

Background

When comparing Hepatitis C Virus (HCV) treatment starts in the province of British Columbia between the first 6 months of 2019 and 2020, a 38% decrease was measured, largely attributed to the changes in health care delivery models in the era of the COVID-19 pandemic. This has affected the inner city in a disproportionate manner. There is an urgent need to develop structures to address this situation and get back on track for HCV elimination by the end of the decade.

Methods

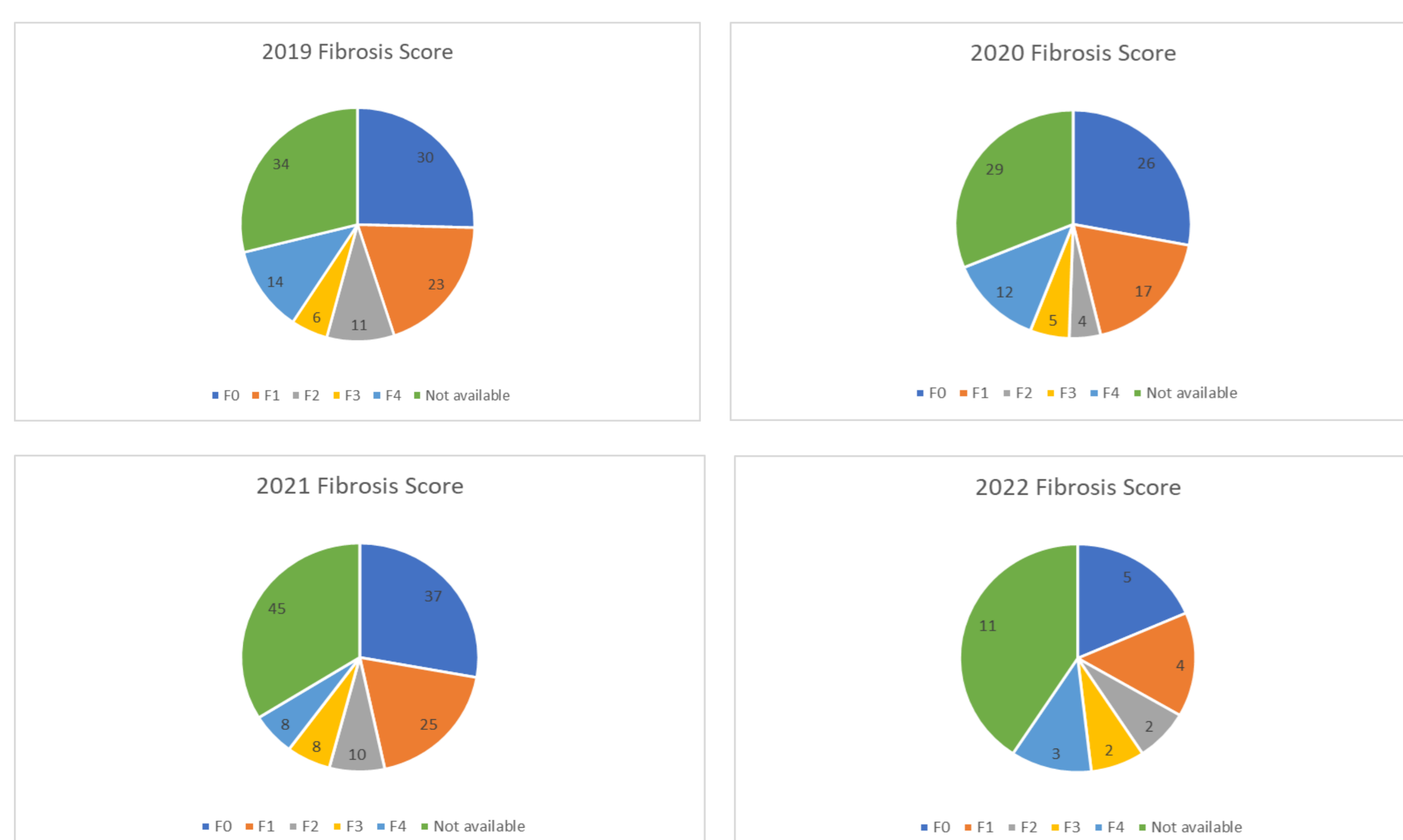
We recorded HCV treatment starts within the context of an intervention designed to provide antiviral therapy within a multidisciplinary program to address medical, psychological, social and addiction-related needs in a low threshold and flexible setting. In the COVID pandemic era, there were short periods (March-May 2020 and again in August 2020) where interactions with the community were limited due to public health measures. Outside of these periods, we were able to implement programs that were based in residences in the inner city with single room occupancy units where we could interact with HCV-infected individuals in a manner consistent with public health regulations: with personal distancing, mask wearing and hand sanitation in a controlled manner while restoring access to antiviral therapy in a consistent manner. This replaced previous programs based in community centres that were closed. We have evaluated HCV treatment starts/month from January 2019 to March 2022 to determine the impact our strategies within the context of the COVID-19 pandemic. Fibrosis scores were determined when possible (Figure 1).

