Lessons from a decade of progress: reigniting momentum for hepatitis C elimination

Executive Summary: Hepatitis C kills 240,000 people a year or about one person every two minutes. Not because there is no cure—a complete 12-week treatment is available for under US$60—but because the sustained political commitment and financing to deliver that cure at scale have not followed.

Since 2016, CHAI has partnered with ministries of health in Cambodia, India, Indonesia, Myanmar, Nigeria, Rwanda, and Vietnam to expand public-sector hepatitis C services. Through market shaping, catalytic resource mobilization, service integration, and health system strengthening, these programs have generated nearly a decade of evidence on how countries can scale hepatitis C care.

This report summarizes the lessons from that decade of implementation experience and identifies the priority investments needed to sustain and accelerate hepatitis C elimination in the years ahead.

What this decade taught us:

1. **Market shaping made public-sector treatment at scale possible**. Coordinated action reduced the cost of a cure from more than US$84,000 to US$60.
2. **Simplified, integrated delivery made scale feasible**. Decentralized, integrated care enabled countries to expand access while maintaining high cure rates.
3. **Treatment alone is not enough**. Scaling hepatitis C programs requires investment in diagnosis and case finding, prevention, equitable access, and robust surveillance and patient tracking systems.
4. **Government leadership and sustained financing drive progress**. Catalytic investments can launch national programs, but countries that have prioritized hepatitis C and invested domestic resources have made the greatest progress towards elimination.
5. **Progress is real, but at risk**. Fragile treatment markets and constrained financing threaten hard-won gains. Sustaining programs is more effective—and less costly—than rebuilding them.

The tools exist. The challenge now is scaling and sustaining them long enough to put multiple countries on the path to elimination. The next decade requires sustained political commitment, increased financing, stronger community engagement, and continued investment in the technical and operational systems needed to scale case finding and turn diagnosis into cure.

10-year impact

Between 2016 and 2026, CHAI partnered with governments and other stakeholders to support hepatitis C scale-up across seven countries.

Program reach

25.4M
People screened

7
CHAI-supported countries across Africa and Asia

525K+
Initiated on treatment

9.5K+
Healthcare workers trained

Estimated health impact[i]

473K
People cured

159K
Premature deaths averted

1.6M
DALYs[ii] averted

Market transformation

88%
Drop in treatment costs, from US$900 to below US$120 in CHAI-supported countries, with prices as low as US$60 for a 12-week WHO quality-assured generic treatment

<$80
Potential total cost of cure—including diagnosis and treatment—in settings able to access the lowest available prices (US$)

[i] *Program data are reported through national monitoring systems. Cure, death, and DALY estimates are based on program evidence and modeling.*
[ii] *DALYs stand for Disability-Adjusted Life Years, a measure of healthy years of life lost due to illness, disability, or premature death*

Five lessons the past decade taught us

Across seven countries, several approaches consistently distinguished programs that scaled successfully from those that struggled. Five lessons emerged.

1 Affordable markets enable scale

In 2013, it could cost as much as US$84,000 per person to cure hepatitis C. Even after cheaper generic treatments became available in many low- and middle-income countries about a decade ago, it still cost between US$750 and US$900 to cure a patient when CHAI launched our hepatitis program.

Through coordinated market shaping—including manufacturer engagement, accelerated registration of WHO-prequalified generics, and demand aggregation—CHAI helped several countries reduce the price of quality-assured treatment to as low as US$60 per course for procurements meeting minimum volume thresholds.

The lowest negotiated price remains achievable. staining the lowest negotiated price depends on procurement volumes that are large enough to support competitive supply. Most procurement today is too fragmented to clear the volume required so manufacturers cannot count on the demand needed to sustain competitive, low-cost supply, and prices have been drifting back up for anyone ordering below the minimum volume required.

2 Integrated health systems sustain scale

Affordable medicine alone won't make it available to the people who need it. Countries had to redesign how care was delivered by simplifying the pathway from screening to diagnosis, treatment, and cure.

