

Quebec's Roadmap



**for the
Elimination
of Hepatitis C**



Citation

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Quebec Hepatitis C Elimination Working Group. *Quebec's Roadmap for the Elimination of Hepatitis C*. Montreal (QC), 2026.

This publication is available in English and French on the Canadian Hepatitis C Network (CanHepC) website:

In English: <https://www.canhepc.ca/en/hcv-elimination-initiatives>

In French: <https://www.canhepc.ca/fr/initiatives-elimination-vhc>

Funding

This document would not have been possible without the financial support of CanHepC, CRISM-ICRIS Québec, AbbVie, Gilead, CATIE, Heritage Canada, and the Feast Centre for Indigenous STBBI research, McMaster University.

Acknowledgement of Territory

The Quebec Working Group for the Elimination of Hepatitis C wishes to express its deep respect for the territory on which much of the drafting of this document took place, namely Tiohtià:ke, the traditional, unceded territory of the Kanien'kehá:ka Nation.

We also wish to emphasize that the over-criminalization, institutionalization and systemic discrimination faced by Indigenous peoples contribute to increasing their vulnerability to hepatitis C virus infection. Sustained action is needed to dismantle the structures of oppression stemming from colonialism.

Reconciliation requires a genuine and lasting transformation of our healthcare system. We reaffirm our commitment to taking concrete steps in this direction, to ensure that everyone has equitable access to healthcare that is dignified and free from all forms of discrimination or prejudice.

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Disclaimer

Wherever possible, a broad consultation process was prioritized in order to solicit input from a diverse and multidisciplinary range of stakeholders. The reviewers were invited to provide comments on the pre-final version of this document; consequently, they did not review the final content or formally endorse it.

Quebec's Roadmap for the Elimination of Hepatitis C was originally written in French. The English translation of this report was generated using DeepL, a machine translation tool (DeepL SE, 2026), and subsequently reviewed and copy edited by staff at the Canadian Network on Hepatitis C (CanHepC) to ensure accuracy and clarity.

Preamble

In 2019, the Canadian Hepatitis C Network (CanHepC) published the *Blueprint to inform hepatitis C elimination efforts in Canada*, a document outlining courses of action designed to complement the *Public Health Agency of Canada's Pan-Canadian Framework for Action on Sexually Transmitted and Blood-borne Infections*. The *Blueprint* provides a menu of activities, best practices and evidence-based recommendations to support Canada's efforts to meet the World Health Organization's HCV elimination targets by 2030. This document was developed through a multi-stakeholder consultative process reflecting cross-sectoral priorities, recommendations and perspectives on HCV in Canada.

As healthcare is primarily the responsibility of the provinces and territories in Canada, since the publication of the *Blueprint*, CanHepC has been supporting the development of regional and provincial roadmaps to guide the implementation of HCV elimination plans tailored to local issues. CanHepC has defined a development framework for these roadmaps and identified regional and/or provincial leads, including network members previously involved in the *Blueprint* drafting committee, to oversee their development. As part of this effort, the roadmap for the elimination of HCV in Quebec aims to adapt the *Blueprint* to the Quebec context by taking into account the specific factors, challenges and catalysts related to the context of HCV elimination in Quebec.

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Abbreviations and Acronyms

ACCM	AIDS Community Care Montreal	OAT	Opioid agonist treatment
AIDQ	Quebec Association of Addiction Professionals	OCAP	Ownership, control, access, possession
CanHepC	Canadian Network on Hepatitis C	PHAC	Public Health Agency of Canada
CAPAHC	Multipurpose Community Centre for Hepatitis C Support	PNMVH	Programme national de mentorat sur le VIH et les hépatites (National Mentoring Program on Human Immunodeficiency Virus and Hepatitis)
CATIE	Canadian AIDS Treatment Information Exchange	PNSP	Programme National de Santé Publique (National Public Health Program)
CHUM	University of Montreal Hospital Centre	PWID	People who inject drugs
COVID-19	Coronavirus disease 2019	PWLLE	People with "lived and living experience"
CSSSPNQL	First Nations of Quebec and Labrador Health and Social Services Commission	PWUD	People who use drugs
DAA	Direct-acting antivirals	RNA	Ribonucleic acid
DSPublique	Direction de Santé Publique (Public Health Directorates)	RSS	Région Socio Sanitaire (Social and health region)
ECHO	Extension for Community Healthcare Outcomes	SI-GMI	Système d'information de gestion des maladies infectieuses (Infectious Disease Information and Management System)
gbMSM	Gay, bisexual, and other men who have sex with men	STBBIs	Sexually transmitted and blood-borne infections
HCV	Hepatitis C virus	SurvUDI	Surveillance épidémiologique chez les utilisateurs de drogues par injection (Epidemiological surveillance among people who inject drugs)
HIV	Human immunodeficiency virus	SVR	Sustained virological response
INESS	Institut national d'excellence en santé et en services sociaux (National Institute of Excellence in Health and Social Services)	WHO	World Health Organisation
INSPQ	Institut national de santé publique du Québec (Quebec National Institute of Public Health)		
IQSSS	Institut québécois de santé et de services sociaux (Quebec Institute of Health and Social Services)		
MADO	Maladie à déclaration obligatoire (Notifiable diseases)		
MSSS	Ministry of Health and Social Services		
NRBHSS	Nunavik Regional Board of Health and Social Services		

Glossary

Micro-elimination

Micro-elimination of hepatitis C virus is a strategic approach aimed at making progress towards national elimination through the implementation of targeted interventions. It involves eradicating HCV within specific segments of the population, including groups defined by particular contexts, geographical regions, sub-populations or age cohorts (1,2).

Health peer navigators

Health peer navigators are individuals with lived experience similar to that of the people they support (e.g. chronic illness, substance use, stigma). They draw on their experiential knowledge to facilitate navigation through the healthcare system, improve access to care, reduce structural and social barriers, and enhance health literacy (3).

OCAP Principles

The First Nations principles of ownership, control, access and possession – better known as OCAP® – affirm that First Nations have control over data collection processes, and that they own and control how this information may be used (4).

Lived and living experience

"Lived and living experience" refers to knowledge acquired through reflection on direct lived experience, through active engagement in concrete situations, generally outside or in addition to theoretical or academic knowledge (5,6).

Syndemic

A syndemic refers to the simultaneous interaction of diseases and biological, social and environmental factors, the synergy of which amplifies the negative impact on the health of a population (7)



Introduction

Introduction

Hepatitis C is an infection of the liver caused by the hepatitis C virus (HCV), a small enveloped ribonucleic acid (RNA) virus (8–10). HCV is detectable in various bodily fluids and can therefore spread in a variety of ways; however, the most common mode of transmission is through direct contact with infected blood. Transmission via other bodily fluids is rare (11,12). Around one in four people manage to clear HCV spontaneously (13). Otherwise, an untreated HCV infection can become chronic and cause progressive liver damage, leading to cirrhosis, liver cancer, and potentially requiring organ transplants or even resulting in death (14–16). It should be noted that there is not yet a vaccine against HCV, but direct-acting antivirals (DAAs) have revolutionized the management of HCV, making treatment short and effective for over 95% of patients (17,18).

In Quebec, the main routes of HCV transmission include sharing equipment used for injecting, smoking or snorting drugs, as well as, to a lesser extent, the reuse of non-sterile tattooing or piercing equipment (19). Sharing personal items such as toothbrushes, razors and nail clippers, which may contain traces of blood, also presents a theoretical risk of transmission (12,20). HCV transmission during sexual intercourse is possible in cases of blood exchange, during unprotected vaginal and anal sex resulting in lesions, and when sharing sex toys (12,21). HCV can also be transmitted to a child during childbirth, although this remains rare. Routine screening of blood, organ and tissue donors since 1990 has made the risk of HCV transmission via blood transfusion or organ transplantation practically non-existent in Quebec (12,20,22).

It is important to note that HCV transmission results from the interaction of individual, social, environmental and structural determinants that shape the conditions of risk exposure and make certain populations more vulnerable to HCV infection (23,24). Individual vulnerabilities, such as mental health issues or limited knowledge of transmission routes, are influenced by contexts characterized by poverty, the criminalization of drugs, stigma and housing instability, which limit access to prevention and treatment services. Populations at risk include people who use drugs (PWUD), whether currently or in the past; members of Indigenous communities; people with a history of incarceration in federal or provincial institutions; immigrants from countries where HCV is endemic; and gay, bisexual, and other men who have sex with men (gbMSM) (23–26). Furthermore, high rates of HCV infection are observed among people born between 1945 and 1975 (25), which likely reflects exposure prior to the implementation of widespread blood donation screening measures. These six groups constitute the main target populations in the fight against HCV in Canada. An individual may have several risk factors, and it is common for some people to belong to more than one risk group.

In Canada, chronic HCV infection remains one of the major threats to public health. It is associated with the greatest loss of life years among all infections (27,28) and is one of the leading indications for liver transplantation (29). The annual healthcare costs associated with this disease could even reach \$260 million by 2032 (28). Despite medical advances, new cases continue to emerge. In 2021, 22 people were newly infected with HCV every day in Canada. There were 8,200 new reported cases of HCV, representing a rate of 21 cases per 100,000 people. It should be noted that approximately 41% of people living with chronic HCV infection have never been diagnosed (30,31). In Quebec, the incidence rate of reported HCV cases was estimated at 9.4 per 100,000 people in 2021 (818 new cases) and 8.3 per 100,000 people in 2022 (722 new cases) (31). The percentage of people who had not been diagnosed with HCV was estimated at 46% in 2018 (32), a figure that may have risen due to service disruptions during the 2019 coronavirus disease (COVID-19) pandemic.

It is also important to highlight the occurrence of reinfection cases, which are not centrally tracked in Canada or Quebec. Although DAAs are effective and spontaneous recovery from HCV is possible, this does not confer immunity against the virus. A person who has recovered can therefore become reinfected if exposed to HCV (33,34). Data from 38 international cohort studies (including 4 Canadian cohorts) compiled in a meta-analysis published in 2023 indicate an overall reinfection rate of 4.13 cases per 100 person-years (95% confidence interval (CI): 3.45–4.81) across all at-risk populations, namely people who inject drugs (PWID), gbMSM, and people with experience of incarceration (35). This same meta-analysis, which included studies with observation periods falling within the era of DAAs, demonstrates that the reinfection rate is higher among gbMSM (7.37 cases per 100 person-years (95% CI: 5.09–9.65), 9 studies) compared to PWID (2.84 cases per 100 person-years (95% CI: 2.19–3.50), 28 studies) and incarcerated people (7.23 cases per 100 person-years (95% CI: 2.13–16.59), 2 studies) (35), highlighting limitations in current prevention strategies.

