Decentralisation, integration, and task-shifting: tools to accelerate the elimination of hepatitis C

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WHO targets for elimination of viral hepatitis as a public health threat require substantial increases in access to testing and treatment worldwide.[1] Although many challenges remain, advances in hepatitis C treatment have given a critical impetus to elimination efforts. Replacing interferon-based therapy with direct-acting antivirals allows treatment that is shorter in duration, more effective, less toxic and, crucially, simpler for patients to take and providers to deliver. No longer does access to specialist care need to hold back more widespread access to hepatitis C treatment in the range of settings where it is needed most.

The simplification of models for treatment and care has three key interrelated components: decentralisation of services from specialised centres, integration with existing services, and task-shifting (in which provision of services is moved, with appropriate training, to less specialised health-care workers). These approaches have been central to enabling widespread access to HIV and tuberculosis services[2] in areas where disease burden is great and health-care infrastructure is weak. In principle, delivering shorter, finite treatment courses for hepatitis C virus (HCV) should be more straightforward than delivering treatment for HIV and tuberculosis. Demonstrating that simplified approaches can be used effectively for hepatitis C is a precursor to their widespread recommendation.

As part of the work underpinning WHO recommendations published in 2018,[3] Ena Oru and colleagues[4] report findings of a detailed systematic review and meta-analysis of decentralisation models, drawing on both published and grey literature. The review comprises heterogenous data from different countries and different settings, where approaches to testing might differ, and data on both interferon-based and direct-acting antiviral therapy. Despite these challenges, some clear messages emerge, particularly the benefits of decentralised care on linkage to care, treatment uptake, and treatment success rates. The authors found strong evidence to support programmes in prisons and for people who inject drugs. High treatment success rates were seen when care was delivered by non-specialists.

What is the wider relevance of these findings? Of the 20 countries with the greatest burden of viral hepatitis,[5] ten are low-income or lower-middle-income, and progress to global elimination targets will be particularly dependent on achievements in these ten countries. Most of the studies in the systematic review by Oru and colleagues[4] are small and done in more wealthy countries, a few of which (such as Australia and the UK) are already on track to achieve WHO elimination targets.[6] With only 20 (14%) of 142 studies from low-income and middle-income countries, these areas are not well represented. However, the largest included study is from Egypt, showing high testing uptake, high linkage to care and treatment, and high treatment success rates with decentralisation.[7] By late 2019, more than 50 million individuals had been tested in Egypt, and treatment had been provided to an estimated 1·02 million people.[8] The provision of simplified care through primary care settings has been a key component of Egypt's progress and shows what can be achieved if there is strong political will.

Oru and colleagues' systematic review[4] did not identify any studies from the majority of the 20 countries with the greatest burden of disease. Of those not represented, only one (Japan) appears to be on track for elimination, but others need a greater focus for elimination efforts. National financing is essential in the absence of a global fund for hepatitis, but substantial falls in drug pricing mean treatment costs are not the barrier they once were.[9] Integration of hepatitis C care into harm reduction and prison health services requires such services to exist and this is not the case in all heavily burdened countries. Overcoming stigma and discrimination towards key risk groups will be essential before integrated care can be delivered universally.

How should the success of programmes be measured? The authors used sustained virological response at 12 weeks after therapy (SVR12) to compare different models of care. SVR12 is useful as a well-validated surrogate endpoint for cure and is relatively easy to measure in the clinic. In the early stages of elimination efforts, it is important to show high SVR12

rates are possible with decentralised care to counter any vested interests or conservatism resisting new initiatives. However, measures such as SVR12 will become less helpful as programmes move into harder-to-treat populations, among whom adherence to treatment is more challenging. Outcomes like SVR12 should not become a single target for programmes, otherwise it is possible that individuals at risk of not completing therapy could become excluded from care.

Scaling up, decentralising, and integrating HCV services will need champions in all parts of the health system. The details of how this is done will depend greatly on local settings. Sharing best practice and innovative solutions will help to accelerate access to treatment and this is one of the key objectives of the recently established Coalition for Global Hepatitis Elimination. Progress towards elimination has been slowed in many countries as resources need to be diverted to help control COVID-19, but the COVID-19 pandemic has also been a driver[10] to greater decentralisation of existing services in many countries. Ensuring these positive changes are harnessed for renewed elimination efforts will be essential to regain the time lost.

For more on the **Coalition for Global Hepatitis Elimination** see https://www.globalhep.org

I declare no competing interests.

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Graham S Cooke
g.cooke@imperial.ac.uk

Department of Infectious Disease, Imperial College London, London W2 1NY, UK

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