

# Addressing inequities in care on the path to eliminating hepatitis C in BC

**W**orld Hepatitis Day, acknowledged on 28 July, provides an opportunity to reflect on BC's journey toward achieving the World Health Organization's target of eliminating hepatitis C by 2030. Treatment for the hepatitis C virus (HCV) is well tolerated and can achieve cure rates greater than 95% after 8 to 12 weeks. Treatment is free for anyone with PharmaCare coverage and is not dependent on fibrosis stage. While current modeling shows that BC is on track to achieve elimination by 2030, 28 607 people living with HCV in BC remain untreated.<sup>1</sup> Many have been previously diagnosed but lost to follow-up care, and they may experience various forms of social and economic marginalization.

Around 17% of people testing antibody positive in BC between 1990 and 2018 did not have a follow-up HCV RNA test to confirm current infection.<sup>2</sup> To help address this gap in care, on 13 January 2020, the BCCDC Public Health Laboratory implemented HCV RNA reflex testing on all first-time anti-HCV reactive specimens. The ability to diagnose HCV infection from a single blood sample greatly improves patient care by decreasing time to diagnosis and treatment, thereby decreasing potential loss to follow-up and related morbidity and mortality.

Recently, the Guidelines and Protocols Advisory Committee approved revisions to the BC Viral Hepatitis Testing Guideline, making BC the first province or territory in Canada to recommend one-time birth cohort screening for people born between 1945 and 1965. As this birth cohort accounts for nearly 60% of positive

hepatitis results in BC, many of whom remain undiagnosed and have not had confirmatory HCV RNA testing, it represents a key population that needs to be engaged in HCV care to reduce liver disease complications.<sup>1</sup>

Even with these changes, there are still challenges to ensuring equitable access to HCV treatment and cure in BC. Approximately 85% of new HCV infections relate to injection drug use, and a smaller number to condomless anal sex in the context of group sex and drug use.<sup>3</sup> Populations with a disproportionately high burden of HCV infection in BC include Indigenous people, people born in endemic countries, and people who are incarcerated (PWAI).

Patient-provider knowledge gaps, stigma, racism, unemployment, unstable housing, and poverty intersect in populations affected by HCV in BC, resulting in reduced access to HCV care. Health equity can be fostered by engaging and including people from affected groups in the creation and implementation of new policies and guidelines. BCCDC is partnering with BC Provincial Corrections and BC Mental Health and Substance Use Services to create policies and guidelines with PWAI and other key stakeholders. Policies and guidelines informed by patient and provider input will help to ensure care is person-centred. This work aims to increase HCV testing, diagnosis, and treatment, all of which is essential to address the gaps in care in provincial corrections programs aiming to achieve elimination targets.

Linkage to care is a major challenge for PWAI due to the absence of coordinated systematic discharge planning services and other competing priorities at release. Further efforts by community health care providers are needed to engage priority populations in comprehensive care, particularly PWAI transitioning back to community. To find those who have

been diagnosed but not successfully treated, support for community-based organizations should be increased, as they are likely to more easily engage with people not in medical care. Approaches such as using notification systems to contact people previously diagnosed are warranted, but community consultation is also needed.

With these innovative community engagement and consultation efforts, along with the recently updated provincial testing guidelines, BC will stay on the right path to addressing inequities in care and achieving HCV elimination by 2030. ■

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*This article is the opinion of the BC Centre for Disease Control and has not been peer reviewed by the BCMJ Editorial Board.*