The most important lesson: Sustainable scale comes from strengthening routine health systems not building stand-alone programs. Countries that embedded hepatitis C services within existing delivery platforms —HIV clinics, primary healthcare, hospitals, prison health services, harm reduction or community outreach programs—expanded access while building lasting capacity within their health systems. Clinical pathways were simplified, care was decentralized, and treatment responsibilities expanded to trained non-specialist providers, bringing services closer to patients.

Evidence from more than 100,000 patients treated through public-sector programs in India, Indonesia, Myanmar, Nigeria, and Vietnam confirms the model works: 91 percent of patients completed treatment and among the roughly 70 percent who were tested to confirm a cure, 93 percent were confirmed cured. These results show high-quality care can be delivered at scale within routine public-sector programs. But they also point to a remaining gap: nearly a third of patients who finish treatment are never tested to confirm whether they are actually cured.

Why market coordination still matters

"When these drugs were first announced, I remember the cost very clearly: US$84,000. That was unaffordable. We had the patients, we had the drugs, but we couldn't afford to get the drugs to the people. We had to change this."

— Dr. Sabin Nsanzimana, Minister of Health, Rwanda

99% reduction in the cost of HCV treatment in Rwanda: from US$84,000 to US$60

85% of reported orders contain fewer than 2,000 bottles, while ceiling prices require minimum orders of 2,500-3,500 bottles

2.4x more amount smaller purchasers may pay per treatment course

1 WHO-prequalified supplier for the most widely procured fixed-dose regimen

Reaching underserved populations

Indonesia's prison program: People in prison carry one of the highest hepatitis C burdens, with prevalence estimated to be 10–15 times higher than in the general population. Despite this, access to hepatitis C testing, treatment, and specialist care is often limited, making prisons a critical setting for elimination efforts. In 2021, CHAI supported Indonesia to integrate hepatitis C services into routine prison healthcare. We used telemedicine, cross-ministry collaboration between Health and Law and Human Rights departments, and community partnerships to combine specialist support, task-sharing, and peer education.

By October 2024: More than 41,000 people had been screened across 23 prisons, identifying over 1,800 people living with chronic hepatitis C and initiating curative treatment for more than 1,000 of them.

3 Case finding, prevention, person-centered care, and data are essential

Curing more people alone will not achieve hepatitis C elimination. Achieving elimination requires sustained investment in smart case finding and diagnosis, prevention, person-centered care that supports treatment completion, and data systems that identify and close gaps along the pathway from diagnosis to cure.

National hepatitis C programs need to pair treatment with interventions that reduce ongoing transmission, including blood safety, infection prevention and control, harm reduction, and other strategies tailored to local epidemiology. Understanding how transmission occurs within a country or region is essential for directing prevention resources where they will have the greatest impact.

Reaching the people who carry the highest risk of transmission matters as much as treating those already identified. Across CHAI-supported programs, hepatitis C services were integrated into HIV clinics, harm reduction and opioid agonist therapy programs, prison health services, and community outreach—bringing testing and treatment to populations that conventional health services often miss. Community engagement and person-centered care were essential to building trust, increasing uptake, supporting treatment completion, and reducing stigma.

None of this works without strong data. Effective programs depend on the ability to track patients from screening through cure, identify where people are lost to follow-up, and monitor reinfection. Case-based monitoring systems, such as Rwanda's national DHIS2 tracker, provided the information needed to improve program performance, target resources more effectively, and sustain accountability.

Why local context changes the strategy

Punjab, India: Working with the Government of Punjab, CHAI-affiliate The William J. Clinton Foundation used operational research to understand both how hepatitis C was being transmitted and why some patients were not completing treatment. A statewide risk-factor study found that injecting drug use was the strongest predictor of hepatitis C infection, with incarceration, tattoos, acupuncture, and household exposure also associated with infection.

These findings showed that infection prevention alone would not be enough and informed greater emphasis on harm reduction, prison health services, and targeted outreach to populations at highest risk.

A second study explored why patients discontinued treatment. Many believed they were cured once they felt better or struggled to return to health facilities because of work or relocation. Most had not been counseled on the importance of completing treatment. The findings informed improvements to patient counseling, follow-up, and service delivery to support treatment completion.

Together, these studies showed how local evidence can shape prevention strategies, person-centered care, and program design to accelerate progress towards hepatitis C elimination.