The Pan-Canadian Framework for Action on Sexually Transmitted and Blood-borne Infections (STBBIs), endorsed by provincial and territorial health ministers and the federal Minister of Health (36), aligns with the World Health Organization's (WHO) global strategy, which aims to eliminate HCV by 2030 (37). The global strategy aims, among other things, to reduce the annual incidence rate of new cases to 5 per 100,000 people, to achieve a rate of 90% of people living with HCV being diagnosed and 80% of people cured, and to reduce the annual number of deaths due to HCV to 2 cases per 100,000 people (37). In this regard, Quebec has not adopted the Pan-Canadian Framework and does not yet have an action plan to achieve the WHO's targets for the elimination of HCV by 2030. However, the elimination of HCV in Quebec is possible if prevention and treatment efforts are stepped up. This approach requires a concerted mobilization of government authorities, healthcare professionals, community organizations and the

most at-risk populations. *Quebec's Roadmap for the Elimination of HCV* represents a strategic opportunity to bring these stakeholders together around concrete measures, which can serve as the foundation for a provincial action plan aligned with the WHO targets.

This document is primarily intended for decision-makers at the Ministère de la Santé et des Services sociaux (MSSS - Ministry of health and Social services), staff at the Institut québécois de santé et de services sociaux (IQSSS – Institute of health and social services in Quebec), healthcare professionals, community organizations and members of at-risk groups. It includes courses of action developed through a consultative process involving stakeholders and experts active in the field. These are also based on evidence, where available, and are centred on proven practices. Although HCV infection is frequently observed in the context of co-infection with other STBBIs, this document focuses specifically on HCV-related guidance. This choice aims to ensure consistency with national and international elimination targets, notably those established by the *Blueprint* and the WHO (23,37). By focusing exclusively on HCV, it becomes possible to propose precise, comparable and measurable actions, while recognizing the importance of an integrated approach in field interventions.



Methodology

Methodology

The development of this *Roadmap* was led by a steering committee comprising doctors, scientific experts and community representatives, including Dr. Julie Bruneau, Research Centre of the University of Montreal Hospital Centre (CHUM); Lorraine Fradette MSc, Canadian Network on Hepatitis C (CanHepC); Dr. Marina Klein, Research Institute of the McGill University Health Centre (RI-MUHC); Carrie Martin, BA, BSW, Tiohtià:ke Indigenous Health Centre; and Laurence Mersilian, Centre Associatif Polyvalent d'Aide contre l'Hépatite C (CAPAHC).

1. Selection of Priority Themes

A multidisciplinary advisory committee comprising 13 members recruited from CanHepC and CAPAHC, representing various regions of Quebec, was established to guide the process of developing the *Roadmap*. The committee brought together complementary expertise from the community sector, public health, the prison system, the field of substance use, and immigration. A total of three meetings were held in May, September and November 2022 to determine the topics to be addressed in the *Roadmap*. Drawing on the analysis of at-risk populations and the measures recommended in the *Blueprint* (23), the advisory committee identified priority themes tailored to the Quebec context. The themes and issues raised during the meetings were approved by the steering committee during a fourth session held in February 2023. These themes, organized according to at-risk groups, served as the basis for discussions throughout the consultation process (see Appendices).

Issues relating to Indigenous peoples

In accordance with the OCAP principles (Ownership, Control, Access, Possession), an independent advisory committee comprising three Indigenous members (a researcher, a person with "lived and living experience" and a spiritual guide) identified the priority themes and the consultation process relating to Indigenous issues. Specific questions were also developed for the meeting with People with "lived and living experience" (PWLLE) (see [Appendices](#)).

2. Consultation Process

A total of 131 multi-sectoral HCV experts, from priority populations or working directly with them, were consulted. These included 27 PWLLE, 45 healthcare professionals (doctors, nurses, pharmacists), 33 community workers, 23 health managers and 16

researchers. The consultation took place between 2023 and 2024. Various methods were used to gather both scientific and experiential knowledge.

Individual interviews

Eighteen individual interviews were conducted with research and healthcare professionals, as well as with representatives from community and government organizations, namely the medical community of practice on addiction, the national mentoring program on human immunodeficiency virus (HIV) and hepatitis – PNMVH, the IQSSS (comprising the former institutes: the Institut national de la santé publique du Québec [INSPQ National Institute of Public Health in Quebec] and the Institut national d'excellence en santé et en services sociaux [INESSS National institute of excellence in health and social services]), the Association des intervenants en dépendance du Québec – AIDQ (Quebec Association of Addiction Professionals), and the Commission de la santé et des services sociaux des Premières Nations du Québec et du Labrador – CSSSPNQL (Commission of health and social services of First Nations of Quebec and Labrador).

Focus group meetings

Focus group discussions were organized to gather additional perspectives.

- Two meetings with the provincial committee on detention brought together 16 participants, including healthcare providers, prison managers and representatives of Indigenous organizations.
- A meeting was held with *AIDS Community Care Montreal (ACCM)*, a community organization working in the field of HIV and sexual health. Five members of the organization attended the session, including PWLLE and Indigenous members.
- A pan-Canadian meeting on the elimination of HCV was organized by CATIE (*Canadian AIDS Treatment Information Exchange* – Canada's source for HIV and HCV information), CanHepC, and the Public Health Agency of Canada (PHAC). This gathering brought together eight stakeholders, including three members of the *Roadmap Steering Committee*, two expert researchers, an expert advisor from the INSPQ, a community advocate from CACTUS, and a medical advisor from the CSSSPNQL.

Meetings on Indigenous issues

The meetings on Indigenous issues were led by members of the Indigenous advisory committee. Three consultative meetings took place in May and June 2023. Meetings 1 and 3, which were held online, were open to all, including 9 Indigenous PWLLE, 9 representatives from Indigenous organizations (Projets Indigènes du Québec, Tio'tià:ke Indigenous Health Centre, Quebec Indigenous Women, CSSSPNQL), 14 healthcare professionals, 5 researchers and 5 individuals from the administrative sector. The

second meeting was held in person in the form of a talking circle and was reserved for individuals with lived experience of HCV, bringing together 20 members of Indigenous communities. Each meeting included an opening prayer, words of welcome, a land acknowledgement and a closing prayer. Simultaneous interpretation in English, French and Inuktitut was provided to facilitate participation. A bilingual (French-English) document setting out the terms of reference was sent to participants prior to the meeting, providing guidance and information.

Survey

Broader professional engagement was achieved through a targeted survey completed by 27 members of the CHUM's ECHO® (Extension for Community Healthcare Outcomes) program, focusing on HCV and substance use disorders. Respondents included 12 nurses, 5 community workers, 5 doctors, 1 pharmacist, 1 program manager, and 1 psychoeducator.

3. Literature Review

A narrative literature review was conducted by an editorial committee comprising five scientists to specifically address the questions and issues raised during the consultations. This type of review is considered appropriate for addressing complex public health topics (38). A non-systematic literature search of peer-reviewed scientific studies was carried out in the MEDLINE database. This search included publications in English and French up to July 2025. An exploration of the bibliographic references of the articles was also carried out, as well as a search of grey literature. In accordance with the principles of a narrative review, articles were selected based on their relevance to support the information gathered during the consultations.

The aim of this review was to present the current state of scientific knowledge on the various topics addressed in the *Roadmap*, taking into account the perspectives of the communities and relevant stakeholders.

4. Development of Recommendations and Courses of Action

The process of formulating cross-cutting recommendations—that is, those applicable to the entire population—involved three key stages. Firstly, the drafting committee analyzed the data gathered during the consultations and the literature review, summarizing the needs expressed by different communities and stakeholders at each level of the care continuum. Next, in collaboration with the advisory committee, the drafting committee identified points of convergence and synergies among the affected

communities in order to develop an integrated understanding of cross-cutting issues and highlight opportunities for collaboration. Finally, based on the synergies observed, twelve strategic priorities were defined with a view to eliminate HCV. Each priority was accompanied by concrete actions aimed at facilitating implementation. The steering committee validated the entire process, ensuring the scientific rigour and relevance of the recommendations made.

With a view to micro-elimination, specific courses of action were also formulated for each of the identified priority groups in order to highlight the particular challenges, structural determinants and social and cultural realities specific to each group.

5. External Review

The *Roadmap* underwent a formal review by a multidisciplinary external committee comprising 20 people, including doctors, pharmacists, nurses, researchers, community workers, public health policy-makers, and PWLLE. This review process took place in two distinct phases:

- *First round of review:* Conducted between January 13th and February 3rd 2025, this first round involved stakeholders directly engaged in the relevant sectors. It was based on an online survey designed to assess the *Roadmap's* objectives, clarity and applicability. Evaluators were also asked to assess the relevance of each recommendation and to provide qualitative feedback.
- *Second round of review:* This second round, held between August 9th and September 21st 2025, involved key organizations in public policy development and in the implementation of the *Roadmap's* recommendations, notably the INSPQ (now IQSSS), the Association of Indigenous Friendship Centres of Quebec (RCAAQ), and the Nunavik Regional Board of Health and Social Services (NRBHSS).

The drafting committee collected and analyzed all the comments made during the two rounds of review. The guidance document was amended accordingly. Recommendations deemed inappropriate were discussed with the steering committee. Amendments were made where the comments from the evaluators highlighted new evidence or relevant justifications, thereby improving the rigour and validity of the proposed recommendations.

6. Management of Conflicts of Interest

Members of the steering committee and the editorial team completed a standardized and tailored conflict-of-interest disclosure form. This process was designed to ensure transparency regarding potential conflicts of interest.



Cross-Cutting Recommendations

Cross-Cutting Recommendations

The elimination of HCV in Quebec is a realistic objective, with positive benefits for those affected and their communities, as well as for the healthcare system as a whole. With this in mind, twelve cross-cutting recommendations, deemed a priority by the key stakeholders consulted in the field, have been formulated to guide the actions necessary to achieve this objective. They are organized around seven key areas of intervention for eliminating HCV: understand, measure, prevent, screen, treat, support, integrate and collaborate.

