Hepatitis C Treatment Market Memo

June 2026 | Protecting a Decade of Progress

Hepatitis C (HCV) is now curable, with safe, highly effective direct-acting antivirals (DAA) available at historically low prices. Over the past decade, coordinated market-shaping efforts have transformed what was once an inaccessible cure into a realistic public health opportunity, with some countries accessing treatment for below US$60 per 12-week treatment course. Countries like Egypt, Rwanda, and Georgia have launched national elimination programs, while targeted investments in countries such as Cambodia and Nigeria have helped initiate treatment access, highlighting both the feasibility of large-scale HCV treatment and the importance of sustained demand and financing to reach this.

This memo provides a retrospective analysis of how the HCV treatment market has evolved over the past decade. The market has achieved a breakthrough in affordability, but this has not yet translated into sustained, large-scale access. While affordable treatment has been demonstrated in some countries and is increasingly within reach, significant uptake remains limited to a few countries. Market landscape and country examples show that **coalition, community, and political will—backed by sustainable financing and strategic procurement structures**—ultimately determine whether affordability leads to scale.

Without the factors above, the gains of the past decade risk remaining underutilized. As a result, millions of people will remain untreated, and preventable deaths will continue despite the availability of low-cost, curative therapy. The opportunity to eliminate hepatitis C remains—but it will depend on how effectively the global community builds on what has already been achieved.

KEY FINDINGS

47M

47 million people live with hepatitis C globally, resulting in 240,000 deaths every year (per WHO).

US$57

Treatment costs have fallen from over US$84,000 to as little as US$57 per course.

20%

Only 20 percent of those eligible have received treatment since 2015. In 2024, 11 million people who had been diagnosed with HCV remained untreated (per WHO).

85%

85 percent of all orders from India fall below 2,000 bottles—and those buyers pay up to 2.4x more per treatment course.

1

SOF/DCV FDC, the most widely procured regimen, now has only one WHO-prequalified supplier.

"While the entry of generic products and subsequent price reductions represent a critical milestone, they are not sufficient on their own. Without strong implementation systems and sustained political commitment, these gains will not translate into broad, equitable, and lasting access to eliminate viral hepatitis by 2030."

—Giten Khwairakpam, Community and Policy Program Manager, TREAT Asia, amfAR – The Foundation for AIDS Research

The 2026 Market Memo builds on the first three editions of the HCV Market Intelligence Report from May 2020, August 2021, and December 2023, and the interim HCV Market Memo in 2022, providing an update on the evolution and current state of the DAA market, the structural vulnerabilities that have emerged since 2022, and the coordinated actions required to protect the gains of the past decade.

1. Background: Hepatitis C and the treatment landscape before 2014

Hepatitis C virus (HCV) is a blood-borne infection that can cause progressive liver damage, cirrhosis, and liver cancer. It is a major yet often overlooked global public health threat, silently affecting 47 million people worldwide and contributing significantly to 240,000 deaths in 2024, placing it among the leading infectious causes of death globally. More importantly, HCV is now curable within 12 weeks with DAAs, reducing the risk of developing liver cancer by 85 percent and lowering overall mortality by 70-75 percent, making elimination a realistic public health goal. Yet despite this, only 20 percent of those eligible have received treatment since 2015, and in 2024, 11 million people who had been diagnosed remained untreated.[1]

Before 2013, HCV treatment relied on injectable interferon and oral ribavirin—costing over US$3,000 per course, with severe side effects and cure rates below 50 percent—making it largely unviable for health systems in low- and middle-income countries (LMICs).

The introduction of all-oral, highly effective DAAs transformed this landscape. Regimens based on sofosbuvir (SOF) and daclatasvir (DCV) enabled a simple, once-daily oral treatment taken over 12 weeks, with cure rates above 95 percent, eliminating the need for injections, cold-chain storage, and intensive clinical management. Pan-genotypic regimens (including SOF/DCV) further removed the requirement for genotyping, enabling simplified, decentralized delivery models with task-shifting and minimal monitoring—lowering the total cost of care while improving access and equity.

Yet these breakthroughs did not immediately translate into access. DAAs remained under patent, were not yet included in the World Health Organization (WHO) or national guidelines, and lacked widespread regulatory approval. Prices hovered near US$750 per course—far beyond the reach of most LMIC health systems—while limited funding, constrained clinical capacity, and low awareness further slowed uptake.

Together, these barriers underscored that scientific innovation alone was not enough. Expanding access required a coordinated approach linking affordable supply with country-led implementation—catalyzing a decade of market-shaping efforts to reduce prices, expand access, and demonstrate that elimination was achievable.

2. A decade of market shaping (2014–2024)

The decade from 2014 to 2024 saw a sustained, coordinated effort to transform the HCV treatment market, making affordable, quality-assured DAAs available to LMICs and demonstrating that national elimination was feasible.

2.1 How Coordinated Action Transformed the Market

Progress over the following decade depended on complementary action across licensing, financing, evidence generation, normative guidance, and country-level implementation—no single actor could address the barriers to access alone.

On the supply side, the foundational step was unlocking generic competition. In 2014, Gilead Sciences licensed SOF to Indian generic manufacturers for supply to 91 LMICs, creating the conditions for price competition.[2] In November 2015, Unitaid's decision to expand Medicine Patent Pool's (MPP) mandate into HCV enabled a further breakthrough: MPP negotiated a royalty-free voluntary license for DCV with Bristol Myers Squibb (BMS), enabling generic manufacturers to produce and sell DCV in 112 LMICs—home to 65.4 percent of people living with HCV in low- and middle-income countries.[3,4] The license also permitted development of fixed-dose combinations of SOF and DCV in a single tablet, the formulation that today accounts for the majority of DAA procurement across LMICs. CHAI worked directly with generic licensees to develop and register affordable formulations of SOF and DCV, achieving substantial cost reductions and building the supplier relationships that would later underpin country-level pricing negotiations. CHAI also negotiated reductions in diagnostic prices, including for rapid diagnostic tests and viral load testing, to enable cost-effective scale-up of testing alongside treatment.

On the demand side, organisations including Médecins Sans Frontières (MSF) began demonstrating from 2013 that simplified HCV diagnosis and treatment was

feasible in resource-limited settings, among the first to procure SOF for use in such contexts, producing clinical evidence that underpinned both guideline updates and advocacy for scale-up.[5] Informed by this clinical evidence and civil society advocacy, WHO updated its treatment guidelines in 2016 to recommend DAA regimens over interferon-based treatment, and again in 2018 to recommend pan-genotypic regimens for all patients regardless of genotype, removing the need for genotyping prior to treatment and enabling simplified, decentralized delivery.[6]

In 2016, CHAI launched the HCV Quick Start Program in partnership with Duke University and BMS across seven countries to translate those guidelines into operational reality, developing national protocols, training clinical providers, integrating HCV care into existing HIV and primary health platforms, and strengthening monitoring systems. A pivotal contribution to the demand side came through a BMS donation of approximately 1.5 million DCV doses to seven countries, catalyzing early treatment programs and generating real-world evidence that public sector-led HCV treatment was achievable at dramatically lower costs — proving the clinical and economic case for scale-up and creating the demand signals that subsequent pricing negotiations required.

By 2018, multiple WHO-prequalified generic options were available at substantially reduced prices, and national programs were launching across a growing number of countries. Rwanda's experience that same year would demonstrate what was possible when these market conditions were met with the political commitment and financing architecture to fully leverage them.

2.2 Aligning supply and demand: Rwanda's breakthrough

In 2018, Rwanda made history as the first country in sub-Saharan Africa to launch a national HCV elimination program. With an estimated prevalence of 4 percent in the general population, the Rwandan Ministry of Health committed to treat 112,000 patients between 2019 and 2024—backed by strong political will, domestic financing, and strategic partnerships.

To enable this vision, CHAI helped the government negotiate a landmark US$60 price for a 12-week WHO-prequalified SOF+DCV (singles) treatment course, bringing the total cost per cure, including diagnostics, to under US$80. This breakthrough set a new global benchmark and enabled rapid price reductions worldwide: the Global Fund adopted an US$80 procurement price, Nasarawa State in Nigeria secured the same US$60 deal, and Indonesia achieved an 85 percent price cut in 2021 (~US$230 down to ~US$35 per bottle).