CHAI supported similar operational research in Nasarawa state in Nigeria.

4 Government ownership determines success

Countries advanced furthest where governments made hepatitis C a national priority, integrated services into national health systems, and progressively increased domestic investment alongside external support. Catalytic financing plays a critical role in this transition. When strategically targeted, it can help countries establish public-sector programs, generate the evidence needed for national scale-up, strengthen health systems, and build the political confidence required for governments to assume long-term ownership.

Rwanda demonstrates what sustained commitment can achieve. Through long-term government leadership, strategic technical assistance, and access to affordable treatment, the country is now seeking WHO validation of its progress on the pathway to hepatitis C elimination. Other countries—including Cambodia, Vietnam, and Nigeria—show how catalytic investments can accelerate this journey by helping governments move from pilot projects to broader programs.

Replicating this success elsewhere has proven harder. Many countries have shown real political will, but progress has stalled on fragmented, unpredictable financing. Governments struggle to procure commodities, retain health workers, or sustain delivery platforms without reliable funding. Catalytic financing can help countries reach the point where domestic investment becomes feasible, but lasting elimination ultimately depends on predictable government financing. Political commitment and financing are mutually reinforcing—neither is sufficient alone.

Catalytic financing in action

Cambodia: CHAI partnered with the Ministry of Health to reprogram Global Fund HIV funding to screen approximately 68 percent of adults receiving antiretroviral therapy for hepatitis C and provide diagnosis and treatment. The program generated the evidence that informed Cambodia's national hepatitis C strategic plan and clinical guidelines.

Vietnam: CHAI supported one of Vietnam's first public-sector hepatitis C demonstration programs, generating the evidence that led the government to include four direct-acting antiviral regimens in the national health insurance scheme, with 50 percent reimbursement, creating a pathway for national scale-up.

Nigeria: CHAI supported the country's first public-sector hepatitis C demonstration programs in Nasarawa and Lagos, helping catalyze government investment. Nasarawa subsequently committed domestic funding and launched a hepatitis C elimination plan.

Catalytic financing has the greatest impact when it helps countries generate the evidence, policies, and government commitment needed to transition from pilot projects to sustainable, nationally-led hepatitis C programs.

Path towards elimination

Rwanda: CHAI partnered with Rwanda's Ministry of Health and the Rwanda Biomedical Center to design and implement the national hepatitis C program in 2016—developing the national strategy, negotiating lower commodity prices, decentralizing services onto existing HIV infrastructure, training 1,500+ health workers, and building a national DHIS2 patient-tracking system.

Program achievements:

10.7M
People screened

65K+
Diagnosed

60K+
Treated

Estimated health impact:

17K+
Premature deaths averted over 30 years

181K+
DALYs averted over 30 years

5

Progress must be protected

The World Health Organization (WHO) has called for an 80 percent reduction in new hepatitis C infections and a 65 percent reduction in hepatitis-related deaths by 2030. A decade on, deaths have fallen by just 12 percent and new infections by just 8 percent.

The conditions that enabled even that progress are increasingly fragile. Health budgets are tightening, supplier competition has narrowed, and procurement remains too fragmented to support the key pricing agreements already negotiated. Program interruptions are already threatening continuity in several CHAI-supported countries. Protecting the workforce, supply chains, and data systems built over the past decade is far more effective—and far less costly—than rebuilding them once momentum has been lost.

This points to a deeper structural gap: unlike HIV or malaria, hepatitis C has no predictable financing architecture that countries can plan against. National programs often depend on fragmented bilateral funding and short-term agreements, leaving both implementation and markets vulnerable to disruption. Without predictable demand, manufacturers struggle to sustain the affordable prices that transformed access to a cure, and governments cannot plan long-term elimination efforts with any certainty.

Political commitment without financing cannot sustain programs. Financing without government ownership won't deliver lasting impact. Elimination requires both.

