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Hepatitis C care in Limited Resource Settings: The experience of Médecins sans Frontières

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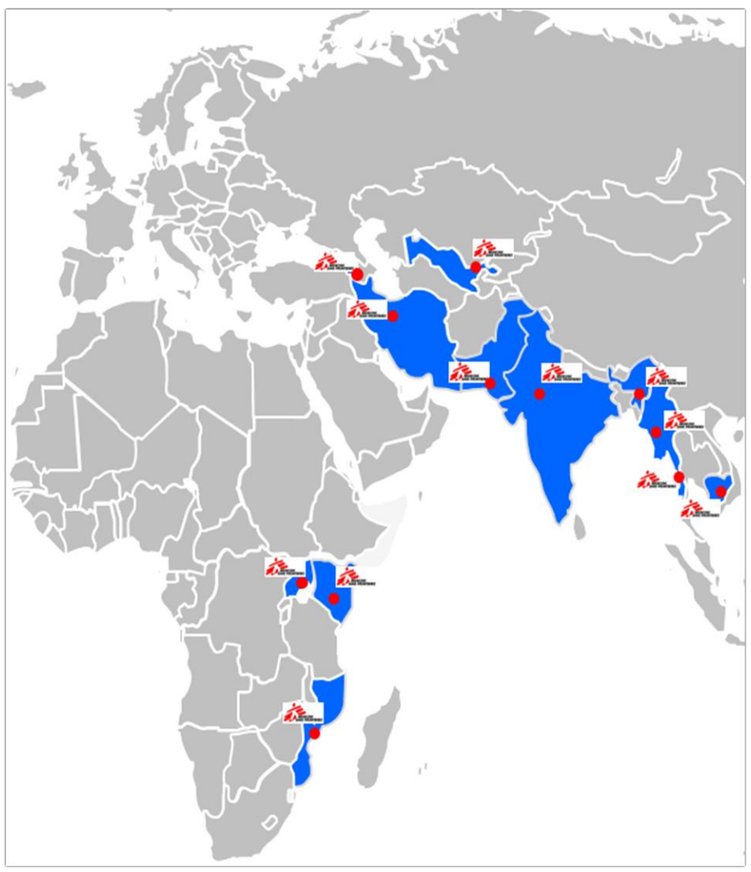
BACKGROUND

- Worldwide, 71 million people are infected by hepatitis C virus (HCV)[1]. The introduction of Direct-Acting Antivirals (DAAs) in 2013 radically changed HCV care and treatment outcomes[2]. Over one million people with HCV have been treated with DAAs according to WHO[1]. Nevertheless, access to diagnosis and treatment is limited to a few countries.
- MSF started HCV activities in 2013 using interferon-based regimens (PEG-IFN), but with the aim to simplify, scale up and decentralize care. In 2014, MSF has started to use DAAs based regimen.
- However, MSF continues to face considerable challenges in meeting these aims, mainly related to diagnosis and treatment.

Figure 1: Map of the MSF projects



METHODS

- MSF conducts HCV activities in 11 countries, in collaboration with the Ministries of Health and local partners.
- Longitudinal cohort data and routinely collected program data are used to document the activities.
- A common database is implemented on site.
- The medical guidelines follow national or international guidelines and the 2014 WHO HCV recommendations.
- Different DAAs based regimens have been used, firstly with PEG-INF and then PEG IFN-free.

Table 1. Baseline characteristics of enrolled CHC patients (as of 20/09/2017)

Characteristics at baseline		Number of patients (N=10,790)
Demographic characteristics		
	Median age, years (IQR)	48 (38-58)
	Female, n (%)	5,752 (53,3)
Virological characteristics		
	Genotype, n (%)	
	1	2,026 (19)
	2	334 (3)
	3	780 (7)
	4	7 (0.1)
	5	0 (0)
	6	1,777 (16)
	Undeterminate	58 (0.5)
	Not typed	5,817 (54)
	Baseline HCV RNA Median VL IU/mL (IQR)	1,210,000 (230,000-4,249,000)
Fibrosis stage (kPa), n (%)		
	<8,5	2,623 (24.3)
	8.5-10.9	840 (7.8)
	>= 11	2,418 (22.4)
	No results	4,918 (45.5)
HIV co-infection, n (%)		1,490 (13.8)

RESULTS

Screening activities:

- Over 40,000 people have been screened by MSF using rapid diagnostic tests.
- Chronic HCV infection was confirmed in 6,247 patients by the presence of HCV RNA.

Care activities:

- Patients presenting a detectable viral load were enrolled in MSF clinics. Baseline interview, clinical and biological assessment were performed.
- Different strategies have been implemented for the different steps of the cascade of care, according to the context and to the patient population.
- The main reported risk factors were history of invasive medical procedures (36%), history of blood transfusion (11%) and history of drug use (9.9%).
- In some sites, patients had to be prioritized, using APRI score or Fibroscan:
  - as VL or genotyping not readily available
  - due to high patient volumes
  - difficulties accessing quality assured DAAs.
- In addition, due to the lack of access to pan-genotypic drug, genotyping had to be maintained in some sites.
- The final outcome is known for 493 patients.

Table 2. Final outcome for enrolled patients (outcome as of 20/09/2017)

Outcome	Number of patients (N=1,737)
Cured (SVR12), n(%)	1,271 (73.2)
Failure	68 (3.9)
Death	55 (3.2)
Loss to follow up	334 (19.3)
Discontinuation of care	9 (0.5)

CONCLUSIONS

- HCV care is **feasible and successful** in resources limited settings and decentralized sites.
- Theoretically, simplification is now possible, as some regimens are recommended regardless of the genotype, the VL or the liver fibrosis staging.
- In practice, access limitations complicate the cascade, impacting patient flow and retention to care.
- Improved access to point of care HCV diagnostic tests and pan-genotypic regimens are required to facilitate scaling up.

REFERENCES

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CONFLICTS OF INTEREST

No conflict of Interest

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