

Proceeding Report of Joint Meeting of Nepalese Association for the Studies of the Liver and Nepalese Society of Gastroenterologists on Overcoming the Challenges for Hepatitis C Virus Elimination in Nepal by 2030

Nepalese Association for the Study of Liver,¹ Nepalese Society of Gastroenterologists²

¹Nepalese Association for the Studies of the Liver, Liver Unit, Bir Hospital, Kathmandu, Nepal, ²Nepalese Society of Gastroenterologist, Kathmandu, Nepal.

INTRODUCTION

The sixty-ninth World Health Assembly meeting held on May 2016 reached a consensus to adopt the first targeted strategy for worldwide elimination of viral hepatitis B and C by the year 2030. While many of its member states are preparing to achieve this goal, Nepal has yet to initiate any steps for the elimination of viral hepatitis. So far, there have been no national programs for surveillance, treatment and prevention of viral hepatitis in the country. However, the announcement by honorable health minister that there would be free treatment of hepatitis C in Nepal is encouraging.

Nepalese Association for the Study of Liver (NASL) in collaboration with Nepalese Society of Gastroenterologists (NSG) held a Panel Discussion program on 28th July 2016 at Manaslu Hotel, Kathmandu, Nepal. The panelists composed of different stakeholders including representatives from the Government institutes. The interactive meeting was participated by Hepatologists, Gastroenterologists, Virologists, Molecular Biologists, Social Activists, Representatives from funding agencies and advocacy groups involved in the care of chronic viral hepatitis infected subjects in the country.

The framework of discussion was predesigned based on five major agendas listed below:

1. Screening, Surveillance and Disease Burden Estimation.
2. Awareness
3. Improving access to diagnostics.
4. Linkage to care
5. Improving and facilitating treatment uptake.

The panelists and participants were encouraged to explore each agenda in terms of current challenges, areas of gap and possible strategies to overcome them through facilitated discussion. The opinions expressed by all the panelists and participants along with recommendations derived by consensus were systematically recorded and have been presented in the current report. We strongly believe that this report will pave the way to achieve the goal set by World Health Assembly in Nepal as generic direct acting antiviral (DAA) are now available in Nepal

Correspondence: Dr. Sudhamshu KC, Nepalese Association for the Studies of the Liver, Liver Unit, Bir Hospital, Kathmandu, Nepal. Email: nepalliversociety@gmail.com, Phone: +977-9851081599.

THE CONSENSUS REPORT

“Overcoming the Challenges for HCV Elimination in Nepal by 2030”

1. Screening, Surveillance and Disease Burden Estimation

Screening and surveillance policies for HCV and estimation of disease burden are the foremost requisites for planning and implementation of elimination strategies. Currently no official evidence based recommendation for screening and surveillance exists in the country. Data on prevalence of HCV in Nepal are scanty; existing data identifies People who Inject Drugs (PWID) as a high risk group for HCV infection. In studies conducted among healthy blood donors, very low seroprevalence for anti HCV antibodies ranging from 0.1%-0.7% were noted. Similarly, in 2860 healthy adults tested in 1998, only 0.6% seropositivity for anti HCV was noted. However, 94% of PWID tested positive for anti-HCV in 1996. In a recent study by Kinkel et al, anti-HCV was found in only 41% of PWID indicating a decreasing seroprevalence of in this group.

Nationwide epidemiological study to estimate seroprevalence of HCV is felt highly necessary for total disease burden estimation. It was also suggested in the meeting that professional bodies like NASL and NSG should engage with funding agencies like Global fund, Save the Children, WHO to carry out well-designed nation wide epidemiological study on HCV infection.

Based on currently available data, screening could be advocated only in high-risk group including people who inject drugs (PWID) apart from standard practice of screening healthy voluntary blood donors.

2. Awareness

Awareness about Hepatitis C virus among general population was realized to be very low. Hazards of injecting drug use and the risk of acquiring HCV infection needs to be highlighted especially among youth population. Because of asymptomatic nature of disease, substantial proportion of HCV infected subjects is unaware of possible risks of liver related mortality, availability of new drugs (DAAs) and benefits associated with viral clearance.

Issue of social stigma about HCV infection in general population is still prevalent and has partly contributed to hesitancy in disclosing infection status and failure to seek medical help. Social and community interventions are needed in order to overcome stigmatization. Further,

it was realized that the face of hepatitis C was lacking in the community. Public figures who have been infected with HCV could act as an excellent representative and strengthen advocacy against social discrimination and might help clarify myths associated with HCV infection in community. Like wise, lack of proper awareness and political will in part of government and the health policy makers was also felt. Evidence based advocacy should draw proper attention of government towards disease burden and identify and prioritize HCV infection as a major public health problem.