Global progress towards HCV elimination

47M	people are still living with chronic hepatitis C worldwide
12%	decline in hepatitis C-related deaths since 2015
20%	of people with hepatitis C treated since 2015
11M	people globally diagnosed still remain untreated

Building on a decade of progress

The past decade has transformed what is possible for hepatitis C. Countries have demonstrated that large-scale hepatitis C testing and treatment programs are technically feasible and operationally achievable. Evidence from multiple settings also shows that these programs can be highly cost-effective. Affordable diagnostics and treatment, market shaping, simplified service delivery, stronger health systems, and sustained government leadership have together created a proven model for delivery.

The last decade of hepatitis C scale-up answered a fundamental question: can elimination be achieved in low- and middle-income countries? The answer is yes. Countries have shown that testing and treatment can be delivered at national scale, cure rates remain high, and affordable commodities have made elimination economically feasible.

The next decade poses a different challenge. Fiscal pressure is increasing, donor resources are tightening, and millions of diagnosed people remain untreated. Future success will depend on continuing to innovate while scaling proven solutions consistently and sustainably.

The lessons presented in this report point directly to where future investment will have the greatest impact.

Priority investments

Together, these five investments address the major barriers preventing countries from reaching elimination.

Help countries finish the job

Several countries have made substantial progress towards elimination and need targeted investments to reach the finish line. Rwanda is among the countries seeking WHO validation of its progress towards elimination —a milestone that would provide proof of concept other countries can replicate. Completing this validation and reaching the remaining people still left to diagnose and treat, requires continued investment in surveillance, case-based monitoring, and case finding.

Support countries to transition to sustainable financing

External funding remains essential, but it should increasingly help countries build domestic ownership rather than indefinitely finance service delivery. Donor investments can accelerate market access, strengthen health systems, generate evidence, and support governments to progressively assume responsibility for financing hepatitis C programs. Every country will require its own pathway and timeline based on its fiscal capacity and health financing system, but that transition is what turns political commitment into a lasting, self-sustaining program.

Find the remaining cases— and link them to cure

Finding people living with hepatitis C remains central to elimination, but the next decade will require more targeted approaches. In some countries broad screening will still be required, in others targeted case finding integrated into routine health services will have greater impact. Just as important is what happens to people we've already found: an estimated 11 million have been diagnosed but never started treatment, lost somewhere between a positive test result and a prescription. Closing that gap—through simplified referral, patient tracking, and follow-up—is one of the largest immediate opportunities to reduce illness and death.

Integrate elimination efforts into routine health systems

Long-term success depends on making hepatitis C services part of routine healthcare rather than stand-alone programs. Integrating testing, treatment, and follow-up into HIV services, primary healthcare, prison health, harm reduction programs, and other existing platforms can expand access while strengthening health systems and reducing costs. Investments should continue to strengthen the workforce, laboratory networks, supply chains, digital information systems, and program management needed to sustain elimination over time.

Protect the market that made elimination possible

Affordable treatment transformed the global hepatitis C response, but those gains are increasingly fragile. As procurement volumes become smaller and more fragmented, maintaining competitive markets will require greater coordination across countries. Investments in demand forecasting, pooled procurement, and other demand aggregation mechanisms can help sustain supplier participation, preserve affordable pricing, and ensure reliable access to quality-assured diagnostics and medicines.

Looking ahead

The last decade proved hepatitis C elimination is possible. The next decade will determine whether it happens.

The tools exist. The evidence exists. The challenge is sustaining the political commitment, financing, and implementation needed to deliver a cure to everyone who still needs it.

Annex

Data sources

Program data: Screening, diagnosis, treatment, and workforce indicators were drawn from routine national or subnational monitoring systems in the seven supported countries through Q4 2024. Data are subject to routine reconciliation and may be revised.

Estimated cures: Because confirmation of sustained virological response was not routinely available for all treated patients, estimated cures were calculated by applying a conservative 90% cure rate to reported treatment initiations. This assumption is supported by published and program evidence. Documented SVR12 results should be reported separately.

Deaths and DALYs averted: CHAI used a Markov state-transition model to estimate the long-term health impact of treatment over a 30-year horizon. The model compares observed treatment scale-up with a counterfactual in which coverage remained at baseline or another specified level. Future costs and outcomes were discounted at 3% annually. Results represent projected rather than directly observed impact.

