

I declare no competing interests.

- 1 Dan C. Viral hepatitis in the US: what is the problem and why are we losing ground? US Department of Health and Human Services, March 15, 2018. <https://www.hhs.gov/hepatitis/blog/2018/03/15/viral-hepatitis-in-the-us-what-is-the-problem.html> (accessed Oct 26, 2018).
- 2 Cooke G, Andrieux-Meyer I, Applegate T, et al. Accelerating the elimination of viral hepatitis: a *Lancet Gastroenterology & Hepatology* Commission. *Lancet Gastroenterol Hepatol* 2018; **4**: 135–84.
- 3 Arora S, Kalishman S, Thornton K, et al. Expanding access to hepatitis C virus treatment – Extension for Community Healthcare Outcomes (ECHO) project: disruptive innovation in specialty care. *Hepatology* 2010; **52**: 1124–33.
- 4 Arora S, Thornton K, Murata G, et al. Outcomes of treatment for hepatitis C virus infection by primary care providers. *N Engl J Med* 2011; **364**: 2199–207.
- 5 Struminger B, Arora S, Zalud-Cerrato S. Building virtual communities of practice for health. *Lancet* 2017; **390**: 632–34.
- 6 Su G, Glass L, et al. Virtual consultations through the Veterans Administration SCAN-ECHO project improves survival for veterans with liver disease. *Hepatology* 2018; published online May 5. DOI:10.1002/hep.30074.
- 7 Beste L, Glorioso T, et al. Telemedicine specialty support promotes hepatitis C treatment by primary care providers in the Department of Veterans Affairs. *Am J Med* 2017; **130**: 432–438.e3.
- 8 Dhiman RK, Satsangi S, Grover GS, Puri P. Tackling the hepatitis C disease burden in Punjab, India. *J Clin Exp Hepatol* 2016; **6**: 224–32.
- 9 Dhiman R, Grover G, Premkumar M, et al. Decentralized care is effective in the management of patients with hepatitis C in a public health care setting: The Punjab Model. European Association for the Study of the Liver 2018 Congress. *Hepatology* 2018; **68** (suppl 1): S50–64.
- 10 Komaromy M, Duhigg D, Metcalf A, et al. Project ECHO (Extension for Community Healthcare Outcomes): a new model for educating primary care providers about treatment of substance use disorders. *Subst Abuse* 2016; **37**: 20–24.

Accelerating the elimination of viral hepatitis for Indigenous peoples

The *Lancet Gastroenterology & Hepatology* Commission on accelerating the elimination of viral hepatitis¹ lays out the broad challenges for the elimination of viral hepatitis worldwide and suggests a set of strategies and actions to address these challenges. The Commission highlights the need to address the epidemic of viral hepatitis among vulnerable populations—including people who inject drugs, incarcerated individuals, and men who have sex with men—but perhaps lacks sufficient emphasis on Indigenous peoples. Strategies and actions towards the elimination of viral hepatitis must include a specific focus on Indigenous peoples and specific mechanisms to involve Indigenous leadership in policy making, research, and service delivery.

Indigenous peoples should be added as a fourth population of focus because, although indigeneity itself does not explain risk, rates of viral hepatitis are higher in Indigenous peoples than in non-Indigenous populations within countries, and many Indigenous people are unable to equitably access health services and treatments. A recent analysis has shown that rates of hepatitis C virus (HCV) in Indigenous peoples are more than three times higher than those in the referent (non-Indigenous) population in English-speaking countries (Canada, USA, and Australia) and are more than five times higher in Latin American countries. For hepatitis B virus (HBV), the difference is up to ten times in English-speaking countries or states (eg, Alaska, Hawaii, Canada, Australia, and New Zealand).²

In order to make progress we need to understand the populations that comprise Indigenous peoples,

the prevalence of viral hepatitis among these populations, health provider attitudes and practices towards Indigenous populations, and the best mechanisms to effect broad progress in this context. Unless their status is established through legislation or treaty, identifying Indigenous people can be challenging. A common and useful definition identifies Indigenous peoples as those who inhabited lands before the establishment of (modern) nation states.³ The establishment of nation states often involved colonisation, and Indigenous peoples frequently found themselves as minority and vulnerable populations within these states.

Estimates suggest that there are around 370 million Indigenous people across 70 countries worldwide.^{3,4} Across the globe, Indigenous populations do not always have influence within nation states, variable access to health services, and poorer profiles of morbidity, mortality, and life expectancy. Viral hepatitis is an area in which there are clear disparities for Indigenous peoples across the care spectrum: immunisation, screening, surveillance, and treatment all have lower rates of access among Indigenous peoples.⁵ Excellent examples of services that improve access to HCV care—eg, the Deadly Liver Mob programme in Australia—demonstrate the potential to improve access through Indigenous leadership.⁶

Many Indigenous peoples have not benefited from the significant advances that have been made in screening, surveillance, and treatment of viral hepatitis, and although the priorities suggested in the Commission are relevant to Indigenous peoples, their relative priority will

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be different in different jurisdictions. In more developed countries in which policies mandate the participation of Indigenous peoples in decisions and service delivery, tailoring these services to the unique needs and cultural preferences of Indigenous populations will be important to ensure equitable coverage in screening, vaccination, surveillance, and treatment programmes. In less developed countries, the rights of Indigenous peoples are often less well established, and these populations have not been explicitly included in discussions, plans, or service delivery. There is much to be done.