Rwanda's success showed the power of aligning supply, financing, and delivery capacity. The government mobilized over US$5 million in domestic funds, integrated HCV care into existing HIV and primary health platforms, and rapidly scaled national services.

> *"When these drugs were first announced, I remember the cost very clearly: US$86,000. 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."*
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> **—Dr. Sabin Nsanzimana, Minister of Health, Rwanda**

Key results included: 1,500 healthcare workers trained; HCV care expanded to all health facilities across the country; over 10 million people screened; and over 65,000 patients treated,[7] with cure rates above 95 percent. Rwanda has since met the WHO 2025 interim treatment coverage target, reduced HCV prevalence to below 1 percent, and is now embarking on the WHO's elimination validation framework — positioning it to become one of the first countries in the world to achieve formally validated HCV elimination.

Rwanda proved that elimination was not just aspirational, but achievable. By combining political leadership, domestic investment, and affordable access, the country established a model for HCV elimination that continues to inspire global efforts.

2.3 The 2023 Global Pricing Agreement: lessons from a broken market

Building on Rwanda's success, global efforts sought to expand access to low-cost treatment pricing across countries. In 2023, anticipating demand commitments to be mobilized through a resource mobilization conference hosted by The Hepatitis Fund (THF), CHAI supported the facilitation of a pricing agreement between two leading generic suppliers—Viatris and Hetero—and THF to establish a global ceiling price of US$60 per WHO-prequalified treatment course for LMICs. To operationalize this and catalyze procurement, THF committed to a soft volume guarantee equivalent to 16,000 treatment courses within an 18-month period. The deal enabled any government or global buyer to access treatment at the same low price during this window, intended to unlock demand and market stability.

However, despite achieving breakthrough pricing, the agreement did not translate into sustained uptake, for two main reasons:

- Anticipated demand commitments, particularly the soft volume guarantees expected to be mobilized through THF did not materialize, as financial commitments to the Fund were not secured.
- Limited and uncertain demand from governments and donors, with small, fragmented procurement and insufficient financing across countries.

By late 2024, both Viatris and Hetero withdrew engagement, reflecting declining supplier confidence in the absence of predictable, aggregated demand.

> *"What was missing was not supply or price, it was the ability to translate intent into predictable, aggregated demand. Even without formal volume guarantees, a broader group of countries demonstrating sustained political commitment and financing or more effective mechanisms to coordinate demand across procurement channels could have helped signal sufficient demand to sustain supplier participation."*
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> **—Oriel Fernandes, Senior Director, Viral Hepatitis, Global Program, CHAI**

TAKEAWAY: Taken together, these experiences show that achieving low prices is necessary, but not sufficient. Where demand is coordinated and financed, as in Rwanda, affordability translates into large-scale access. Where demand remains fragmented and underfinanced, even the lowest prices may not translate into sustained uptake.

3. Evolution of HCV treatment market and current status

Following a decade of progress in reducing prices, recent market trends reflect a more complex picture. While affordable HCV treatment is now widely achievable, demand has not scaled accordingly. This section examines how supply, demand, and pricing dynamics have evolved in recent years, and what this implies for the sustainability of the HCV treatment market.

3.1 Supply: navigating a narrowing landscape

Since the introduction of DAAs in LMIC markets in 2014, a broad supplier base has emerged across key regimens, particularly pan-genotypic regimens prioritized for streamlining treatment.

As of January 2026, 14 generic DAA formulations hold WHO-prequalification (PQ) across SOF, DCV, SOF/DCV fixed-dose combination (FDC), SOF/VEL FDC (Table 1).

This portfolio provides countries with access to multiple quality-assured treatment options, notably at some of the lowest prices available through pooled procurement mechanisms that require WHO PQ as a condition of purchase (e.g., the Global Fund Pooled Procurement Mechanism and the PAHO Strategic Fund—see Section 3.3).

Table 1: WHO PQ products		
DAA	**Suppliers with WHO PQ Products**	**Suppliers that did not retain WHO PQ**
SOF (400mg)	Viatris (formerly Mylan), Hetero Labs, European Egyptian Pharmaceutical Industries Co (Pharco), Strides Pharma Science	Cipla (WHO PQ from 2017 to around 2022-2023)
DCV (30mg)	Hetero Labs, Laurus Labs, Zydus Lifesciences	Viatris (WHO PQ from 2019 to around 2022-2023), Cipla (WHO PQ from 2019 to around 2024-early 2025)
DCV (60mg)	Viatris, Hetero Labs, Laurus Labs, Zydus Lifesciences	Cipla (WHO PQ from 2019 to around 2024)
SOF/DCV FDC (400mg/60mg)	Viatris	
SOF/VEL (400mg/100mg)	Viatris	
SOF/LDV (400mg/90mg)	None	Viatris (WHO PQ from 2019 to around 2022-2023)
SOF/VEL/VOX (400mg/100mg/100mg)	While recommended by WHO for retreatment of HCV, currently no generic product due to small/fragmented market.	
Glecaprevir/Pibrentasvir (300mg/120mg)	Currently, there is no generic G/P product available, despite MPP-AbbVie license.	

***Source**: The WHO List of Finished Pharmaceutical Products (FPPs) that have received WHO PQ as of December 2025*

However, some suppliers have chosen not to retain WHO prequalification for select products. This reflects not only suppliers' adjustments to evolving and less predictable demand, but also a structural gap on the buyer side: unlike HIV and TB, where large-scale donor financing flows through procurement channels that mandate WHO PQ, most HCV procurement occurs through national budgets and hospital-level purchasing systems that rely on local stringent regulatory authority (SRA) approvals rather than WHO PQ. The ongoing costs of maintaining WHO PQ—including annual fees, compliance inspections, regulatory submissions, re-inspections every 3–5 years—become difficult to justify commercially in the absence of sufficient demand through PQ-required channels. This creates a reinforcing dynamic: fewer buyers require PQ, more suppliers exit PQ and the procurement channels that have delivered the lowest prices risk losing their product base. These trends reflect not a supply constraint, but a response to limited and unpredictable demand—highlighting the interdependence between buyer-side financing and supplier participation.

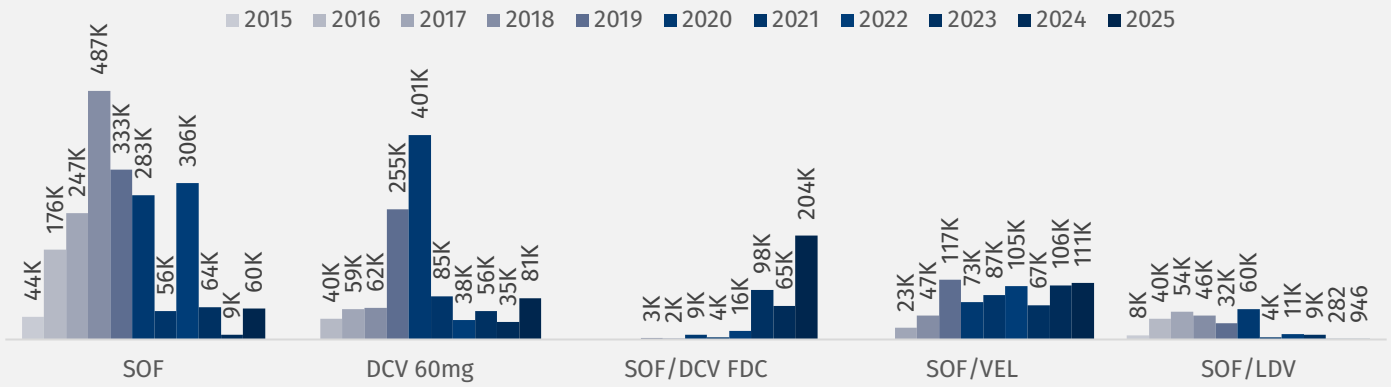
The risk is most acute for SOF/DCV FDC, which accounts for over half of DAA export volume in 2025 but has only one WHO PQ supplier (Viatris). If Viatris were to exit or allow its PQ to lapse, access to the most widely procured affordable regimen through the lowest-cost procurement channels would be significantly compromised.

