

Prevalence of active Hepatitis C Virus (HCV) infection and associated factors among Forcibly Displaced Myanmar Nationals residing in camps, Cox's Bazar, Bangladesh

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NOTE: This is a work of the FETCH fellow that was completed on December 2023, when only study preliminary results were available. Final results are presented at the Epicentre Scientific day in 2024 as oral presentation (Results may slightly differ)

BACKGROUND

- HCV is a bloodborne virus that commonly spreads through unsafe injection practices and medical procedures. Most infections are asymptomatic initially but can develop into chronic liver infection or cancer without treatment.
- WHO aims to eliminate HCV as a public health threat by 2030 but access to diagnosis and treatment is limited globally, especially in low-income countries where most infections occur.
- Studies in Rohingya refugee camps show concerning levels of HCV infection, with 8-11% seroprevalence found among various groups. However, representative data is lacking on active infections and risks.
- MSF currently provides the only HCV services in Cox Bazar camps housing nearly 1 million people.

OBJECTIVES

Primary objective

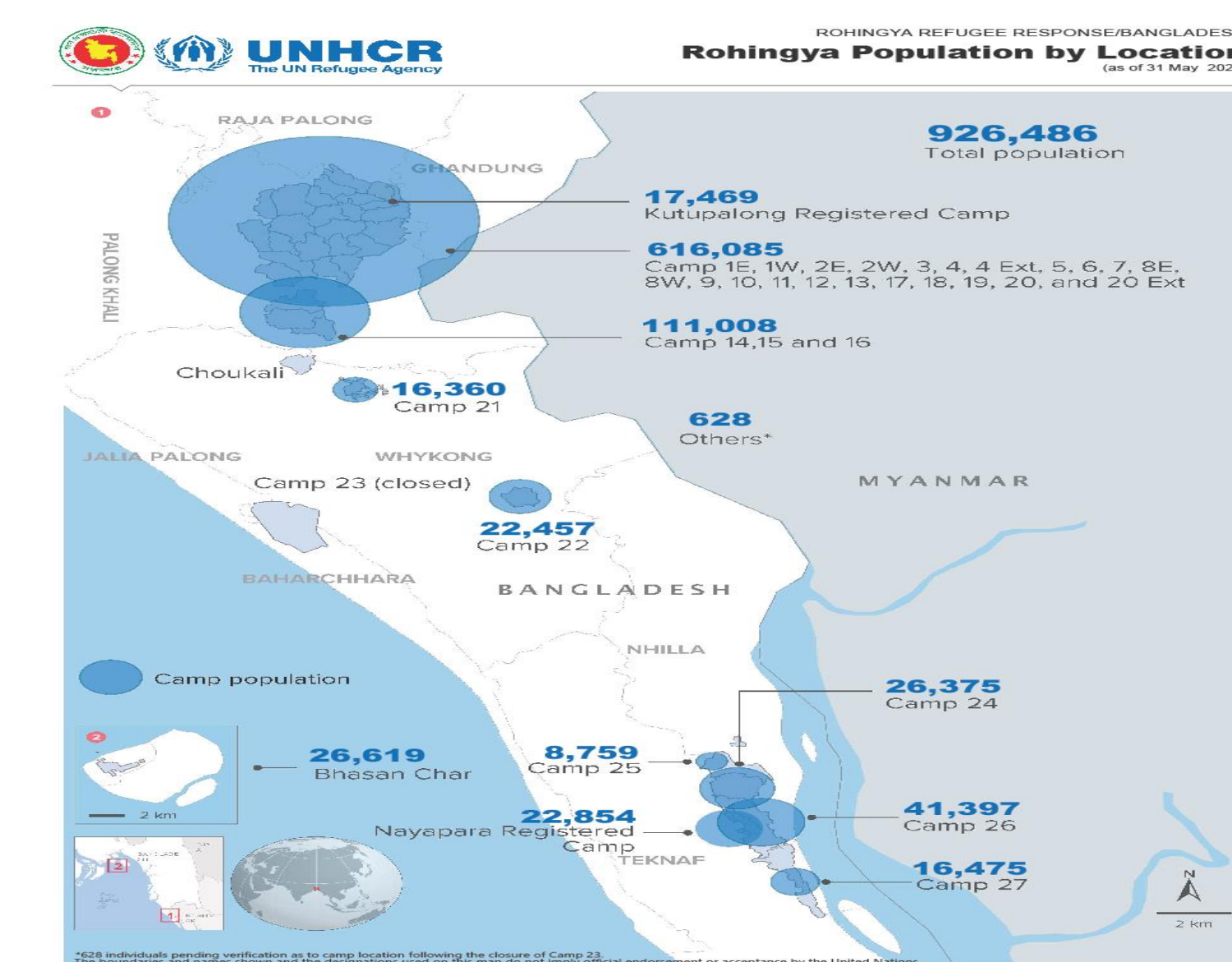
To estimate the prevalence of active HCV infection (seropositive and viremic) in the general adult FDMN population residing within camps.