These recommendations aim to adapt the measures set out in the 2019 *Blueprint* to the Quebec context. They are based on measurable targets for 2030 that are aligned with those of the *Blueprint* (23) and the WHO (where available) (37), thereby enabling progress in Quebec to be compared with that of the rest of Canada and other countries.

TABLE 1

Objectives and Targets for the Elimination of HCV in Quebec

Recommendations	Impact and coverage indicators – Targets for 2030
Understand 1 Promote the dissemination of general knowledge about HCV, including simplified treatments, to all relevant audiences. 2 Promote, implement and institutionalize best practices from ongoing or completed projects in Quebec.	Reduce the percentage of people living with HCV who experience stigma and discrimination to $\leq 10\%$.
Measure 3 Strengthen HCV monitoring and surveillance capabilities by standardizing data collection.	100% of public institutions within the health and social services network have implemented the Electronic Health Record system. Annual update of the population cohort of people at risk and living with HCV based on administrative data accessible in real time. Implementation of advanced surveillance protocols integrating administrative databases, links to anonymized individual data (cohorts, electronic health records) and modelling tools, with an annual update. Demographic identification of clinical subgroups, particularly Indigenous populations and immigrant communities.

Recommendations	Impact and coverage indicators – Targets for 2030
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Prevent

4 Support and fund the implementation of HCV prevention programs tailored by and for affected communities.	750 syringes and needles/PWID/year ≥60% of PWIDs receiving OAT^a ≥50% of PWIDs reached/supervised consumption site within a 1 km radius^b
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Screen

5 Introduce universal HCV screening for people born between 1945 and 1975 and implement routine screening as part of prenatal care for every pregnancy.	
6 Expand the group of practitioners, beyond healthcare workers, who can administer rapid HCV antibody tests and communicate the results.	90% of people living with HCV are diagnosed and have undergone testing to confirm active infection 100% of people born between 1945 and 1975 living with HCV are diagnosed and have been tested to confirm active infection
7 Standardize the use of the reflex test so that HCV RNA testing is automatically carried out when an HCV antibody test is positive.	100% of pregnant women living with HCV are diagnosed and have been tested to confirm active infection 100% of people who tested positive for antibodies have been tested for HCV RNA
8 Optimize screening by adopting new point-of-care laboratory tests	

Recommendations	Impact and coverage indicators – Targets for 2030
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Treat and Support

9 Strengthen HCV care by increasing the number and diversity of frontline professionals involved, and by promoting innovative approaches to task-sharing.	90% of those diagnosed are connected to a healthcare provider with expertise in HCV. 80% of people living with HCV have started DAA treatment.
10 Integrate HCV care into harm reduction and substance use treatment programs.	95% treatment completion rate with 85% documented SVR.

Integrate and Collaborate

11 Place affected individuals and communities at the heart of the HCV response, recognizing their central role in care and the development of interventions.	Creation of 2 permanent posts for people with lived experience within the body responsible for STBBI prevention and harm reduction in Quebec (formerly INSPQ)
12 Make the fight against HCV a strategic priority and allocate the necessary resources to implement the identified courses of action	Elimination of HCV • Annual number of deaths due to HCV: 2 per 100,000 people • Annual number of new HCV infections: 5 per 100,000 people • Annual number of new HCV infections among people who inject drugs: 2%

Abbreviations: DAAs: direct-acting antivirals, RNA: ribonucleic acid, STBBIs: sexually transmitted and blood-borne infections, INSPQ: Institut national de santé publique du Québec PWIDs: people who inject drugs, SVR: sustained virological response, OAT: opioid agonist therapy, HCV: hepatitis C virus. ^a The target has been revised upwards in light of two studies published in 2023. These studies show, on the one hand, that 40% coverage has a limited impact on achieving HCV elimination targets(39) , and, on the other hand, that the Montreal population already had high OAT coverage, reaching 54% in 2018(40) . ^b New target supported by studies in Quebec and Canada, showing that access to needle exchange programmes and supervised sites within a radius of less than 1 km reduces risky behaviour and fatal overdoses (41–43).

Understand

Recommendation 1

Promote the dissemination of general knowledge about HCV, including simplified treatments, to all relevant audiences

In 2018, a meta-analysis of 19 studies revealed that both healthcare professionals and the Canadian public have gaps in their understanding of HCV transmission and risk factors (44). The experts consulted for this *Roadmap* highlighted persistent gaps in Quebec, emphasizing that the fight against HCV must be based on the effective dissemination of fundamental knowledge about the disease to a wide audience. This includes political actors, decision-makers, provincial public health authorities (MSSS) and regional public health authorities (public health directorates [DSPublique]), healthcare professionals, community stake-

holders, affected communities and the general public. To maximize impact, information must be tailored to each target group and disseminated through appropriate communication channels.

In addition to transmission and prevention, it should be noted that HCV treatment has been greatly simplified in recent years thanks to DAAs and is now within the reach of frontline clinicians. Educating people about HCV will help reduce the stigma surrounding this disease, which is a major barrier to patient care.

Courses of Action

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| Action 1 | Work with specialist firms, the MSSS and the IQSSS to develop HCV awareness campaigns tailored to engage different audiences. |
| Action 2 | Train practitioners in contact with affected individuals and communities in basic knowledge about HCV. |
| Action 3 | Use communication channels and tools intended for healthcare professionals to disseminate basic information on HCV and its treatment. |

Understand

Recommendation 2

To promote, implement and institutionalize best practices from ongoing or completed projects in Quebec

Quebec has a wealth of HCV research projects covering various aspects such as the epidemiology of the virus and the search for innovative strategies to reach affected communities (45,46). These research projects are a valuable source of information and regional strategies. They also offer excellent models of networks for multidisciplinary collaboration at the provincial level. The community sector is another source of innovative strategies, involving people with lived experience in initiatives designed for them. This approach facilitates their engagement and sup-

port. These communities or organizations provide low-threshold services, removing barriers and reaching many people to reintegrate them into a sensitive and safe care setting.

Although numerous provincial initiatives rely on limited and non-renewable funding, thereby restricting the dissemination of good practices. The challenge is to ensure the sustainability of these projects and to share lessons learned at the provincial level.

Courses of Action

Action 4	Bring together key stakeholders, including public health authorities, to define a strategy for the large-scale roll-out of innovative, evidence-based practices across various regions and communities
Action 5	Organize inter-regional field visits to encourage on-site learning and the adaptation of effective initiatives.
Action 6	Use standard practices and methodologies from the implementation sciences to propose solutions, facilitate knowledge transfer and support program roll-out in different contexts (47).

Measure

Recommendation 3

Strengthen HCV monitoring and surveillance capacities by harmonizing data collection

Public health surveillance data enable the identification of people affected by HCV and their access to the cascade of services. A detailed profile of individuals at each stage of the care cascade and across regions is essential to effectively meet their needs.

Quebec's provincial surveillance data includes data recorded in the Infectious Disease Information and Management System (SI-GMI) for notifiable diseases (MADO). HCV is a notifiable disease that must be reported by doctors and clinical laboratories to regional public health authorities, as stipulated by the Public Health Act and its regulations (48). Case reports are recorded as new episodes in the SI-GMI, classified as acute or recent cases and unspecified; the records of these episodes contain certain basic demographic information, such as age, sex and place of residence, enabling the data to be analyzed according to descriptive characteristics in terms of time, place and individual. However, they do not necessarily include other relevant information such as ethnicity, immigration status, sexual orientation or gender identity, nor do they include exposures and risk factors. Furthermore, reported cases of HCV are not necessarily investigated by regional public health authorities due to available human resources and priorities relative to other notifiable diseases.

Administrative data from the *Régie d'assurance maladie du Québec* (Health Insurance Board of Quebec) provide an overview of the number of HCV treatments administered by the public health system to registered patients. However, these data do not account for treatments covered by private insurance schemes, pharmaceutical companies' compassionate access programs, the federal Uninsured Health Benefits program covering eligible members of Inuit or First Nations communities, or the federal Interim Health Program for newcomers and refugees. These various data sources are managed by different entities at the provincial, regional, or commercial level. They are not centralized and were not developed to capture the specific characteristics of HCV.

The picture of the situation in Quebec is also based, in particular, on population-based surveys and cohort studies that provide partial data on the impact of HCV in the province. For example, cohort studies such as the Hepatitis C Cohort and the Canadian Co-infection Cohort are mainly conducted in large urban centres, which limits the representativeness of their results for the population as a whole (45,49). Furthermore, Quebec has the SurvUDI network, an effective sentinel surveillance system for PWID. Initially established in eight health regions (RSS) in Quebec, only the Montreal region is currently continuing to collect data (50).

Courses of Action

Action 7 Collect additional demographic data, including ethnicity, immigration status and risk factors, on new HCV cases reported in the SI-GMI to better characterize high-risk populations.

Action 8 Establish a collaborative committee on HCV data, bringing together representatives from the various bodies involved in data collection and use, to:

- a. Assess and harmonize existing data sources to improve the accuracy of the HCV epidemiological portrait in Quebec;
- b. Oversee data-sharing agreements for access to harmonized data;
- c. Identify priority research questions and develop appropriate research protocols.

Prevent

Recommendation 4

Support the implementation of HCV prevention programs tailored by and for affected communities

HCV transmission is not merely a biological phenomenon involving the exchange of bodily fluids. New infections in Quebec are predominantly linked to the sharing of injection equipment among PWID (19,51). Transmission, however, occurs within a much broader context of interpersonal dynamics, which are themselves shaped by complex socio-economic, gender, cultural and political issues. In this regard, communities affected by HCV, as well as the organizations providing services to them, are best placed to understand the risk factors associated with infection and

effective prevention strategies. It is therefore essential to work closely with the relevant target groups to provide them with the necessary information and tools, while giving them the freedom to determine the most appropriate methods for disseminating this information.

To optimize prevention efforts, it is crucial to recognize that individuals may belong to several communities. We must therefore encourage dialogue between different sectors in order to promote best practice.

