territorial systems.** Provincial and territorial governments play a central role in shaping the environments where HCV transmission occurs. Funding agreements for shelters, supportive housing, health services, and community programs should include harm reduction principles and minimum service standards, including access to safer-use supplies, testing pathways, and treatment connections. Consistent access to evidence-based prevention tools is essential to reducing HCV and other STBBI transmission.

3. **Align testing and treatment scale-up with prevention infrastructure in high-transmission environments.** Public investments in testing and treatment should be routinely paired with prevention supports where transmission continues to circulate through social or service networks. Program models should combine testing access, rapid treatment linkage, safer-use supplies, and ongoing care connections to reduce reinfection risk and transmission.

4. **Reform drug policies that produce preventable HCV risk.** Federal, provincial, territorial, and municipal governments should review and reform laws, bylaws, enforcement practices, and funding conditions that increase rushed or hidden drug use, restrict harm reduction access, interrupt care, or criminalize survival strategies. Drug policy reform should be treated as viral hepatitis prevention, not a separate issue.

5. **Strengthen viral hepatitis prevention and care within carceral settings and during transition back to community.** Federal, provincial, and territorial correctional systems should implement minimum standards for evidence-based opioid agonist therapy, safer-use supply access, testing, treatment, and vaccination coverage. Discharge planning should include confirmed linkage to community health care, medication continuity, and prevention supports. Public reporting on access and outcomes would accelerate progress and accountability.

6. **Expand HBV vaccination through universal birth-dose programs and adult catch-up access.** Provincial and territorial governments should implement universal birth-dose or infant vaccination schedules where not already in place, and expand catch-up access for adolescents and adults who missed earlier immunization. Integrating vaccination into prenatal care, primary care, pharmacy programs, newcomer health services, and corrections intake would accelerate gains and reduce the risk of future transmission.

Conclusion: Prevention Infrastructure Makes Elimination Possible

In many cases, the environments where HCV (and other STBBI) risk is prevalent are precisely the same environments where access to health care has been fragmented or restricted. Addressing this gap is essential not only for prevention but also for ensuring that people already affected by these conditions can receive timely diagnosis and care, and the opportunity to live long, healthy lives.

Looking at HCV transmission through the lens of environments helps clarify where progress is still needed. When prevention tools are available consistently across healthcare settings, correctional facilities, shelter systems, and community services, exposure risk falls, and continuity of care improves.

Canada already has the tools required to reduce viral hepatitis transmission. Strengthening prevention infrastructure in the places where access has been uneven is one of the most practical and achievable steps Canada can take to close the remaining elimination gap.

In environments where access to care is fragmented or unstable, community-based prevention services often remain one of the only consistent points of connection to health systems.

> Don’t give up on us. We can be at a point in our lives where we have no family, no friends, just drugs. Sometimes you guys are all we have.
> *- panellist sharing her lived experience at a November 2025 HCV Symposium in Winnipeg*

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