

Making DAAs universally accessible was an essential step towards HCV elimination among people living with HIV-HCV co-infection, but *alone was not sufficient*.

Efforts are needed to *re-engage those disengaged from care* and *reduce mortality* in people living with HIV-HCV co-infection.

Progress Towards HCV Elimination Among People Living with HIV-Hepatitis C Virus Co-infection.

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Background

The World Health Organization set targets to eliminate Hepatitis C virus infection (HCV) globally by 2030. In late 2013 the new direct-acting antivirals (DAAs) were approved in Canada. DAA reimbursement eligibility in Canada was initially restricted to people with advanced fibrosis because of cost. These restrictions were lifted in different provinces at different times but by 2018 all restrictions were removed making DAAs universally accessible in Canada.

We assessed progress towards HCV elimination among a population of people living with HIV-HCV co-infection linked to care across Canada.

Methods

Data: Canadian Co-Infection Cohort (CCC): a multi-site open prospective cohort following HIV-HCV co-infected participants since 2003 from 18 sites in 6 provinces.

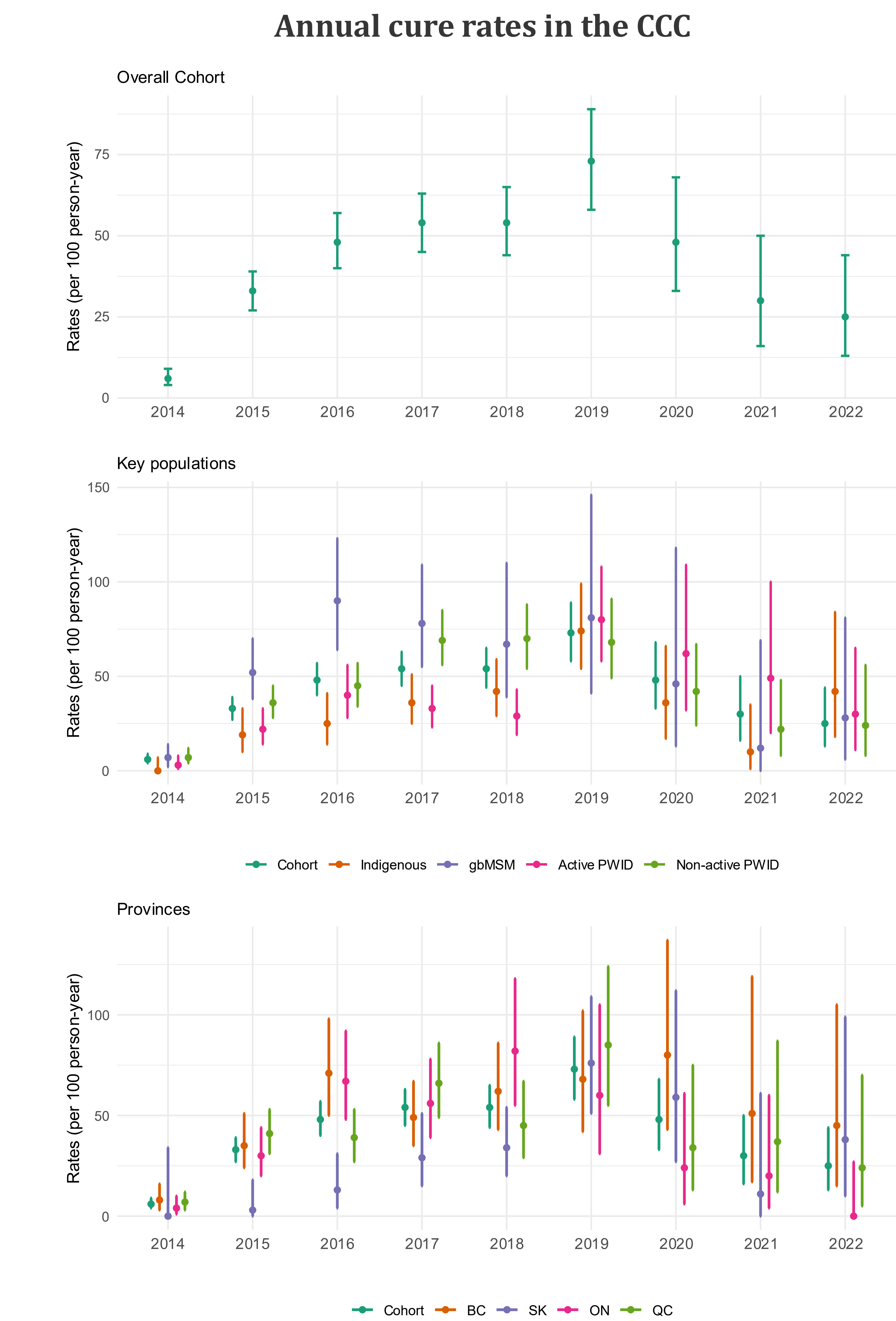
Study period: 2014-2022 (DAA era)

Inclusion/Exclusion: All participants with a positive HCV RNA result on or after the study start date who were eligible for DAA treatment coverage were included. Participants were excluded if they: initiated IFN or 1st generation DAA regimens (before or after the study start date) or, did not have enough time to achieve SVR.

Analysis: Assessed the progress towards HCV elimination, defined as being successfully treated, by calculating annual cure rates overall, by province and by key population.

Conclusions & Significance

- Overall, 72% of those eligible for treatment started DAA and 65% were cured by the end of 2022.
- In cohort overall, across provinces and key populations most of those who remain to be cured were disengaged from care, and mortality was high - **many deaths due to drug poisoning**.
- Annual cure rates increased from 2014 to 2019 then dropped across the cohort overall, in all key populations and across provinces. gbMSM had the highest cure rates, but by 2019 the rates among PWID and Indigenous peoples had caught up.
- Variability in treatment uptake across provinces tracks with universal DAA availability which democratized treatment access. Across provinces there was a general increase in cure rates after the removal of restrictions. By the end of 2019, once policies were consistent across all provinces, cure rates converged despite demographic differences.
- Patterns of intersectionality between key populations in the CCC differs across provinces. Active PWID is one of the largest key population, however it intersects differently with other populations across provinces. This underscores that not all active PWID are the same and they should be targeted differently.
- When considering HCV elimination, it is equally important to consider initiatives that enhance prevention, reduce the harms of injection drug use and address the problem of a toxic drug supply.
- Tailored policies and holistic interventions are needed for people living with HIV-HCV co-infection, to re-engage those who are disengaged from care and to reduce mortality.



	TOTAL ¹	HCV RNA NEGATIVE ²	NOT CURED (100%)		
			LTFU	ADMIN CENSORED	DIED ¹
PROVINCES					
QC	293	73.4%	46	18	36
ON	231	64.5%	46	21	33
BC	261	74.7%	47	20	33
SK	134	59%	54.5	25.5	20.0
KEY POPULATIONS					
Indigenous	252	63.5%	44.6	25.0	30.4
Active PWID	412	65.8%	50.4	19.9	29.8
gbMSM (self-identified at baseline)	207	76.8%	54	23	23
Women	274	70.8%	46.2	26.2	27.5
Heterosexual Men	448	65.2%	47	15	37
Cohort Overall	940	69%	47	20	33

¹ This doesn't include the 12 people who officially withdrew from the cohort. Admin Censored includes people with end point after study end date (2022-12-31) and people with last visit within 18 months before study end date.

² This includes people who achieved SVR and those who achieved late spontaneous clearance

Intersectionality in the CCC

