

Eliminating Viral Hepatitis in India: Are We on Track to Achieve the 2030 Targets?

Garima Namdev^{1*}, Monesh Verma²

^{1,2}Department of Community Medicine, Chirayu Medical College and Hospital, Bhopal, Madhya Pradesh, India

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***Corresponding author:** Dr. Garima Namdev (Email: Namdevgarima50@gmail.com)

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INTRODUCTION

In India, Viral hepatitis remains a major public health challenge, accounting for substantial morbidity and mortality. Recognizing the growing burden of viral hepatitis and aligning with the World Health Organization (WHO) Global Health Sector Strategy on Viral Hepatitis (2016-2021), which called for the elimination of viral hepatitis as a public health threat by 2030, Govt. of India launched the National Viral Hepatitis Control Programme (NVHCP) on 28 July 2018, coinciding with World Hepatitis Day.[1]

This programme also contributes directly to the achievement of Sustainable Development Goal (SDG) 3.3, which calls for ending the epidemics of AIDS, tuberculosis, malaria, neglected tropical diseases, and combating viral hepatitis by 2030.[2]

It was introduced as the first comprehensive national programme emphasizing prevention and control, enhancing diagnostic capacity, increasing access to treatment and accelerating surveillance of all types of viral hepatitis. It also addresses inter-sectoral coordination with other national health programmes such as the National AIDS Control Programme (NACP), Universal Immunization Programme (UIP) for hepatitis B vaccination, and National Blood Transfusion Services (NBTS).[3] So, overall, this programme aims to strengthen health sys-

tem capacity and ensure equitable access to quality hepatitis care across the country.

Over the past seven years of inception, all the strategies have been implemented at almost all health care level, but significant gaps remain, especially in screening coverage, case detection and linkage to care, treatment uptake, and long-term follow-up of patients.

And now, with only four years remaining to achieve the 2030 elimination targets, an important question remains: Can we actually achieve this? It seems almost impossible to reach the target as there are various hurdles facing by each level of health care facility that need to be addressed timely and rectify at their respective level. It needs to streamline all the components of this programme with the present health care system.

PROBLEM STATEMENT

According to the WHO's Global Hepatitis Report 2026, the world is currently off track to meet the 2030 elimination targets. Approximately 1.34 million new infections (0.9 million HBV and 0.9 million HCV) and 1.34 million deaths (1.1 million due to HBV and 240,000 due to HCV) occurred globally in 2024.[4] Viral hepatitis was the second leading infectious cause of death globally, alongside tuberculosis, in 2022. Despite advances in diagnosis and treatment, only 13% of people living with chronic hepati-

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tis B virus (HBV) infection had been diagnosed, and approximately 3% had received antiviral therapy by the end of 2022. Among people living with hepatitis C virus (HCV) infection, 36% had been diagnosed between 2015 and 2022, and 20% had received curative treatment.[4]

India has one of the largest burdens of viral hepatitis globally. In 2022, an estimated 29.8 million people were living with hepatitis B virus (HBV) infection and 5.5 million with hepatitis C virus (HCV) infection, giving a combined burden of approximately 35.3 million cases and accounting for 11.6% of the global HBV and HCV burden. India ranked second globally after China in terms of the combined number of HBV and HCV infections.[5]

CONCURRENT CHALLENGES IN INDIA

Several challenges continue to impede India's progress towards achieving the 2030 hepatitis elimination targets. The most common challenge encountered is inability to detect the infection as these remain asymptomatic for many years, representing the submerged part of an iceberg phenomenon.[6]

India has incorporated hepatitis B vaccination into the Universal Immunization Programme (UIP), including a birth dose to be administered as early as possible, preferably within 24 hours of birth. However, coverage of the hepatitis B birth dose remains suboptimal. Healthcare workers are at increased occupational risk of HBV infection because of exposure to blood and contaminated sharps, particularly in the presence of unsafe injection practices and inadequate infection-prevention and control measures.[7]

Vertical transmission is also a significant route of transmitting hepatitis B infection to new born, yet mandatory antenatal screening and immediate post exposure prophylaxis are not in practice across all healthcare settings.[8]

In addition, screening coverage among high-risk groups like intravenous drug abusers, patients undergoing haemodialysis, recipients of multiple blood transfusions, healthcare workers, sex workers and prison inmates remain suboptimal.