Courses of Action

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| Action 9 | Offer harm reduction programs to reach and meet the needs of people who use drugs throughout Quebec. |
| Action 10 | Assess the effectiveness of HCV treatment as a prevention tool. |
| Action 11 | Support the development of accessible prevention programs that meet the specific needs of all affected communities. |
| Action 12 | Recognize the shared values and principles that guide community actions, as well as the importance of a cross-sectoral approach that fosters collaboration between different stakeholders. |

Screen

Recommendation 5

Introduce universal HCV screening for people born between 1945 and 1975, and implement routine screening as part of prenatal care for every pregnancy

In Canada, it is estimated that 25% of people infected with HCV are unaware of their status (31). People born between 1945 and 1975 constitute the group most likely to remain undiagnosed, with data suggesting that approximately 70% of this cohort have never been tested for HCV (25,52). In Quebec, the HCV screening strategy remains based on the identification of individual risk factors. However, this approach can lead to under-screening when these factors are not systematically assessed, when exposure occurred long ago and has been forgotten, or when people prefer not to disclose it for fear of stigma or repercussions. Elimination efforts should therefore be accompanied by universal screening campaigns for people born between 1945 and 1975 and systematic screening of pregnant women in order to reach more individuals.

HCV screening could be integrated into existing processes, such as the STBBI screening recommended as part of prenatal care. This approach would avoid additional steps for both patients and

healthcare professionals. Combining HCV screening with other campaigns, such as vaccination against hepatitis A, hepatitis B, influenza and COVID-19, invasive pneumococcal infections or cancer screening, would be another example of a strategy to reach people by maximizing the use of existing resources and opportunities. It is also important to facilitate community-based screening to reach people who are further removed from health services.

It should be noted that, even in the context of universal screening, this must be carried out with a view to informed decision-making. Information regarding the positive and negative impacts associated with a positive screening result should be standardized and well-documented. Beyond universal access to HCV treatment and other preventive measures, the information must include support mechanisms addressing the social and legal issues that a diagnosis might entail.

Courses of Action

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| Action 13 | Integrate HCV screening into every pregnancy and, at least once in a lifetime, for people born between 1945 and 1975, by including this recommendation in the clinical prevention guidelines of the <i>Collège des Médecins du Québec</i> . |
| Action 14 | Conduct pilot projects to integrate HCV screening into other health promotion and prevention campaigns targeting people born between 1945 and 1975, evaluate their effectiveness, and roll them out on a larger scale where appropriate. |

Screen

Recommendation 6

Expand the group of healthcare professionals, beyond healthcare workers, who can administer rapid HCV antibody tests and communicate the results

Screening is a key component of HCV management and access to appropriate services. A person who is unaware of their status will not proceed to the next stages of care and may fail to take the necessary steps to prevent the transmission of HCV. In Quebec, the ordering and interpretation of laboratory tests on a blood sample for STBBI screening via venipuncture are procedures reserved for doctors and registered nurses (53). Furthermore, at the time of drafting this document, the point-of-care rapid screening kits approved by Health Canada are still used solely within the context of research projects or one-off activities (54). In particular, the rapid HCV antibody test using dried blood spots cannot be used in community settings in the absence of a healthcare professional, unlike the practices authorized in all other Canadian provinces (55).

Authorizing and training pharmacists, community workers, social workers and peer support workers to carry out rapid HCV antibody tests would significantly increase the availability of screening across the whole of Quebec. These community workers and peer support workers have close, trusting relationships with the communities they serve, which makes it easier to support people who are disconnected from the healthcare system.

Although the simplicity of rapid tests makes this measure feasible, the implementation of rigorous training programs and quality assurance mechanisms is essential to ensure their reliability and effectiveness.

Courses of Action

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| Action 15 | Change the policy surrounding HCV screening to expand service provision by increasing the list of service providers who can offer and administer screening. |
| Action 16 | Ensure that HCV screening tests are free of charge in all settings (community organizations, pharmacies, medical clinics) and establish funding mechanisms to support community screening programs. |
| Action 17 | Establish a mechanism for reporting new cases of HCV detected in the community and ensure their integration into the existing surveillance system. |

Screen

Recommendation 7

Systematize the use of reflex testing so that HCV RNA detection is automatically performed when an HCV antibody test is positive

In Canada, data indicate that only 70% to 85% of people who test positive for HCV antibodies go on to undergo a confirmatory test (56,57). And with good reason: the multiple appointments required to confirm active HCV infection constitute a major barrier to diagnosis, particularly due to language barriers among immigrants, incomplete reporting of results in prison settings, or the difficulty in contacting people without a telephone or fixed address (58). By combining the detection of anti-HCV and HCV RNA, this reflex test reduces the number of samples and appointments required, and consequently the waiting time between a positive result and potential access to treatment.

Routinely performing HCV RNA testing following a positive anti-HCV result is therefore a potentially effective strategy in efforts to eliminate HCV.

The COVID-19 pandemic has led to the decentralization of testing laboratories and the deployment of diagnostic devices that can be used for HCV screening. Although their use requires resources to ensure adequate user training, improved access to these technologies in more remote areas would significantly reduce waiting times for results, thereby enabling faster management in the event of a positive result.

Courses of Action

Action 18	Systematize reflex testing for HCV RNA in all cases of positive HCV antibody results.
Action 19	Standardize the inclusion of HCV RNA testing in referral protocols sent to the Service Request Coordination Centre.
Action 20	Optimize the use of RNA detection test kits deployed across the province in response to the COVID-19 pandemic.

Screen

Recommendation 8

Optimize screening by adopting new point-of-care tests

Recent years have seen significant developments in point-of-care testing (54).

- Dried blood spot collection is a minimally invasive technique that can be performed at the point of care, involving the collection of a small amount of blood via a finger prick, which is then applied to a specialized filter paper. Once dried, the sample remains stable for several days, allowing for safe transport to a laboratory for analysis. This method is particularly advantageous in remote or rural areas, where access to conventional venous blood collection may be limited (59,60).
- Rapid point-of-care testing for HCV antibodies provides a result in just one minute(54,61).
- Rapid HCV screening using RNA detection can confirm an active infection following a positive antibody test in just 60 minutes using a blood sample obtained via a finger-prick test (54,62).

Courses of Action

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| Action 21 | Evaluate the rapid HCV screening tests approved by Health Canada (61,62), analyzing their costs and their potential to remove barriers to access for currently underserved populations. |
| Action 22 | Use the results of a cost-effectiveness analysis to determine which laboratory tests should be made available and in which appropriate settings, then ensure their roll-out under suitable arrangements |

Treat and Support

Recommendation 9

Strengthen HCV care by expanding the number and diversity of frontline professionals involved, and by promoting innovative approaches to task-sharing

Research shows that decentralizing HCV care is effective and helps reduce barriers to accessing care (63,64). In line with these findings, the stakeholders consulted emphasized that the involvement of primary care professionals, particularly family physicians and nurse practitioners, is essential for eliminating HCV and reaching underserved populations. Pharmacists also play a key role, particularly in initiating and monitoring treatment, as well as in supporting screening and prevention through patient education and the distribution of educational materials.

The consultations also highlighted gaps in academic and professional curricula. Better integration of HCV and other STBBIs – taking into account the real-

ities of the most affected populations – into programs in medicine, nursing, social work, pharmacy and paramedical sciences would help to harmonize core knowledge. Given the heavy workload of frontline healthcare workers, it is essential to facilitate access to information by integrating HCV into existing tools and workflows. Furthermore, a significant proportion of continuing professional development relies on informal peer-to-peer initiatives, which are often unpaid. Structuring and supporting these efforts would strengthen a vital but undervalued aspect of professional development.

Courses of Action

Action 23	Highlight existing training and educational opportunities to broaden their reach and audience, such as the CHUM ECHO® program on HCV and substance use disorders, the PNMVH, and training courses from the IQSSS (formerly INSPQ) and the <i>International Network on Health and Hepatitis in Substance Users</i> , adapted for Canada.
Action 24	Explore opportunities for collaboration and service pathways between different professional bodies, such as the <i>Fédération des médecins omnipraticiens du Québec</i> (FMOQ), the <i>Fédération des médecins spécialistes du Québec</i> , the <i>Collège des médecins du Québec</i> and the <i>Association des infirmières praticiennes spécialisées</i> .
Action 25	Develop a training and mentoring program that would facilitate access to information and support for less experienced practitioners as they learn to treat HCV. More complex cases could continue to be managed by specialist doctors.

Treat and Support

Recommendation 10

Integrate HCV management into harm reduction and addiction treatment programs

A significant proportion of HCV transmission occurs in the context of sharing equipment for the inhalation or intravenous use of drugs (19,65). Evidence indicates that harm reduction programs, such as opioid agonist treatment (OAT) and the distribution of syringes and needles, can reduce the risk of HCV infection by up to 74% (66). Furthermore, integrating HCV treatment into OAT programs promotes adherence to OAT and enables high rates of sustained virological response (SVR) to be achieved (67).

In light of the available data and feedback gathered from stakeholders, it is recommended that an HCV prevention strategy be adopted, centred on an accessible and multidimensional approach to harm reduction. Furthermore, HCV screening and treatment should be integrated into existing services for people who use drugs, such as harm reduction services, substance use treatment programs and correctional health services.

Courses of Action

- Action 26** Collaborate with existing organizations, including the medical addiction practice community, the university institute for addiction, the AIDQ, the Quebec Association of Addiction Intervention Centres, and the Quebec coalition of community organizations for street work, to:
- Identify existing best practices and contextual realities;
 - Integrate and standardize HCV screening and treatment within harm reduction services and substance abuse rehabilitation centres.

Integrate and Collaborate

Recommendation 11

Place affected individuals and communities at the heart of the response to HCV, recognizing their central role in care and the development of interventions

The involvement of people with lived experience can take various forms within HCV elimination initiatives, including the contribution of specific expertise and participation in decision-making processes. A recent qualitative study highlights three fundamental dimensions of lived experience: significant individual events, a sense of belonging and shared values among peers, and lived expertise, considered as a unique form of experiential knowledge that can benefit others (68). Understanding this concept is essential for designing roles, recruitment strategies and support for the peer workforce.

