Hep C-CURE Rohingya: a large retrospective cohort study of hepatitis C virus treatment outcomes among Rohingya refugees in Bangladesh

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MSF's simplified model reduced lab, staff, and patient burden, while maintaining per-protocol cure rates over 93%

Background

Hepatitis C virus (HCV) infection is a major health concern in Cox's Bazar camps.

2020: MSF started HCV screening, diagnosis, and treatment

2023: A cross-sectional study by Epicentre[1] showed an alarming 19.6% prevalence of active HCV infection (n= 641)

Predominance of genotype 3

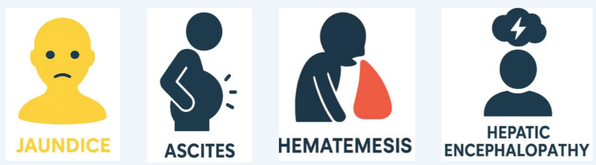
- Prevalence up to **80%** in Bangladesh and **39%** in Myanmar [2,3]
- WHO recommends longer treatment for cirrhotic patients

How was treatment simplified?

A patient tested positive via Hepatitis C RDT and PCR, now what?

MSF's simplified protocol

Clinical assessment:



Asymptomatic = no clinically decompensated cirrhosis → SOF/DAC 12-week treatment

Symptomatic = clinically decompensated cirrhosis → SOF/DAC 24-week treatment

Standard protocol

For regions with high prevalence of genotype 3

Blood drawn and sent to lab

Patient returns after 1-7 days

Clinical assessment + APRI score calculated

Asymptomatic + Negative APRI = no cirrhosis → SOF/DAC 12-week treatment

Asymptomatic + Positive APRI = compensated cirrhosis → SOF/DAC 24-week treatment

Symptomatic + Positive APRI = decompensated cirrhosis → SOF/DAC 24-week treatment

What makes the MSF protocol different?

Fewer laboratory tests, fewer trips for patients, and **immediate treatment start**

Table 1. Cure rates by treatment group	Per-protocol n/total	Per-protocol %	Intent-to-treat n/total	Intent-to-treat %
12-week treatment				
Cure rate	5,481/5,845	**93.8%**	6,060/7,297	**83.0%**
Treatment failure	364/5,845	6.2%	399/7,297	5.5%
24-week treatment				
Cure rate	236/252	**93.7%**	247/421	**58.7%**
Treatment failure	16/252	6.3%	16/421	3.8%
Total				
Cure rate	5,717/6,097	**93.8%**	6,307/7,718	**81.7%**
Treatment failure	380/6,097	6.2%	415/7,718	5.4%
Died			151/7,718	2.0%
Lost to follow up			832/7,718	10.8%
Transferred			13/7,718	0.2%

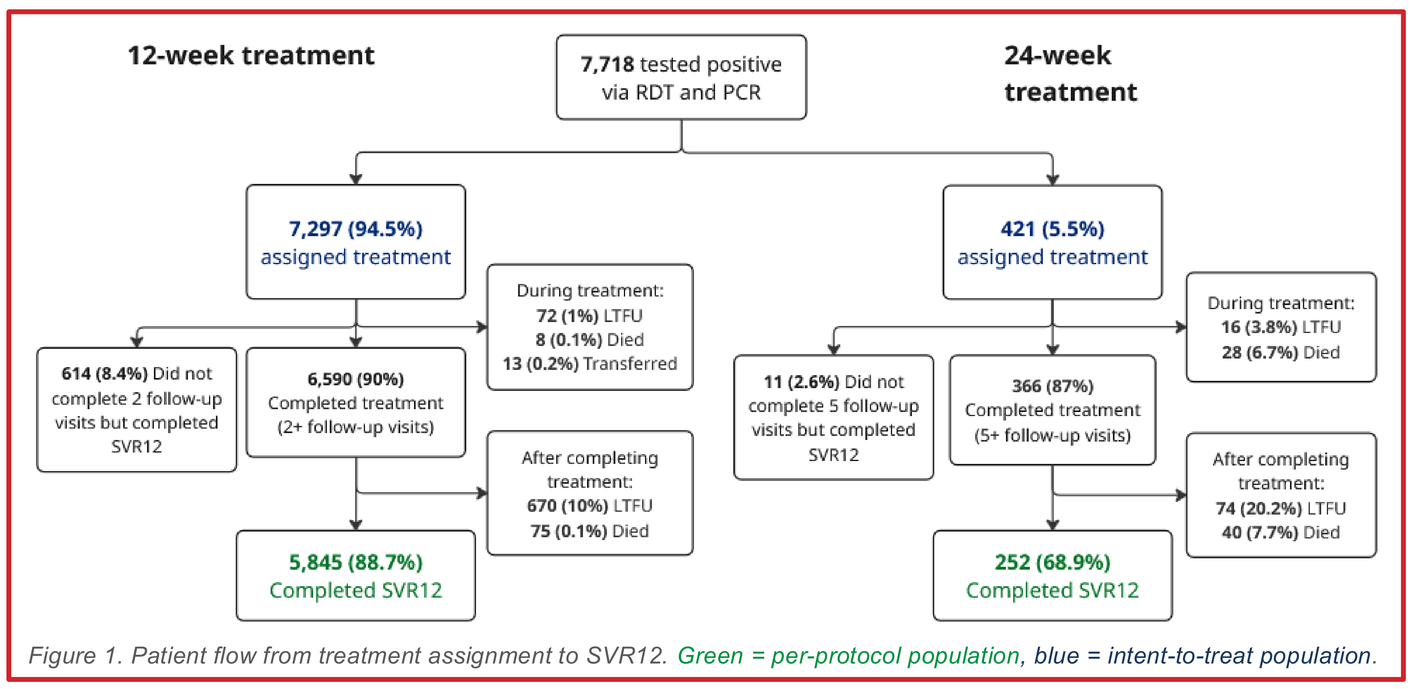


Figure 1. Patient flow from treatment assignment to SVR12. Green = per-protocol population, blue = intent-to-treat population.

Retrospective cohort study

Population: Non-pregnant adults enrolled from Oct 2020 to Mar 2025, treated with Sofosbuvir/Daclatasvir (SOF/DAC) at the MSF-OCP Hepatitis C clinic in Ukhiya, Cox's Bazar.

Primary outcome: Cure rate, defined as the proportion of patients with sustained virological response 12 weeks after treatment completion (SVR12, viral load < 1000IU/mL).

Patient demographics

- Median age was 48 years
- 69% were female
- 99% were forcibly displaced Myanmar nationals
- 25% lived in the MSF-OCP catchment area
- 1% were co-infected with HIV
- 2% were co-infected with hepatitis B

Despite limited resources and the burden of competing health priorities, this simplified approach allowed scale-up of HCV care

- Supports integration into routine packages of care in Cox's Bazar and uptake by other actors (UNHCR, IOM)
- The 82% intent-to-treat cure rate highlights follow-up challenges and the need for post-treatment counselling
- Some reasons for LTFU include migration, withdrawing from care, and patients becoming pregnant

[1]Schramm et al., 2025
[2] Sufian A. et al., 2021
[3] Aye KS. et al., 2017

Ethics: This research fulfilled the exemption criteria set by the MSF ERB for a posteriori analyses of routinely-collected clinical data. It was conducted with permission from the OCP Medical Director.

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