In 2014 and 2017, Indigenous people and other hepatitis experts gathered at the World Indigenous Peoples' Conference on Viral Hepatitis to discuss viral hepatitis in Indigenous peoples and to bring forward the voices of Indigenous communities that are addressing viral hepatitis and Indigenous people living with these diseases. These meetings illustrated the strong interest of Indigenous peoples in addressing viral hepatitis in their communities, the strong support of non-Indigenous clinicians, researchers, and policy makers, and the effectiveness of assembling diverse groups united by the common purpose of improving Indigenous health and wellbeing. The 2017 World Indigenous Peoples' Conference on Viral Hepatitis, hosted by the Alaska Native Tribal Health Consortium, produced a consensus statement⁷ that included a call for formation of a working group led by Indigenous people to promote international action on elimination of viral hepatitis among Indigenous populations, with a broader goal of achieving elimination by 2030.

The aims outlined by the consensus statement are ambitious, but many of them would be achieved if Indigenous people enjoyed the same level of access as non-Indigenous people to services and treatments across the world. Although the priority remains the Asia-Pacific region, Indigenous peoples should also be prioritised in countries with lower prevalences of viral hepatitis. There are many effective models for policy making, service delivery, and research for and by Indigenous people across the world. These models can be useful in demonstrating progress, but the quality (or even existence) of effective relationships between Indigenous peoples and nation states is the key factor that determines their success.

Countries like New Zealand, Australia, Canada, and the USA have made good progress in addressing

the needs and expectations of Indigenous people. Although New Zealand and Australia have relatively straightforward relationships with their Indigenous peoples, Canada has more complicated arrangements involving treaties, legislation, and other agreements. The USA has three different groups of Indigenous people (Native Americans, Native Alaskans, and Native Hawaiians) and is making solid progress in each population using different mechanisms.

Engagement is key. Shared decision making is more effective than purely consultative mechanisms. Reducing financial barriers to accessing treatment and care is frequently necessary, since many Indigenous people have cumulative intergenerational risks of low socioeconomic and educational status. Additionally, it is not just an issue of rural outreach—large populations of Indigenous people live in urban settings in Australia, Canada, and the USA (eg, >200 000 Native Americans reside in urban Los Angeles). Indigenous peoples deserve to be a focus of efforts towards the elimination of viral hepatitis. Indigenous people are showing leadership, and partnership in decision making will see further gains as we jointly address these ambitious goals.

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- 1 Cooke G, Andrieux-Meyer I, Applegate T, et al. Accelerating the elimination of viral hepatitis: a *Lancet Gastroenterology & Hepatology* Commission. *Lancet Gastroenterol Hepatol* 2018; **4**: 135–84.
- 2 Razavi-Shearer D. Estimating the HBV and HCV burden of disease for Indigenous peoples and Nations. 2017 World Indigenous Peoples' Conference on Viral Hepatitis; Anchorage, Alaska; Aug 8–9, 2017. <https://www.wipcvh2017.org/wp-content/uploads/2017/02/Plenary-Tues-AM-Burden-of-Disease-for-Indigenous-Peoples-Globally-Devin-Razavi-Shearer.pdf> (accessed Dec 4, 2018).
- 3 Sanders DE. Indigenous peoples: issues of definition. *Int J Cult Property* 1999; **8**: 4–13.
- 4 United Nations Permanent Forum on Indigenous Issues. Fact sheet 1: Indigenous peoples and identity. United Nations Permanent Forum on Indigenous Issues. https://www.un.org/esa/socdev/unpfii/documents/5session_factsheet1.pdf (accessed Dec 4, 2018).
- 5 Graham S, Guy RJ, Cowie B, et al. Chronic hepatitis B prevalence among Aboriginal and Torres Strait Islander Australians since universal vaccination: a systematic review and meta-analysis. *BMC Infect Dis* 2013; **13**: 403.
- 6 Treloar C, Hopwood M, Cama E, et al. Evaluation of the Deadly Liver Mob program: insights for roll-out and scale-up of a pilot program to engage Aboriginal Australians in hepatitis C and sexual health education, screening, and care. *Harm Reduct J* 2018; **15**: 5.
- 7 World Indigenous Peoples' Conference on Viral Hepatitis. Anchorage Consensus Statement. 2017 World Indigenous Peoples' Conference on Viral Hepatitis; Anchorage, Alaska; Aug 8–9, 2017. <https://www.wipcvh2017.org/wp-content/uploads/2017/02/Anchorage-Consensus-with-Photo-FINAL.pdf> (accessed Dec 4, 2018).