Two formulations remain without a generic equivalent. SOF/VEL/VOX—the only WHO-recommended retreatment regimen for patients who fail first-line therapy—faces a small and fragmented market that has not attracted sustained generic investment or WHO PQ participation. As first-line treatment scales, the need for retreatment is expected to grow, increasing the importance of this gap. G/P—the shortest WHO-recommended pan-genotypic regimen—offers operational advantages for simplified service delivery. Although licensed through the Medicines Patent Pool (MPP) for 96 LMICs and generic versions are available in some markets, uptake remains relatively limited and, unlike several other HCV regimens, no G/P products have yet obtained WHO PQ.

3.2 Demand: post-pandemic decline has not recovered

Over the past decade, HCV treatment markets in LMICs have followed a clear pattern: rapid growth as countries launched and scaled programs, followed by COVID-19 disruptions from which most markets have not recovered. In most LMICs, treatment volumes dropped during the pandemic and have remained low since, with a few exceptions. India export data[8], representing the primary source of generic DAAs for LMICs, reflect global market trends (Charts 1.a. and 1.b.).

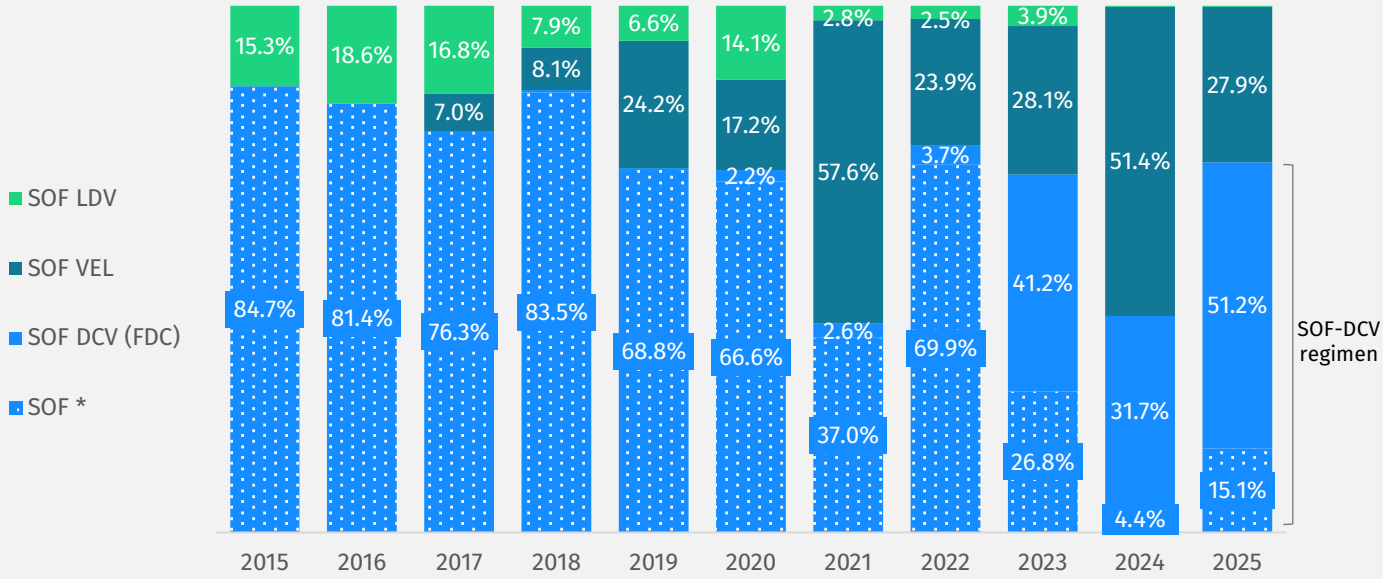
Chart 1.a: Volume DAAs export from India to LMIC (bottles)* (2015-2025)



*A 12-week treatment course requires ~3 bottles per patient (1 tablet/day × 84 days; 28 tablets/bottle). Bottle volumes can be divided by 3 to estimate patient courses.
**SOF and DCV (60 mg and 30 mg) are administered together and are available as single agents and as a fixed-dose combination (FDC). However, due to limited volume for DCV 30mg (<1 percent over the decade), its data has been omitted from the chart above.

The export product mix from India has largely been dominated by pan-genotypic SOF/DCV–based regimens: SOF/DCV regimen (singles and FDC) makes up around two-thirds of total volume across the decade, while the export shares of SOF/DCV FDC and SOF/VEL have increased to 70 percent and 25 percent by 2025, respectively.

Chart 1.b: Share of each regimen as part of annual export volume from India (2015-2025)



* SOF & DCV 60mg combinations: SOF volumes are used as a proxy. as SOF and DCV are prescribed as a combination treatment. While export data may not show a 1:1 procurement of SOF and DCV, countries will be procuring them in equal quantities either from India or from other non-India suppliers.

A separate dataset from MPP,[9] which tracks deliveries from both Indian and non-Indian manufacturers, confirms the same picture. It does, however, point to one area of recovery: since 2023, supply of DCV-based medicines has grown in a small number of large markets—India, Bangladesh, and Pakistan—suggesting demand may be returning in a few countries. For most LMICs, though, the market remains well below its pre-pandemic peak.

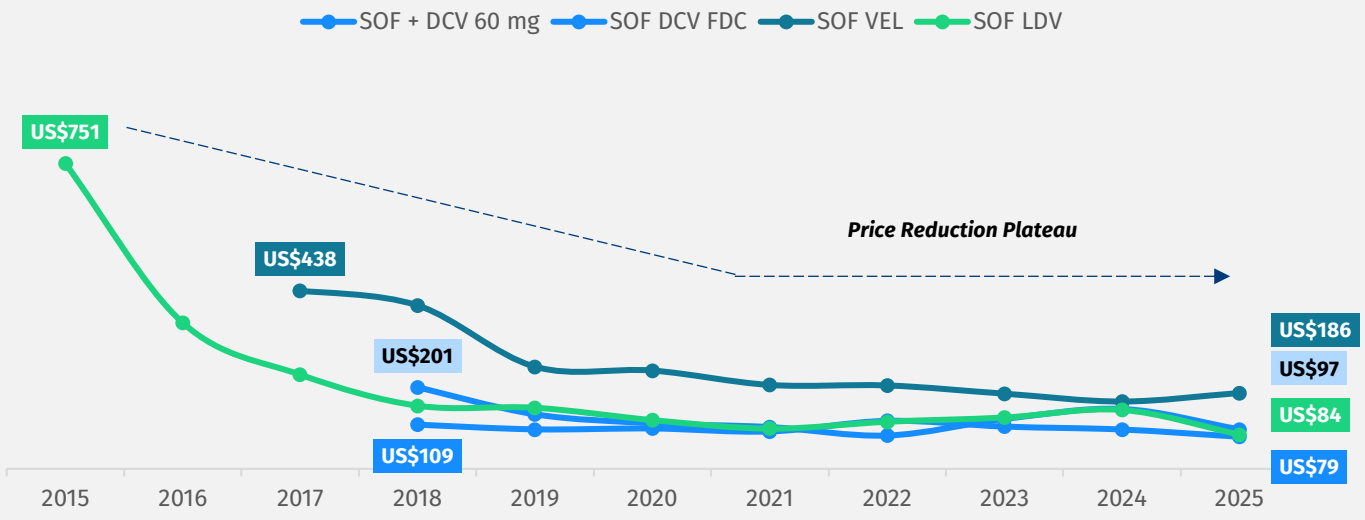
3.3 Prices: affordability plateau and fragmentation risk

Prices for all four SOF-based regimens have fallen over the past decade, though the decline has slowed—and even reversed recently for SOF + DCV 60 mg singles (Chart 2).

While prices remain low today, that may not last. Declining volumes and fragmented orders are already eroding the commercial case for suppliers to stay in the market—and some have already responded by dropping their WHO PQ. If this continues, the risk is not just higher prices but fewer suppliers willing to serve LMIC markets at all. Early signs of this dynamic are already visible: as documented in Section 3.1, several suppliers have allowed WHO PQ to lapse on key formulations since 2022.

In parallel, experiences from countries like Rwanda show that prices could be brought down in other geographies, but achieving that requires sustained, coordinated demand.