Secondary objectives

- To estimate the proportion of undiagnosed active HCV infections (individuals not aware of their HCV infection).
- To estimate the prevalence of past/cleared HCV infection (individuals HCV seropositive but non-viremic).
- To describe the sociodemographic characteristics of participants with past/cleared HCV infection and current active HCV infection.
- To assess factors associated with HCV exposure in the FDMN population.

METHODS

- Survey design: Cross-sectional, point prevalence survey
- Population: Adult (≥ 18 years) FDMN (Forcibly Displaced Myanmar National) population.
- Sites: OCP-supported camps (8W, 12, 13, 16, 17, 18, 19) in Cox's Bazar District, Bangladesh
- Sampling: Simple probability sampling, using geospatial sampling methods.
- Sample size: 680 Households (HH), one adult participant randomly selected per HH from geo-point
- Survey measures:
 - Rapid HCV antibody test (SD Bioline)
 - Xpert[®] HCV Viral Load test (Cepheid) if seropositive
 - Participant questionnaire (characteristics, risk factors)
- Ethics:
 - Protocol approved by MSF ERB and Bangladesh University of Health Sciences (BUHS)
 - Verbal consent head of household, written informed consent study participant

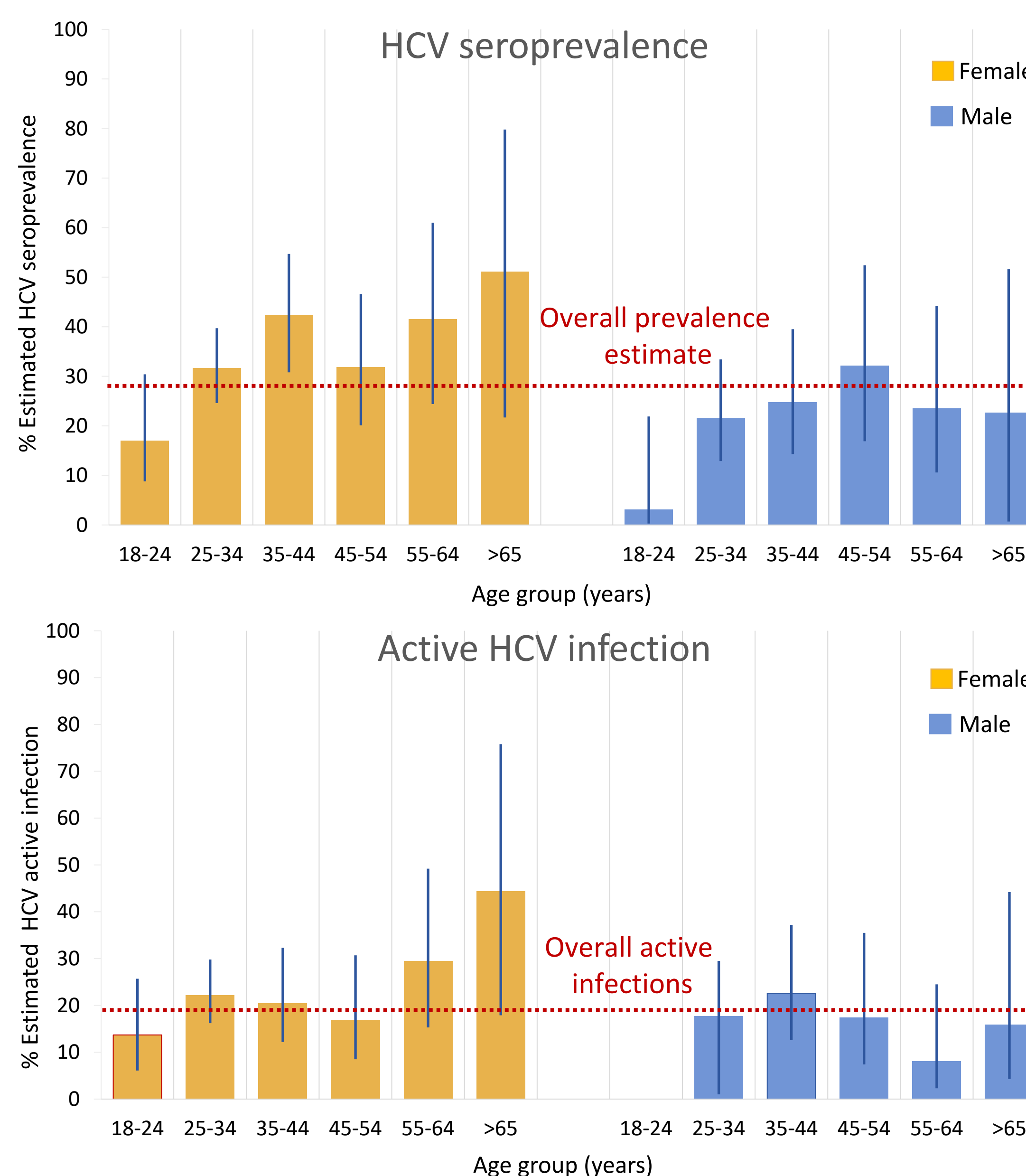


RESULTS

| Participants | HCV seroprevalence (95% CI) | Active HCV infection (95% CI) |
|--------------|-----------------------------|-------------------------------|
| N = 641 | 29.7 % (26.9 – 33.8) | 19.6 % (16.4 – 23.2) |

Survey sample distribution by camp compared with the camp population distribution by UNHCR

| Camp | Survey sample | | Adult camp population (UNHCR Sept 2023) | |
|--------------|---------------|------------|---|------------|
| | N included | % of total | N | % of total |
