LETTER TO THE EDITOR

Striving toward hepatitis C elimination in the era of COVID-19

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TO THE EDITOR:

Governments worldwide have committed to achieving the World Health Organization (WHO) targets to eliminate the hepatitis C virus (HCV) as a public health threat by 2030 (1). Although recent modelling studies suggest that some countries, including Canada, are on track to eliminate HCV, they could not account for the emergence of the coronavirus disease 2019 (COVID-19) pandemic, which may jeopardize progress toward elimination (2, 3).

The pandemic has had an impact on all stages of the HCV care cascade and has reduced access to essential medical services among priority populations (ie, people disproportionately affected by HCV), including people who use drugs (4). Although governments are rightfully focused on controlling transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), marginalized populations struggle to maintain access to harm reduction and drug treatment services (5–8). Beyond interfering with HCV elimination efforts, the pandemic may, through increased inequity and changes to social service and community support structures, exacerbate existing challenges faced by these groups, including stigma and discrimination, overdose risk, comorbidities, poverty, precarious housing, and domestic violence (9–12). Recent increases in overdose-related deaths in North America reflect this reality (13–15).

The massive mobilization for COVID-19 prevention and testing has enabled the control of SARS-CoV-2 transmission in many settings and has demonstrated the feasibility of rapid and widespread public health action. Factoring in the risk of COVID-19 re-emergence (16), we must build on these lessons to counteract growing health care inequities among marginalized populations and promote a holistic approach to care. We need innovative, person-centred, and culturally sensitive approaches to ensure access to harm reduction services and to prevent HCV (re-)infection and other drug-related harms. By mirroring models implemented to test for SARS-CoV-2 and by co-locating services for HCV and COVID-19 surveillance and care, we can simultaneously reduce the consequences of both viruses in our communities (17). For example, HCV testing and treatment can be further scaled up by offering self-collected dried blood spot testing and telemedicine. Remote testing, embedded with a supportive care pathway, respects autonomy and privacy (18). Telemedicine can produce favourable HCV outcomes and has seen widespread adoption during the pandemic (19). Rapid implementation of these models can ensure that the SARS-CoV-2 pandemic does not lead to setbacks in achieving HCV elimination goals.

The WHO's HCV elimination targets are ambitious and require continuing efforts by committed governments to address the intersectional issues faced by priority populations. The COVID-19 pandemic has further marginalized the most underserved in our communities, yet it has demonstrated that concentrated action can minimize infectious disease transmission. These lessons should be applied in the context of hepatitis C as we continue to strive toward elimination.

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