Chart 2: Weighted average FOB price of 12-week treatment (USD) from 2015 to 2025, with price reduction plateauing since 2021.



The price for a 12-week SOF + DCV 60 mg regimen was estimated by combining the weighted average price of three bottles each of SOF and DCV 60 mg. DCV 60 mg (rather than 30 mg) was selected for comparability purposes and because export volumes for DCV 60 mg were substantially higher overall.

Pooled procurement mechanisms continue to demonstrate what is achievable when demand is aggregated. Reference prices from the Global Fund (since 2020) and the Pan American Health Organization (PAHO) (since 2017) show that 12-week SOF/DCV treatment courses can be procured for as low as US$57 today (Table 2).

Table 2: Global reference pricing for 12-week treatment (EXW price) (2025)		
DAAs	**The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)**	**Pan American Health Organization (PAHO)**
SOF+DCV	US$63	US$57
SOF/DCV FDC	US$75	US$60
SOF/VEL FDC	US$174	US$174

***Sources**: GFATM and PAHO reference price lists (see respective GFATM and PAHO eligibility criteria).*
***Note**: The only WHO-recommended retreatment regimen, SOF/VEL/VOX, has no generic equivalent. As first-line treatment scales, this gap will widen; no coordinated response currently exists.*

The data also suggests a general pattern of higher costs associated with smaller order volumes.

Small orders (<2,000 bottles) accounted for an average of 85 percent of all purchases; for SOF/DCV (singles and FDC), the average is lower at 77 percent (Chart 3).

This translates into higher average prices for small-batch procurement. For example, the global weighted average FOB price of a 12-week SOF/DCV treatment course from 2021–2025 was US$117 for orders of <2,000 bottles, compared to US$49 for orders >8,000 bottles (Table 3).

By contrast, large, aggregated orders (e.g., pooled procurement or centralized purchasing mechanisms) allow manufacturers to plan production, optimize supply chains, and leverage economies of scale, driving prices lower.

Chart 3: Breakdown of procurement order size (2021-2025)

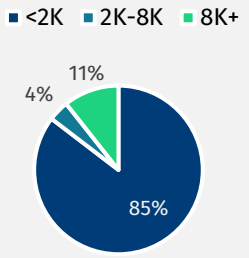


Table 3: Weighted average FOB price for 12-week treatment course by order volume size (US$)[a] from 2021-2025

Regimen	Below 2,000	2,000 - 8,000	Above 8,000
SOF + DCV 60mg	US$117 **(2.4x)**	US$78 **(1.6x)**	US$49[b]
SOF DCV	US$101 **(1.4x)**	US$76 **(1.1x)**	US$72
SOF LDV	US$115	US$108	-
SOF VEL	US$192 **(1.3x)**	US$177[c] **(1.2x)**	US$147

*[a] Approximate price uplift (**x** multiple) relative to ≥8,000 orders.*
[b] Pakistan's 2022 procurement was atypically large and above-market volume, distorting the period average. When excluding Pakistan's bulk shipments from 2022, the weighted average price is up to US$58.
[c] The 2K-8K tier is dominated by Vietnam orders at $76-85/pack (pricing on the higher end).

WHAT SMALL ORDERS COST – AN ILLUSTRATIVE EXAMPLE: A program treating 3,000 patients annually could either procure 9,000 bottles of SOF + DCV 60mg singles through multiple smaller orders (each <2,000 bottles) at US$117 per treatment course, or consolidate procurement into a larger order (>8,000 bottles) at US$49 per course. This would result in a saving of ~US$204,000 thanks to the consolidated procurement price to treat an additional ~4,200 patients (140 percent more) — more than doubling the program's reach.

IMPLICATION: Consolidating purchasing is one of the clearest opportunities to lower prices and stabilize the market. Large, aggregated orders allow manufacturers to plan production, optimize supply chains, and leverage economies of scale.

WHAT IS AT STAKE: Unlike HIV, TB, and malaria, HCV lacks sustained global financing mechanisms or long-term volume commitments. As a result, national choices around financing, procurement coordination, and service integration play a greater role in shaping treatment access.

But the market conditions that underpin today's affordability are not self-sustaining. Post-pandemic volume stalling, small-order procurement, and suppliers' exit of the WHO PQ market are weakening the supplier base and narrowing the procurement channels that have delivered the lowest prices.

4. Country experiences and market insights

With DAA now available at historically low prices, more countries than ever have the conditions in place to accelerate progress toward elimination. The four countries below were selected to illustrate how DAA affordability and access can be achieved and enhanced with political will and through different financing strategies, procurement architecture. They are not intended to be representative of all LMIC contexts or to imply definitive causal relationships, but rather to surface transferable market insights across a range of program maturity levels and health system settings.

Rwanda is a prime example of how political will and aggregated demand can support affordable pricing, demonstrating that predictable, centrally coordinated demand is a critical enabler of sustained low prices and large-scale treatment delivery. Cambodia and Nigeria illustrate how countries can begin to convert affordability into increased treatment access, though scale remains constrained by financing and procurement structures. Vietnam shows that where supply-side conditions are largely in place, demand-side policy decisions become the primary lever for expanding access and reducing costs.

Table 4: Summary of Country Examples

Country	What drove procurement?	Market Signal	Key Constraints
Rwanda	Political will and domestic financing commitment leading to centralized procurement through a single national entity; US$60 price per 12-week treatment course secured before programmatic launch	Predictable, consolidated demand sustains competitive pricing over time, even as procurement volumes decrease with program maturation	As the program transitions from large-scale treatment to targeted case-finding, continued financing commitment is needed to maintain procurement volumes and supplier engagement
Cambodia	Modest but recurring annual domestic financing commitment (US$1M) for hepatitis commodities; procurement consolidated through UN agencies	Even small, predictable financing commitments can unlock competitive procurement and build multi-year evidence for program viability	Program has not yet scaled to national level; the annual budget has remained flat, limiting the pace of treatment expansion
Nigeria	Subnational political commitment in Nasarawa State; integration into existing HIV treatment platforms; US$60 price agreement for 12-week treatment secured at state level	Enabling conditions for affordable access can be established at subnational level in large federal systems, even without a national program	Treatment volumes remain modest relative to Nigeria's estimated HCV burden; no national aggregation mechanism exists to connect state-level progress into a consolidated market signal
Vietnam	DAA reimbursement included in national social health insurance at up to 50 percent.	Many building blocks are in place—guidelines, infrastructure, social health insurance—but structural constraints in reimbursement, procurement, and market competition have limited translation into scale	Social health insurance reimbursement capped at 50 percent and restricted to higher-level hospitals; DAAs are not on national centralized procurement list; screening not covered without doctor's referral

Note: Chart prices reflect weighted average FOB prices across all India export shipments and may differ from negotiated program prices. See Methodology for further details.

4.1. Rwanda: Early national scale and program maturation

Rwanda's experience demonstrates that centrally coordinated procurement—backed by domestic financing and a firm price secured before program launch—can sustain competitive pricing even as treatment volumes moderate over time.