| 8W | 101 | 15.8 | 15808 | 16.1 |
| 12 | 90 | 14.0 | 13931 | 14.2 |
| 13 | 134 | 20.9 | 21700 | 22.1 |
| 16 | 72 | 11.2 | 10716 | 10.9 |
| 17 | 60 | 9.4 | 8928 | 9.1 |
| 18 | 100 | 15.6 | 14210 | 14.5 |
| 19 | 84 | 13.1 | 12941 | 13.2 |
| Total | 641 | 100 | 98234 | 100 |



Among HCV seropositive:

- 66.6% (58.9-73.6) with active infection, 33.4% (26.4-41.2) non-viremic
- 35% (0.3-43.5) reported previous HCV diagnosis (3.1% (1.7-5.6) among seronegative)
- 9.8% (6.2-15.5) reported previous HCV treatment (3.2% (1.8-5.9) among seronegative)
- Extrapolation of survey estimates to total adult camp population: approx. **85,000 adults undiagnosed with active HCV infection** (estimate based on UNHCR adult population data, Sept 2023)
- Limited HCV awareness:
 - 51.0% of participants reported to have heard of HCV
 - 61.6% (53.8 – 68.8) among seropositive
 - 60.4% (50.8 – 69.4) of those with active infection
- 12% of 114 who said they have seen shaved at the barber using unclean razor (few are RDT-pos).
- 5 participants used injections for non-medical purposes (the camp, and Myanmar), 2/5 RDT-pos.

CONCLUSIONS

This survey revealed a high burden of active HCV infection among the general adult FDMN population in the camps, along with a low coverage of HCV diagnosis and care -> HCV activities need to be scaled-up urgently.

The findings of this survey will directly inform tailored interventions for prevention, diagnosis, and treatment in the FDMN community, urge other actors present in the camps to take up HCV care, and advocate for integration of HCV prevention, diagnosis, and care into the general health care package for the entire Cox's Bazar camp community, as well as in any IDP or Refugee camp where the population is at risk.