The next challenge facing HCV infection that is that a considerable gap persists between initial screening and confirmatory diagnosis to detect this infection, as patients suspected with hepatitis C using rapid antibody tests frequently fail to undergo confirmatory nucleic acid testing. This is mainly due to limited laboratory infrastructure, geographical barriers and treatment delays.

Despite the availability of free antiviral therapy for hepatitis C under the NVHCP[9], many patients could not avail treatment due to lack of proper knowledge. In parallel, some sort of social stigma also exists in certain communities about the chronic infection form. Certain other loopholes found in loss to follow-up and a weak surveillance system further limit this programme's effectiveness. It is also noticed a lack of comprehensive and reli-

able epidemiological data on viral hepatitis in our country due to a weak surveillance and reporting system, which further creates a hurdle to plan interventions accordingly. Routine screening for hepatitis D infection among hepatitis B-positive individuals is not incorporated into this programme.[10]

Similarly, screening and prevention against food-borne hepatitis (Hepatitis A and E), including access to safe drinking water, adequate sanitation, food hygiene, and surveillance of food- and water-borne outbreaks, remain inadequate in many parts of the country particularly in rural, remote and urban slum populations.[11]

FUTURE DIRECTIONS AND RECOMMENDATIONS

Achieving hepatitis elimination by 2030 will require strengthening the NVHCP beyond its current framework and focus on certain aspects.

Inculcating digitalization in surveillance: Priority should be given to establish nationwide hepatitis surveillance by adopting digital technology. A national hepatitis digital registry should be developed under the Ayushman Bharat Digital Mission (ABDM) that would facilitate case notification, treatment monitoring, referral tracking, follow-up reminders, and long-term outcome assessment, similar to the Nikshay portal for tuberculosis.

Emphasis on screening: Active screening should be expanded among high-risk groups such as healthcare workers, pregnant women, prisoners, people who inject drugs, haemodialysis patients, and recipients of multiple blood transfusions. Universal antenatal screening for hepatitis B and hepatitis C should be implemented across both public and private healthcare facilities to reduce vertical transmission. Timely hepatitis B birth-dose vaccination should be ensured in all new-borns, particularly in remote and underserved regions.

Improvement in diagnostic capacity with easy access: Diagnostic and treatment services should be decentralized by establishing district-level hepatitis care centres and integrated "one-stop hepatitis clinics" capable of providing screening, confirmatory diagnosis, counselling, treatment, vaccination, and long-term follow-up under one roof. Telemedicine services should be expanded to improve specialist consultation and treatment access in rural and geographically inaccessible areas.

Applying preventive modality: Emphasis should be placed on preventive hepatology through incorporation into undergraduate and postgraduate medical curricula, continuous professional training, and strengthening infection prevention and control practices. There should be establishment of one-stop hepatitis care centres and preventive hepatology clinics in all district hospitals and medical colleges that would help in improving early diagnosis, comprehensive treatment, and continuity of care. Comprehensive information, education, and communication (IEC) activities, community outreach programmes, and behavioural change communication should be on priority.

Accelerating efforts for Integration with other national health programmes: The programme should strengthen collaboration with other national initiatives, including the National Immunization Programme, National AIDS Control Programme, National Tuberculosis Elimination Programme, National Blood Transfusion Services, Ayushman Bharat, Swachh Bharat Mission, and water, sanitation, and hygiene (WASH) programmes, Jal Jeevan, to address both blood-borne and enterically transmitted hepatitis comprehensively.

Including acute forms of viral hepatitis - Finally, future programme expansion should adopt a broader public health perspective by incorporating hepatitis A, hepatitis D, and hepatitis E into surveillance, outbreak response, and policy planning, thereby ensuring a comprehensive national strategy for viral hepatitis elimination in India.

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