Chart 4.a : India Exports to Rwanda 2015-2025 (SOF singles)

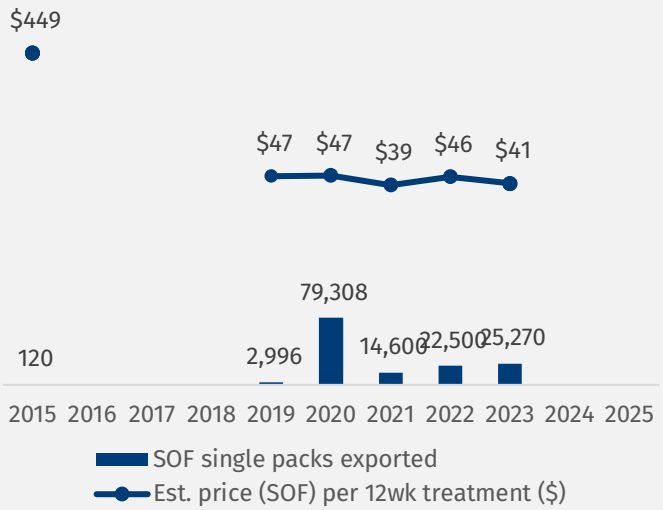
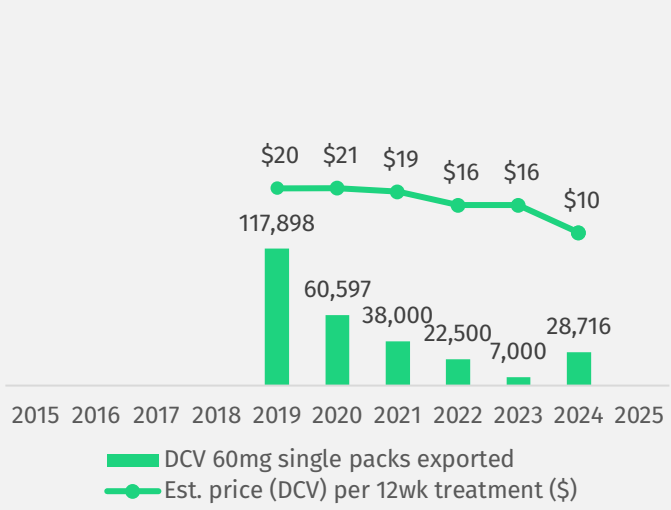


Chart 4.b : India Exports to Rwanda 2015- 2025 (DCV 60mg singles)



What happened? The US$60 price secured before program launch was operationalized through a nationally coordinated procurement structure, with Rwanda Medical Supply managing procurement in collaboration with the Rwanda Biomedical Center. SOF+DCV singles accounted for over 98 percent of total DAA procurement throughout the program. Following program launch in 2019, Rwanda became one of the largest DAA importers in Africa after Egypt, with procurement volumes peaking in 2019 to 2020 as the program addressed a substantial accumulated burden. In subsequent years, volumes moderated as the initial backlog was cleared, while prices remained consistently low and stable throughout.

What can we take away? Three features of Rwanda's approach drove this outcome: a single national procurement entity consolidated demand into large, predictable orders; a firm price was secured in advance of program rollout; and domestic financing provided continuity independent of external funding cycles. Together, these conditions enabled the program to sustain competitive pricing even as volumes decreased over time. As the program transitions from large-scale backlog clearance to sustained case-finding for new infections, maintaining that financing commitment will be critical to preserving both procurement volumes and supplier engagement.

4.2. Cambodia: Building the evidence base through domestic financing

Cambodia demonstrates how a modest but recurring domestic budget can sustain meaningful progress and build the foundation for national scale. The country's DAA procurement has grown over the years, anchored by a modest but recurring annual domestic budget in 2022 that has enabled centralized purchasing at competitive prices—though overall scale remains constrained by the size of that budget.

What happened? Early access to DAAs in Cambodia was established through pilot programs led by in-country partners, notably Médecins Sans Frontières–France, beginning around 2016.[10] These initial procurements were small in volume but established operational experience with DAA-based treatment and contributed to early price reductions. In 2018, leveraging Global Fund grant underspend, the national HIV program launched an HIV/HCV coinfection program, marking a shift from partner-led pilots to government-led implementation. Building on this momentum, the government launched the national hepatitis program in early 2021.

Chart 5.a : India Export to Cambodia 2015 - 2025 (SOF singles)

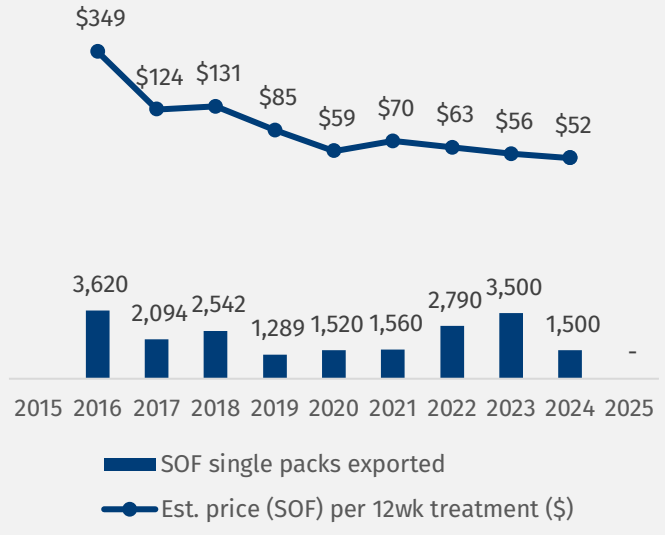
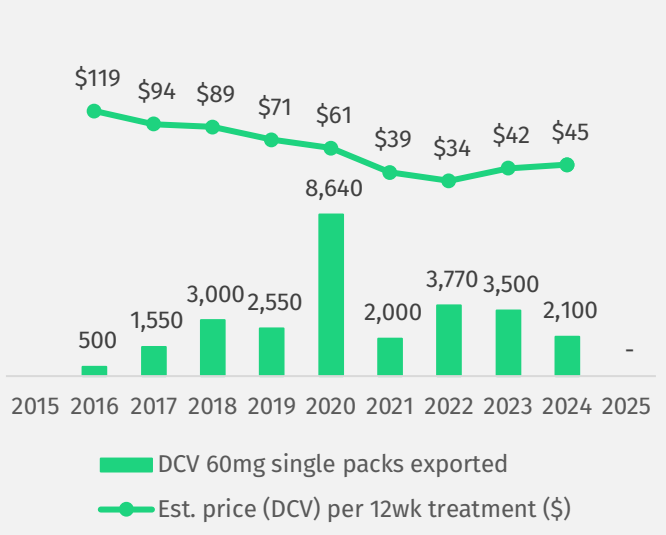
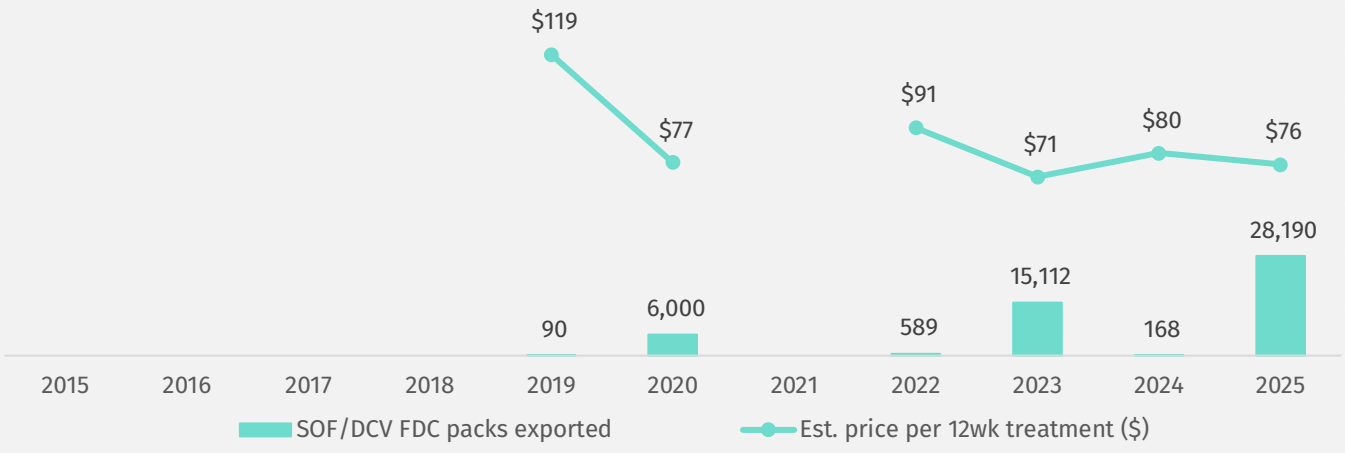


Chart 5.b : India Export to Cambodia 2015 - 2025 (DCV 60mg singles)



A pivotal step came in late 2022, when the Ministry of Health secured US$1 million in annual domestic financing dedicated to hepatitis commodities. This enabled planned and predictable procurement, with volumes consolidated via UN agencies at competitive prices. In 2023, approximately 13,000 bottles of SOF/DCV 60mg FDC were procured at a weighted average of US$25 per bottle—equivalent to approximately US$75 per 12-week treatment course. Procurement plans for 2025 targeted around 16,500 bottles, with a projected renewal of the US$1 million budget for 2026 to support continued expansion under the forthcoming National Strategic Plan II (2025–2030). Service delivery is led by the public sector and complemented by partnerships with implementers and technical partners.