By recognizing and valuing this lived expertise, it becomes possible to develop more inclusive and tailored intervention approaches, which rely on the active contribution of peers to strengthen the reach and relevance of public health initiatives. Thus, lived expertise can be used to enrich support and navigation programs, where people further along their journey support their peers in accessing services. This approach constitutes an effective strategy for ensuring access to health and social services for communities facing stigma and discrimination (69).

Courses of Action

Action 27	Establish an advisory committee comprising people with experiential knowledge of HCV, representing a diversity of perspectives and from different RSSs, to guide the implementation of the <i>Roadmap</i>
Action 28	Develop a training program to equip expert counsellors so that they can support stakeholders on key issues and the best strategies for engaging affected individuals and communities.
Action 29	Establish a separate training program for community navigation roles, to support the provision of guidance to people affected by HCV in accessing services and resources.

Integrate and Collaborate

Recommendation 12

Make the fight against HCV a strategic priority and allocate the necessary resources for the implementation of the identified courses of action

Political will is the backbone of HCV elimination, and this goal cannot be achieved without a concerted effort that brings together the various stakeholders from the health, social services and community sectors, as well as the individuals and communities affected. Stakeholders recommend that the fight against HCV be incorporated into the National Public Health Program (Programme National de Santé Publique – PNSP), regional public health plans, and policies and guidelines affecting the communities concerned.

The implementation of the *Roadmap* must also be underpinned by concrete and coordinated actions, led by individuals who are designated and compensated for their work. As a first step, the creation of paid positions and a provincial working group would enable the identification and prioritization of the next steps required to implement the strategies set out in this *Roadmap* for the Elimination of HCV.

Courses of Action

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| Action 30 | Prioritize the fight against HCV in the National Public Health Program (Programme National de Santé Publique – PNSP), regional public health plans, and in policies and guidelines affecting the communities concerned |
| Action 31 | Establish a provincial working group bringing together representatives from various sectors and the public health system, including people with lived experience, to define the mechanisms necessary for implementing the <i>Roadmap</i> . |
| Action 32 | Create coordination roles across different sectors (MSSS, community and care settings), as well as expert advisor roles drawn from affected communities, to support the working group and the implementation of the <i>Roadmap</i> . |



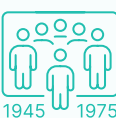
Specific Interventions for Priority Populations

Specific Interventions for Priority Populations

To eliminate HCV as a public health threat in Quebec, it is imperative to complement the general recommendations with a micro-elimination approach focused on priority populations. This strategy allows for the concentration of screening, treatment, prevention and follow-up efforts within well-defined contexts, in order to optimize the adaptation, coordination and evaluation of interventions.

By adopting this targeted approach, it becomes possible to take into account the specific realities of each at-risk group and to co-design more relevant and effective actions with the people concerned. It is important to note here the interdependence between the risk factors associated with HCV. Thus, certain recommendations may apply to several population groups, as a single individual may belong to different at-risk groups. It should also be noted that data specific to Quebec for each of these groups is limited or outdated. Consequently, national data have been utilized and supplemented by input from Quebec stakeholders.

This section, therefore, outlines specific courses of action for each of the six priority populations identified in the national *Blueprint* (23). These courses of action have been developed based on discussions with members of these communities and the service providers who support them. Roadmaps for each population, including detailed contextual descriptions, are available via the following links:

	1. People who use drugs		4. Indigenous peoples living in Quebec
	2. People with a history of incarceration		5. Immigrants and Newcomers from countries with a high prevalence rates of HCV
	3. Gay, bisexual, and other men who have sex with men (gbMSM)		6. People born between 1945 and 1975



Specific Interventions

1. People Who Use Drugs

People who use drugs represent a priority population in the effort to eliminate HCV, due to the high prevalence of the virus and the many barriers they face in accessing prevention, testing and care. In 2021, the PHAC estimated that 64.2% of PWID living in Canada had already contracted HCV. Of these, 37% were living with chronic infection, and approximately half were unaware of their serostatus, highlighting the importance of early testing and raising awareness (24,31). Furthermore, research shows that there is a high risk of reinfection following DAA treatment among people who have recently used drugs, whether by injection or otherwise (70). Indeed, studies conducted among participants with recent drug use show higher rates of reinfection. An adjusted meta-regression demonstrates that people with recent drug use who are also receiving OAT have a 3.5 times higher risk of reinfection (adjusted rate ratio [aRR] 3.50; 95% CI: 1.62–7.53; $p = 0.002$) compared to those receiving OAT without recent drug use. Those with recent drug

use not receiving OAT, meanwhile, have a 4-fold higher risk of reinfection (aRR 3.96; 95% CI: 1.82–8.59; $p = 0.001$) (70).

These figures indicate that HCV transmission remains a persistent issue in Canada and likely also in Quebec, which ranks among the three provinces furthest behind in meeting elimination targets (71). This situation is primarily linked to the use and sharing of non-sterile drug-use equipment (65,72), but also to various structural and social barriers limiting access to care, such as criminalization, stigmatization, housing instability and economic marginalization (73,74). Approaches such as streamlining services and expanding access to HCV care by integrating harm reduction, treatment and psychosocial support were proposed by the stakeholders consulted, including the involvement of those affected and the training of professionals to adapt practices and reduce stigma.

Courses of Action

PWUD – Action 1.	Update the profile of HCV among PWUD, taking into account the impacts of the COVID-19 pandemic on infections, access to testing, treatment and prevention.
PWUD – Action 2.	Establish advanced surveillance protocols integrating administrative databases, anonymized individual data (cohorts, electronic records) and modelling tools, with annual updates.
PWUD – Action 3.	Promote prevention campaigns to address knowledge gaps regarding the various modes of HCV transmission, beyond needle-sharing, in the context of drug use.

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| PWUD – Action 4. | Provide harm reduction programs and increase the budgets available to organizations working with PWUD to meet their needs across Quebec, particularly regarding prevention supplies (consumption equipment and condom distribution). |
| PWUD – Action 5. | Integrate the HCV care cascade into primary care, as well as into harm reduction and addiction treatment programs, to better reach PWID at high risk of infection and reinfection. |
| PWUD – Action 6. | Integrate RNA testing methods, including on-site testing and dried blood spot tests, into clinical and community settings frequented by PWUD at high risk of infection and reinfection. |
| PWUD – Action 7. | Raise awareness among healthcare providers and PWID about simplified HCV treatment |
| PWUD – Action 8. | Promote collaboration between professionals involved in HCV care and the community sector, including peer-led interventions, and ensure funding for community activities in partnership with the relevant authorities (MSSS, Santé Québec) to provide services tailored to PWUD. |



Specific Interventions

2. People with a History of Incarceration

According to 2021 data from the PHAC, 11% and 14% of individuals incarcerated in federal and provincial prisons, respectively, have previously contracted HCV (24,31). Indeed, the prison setting is conducive to the transmission of this virus, particularly due to the sharing of non-sterilized equipment for substance use, tattooing and piercing, as well as, possibly, sexual relations involving blood exchange (75).

The experts consulted highlighted the complexity of the needs of the prison population in Quebec, particularly due to the short duration of stays and

the frequency of transfers within provincial prisons. These factors hinder access to HCV treatment as well as follow-up care after release from custody. Furthermore, the lack of visibility of people in prison living with HCV in provincial policies and recommendations contributes to the situation. The legal status of these individuals is not explicitly defined in the Act respecting health services and social services, resulting in a lack of a framework regarding legislation on the quality of care.

Courses of Action

Incarceration – Action 1.	Strengthen epidemiological surveillance of HCV among prisoners
Incarceration – Action 2.	Update provincial public health and prison policies and guidelines to explicitly include the needs of prisoners in relation to HCV.
Incarceration – Action 3.	Provide harm reduction and substance use treatment programs in prisons and integrate the HCV care cascade into them.
Incarceration – Action 4.	Introduce consent-based routine HCV screening upon prison admission to promote early detection and better access to care.
Incarceration – Action 5.	Promote and value healthcare roles within prisons, explore best practices for task sharing, and encourage the exchange of models between institutions.

Incarceration – Action 6.	To facilitate the establishment of a structured mechanism to ensure continuity of care following release, by connecting each individual with community resources in their local health and social care area, including harm reduction and addiction treatment services.
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Incarceration – Action 7.	Support and promote HCV training programs for general practitioners and other professionals working in the prison system.
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Incarceration – Action 8.	Raise awareness and train correctional staff on physical and mental health issues, HCV and harm reduction approaches.
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Specific Interventions

3. Gay, Bisexual, and Other Men Who Have Sex with Men (gbMSM)

Data from the PHAC estimate that approximately 3% of gbMSM living in Canada have been infected with HCV (24,31), with gbMSM living with HIV having a prevalence four times higher than that of their HIV-negative counterparts, at 11.2% (95% CI: 4.7–20.1) (76). In Canada, as in Quebec, the main route of HCV transmission in this group is injection drug use, although transmission can also occur through blood contact during sexual intercourse (77,78). Certain practices such as chemsex—that is, the use of psychoactive substances before or during sexual intercourse—are frequently observed in this population and may increase the risk of HCV transmission through the sharing of drug-use equipment or blood contact during sexual intercourse (79). Studies indicate that injection drug use and HIV co-infection are associated

with an increased risk of HCV reinfection within this community (80,81). In a Canadian cohort, reinfection rates were 3.13 cases per 100 person-years among gbMSM living with HIV, 3.25 cases among those using drugs, compared with 1.88 cases among all gbMSM (80). It is important to reiterate that a recent meta-analysis indicates a higher incidence of reinfection among gbMSM (7.37 per 100 person-years; 95% CI: 5.09– 9.65) compared with other exposed populations, such as PWID (2.84 per 100 person-years; 95% CI: 2.19–3.50) (35) . It is therefore necessary to establish systematic surveillance among gbMSM who are sexually active or inject drugs, and to incorporate interventions specifically targeting this population into the HCV elimination plan.

Courses of Action

MSM - Action 1.	Allocate the necessary resources to research on gbMSM in order to better understand the modes of HCV transmission and the risk factors associated with reinfection in this population.
MSM - Action 2.	Raise awareness among gbMSM of the risk of HCV transmission associated with the presence of blood during sexual intercourse, emphasizing the effectiveness of condoms in reducing this risk.
MSM - Action 3.	Assess the effectiveness of HCV treatment as a prevention tool among gbMSM living with HIV in Quebec, and adapt public health approaches based on the results.
MSM – Action 4.	To standardize practices governing HCV screening among gbMSM in order to ensure equitable access to care across Quebec.

