HIGH UPTAKE OF TREATMENT AND CURE RATES IN A DECENTRALIZED COMMUNITY-BASED GENERAL PRACTITIONER-LED HEPATITIS C MODEL OF CARE FOR PEOPLE WHO INJECT DRUGS AND PEOPLE AFFECTED BY LIVER DISEASE IN YANGON, MYANMAR

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Background:
In many countries access to direct-acting antivirals (DAAs) for hepatitis C (HCV) treatment is restricted to tertiary hospitals. There is increasing recognition of the need for decentralized models of care. However, data from low-and middle-income countries (LMICs) is limited. This study demonstrates a decentralized, non-specialist delivered model of HCV care in Yangon, Myanmar.

Description of model of care/intervention:
The feasibility study was conducted at two community-based sites: Burnet Institute (BI) site for people who inject drugs and Myanmar Liver Foundation (MLF) site for people with liver disease. Participants underwent rapid anti-HCV testing and HCV RNA testing using GeneXpert on-site. An external laboratory performed pre-treatment tests, including APRI score to determine presence of cirrhosis, using blood sample collected at study site. Trained general practitioners determined whether participants commenced DAA therapy immediately or required specialist review. Primary outcome measures were progression through the HCV care cascade, including uptake of testing and treatment, and SVR12 outcomes.

Effectiveness:
633 participants underwent anti-HCV testing and 606 (96%) were anti-HCV positive. All 606 had HCV RNA testing; 535 (88%) were RNA positive. All 535 (100%) had pre-treatment assessments and 30 (6%) underwent specialist review. 489 (91%) were eligible for and initiated DAAs and 477 (98%) completed DAA therapy. 421 achieved SVR12 (92%;421/456); outcomes were similar by site (BI site:91% [146/161]; MLF site:93% [275/295]). At BI site, 93% (235/253) reported injecting drugs in previous six months. Median time from RNA test to DAA initiation was 3 days (IQR:2–5).

Conclusion and next steps:

The study results suggest providing decentralized point-of-care testing and treatment initiated by general practitioners is feasible in LMICs. Linkage to treatment, retention in care, and SVR12 rates were high at both sites demonstrating the effectiveness of a simplified model. Evidence from this study will inform scale-up of HCV programs in Myanmar and globally.

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