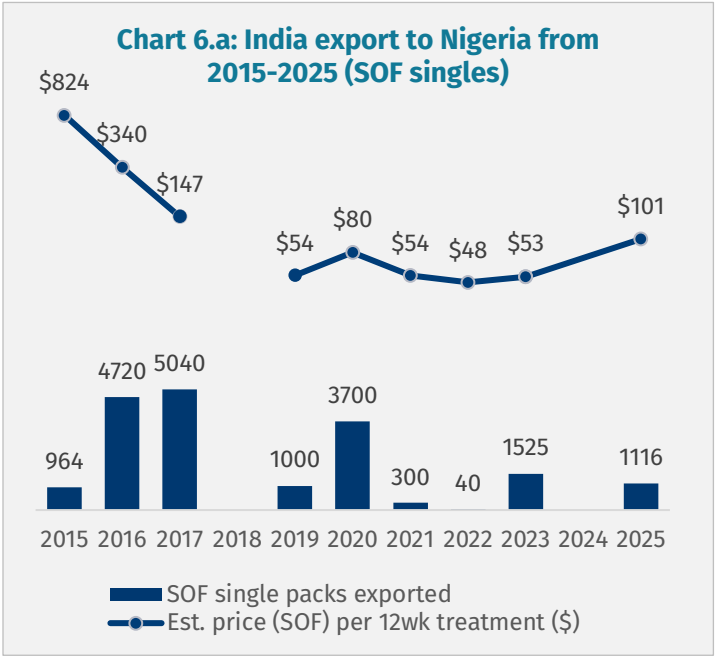
Chart 5.c : India Exports to Cambodia 2015 - 2025 (SOF + DCV 60mg FDC)*

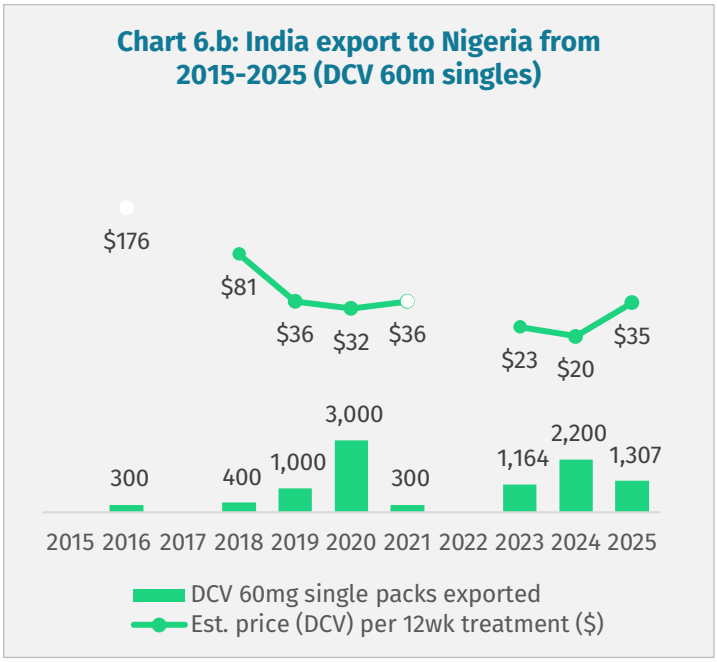


What can we take away? Cambodia's trajectory illustrates that even a modest, recurring financing commitment can convert affordable DAA into expanded access to treatment when paired with centrally-coordinated pooled procurement mechanisms and predictable ordering. This has helped build multi-year operational evidence on the feasibility and value of integrated HCV treatment delivery—strengthening the case for future budget increases to the level required for national-scale elimination, donor co-investment, and eventual inclusion of HCV treatment in social health protection benefit packages. However, at US$75 per treatment course in 2023, Cambodia remains above the lowest prices observed globally. Increased financing and larger procurement volumes could help improve purchasing power and create conditions for additional price reductions over time.

4.3. Nigeria: Subnational activation in a large federal system

Nigeria illustrates how subnational leadership and service integration can convert affordable DAA pricing into expanding treatment access within a large, federal health system. While the country's DAA procurement volumes have remained small relative to the overall estimated HCV burden, activity driven by a few states such as Nasarawa has, in recent years, shown signs of broadening engagement.





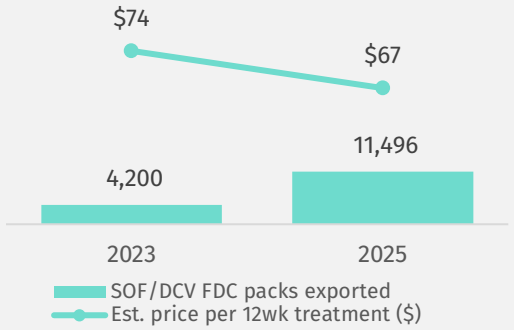
What happened? DAA procurement in Nigeria began in 2015, with early orders of SOF at relatively high unit prices. Prices fell sharply between 2015 and 2017 as volumes grew, and by 2019 had stabilized at low levels, establishing an affordability baseline consistent with broader global trends in generic DAA pricing. A notable milestone came in 2021, when Nasarawa State committed to HCV elimination and secured a US$60 SOF/DCV agreement per 12-week treatment course, supported by domestic financing and procurement coordinated at the state level.[11] This enabled targeted scale-up through existing HIV treatment platforms, particularly for people living with HIV—an early example of subnational micro-elimination within a large federal system.

However, the conditions that enabled progress in Nasarawa have not yet been replicated at national scale. Nigeria's decentralized health system means that procurement and program implementation vary across states, and no national aggregation mechanism currently exists for HCV to connect state-level activity into consolidated demand. Total procurement volumes across the decade remain modest—approximately 40,000 packs over the full 2015–2025 period, of which SOF+DCV singles account for around 53 percent, SOF/DCV FDC for 29 percent, and SOF/VEL and SOF/LDV for the remainder—with individual orders typically small and spread across multiple suppliers and regimens. More recent

activity from 2023 to 2025 suggests expanding engagement across multiple states, alongside efforts to align regimens with WHO guidance and integrate HCV services into platforms for key populations, including people who inject drugs and those in correctional settings.

What can we take away? Nigeria's experience suggests that the enabling conditions for affordable access—political commitment, domestic financing, and integration into existing service platforms—can be established at the subnational level even in the absence of a national program. At the same time, subnational progress alone has not yet generated the consolidated demand signal needed to sustain competitive pricing or attract sustained supplier engagement at scale.

Chart 6.c: India export to Nigeria 2015-2025 (SOF/DCV FDC)



**Note: No export volume recorded for other*

4.4 Vietnam: Supply-side foundations in place, demand-side policy gaps remaining

Vietnam illustrates a case where many of the building blocks for HCV elimination are in place—national treatment guidelines, health system infrastructure, social health insurance covering over 90 percent of the population, and available generic DAAs—but where structural constraints in reimbursement policy, procurement architecture, and market competition have limited the pace and cost-efficiency of scale-up.

