Eliminating viral hepatitis: no room for complacency

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The first *Lancet Gastroenterology & Hepatology* Commission on the elimination of viral hepatitis,[1] published in 2019, gathered a team of experts to assess preparedness for elimination and priorities to accelerate progress towards the 2030 targets that had been set by WHO in 2016.[2] The Commission identified the 20 countries with the highest burden of viral hepatitis, accounting for more than 75% of the global burden, with most countries being of low or middle income. Key factors that were identified to accelerate elimination efforts included the need for greater investment, scale up of diagnosis and prevention measures, and increased access to treatment.

We are now approximately at the halfway point between WHO's setting of elimination targets and their deadline; how have we fared in elimination efforts? A new update from the Commission[3] summarises progress. There are some successes to be celebrated. Egypt serves as an exemplar of what can be achieved with political will and funding, having taken huge steps towards elimination of hepatitis C via a mass screening and treatment programme. The effects of this programme are to be celebrated, and the country has become the first to be awarded WHO gold-tier status on the path to elimination.[4] Models of care for hepatitis C have been simplified, expanding access to diagnosis and improving linkage to care.[5] Access to effective drugs has been improved via voluntary licencing and recent price agreements forged between generic manufacturers, the Hepatitis Fund, and the Clinton Health Access Initiative.

Nonetheless, progress towards the 2030 targets has been slower than initially hoped. At least part of this stagnation is due to the inevitable impact of the COVID-19 pandemic. There are signs of recovery—Gavi, the Vaccine Alliance's resumption of support for the roll-out of birth-dose vaccination programmes for hepatitis B virus (HBV),[6] which had been paused due to the pandemic, is a welcome step forward. The complexity of care for hepatitis B remains a barrier to progress, and simplification is urgently needed; one hopes that WHO's long-awaited new guidelines in this area emerge soon. Further efforts to develop rapid diagnostics, particularly point-of-care tests, will be crucial to support simplified treatment algorithms, and much can be learned from the response to COVID-19 in terms of the development, adoption, and acceptability of such rapid testing. Simplified treatment eligibility scores—eg, the HEPSANET score[7]—could also allow the decentralisation of care in regions without access to costly tests such as HBV DNA quantification or transient elastography. Despite progress in making treatments for viral hepatitis more affordable, restrictions for reimbursement and prescription of pangenotypic direct-acting antivirals for hepatitis C remain, particularly in the low-income and middle-income regions of the world that shoulder most of the disease burden.[8]

By far the biggest barrier, however, is a continued lack of political will and resultant inadequate funding for viral hepatitis elimination. The case for investment is clear, with adequate funding becoming cost-saving and of net economic benefit over relatively short timelines.[9,10] Yet viral hepatitis continues to be overlooked, perhaps due to a lack of awareness, but also as a victim of political and social short-termism. An emphasis on viral hepatitis being not only infectious but also oncogenic in nature might help to reframe elimination as a cancer prevention initiative, potentially elevating the position of viral hepatitis on the global agenda.

We have the tools needed to make serious progress towards elimination, and further inaction is to deprive those affected by viral hepatitis of their basic right to health. The voice of civil society can be ignored no longer—there is no room for continued complacency if we are to meet the 2030 elimination targets.

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