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| MSM – Action 5. | Offer regular HCV screening (at least once a year) to all sexually active gbMSM, particularly during routine STBBI screenings and consultations for pre-exposure prophylaxis (PrEP). |
| MSM – Action 6. | Expand access points for screening by involving community workers. |
| MSM – Action 7. | Allocate the necessary resources to meet the socio-economic needs of gbMSM living with HCV and enable them to prioritize access to care and treatment. |
| MSM – Action 8. | Promote HCV training programs for healthcare professionals and community workers across Quebec, with a focus on the specific needs of gbMSM. |
| MSM – Action 9. | Support, promote and fund community programs that assist gbMSM living with HCV in accessing care and treatment. |



Specific Interventions

4. Indigenous Peoples

In 2021, the PHAC estimated that 8% of First Nations peoples living in Canada had already contracted HCV; there was insufficient data to estimate prevalence among the Inuit (82). It is important to note that being Indigenous is not a risk factor in itself. Rather, it is structural determinants (colonization, residential schools, colonial ideology), systemic determinants (education, health and justice systems), and immediate determinants (socio-economic factors: income, personal and community resources) that interact and increase this population's vulnerability to HCV infection (83). The colonial legacy has profoundly shaped current social inequalities among Indigenous peoples by depriving them of self-determination and leading to the disintegration of traditional structures, the marginalization of cultural practices and the loss of economic resources (83,84). Furthermore, even more recent experiences of assimilationist policies, such as residential schools—the last of which closed as recently as 1991—have caused intergenerational trauma. These historical injustices have contributed to limiting access to resources, weakening social ties and compromising living conditions, resulting in marked disparities in health, housing, education and socio-economic well-being between Indigenous and non-Indigenous populations (83,84). Furthermore, Quebec's systems and policies, shaped by colonial ideology, are still marked today by racism and racial and social profiling (84–87). This is reflected in particular by the over-representation of Indigenous peoples in prisons (88,89). The incarceration rate in Quebec's correctional system between 2015 and 2016 was 20.7 per 1,000 inhabitants among First Nations and Inuit, compared with 4 per 1,000 inhabitants among non-Indigenous peoples – five times higher (90). It should be noted that Indigenous peoples are also over-represented among victims

of crime. In 2014, the federal Department of Justice reported that 28% of Indigenous peoples aged 15 and over reported having been victims of a crime, compared to 18% of non-Indigenous people (91). In 2019, the rate of violent victimization among Indigenous peoples aged 15 and over was twice as high as among non-Indigenous people (92). Discrimination, stigmatization and systemic racism within the health-care system also contribute to limiting access to culturally safe care for Indigenous peoples (86,93). Furthermore, geographical isolation is also a major factor limiting access to healthcare for Indigenous populations. Data from Statistics Canada reveal that in 2021, more than 27% of First Nations communities and 76% of Inuit lived in remote areas, a significant distance from essential services (94). This remoteness means that people must travel long distances, often at high cost, to access care (95).

It is essential to consider these root causes in the fight against HCV, which puts into context the over-representation of Indigenous peoples among high-risk populations. While First Nations and Inuit in Quebec live in a variety of settings—whether urban, rural or remote—it is imperative to adopt differentiated approaches tailored to their realities and their cultural, social and territorial needs. We must also address gaps in public health data to fill in the information regarding HCV among Inuit and other Indigenous peoples.

Courses of Action

Indigenous – Action 1.

Foster partnerships between healthcare providers and Indigenous organizations to develop HCV training programs that incorporate the concept of cultural safety, a trauma- and violence-informed approach, and recognition of the impacts of colonization.

Indigenous – Action 2.

Strengthen public health surveillance by and for First Nations and Inuit and improve methods to address significant gaps in data relating to the health of Indigenous peoples.

- Fund and allocate the necessary resources to support HCV health assessments designed, led and governed by Indigenous communities.
- Respect Indigenous data sovereignty by developing robust governance frameworks and government-to-government data-sharing agreements.

Indigenous – Action 3.

Fund and support the implementation of comprehensive awareness campaigns on HCV and liver health, designed, led and facilitated by Indigenous communities. Encourage knowledge-sharing among Indigenous communities to strengthen local capacity for HCV management.

Indigenous – Action 4.

Establish partnerships (i.e. with health systems, service providers and community organizations) with local Indigenous leaders to adapt, develop and expand HCV care services, in order to improve access in remote and underserved communities through innovative approaches, for example:

- Setting up mobile clinics and telemedicine services to deliver care directly within communities, thereby reducing long and costly journeys.
- Implementing point-of-care RNA testing to eliminate waiting times and missed appointments, or using dried blood spot testing to address sample storage challenges in remote areas.
- Integrate HCV into primary healthcare by simplifying treatment protocols, involving a wide range of healthcare providers and promoting innovative models of task delegation.

**Indigenous –
Action 5.**

Ensure accessible and culturally safe healthcare for urban Indigenous peoples, for example:

- Increasing the involvement of peer health navigators in HCV management.
- Strengthen collaboration with Indigenous-led health and wellbeing initiatives, such as Friendship Centres, which serve as trusted spaces within communities, to integrate HCV-related care services, including those described in Action 4 where relevant.
- Integrate HCV screening and treatment pathways into harm reduction and substance use treatment services.

**Indigenous –
Action 6.**

Facilitate collaboration between healthcare professionals and Indigenous Elders, knowledge keepers and traditional healers to ensure the delivery of person-centred care. It is essential to integrate traditional medicines, practices and perspectives into the HCV care continuum, promoting a holistic approach to health and interventions that take diversity into account.



Specific Interventions

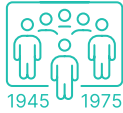
5. Immigrants and Newcomers from Countries with a High Prevalence of HCV

In 2021, 4% of immigrants to Canada from countries where HCV is endemic had previously had HCV, of whom 2.2% had a chronic infection (82). In these countries of origin, HCV transmission is often linked to high-risk medical practices, such as the use of contaminated blood during transfusions, the use of unsterilized equipment, or unsafe injections (96–98). The migration journey itself can also represent a risk factor for exposure to the virus (99).

People with an immigrant background face multiple barriers to accessing care, which often delays HCV diagnosis by around ten years after their arrival in Canada, thereby increasing the risk of complications (100–102). These barriers include limited knowledge of the healthcare system, language and cultural barriers, as well as priority needs such as housing and employment, which take precedence over HCV management (103–106).

Courses of Action

Immigration – Action 1.	Update HCV surveillance data to better understand the impact of new migration flows, paying particular attention to people with a migration background living outside major urban centres such as Montreal and Quebec City.
Immigration – Action 2.	Collaborate with frontline clinics and community organizations providing services to people with a migration background to offer free, systematic and voluntary HCV screening with a view to linking them to care and treatment.
Immigration – Action 3.	Raise awareness among healthcare staff of the specific needs of people with a migration background regarding HCV, in order to promote screening, access to treatment and related resources (language interpretation, food support and other essential services).
Immigration – Action 4.	Provide access to free language interpretation services available at all times, from French into other languages.
Immigration – Action 5.	Systematically offer free HCV screening, and treatment where necessary, to immigrants from countries with high prevalence rates.
Immigration – Action 6.	Fund and collaborate with immigrant communities to adapt existing HCV prevention, screening and treatment programs in a culturally and linguistically appropriate manner across various regions of Quebec.



Specific Interventions

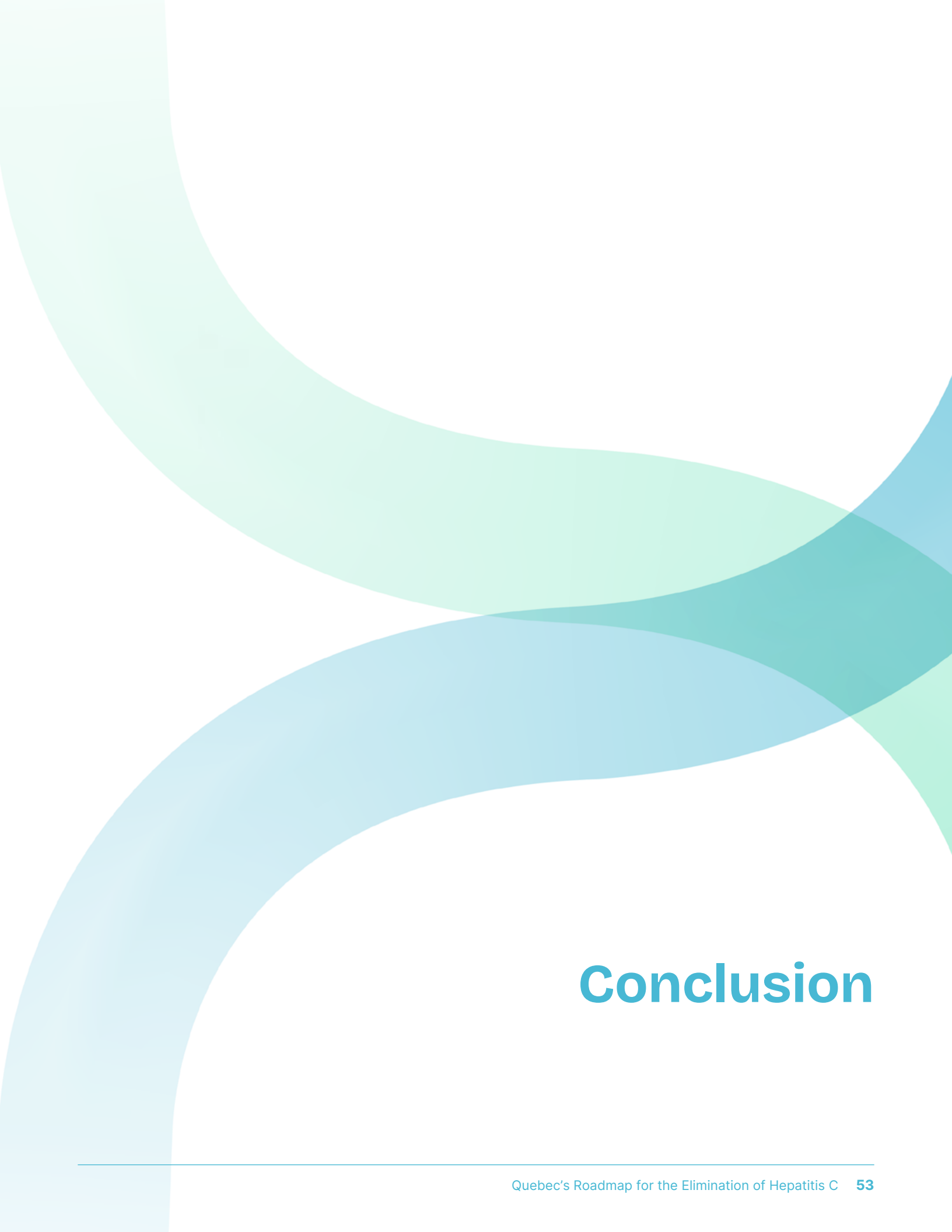
6. The 1945–1975 Birth Cohort

Data from the PHAC estimate that in 2021, 1.9% of adults in the 1945–1975 birth cohort living in Canada had previously contracted HCV, while 1.1% were living with chronic infection. Among the latter, one in three people were unaware that they were infected with HCV (82). Age is not a risk factor in itself. The exposure observed in this group is mainly attributable to events that occurred before HCV was identified in 1989, including unsafe medical practices, shortcomings in infection control, as well as the use of injection drugs or the transfusion of untested blood products (107–109).