Results

Table 1. Participant Demographics

	2019 (n=118)	2020 (n=93)	2021 (n=133)	2022 (Jan-Mar) (n=27)
Age (median years, range)	52 (24-75)	48 (23-77)	48 (23-77)	47 (31-67)
Gender (n, %)	Male 83 (70.3%); Female 45 (29.7%)	Male 70 (75.3%); Female 23 (24.7%)	Male 91 (68.4%); Female 42 (31.6%)	Male 20 (74.1%); Female 7 (25.9%)
HIV co-infected (n, %)	11 (9.3%)	6 (6.5%)	6 (4.5%)	1 (3.7%)
Unstably Housed (n, %)	53 (44.9%)	40 (43.0%)	86 (64.7%)	12 (44.4%)
Methadone (n, %)	36 (30.5%)	32 (34.4%)	49 (36.8%)	13 (48.1%)

Figure 1. Fibrosis Score 2019-2022



Results (continued)

Figure 2. Number of HCV Treatment Starts (2019-Mar2022)

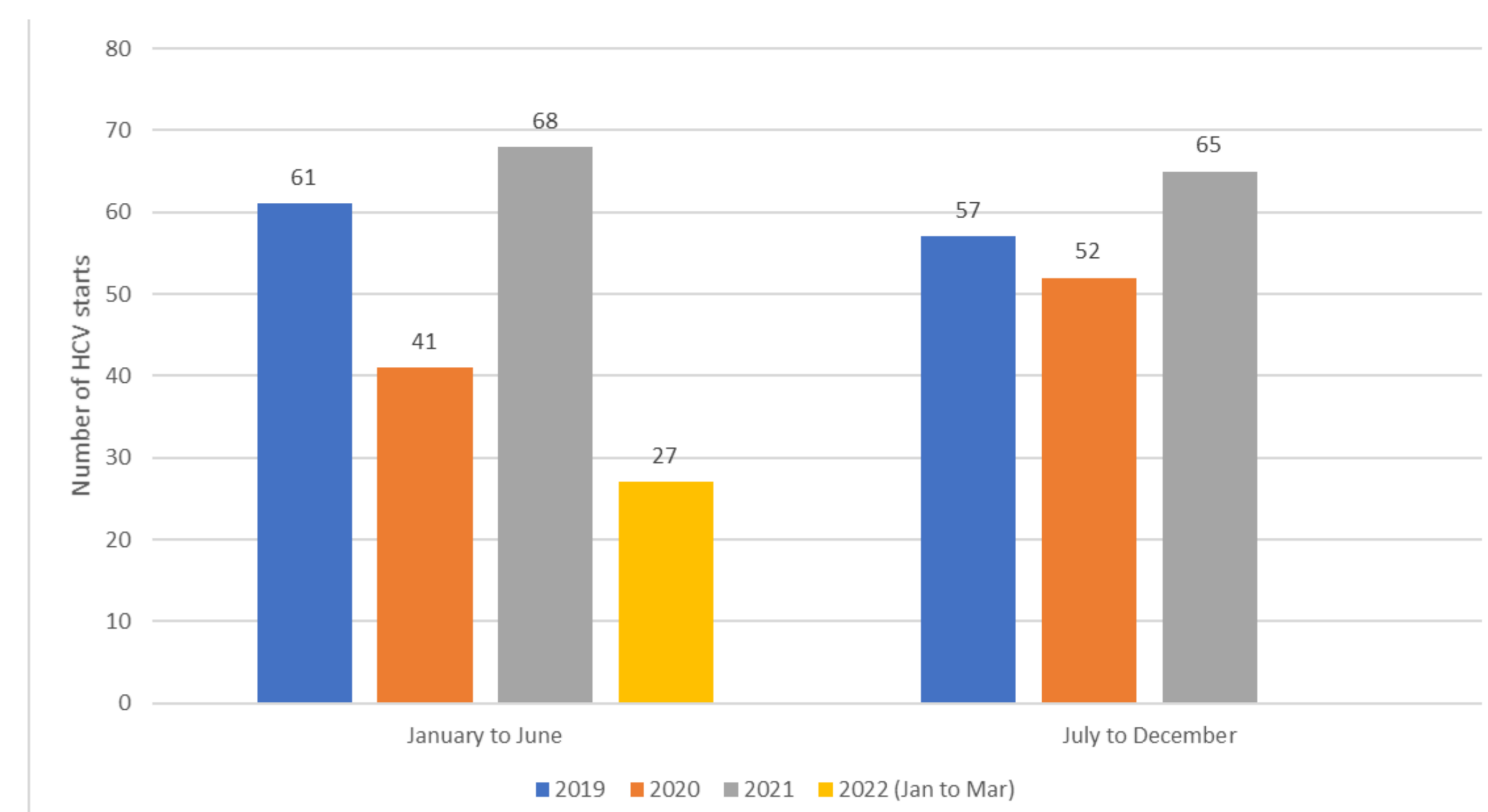
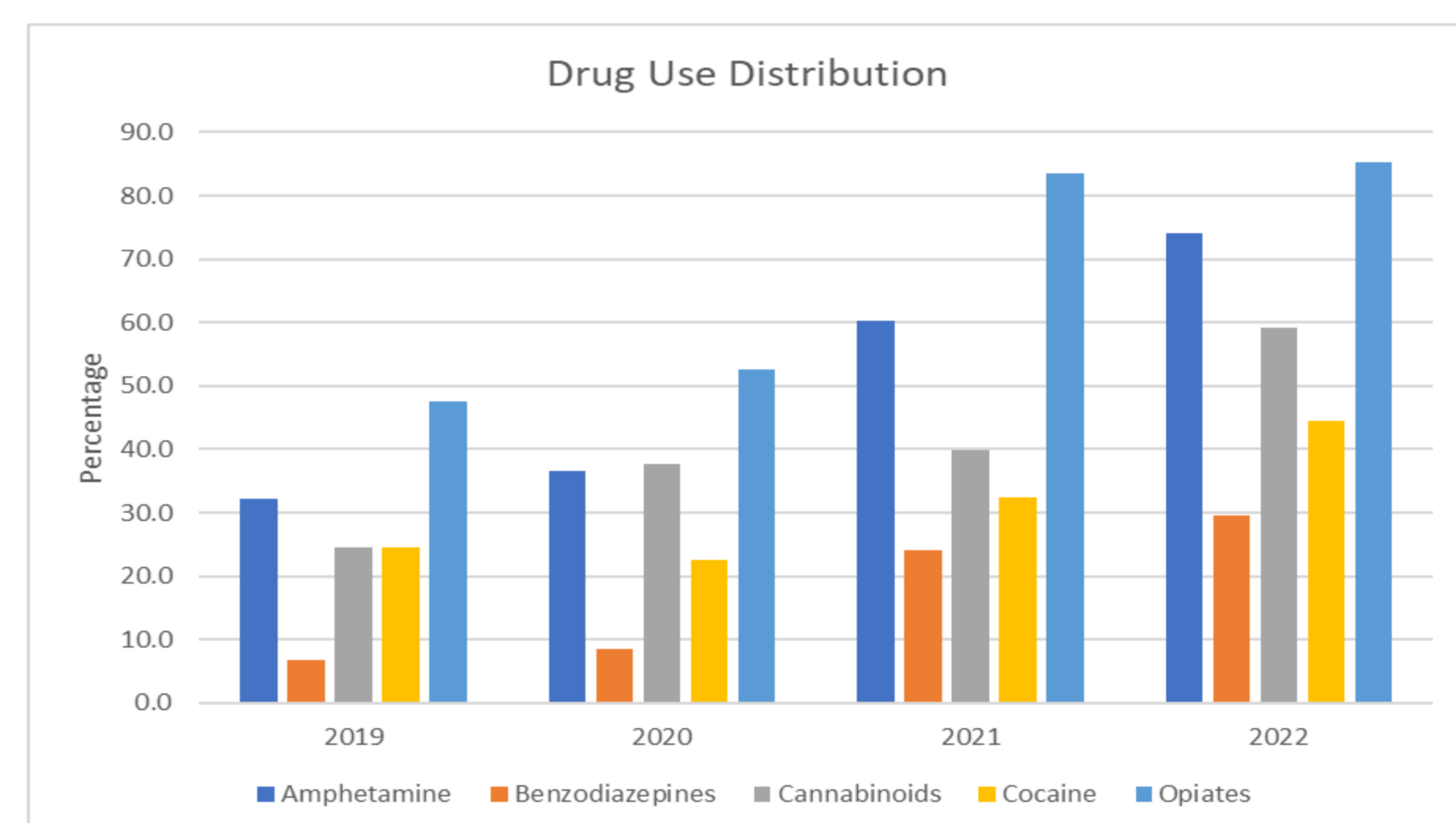


Figure 3. Participant Drug Use Distribution



Participants' median age varied between 47-52 and with about 70% of the participants identifying as male (Table 1). As shown in Figure 2, between January to June, we had 61 HCV treatment starts in 2019, and 41 in 2020, a 33% year-to-year decrease. This was largely due to a significant reduction in April and May 2020, at the height of public health restrictions on the provision of direct health care. In the second half of 2020, there was an increase to 52 treatment starts. In 2021, there has now been an average of 67 starts/6 months, maintained into 2022. Thankfully, despite treatment delays, there was no increase in the proportion of cirrhotic patients treated over time.

Conclusion

With insightful programs consistent with current public health regulations in COVIDworld, it is possible to provide HCV treatment in the inner city at a rate that equals or exceeds that achieved in the pre-pandemic era, restoring the interventions required to achieve HCV elimination at the earliest possible time.

Acknowledgements

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Disclosures

Dr. Conway has received research grants, honoraria and/or acted as a remunerated advisor for AbbVie, Astra Zeneca, Gilead Sciences, Indivior Canada, Merck, Moderna, Sanofi Pasteur, Seqirus, and ViiV Healthcare.