Limitations: Program scope, reporting periods, case-finding strategies, service-delivery models, and data completeness differ across countries. Aggregate portfolio results should therefore be interpreted as the cumulative reach and estimated impact of a heterogeneous set of programs, not as a controlled comparison across countries.

Key CHAI publications and resources

Market Reports

- Hepatitis C Treatment Market Memo: Protecting a Decade of Progress (June 2026)
- Hepatitis C Market Intelligence Report (December 2023)
- Hepatitis C Market Memo (July 2022)
- Hepatitis C Market Intelligence Report (August 2021)
- Hepatitis C Market Report (May 2020)
- Hepatitis C Diagnostics Market Intelligence Report (April 2018)

Press Releases

- CHAI and The Hepatitis Fund announce pricing breakthrough to reduce cost of viral hepatitis treatment by over 90 percent (May 2023)
- The Hepatitis Fund and CHAI announce high-level donor mobilization conference to eliminate viral hepatitis to be held in Geneva, Switzerland, on May 17, 2023 (April 2023)
- Breakthrough agreement will reduce costs and increase access to diagnostics technology for millions in low- and middle-income countries (July 2018)
- CHAI announces partnership with governments in six low- and middle-income countries to initiate and expand hepatitis C treatment programs (April 2016)
- BMS to support AmeriCares and CHAI in a new program aimed at targeting patients coinfected with Hepatitis C and HIV (April 2016)

Global Fund Toolkits

- Strengthening HIV outcomes through integration with hepatitis, harm reduction, and triple elimination within Global Fund Grant Cycle 8 (April 2026)

- Opportunities and Risks for Hepatitis in Global Fund Programs in Grant Cycle 7 (October 2025)
- Resource Toolkit of Global Fund Grant Cycle 7 Funding Opportunities for Hepatitis (December 2022)

Manuscripts

- An alternative hepatitis C treatment in Rwanda cures 75 percent of those who failed initial therapy (January 2025) – Introducing Sofosbuvir/Velpatasvir + Ribavirin as a Generic Retreatment Regimen for Hepatitis C: Evaluation of a Government Program in Rwanda
- A study to understand reasons for early treatment discontinuation among people living with hepatitis C in Punjab, India (January 2025)
- A cross-sectional study to identify risk factors for hepatitis C in Punjab, India (September 2024)
- Lessons learned from global hepatitis C elimination programs (May 2024)
- Expanding Hepatitis C virus testing in Myanmar: Integration with HIV diagnostics (May 2023) – The feasibility and acceptability of integrating hepatitis C and HIV diagnostics testing on centralized molecular laboratory platforms in Myanmar
- Progress towards hepatitis C elimination in Punjab, India (January 2023)
- Patient Outcomes in public sector hepatitis C treatment programs: a retrospective cohort analysis across five low- and middle-income countries (December 2022)
- For hepatitis C patients who fail initial therapy, treatment is costly and often unavailable. New study shows alternative products could change that (July 2021) – Retreatment of Chronic Hepatitis C Infection: Real-World Regimens and Outcomes From National Treatment Programs in Three Low- and Middle-Income Countries
- Simplified approach to hepatitis C testing, treatment shows promise in seven countries (December 2020) – Initial success from a public health approach to hepatitis C testing, treatment and cure in seven countries: the road to elimination

Blog Posts

- A $60 cure exists. So why are millions still dying of Hepatitis C? (July 2025)
- Hepatitis treatment is more affordable than ever, but we still need more resources for elimination (July 2023)
- Bringing the hepatitis C cure closer to patients in Nigeria (August 2022)
- Hepatitis programs should invest in hepatitis services to procure diagnostics and drugs at affordable prices (July 2022)
- World Hepatitis Day 2020: finding the missing millions (July 2020)
- Partnerships will help Rwanda eliminate hepatitis C in five years (July 2019)
- Increasing affordable access to hepatitis C treatment and paving a path towards elimination (July 2018)
- New medications are a lifesaver for people with chronic hepatitis C (July 2017)
- World Hepatitis Day 2016 (July 2016)
- World Hepatitis Day 2015 (July 2015)

Rwanda's Hepatitis C Elimination Program

- Eliminating Hepatitis C – Rwanda: Access for All
- Eliminating Hepatitis C in Rwanda – Video on YouTube