3. Diagnostics

Until recently, molecular diagnostic testing for HCV RNA quantification and genotyping were not available in Nepal. The samples had to be sent to Indian commercial laboratories for testing with usual waiting time of 7-10 days for reports and cost as much as 70\$ for viral load and 110- 170\$ for genotyping. Recently viral load testing has been made available at National Public Health Laboratory (NPHL) with a shorter waiting time and cost of nearly 30\$. Genotyping, however, is yet to be commenced in government sector. The start of molecular testing has been commendable but improvement in linear dynamic range in terms of lower limit of detection of at least up to 15 IU/ml has to be considered. Apart from public laboratory, several private laboratories have commenced molecular diagnostic testing for HCV. Though the waiting time for reports have improved, the cost is still high and is comparable to Indian commercial laboratories. Reagents and primers used for molecular assays are imported which has to undergo taxation. Advocacy for cutting down government taxation of these reagents could be a way of making molecular diagnostic testing more affordable.

Easy availability of molecular testing at a reasonable cost is a prerequisite for HCV treatment and eradication. It was realized that establishing molecular testing laboratory in different regions was essential to assure accessibility to diagnostics. Extension of molecular diagnostic platforms in major regions of the country can be facilitated by public private partnership.

4. Linkage to Care

Elaborate discussion on linkage to care of diagnosed HCV infected subjects were made. Once diagnosed, linking the subject to a physician trained properly in holistic management of HCV infection is necessary for comprehensive management of the affected subject. Due to limited numbers of Hepatologists and Gastroenterologists in the country, it was felt that the amplification in numbers of HCV care provider is necessary. In this regard, Internists with special interest

in HCV management could be considered as care provider for management of HCV infected subjects. Capacity building for interested physicians could help upgrade their skills and update their knowledge to meet current standard of care. However, HCV infection co exists with multiple comorbidities and complex case scenarios with multiple medical issues are not uncommon. Facilitation in such cases should be made by opinions from experts, which should include Hepatologists and Gastroenterologists who are properly trained and updated in management of complex clinical scenarios. Accessibilities to expert opinions may be made easy by different communication tools including telemedicine. It was also appreciated that a solid guideline based compatible and pertinent with Nepalese context is needed which should help to maintain uniform treatment protocols among HCV care providers throughout the nation.

5. Facilitation of treatment uptake

It was realized and agreed that the current treatment uptake for HCV infection is dismal. Since the availability of DAAs in Nepal, the treatment uptake rate is nearly about 500 persons per year. In order to achieve HCV elimination by 2030, at least 10,000 infected subjects

need to be treated every year. Lack of awareness in general population regarding need for HCV treatment, availability of DAAs at subsidized cost and its efficacy needs to be addressed.

Despite subsidized cost, DAAs still appears to be beyond affordability in large group of patients. Strategies to overcome cost as a barrier to treatment are felt necessary. Department of Drug Administration (DDA) may have a pivotal role in making the DAAs more affordable and accessible in needy population of Nepal. Price regulation of DAAs through negotiation with pharmaceutical industries can reduce the existing price of DAAs in the country.

Making treatment affordable and accessible can facilitate treatment uptake. Micro financing for treatment and payment by the client in (EMI) equated monthly installments may encourage HCV treatment uptake. Punjab model was also discussed in the meeting that has decreased the case of HCV infection dramatically in that area.

Conflict of Interest: Corresponding Author is current President of Nepalese Association for the Studies of the Liver.

ACKNOWLEDGEMENTS

1. Panelists: Dr. Dinesh Shrestha (President NSG), Dr. Sudhamshu K. C. (President NASL), Dr. Dilip Sharama (Liver unit, Bir hospital), Dr. Ananta Shrestha (Alka hospital), Dr. Sameer Duxit (CMDN), Mr. Bal Krishna Khakurel (DDA), Mr. Sanjeev Neupane (Save the Children), Mr. Prawachan K. C. (Sparsha Nepal), Mr. Anjay K. C. (Activist group)
2. The session was Moderated by Dr Sudhamshu KC.
3. The draft was prepared by Dr Ananta Shrestha and Dr. Sudhamshu K. C. and circulated among all the panelist
4. The draft was unanimously approved by all the panelists