Quebec administrative data indicate an increase in the incidence of hepatocellular carcinoma between 2004 and 2006 among people aged 50–59 (110), which may correspond to the onset of the first HCV-related complications in the 1945–1975 birth cohort. Similarly, it is noted that from 2003 to 2012, the majority of liver transplants in people aged 35 to 59 were primarily linked to HCV (111). It is therefore clear that the aging of this birth cohort is placing increased pressure on the healthcare system. The stakeholders consulted therefore recommend raising public awareness, early screening and rapid access to treatment for this cohort in order to prevent serious complications associated with HCV.

Courses of Action

Cohort 45/75 – Action 1.	Establish continuous monitoring of the incidence of HCV-related complications among people in the 1945–1975 birth cohort.
Cohort 45/75 – Action 2.	Screen for HCV at least once in a lifetime among people born between 1945 and 1975.
Cohort 45/75 – Action 3.	Train a large number of healthcare professionals and community workers to facilitate access to screening and other stages of the care cascade.
Cohort 45/75 – Action 4.	Conduct a large-scale awareness campaign on HCV targeting people born between 1945 and 1975, using appropriate media platforms.
Cohort 45/75 – Action 5.	Collaborate with organizations serving members of the birth cohort to integrate HCV prevention, screening and treatment into their services.



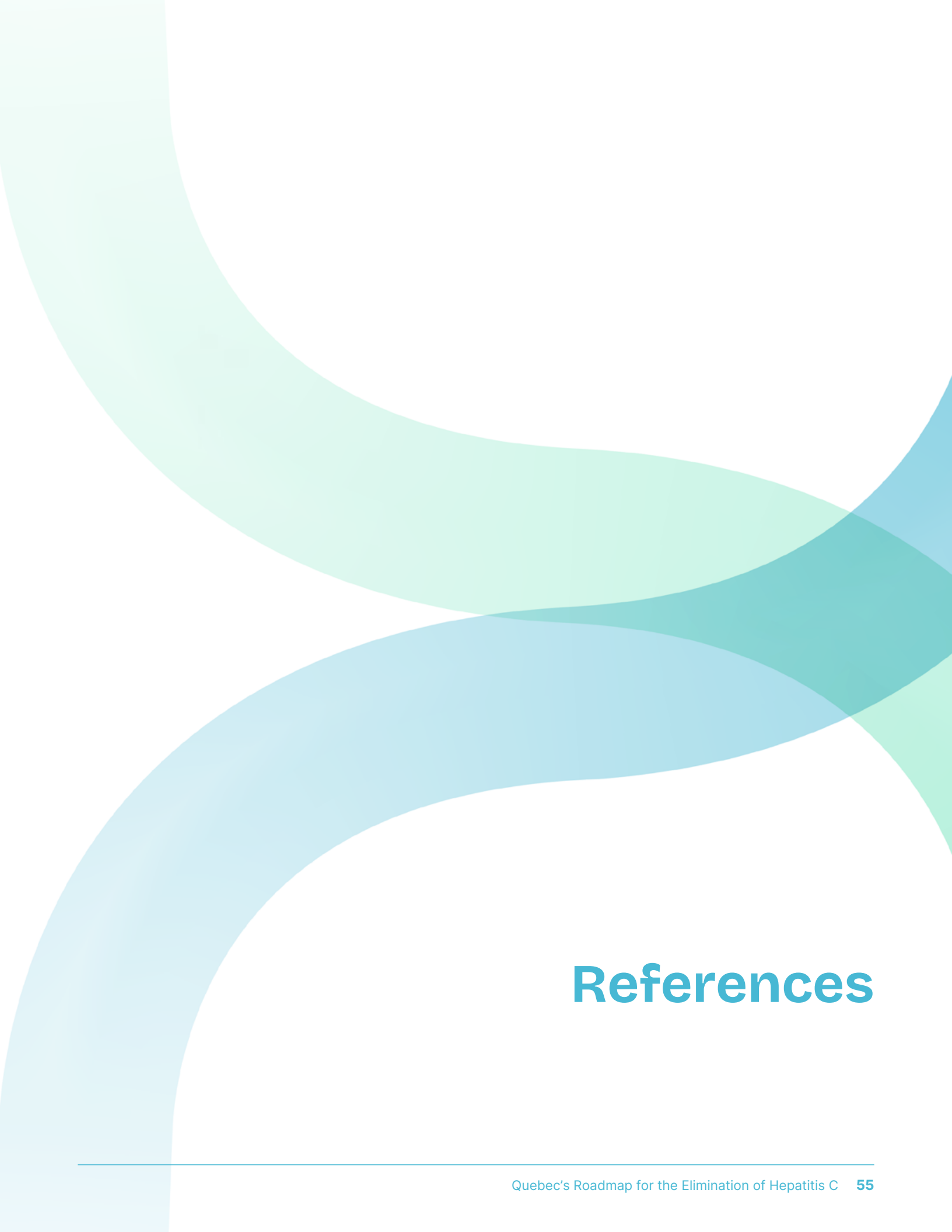
Conclusion

Conclusion

Canada has committed to eliminating HCV by 2030, in line with the WHO strategy. Although significant progress has been made in recent years, the COVID-19 pandemic has led to a notable slowdown in screening, treatment and resource mobilization efforts. Furthermore, the current syndemic – characterized by crises related to opioids, mental health and homelessness – exacerbates social inequalities and increases the vulnerability of many people, while complicating their access to services. In this context, achieving the elimination target by 2030 poses a major challenge, particularly for the most marginalized groups.

The recommendations focus on knowledge dissemination, the harmonization of surveillance data and the mobilization of practices currently in use in Quebec. They emphasize the adaptation of prevention, screening and care measures to the contexts of different communities, notably by expanding the range of healthcare professionals authorized to screen for and treat HCV, as well as the use of appropriate technologies at the point of care. They also call for the integration of HCV care into primary care services, harm reduction programs and substance use treatment initiatives. Finally, they advocate placing those affected at the centre of the approach and treating the elimination of HCV as a strategic priority, supported by adequate funding.

In short, these recommendations constitute a pragmatic and coordinated roadmap for the elimination of HCV. Quebec now has the tools to turn this public health objective into reality. It is at this cost that the elimination of HCV by 2030 can become a lasting collective success.



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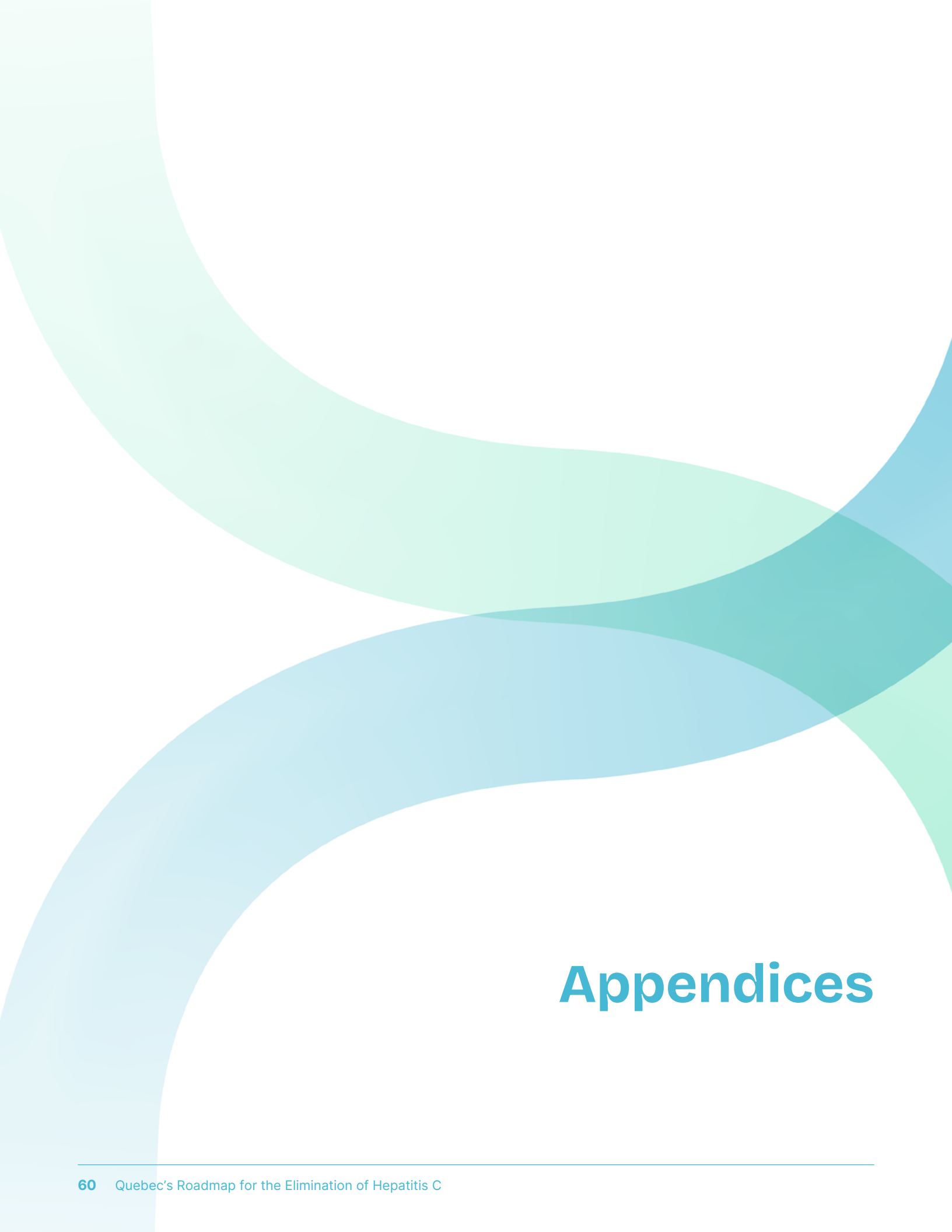
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Appendices