Chart 7.a: India export to Vietnam from 2015 - 2025 (SOF singles)

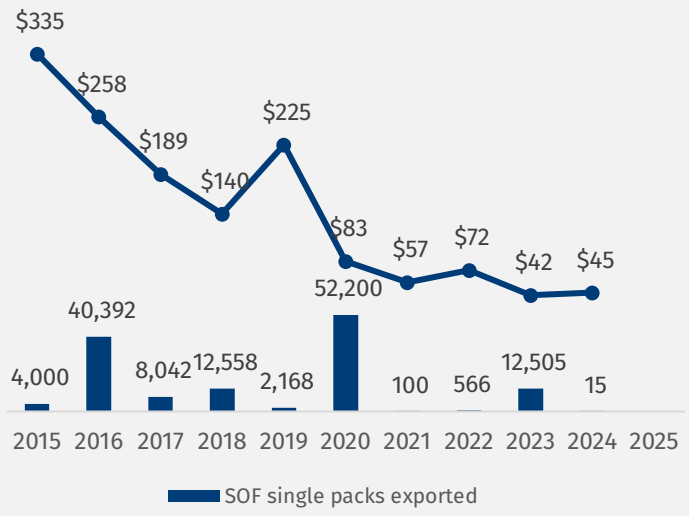
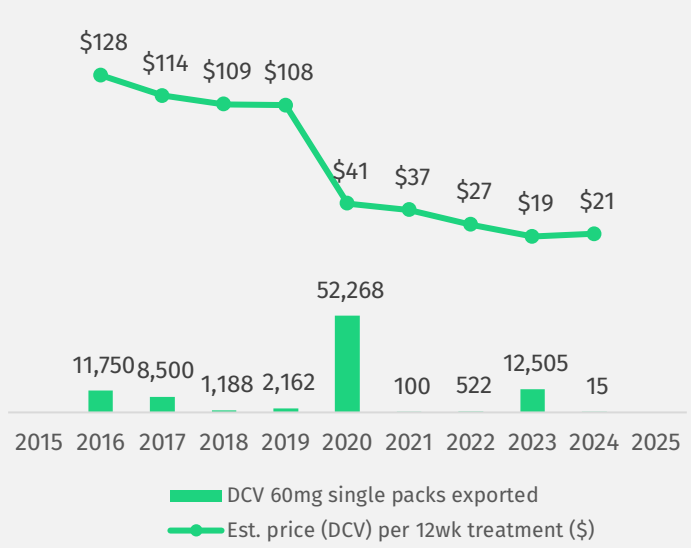


Chart 7.b: India export to Vietnam from 2015 - 2025 (DCV singles)

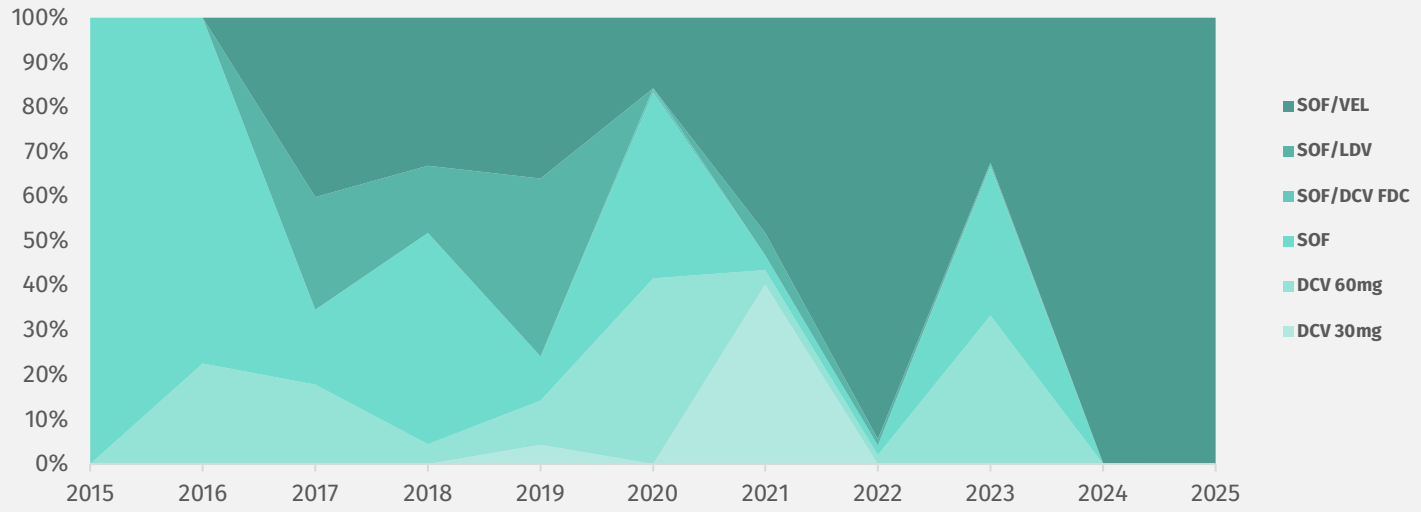


**Note: MPP data for the same periods indicated a higher volume exported to Vietnam for 2024 (~12,000 bottles) from Indian MPP licensees that might have been channeled through a third country..*

What happened? Vietnam has taken meaningful steps toward enabling HCV treatment access. In 2017, with CHAI's support, the country initiated a small-scale public sector HCV program in select provinces to generate evidence for scale-up of services. Building on the program's strong results and following advocacy from a coalition of government champions and partners, Vietnam included DAA reimbursement under its social health insurance scheme—a significant policy milestone. Early advocacy efforts around 2019–2020 supported the integration of HCV management within HIV programs, and national HCV treatment guidelines were updated around 2021 to specify SOF/DCV as the pan-genotypic first-line regimen.

However, several policies and market constraints continue to limit how effectively these foundations translate into treatment at scale. On the demand side, screening and testing, while available even at the primary health care level, are not covered by the social health insurance without doctor's referral which can act as an early barrier to case-finding and treatment uptake in the general population. For patients who do reach treatment, DAA treatment reimbursement is capped at 50 percent. Reimbursement is also restricted to higher-level hospitals, limiting access at the primary care level where many patients first enter the health system.

Chart 7.c: Shift in DAA regimen export share in Vietnam, from 2015-2025



On the supply side, while generic DAAs are available, procurement has been concentrated with one key distributor, constraining the competitive dynamics that have driven price reductions in other markets. DAAs are also not included on the national centralized procurement list, resulting in fragmented purchasing by hospitals and provincial health departments: 82 percent of shipments between 2021 and 2025 were for fewer than 2,000 bottles, with a median order size of just 100 bottles. The regimen mix further compounds the cost challenge — SOF/VEL has dominated procurement at a weighted average of approximately US$213–251 per 12-week course, roughly three times the cost of SOF/DCV-based alternatives (approximately US$78 per course for SOF/DCV FDC when last procured in 2023).[12] Whether the regimen mix reflects preference, familiarity with the product or institutional procurement practices is not fully clear from the available data.

What can we take away? Vietnam has the procurement infrastructure and social health insurance coverage to scale HCV treatment. What remains is to address the structural constraints: expanding DAA reimbursement coverage and levels, including DAAs on the national centralized procurement list or other pooled mechanism, and broadening the distributor base. Together, these changes would generate more predictable and aggregated demand, lower overall treatment costs, and accelerate treatment expansion.

5. Way forward: protect the DAA market and accelerate elimination

What to look forward to

Looking ahead, several long-acting formulations of DAAs are under active development, with the goal of enabling a single-administration cure that could simplify treatment delivery, particularly for populations facing adherence or access barriers (e.g., people who use drugs, incarcerated individuals, mobile populations). These remain in early stages of research and are not expected to affect near-term programmatic decisions but represent a potentially significant shift in how HCV treatment could be delivered over the longer term.[13]

What's next for all stakeholders

The DAA market remains affordable, but the trends documented in this memo suggest this may not hold. The country experiences in Section 4 point to a consistent set of demand-side constraints—financing predictability, procurement consolidation, and data visibility—that the following actions are intended to address. Decisions made by governments, donors, civil society, and manufacturers over the next two to three years will determine whether the gains of the past decade are consolidated or lost.

5.1 For Ministries of Health

- Establish or expand national procurement mechanisms that are accessible across all demand channels — public health facilities, private sector, and individual out-of-pocket purchasers — to consolidate fragmented orders into a single national demand signal and materially improve pricing and supplier engagement
- Commit to multi-year forecasts and procurement plans
- Integrate HCV into existing HIV, non-communicable diseases, harm reduction, and primary health care platforms
- Include DAAs on national essential medicines lists and central procurement schedules
- Expand screening and diagnosis to identify more patients, including via decentralized, simplified models, to generate predictable demand
- Develop domestic financing transition plans that reduce reliance on external donors and integrate HCV into national health insurance benefit packages ahead of funding transitions.