Appendix 1 – Research Questions for the Consultations

People with a History of Incarceration

Issues	Questions
Theme 1: Access to and organisation of care	• What are the most effective strategies for improving access to HCV screening, treatment and follow-up services in prisons? • How has the transfer of healthcare management from the Ministry of Public Security to the MSSS influenced the quality and equity of healthcare services in prisons? • Which models of coordination between prisons, public health services and community organisations promote optimal continuity of care following release? • What is the impact of integrated HCV screening and treatment programmes on prevalence and reinfection rates in prisons?
Theme 2: Human Resources	• What are the enabling factors and barriers to the implementation of best practices, such as universal screening on admission, in correctional facilities?
Theme 3: Equity, Diversity and Inclusion	• How are the specific needs of women, trans people and non-binary people taken into account in prison health programmes?

People Who Use Drugs

Issues	Questions
Theme 1: Geographical inequalities and access to services	• What are the differences in access to testing, treatment and harm reduction services between people who use drugs living in urban, rural, remote or suburban areas in Quebec (or in similar contexts)? • Which interventions have proven effective in improving access to HCV treatment for people who use drugs living in rural or remote areas? • Which service delivery models (e.g. mobile teams, community clinics) help to reduce regional inequalities in access to HCV care?
Theme 2: Knowledge, attitudes and barriers related to treatment	• What are the main misconceptions regarding HCV treatments among people who use drugs, and how do they influence the pursuit of care? • Which educational or communication strategies have been effective in increasing treatment adherence and correcting misconceptions about HCV cure?
Theme 3: Integration of services and models of care	• What are the effects of integrating HCV treatment with harm reduction, substance use treatment or rehabilitation services on rates of access and treatment success? • Which peer-based intervention models (navigation, accompaniment, community support) have proven effective in engaging and retaining people who use drugs (PUDs) with HCV in care?
Theme 4: Stigma, trauma and psychosocial factors	• How do stigma and experiences of trauma influence access, adherence and continuity of care for people who use drugs living with HCV? • Which care approaches that take into account trauma and the reduction of stigma have been effective in the management of HCV among people who use drugs?
Theme 5: Comorbidities and risk behaviours	• What is the role of pain management in continued drug use or HCV reinfection among people who use drugs? • What is the relationship between stimulant use and the risk of HCV transmission or reinfection?

People with a History of Migration

Issues	Questions
Theme 1: Epidemiology and identification	• What is the actual prevalence of HCV among immigrants or refugees from countries with high endemicity living in Quebec (or in comparable settings)? • What factors influence the under-diagnosis of HCV in these populations (e.g. language barriers, stigma, limited access to care, lack of awareness of the risk)? • How do immigration status, length of residence in Canada and country of origin influence the likelihood of HCV screening and treatment?
Theme 2: Access to care	• What are the main barriers and facilitators at each stage of the HCV care pathway (screening, diagnosis, treatment, follow-up) among immigrants? • What intervention strategies have been effective in improving HCV screening, linkage to care and treatment retention in these groups? • How can we reach long-established immigrants who no longer use integration or community services? • How does stigma related to HCV, drug use or immigrant status influence the pursuit of care and disclosure of HIV status?
Theme 3: Culturally appropriate approaches	• Which culturally and linguistically adapted models of care or prevention have proven effective for HCV among immigrant or refugee populations? • What is the role of community and religious leaders and integration organisations in promoting HCV screening and treatment? • What cross-sectoral collaborations (health, integration, French language acquisition, employment) are most effective in reaching people with an immigrant background?

1945–1975 Birth Cohort

Issues	Questions
Theme 1: Prevalence, screening and identification	• What is the current prevalence of HCV among people born between 1945 and 1975 in Quebec (or in comparable contexts)? • What are the most effective screening strategies for identifying infected individuals within this large and heterogeneous age group? • What are the barriers and facilitators to HCV screening by healthcare professionals among people born between 1945 and 1975?
Theme 2: Intervention models	• How can targeted screening strategies be developed that take into account the socio-economic, geographical and behavioural diversity of this group? • Which population-based or opportunistic approaches (e.g. screening during a health check-up, in a pharmacy, or in A&E) have helped to increase screening rates among people in this cohort? • What is the acceptability of universal HCV screening in this population, from the perspective of both patients and clinicians? • Which screening programmes implemented in other jurisdictions (e.g. the United States, the United Kingdom, Australia) could be adapted to the Quebec context?

Issues	Questions
Theme 1: Risk factors and transmission dynamics	• What is the impact of chemsex (drug use in a sexual context) on HCV transmission among gbMSM? • Which types of substances, modes of use (injection, inhalation, shared use) and sexual practices are most strongly associated with HCV risk? • How do sexual and drug-use networks (density, multiple partners, group events) influence the dynamics of HCV transmission?
Theme 2: Co-infection and clinical interactions	• What is the prevalence and incidence of HIV/HCV co-infection among gbMSM, and how does this co-infection influence disease progression and clinical outcomes? • What are the most effective prevention and treatment strategies for reducing HCV transmission among people living with HIV in this population?
Theme 3: Prevention and screening	• Which combined prevention interventions (sexual, biomedical and substance-use-related) have been shown to be effective in preventing HCV among gbMSM? • Which screening models (e.g. regular screening coupled with HIV testing, community-based approaches) are effective in reaching the subgroups most at risk?
Theme 4: Perceptions and Stigma	• How does stigma associated with HCV, HIV and chemsex influence uptake of testing, treatment and combined prevention? • Which communication and intervention approaches have been most effective in promoting gbMSM engagement in HCV prevention and care?

Appendix 2 – Research Questions for Consultations Regarding Indigenous Peoples

Professionals Working with Indigenous People

Issues	Questions
Theme 1: Current situation and challenges in the community	• What is happening in your community regarding HCV and other interrelated factors (access to healthcare and other forms of support, harm reduction)? • What could be done to better meet the needs of people affected by HCV, in your community or in general? • How can we address HCV whilst recognising that people face a range of other health and life issues? • How can people maintain their overall liver health
Theme 2: Policy advocacy, awareness-raising and community mobilisation	• Is the elimination of hepatitis C a valid goal? If so, what should we prioritise at local, regional and provincial levels? What recommendations should be included in the roadmap? • How should information about HCV be communicated? What are the best ways to share this type of information? • What messages should we convey to politicians to improve the response to HCV in Quebec? • What messages should we share within the community to reduce stigma and promote openness regarding HCV? What actions can we take? Who should be involved in these actions (e.g. community leaders, healthcare providers, young people, etc.)?
Theme 3: Cultural issues and care approaches	• How do holistic and culturally safe care approaches influence adherence to HCV treatment? • What role do traditional knowledge and practices play in the healing and support of people living with HCV? • How can trust between Indigenous communities and the healthcare system be strengthened to reduce HCV-related stigma? • What are the effects of training healthcare providers in cultural safety on the quality of care provided to Indigenous people with HCV?

Indigenous Members with Experiential Knowledge

Issues	Questions
Theme 1: Issues related to living environment (urban, rural, northern or on-reserve)	• What do people need when living with HCV? • What are the differences in access to HCV screening, treatment and follow-up between Indigenous people living in urban, rural or on-reserve settings? • How does frequent travel between home communities and urban centres affect continuity of care and retention in treatment programmes?
Theme 2: Issues related to access to care	• What structural and historical barriers (e.g. systemic racism, colonial experiences, mis-trust of institutions) limit access to services for Indigenous people living with HCV? • What community-based strategies promote access to HCV care in remote or northern regions? • What lessons and insights can we draw from Indigenous approaches to wellbeing and health to guide our response to HCV?
Theme 3: Policy advocacy, awareness-raising and community mobilisation	• Is the elimination of hepatitis C a valid goal? If so, what elements should we prioritise at local, regional and provincial levels? What recommendations should be included in the roadmap? • How should information about HCV be communicated? What are the best ways to share this type of information? • What messages should we convey to politicians to improve the response to HCV in Quebec? • What messages should we share within the community to reduce stigma and promote openness regarding HCV? What actions can we take? Who should be involved in these actions (e.g. community leaders, healthcare providers, young people, etc.)?

Appendix 3 – Declaration of Conflicts of Interest

Julie Bruneau reports having received consulting fees as a member of AbbVie's advisory board, as well as fees for a presentation to Gilead Sciences. She has also received research support from Gilead Sciences. Dr. Bruneau's research focuses on HCV infection prevention, related models of care, and access to health services for people who use drugs.

Lorraine Fradette declares having received research grants from AbbVie and Gilead Sciences in connection with the development of this document; these grants were awarded to CanHepC.

Marina Klein states that she has received research support from Gilead Sciences and AbbVie. With more than 20 years of experience in research and clinical practice, she has recognized expertise in access to HCV treatments and their outcomes.

Carrie Martin is a researcher specializing in sexually transmitted and blood-borne infections (STBBI), including HIV and HCV, and receives research grants from CIHR. She also holds a leadership position at the Tiohtià:ke Indigenous Health Centre, where she leads work and research on hepatitis C.

No other conflicts of interest were reported.