5.2 For Donors and Funding Partners

- Provide catalytic funding for hepatitis screening, diagnosis, and treatment scale-up — particularly to restart momentum, re-engage suppliers, integrate HCV services into existing platforms, and boost community engagement.
- Support multi-year volume guarantees and pooled procurement mechanisms to stabilize supplier engagement
- Share procurement data across agencies to enable aggregate demand visibility
- Invest in integrated delivery (e.g., primary health care systems and harm reduction services) and in retreatment access, including exploring advance purchase mechanisms for SOF/VEL/VOX generics – the only WHO-recommended retreatment regimen – given the current market gap

5.3 For Civil Society

- Advocate for domestic financing and national elimination plans focused on simplified, decentralized service models
- Monitor price transparency and access disparities, particularly for high-risk populations
- Sustain political attention on HCV in global health financing discussions
- Advocate for inclusion of retreatment options in national protocols and global procurement planning and for coordinated global financing of retreatment access, given the absence of an affordable generic option.

> *"Groundbreaking innovations such as long-acting DAAs are around the corner, but it will require much more than a magic bullet to make it accessible for all: demand is essential, with public health focused licenses as the framework, national procurement as the cornerstone and donor-driven market shaping as the catalyzer."*
> **— Charles Gore, Executive Director, Medicines Patent Pool**

5.4 For Manufacturers and Market Stewards

- Maintain WHO PQ status for key formulations, particularly SOF/DCV FDC (for which only one supplier holds PQ status), enabling continued access through Global Fund and PAHO channels at the lowest ex-works price.
- Improve transparency on minimum order quantities and pricing tiers
- Engage in collaborative demand forecasting with procurement agencies and country programs
- Explore advance purchase commitments and coordinated forecasting to address the retreatment market gap

Direct-acting antivirals have made HCV elimination a technically and financially achievable goal. Rwanda has demonstrated what is possible. Cambodia has shown that modest, sustained domestic financing is sufficient to maintain program momentum. The limited uptake of the 2023 global pricing agreement has shown what happens when predictable demand, coordinated procurement, and shared data are not in place.

The window to consolidate the gains of the past decade is narrowing. Decisions made by governments, donors, civil society, and manufacturers over the next two to three years will determine whether the HCV market stabilizes or continues to erode. The tools, the evidence, and the prices still exist. What is needed is the coordination to use them.

"It is unacceptable that people continue to die from hepatitis C when a cure already exists. Every day, friends, loved ones, and caregivers are lost needlessly because treatment remains out of reach. Having lost my mother to viral hepatitis related liver disease, I know this urgency is deeply personal. The question now is not whether we can cure hepatitis C, but whether we will ACT NOW and fast enough to make that cure accessible to all."
— Danjuma Adda, Founder and Executive Director of the Centre for Initiative and Development in Taraba State, Nigeria

Notes

Acronyms:

DCV	Daclatasvir
EXW	Ex-Works Price
FDC	Fixed dose combination
FOB	Freight on Board
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
LMICs	Low-and Middle-Income Countries
MSF	Médecins Sans Frontières
MPP	Medicines Patent Pool
PAHO	Pan American Health Organization
SOF	Sofosbuvir
SOF/DCV	Sofosbuvir/Daclatasvir
SOF/VEL	Sofosbuvir/Velpatasvir
SOF/LDV	Sofosbuvir/Ledipasvir
SOF/VEL/VOX	Sofosbuvir/Velpatasvir/Voxilaprevir
WHO	The World Health Organization

Methodology:

Data sources and scope. Visibility into DAA volume trends remains limited due to the lack of robust and reliable publicly available data sources. We focus primarily on India's generic export market and public sector program data, for which data is robust and encompassing of sales to LMICs. India export data captures shipments from both MPP-licensee and non-MPP-licensee Indian generic manufacturers. India export data captures commercial procurement only and does not include domestic consumption in India.

Price calculation. Prices shown in the accompanying charts in country sections reflect weighted average freight-on-board (FOB) prices across all India export shipments to each country in a given year, which may include procurement by multiple buyers at varying rates. The negotiated price for a given program is captured within the weighted average, but other transactions in the same year may shift the average above or below the pricing secured for the national program. This explains apparent discrepancies between prices cited in the country narratives and prices shown in the charts.

This methodology is therefore limited as follows:

- It does not account for the use or export of drugs manufactured outside India including sales or donations by originators.
- The transaction data is not available in a standardized manner and is sometimes incomplete. Certain assumptions and judgement need to be exercised to clean the data for analysis.
- The database has several identical transactions that were removed to avoid data duplication. Duplicate transactions are identified and removed where two or more records share the same shipment date, destination country, supplier, regimen, pack quantity, and unit price.
- As SOF and DCV are co-administered but may be procured separately and at different times, SOF volumes are used as the anchor for estimating SOF+DCV singles regimen volumes.

These limitations may lead to underestimating the volume of drugs procured across LMICs.

Endnotes:

[1] WHO, 2026, Global Hepatitis Report 2026

[2] Gilead Sciences voluntary license for sofosbuvir, 2014, covering 91 LMICs. See: Gilead Sciences, "Gilead Sciences Establishes Licensing Agreements with Generic Drug Manufacturers to Increase Access to Sofosbuvir in Developing Countries," 2014.

[3] MPP, "The Medicines Patent Pool Signs Licence with Bristol-Myers Squibb to Increase Access to Hepatitis C Medicine Daclatasvir," 23 November 2015, medicinespatentpool.org. Covered 112 LMICs, home to 65.4 percent of people living with HCV in LMICs. Unitaid's board decision to expand MPP's mandate into HCV directly enabled this license. First sub-licenses to Cipla, Emcure, Hetero, and Natco announced January 2016. License explicitly permitted development of SOF/DCV fixed-dose combinations.

[4] BMS withdrew its patent in 2020, enabling access across all low- and middle-income countries (LMICs).

[5] MSF began treating HCV patients in India in 2013, among the first organizations to procure sofosbuvir for use in resource-limited settings. The MSF Cambodia program (2016 to 2018) at Preah Kossamak Hospital established a simplified care model using rapid diagnostic tests, reduced follow-up visits, and task-shifting, subsequently published in The Lancet Gastroenterology and Hepatology (2021). See: MSF Access Campaign, msfaccess.org, 2014.

[6] WHO, "Guidelines for the Screening, Care and Treatment of Persons with Chronic Hepatitis C Infection," April 2016; WHO, "Guidelines for the Care and Treatment of Persons Diagnosed with Chronic Hepatitis C Virus Infection," July 2018. The 2018 guidelines recommended pan-genotypic DAA regimens for all persons aged 18 and older, removing the need for genotyping prior to treatment initiation.

[7] The reduction from the initially estimated 112,000 cases to approximately 65,000 reflects updated aggregate screening data, which showed lower-than-expected HCV prevalence as screening expanded across the population.

[8] India export data captures shipment-level supplier, destination, and price detail across all DAA regimens leaving Indian ports but does not cover Indian domestic consumption or generics manufactured outside India.

[9] MPP holds voluntary licenses for daclatasvir-containing products (DCV, SOF/DCV FDC) and for glecaprevir/pibrentasvir (G/P), and reports aggregate sublicensee deliveries — including from non-Indian manufacturers and within domestic markets. MPP data does not cover sofosbuvir singles, SOF/VEL or SOF/LDV.

[10] Note: Data not available prior to 2016 and 2019, for SOF+DCV Singles and FDC, respectively.

[11] Note: The US$60 per treatment course secured in Nasarawa reflects a negotiated program price. The weighted average FOB prices shown in the accompanying chart capture all India export shipments to Nigeria in a given year, which may include procurement by other buyers at different rates, and therefore may diverge from the negotiated price.

[12] Note: Procurement under the Global Fund–supported co-infection program are note reflected in India Export data.

[13] Glecaprevir/pibrentasvir (G/P) has been identified as a leading candidate for long-acting parenteral formulation given its potency, pangenotypic coverage, and favorable pharmacological profile. However, data on long-acting G/P formulations remain at an early stage, with published evidence currently limited to preclinical (rodent) studies; no human clinical trial data are yet available. Several other direct-acting antiviral compounds are also under active investigation as long-acting formulations. See: Furl R, et al. *Preferences and Feasibility of Long-Acting Technologies for the Treatment of Hepatitis C Virus: A Survey of Patients in Diverse Low- and Middle-Income Countries.* J Viral Hepat. 2025;32(4):e14031