



INTERNATIONAL HARM REDUCTION ASSOCIATION



EURASIAN HARM REDUCTION NETWORK

EHRN

Poor access to HCV treatment is undermining Universal Access A briefing note to the UNITAID Board

The growing crisis of HIV/HCV coinfection

It is estimated that 4-5 million people living with HIV (PLHIV) are coinfecting with the hepatitis C virus (HCV) around the world.¹ Although data are scarce, research shows that many Asian and Eastern European countries have extremely high HCV prevalence rates among PLHIV (see tables 1 and 2). In parts of China, Thailand and Vietnam for example, where injecting drug use is a key driver of HIV epidemics, the prevalence of HIV/HCV coinfection among PLHIV reaches over 95%.² Similarly, in Russia and the Ukraine, 70-95% of people living with HIV are coinfecting with HCV.³ In countries where HIV is predominantly sexually transmitted, HIV/HCV co-infection prevalence may be low among PLHIV in general, but remains much higher among PLHIV that inject drugs (for example, in Manipur, India).⁴ In fact, the vast majority of people living with HIV/HCV coinfection have acquired these viruses through the sharing of equipment when injecting drugs.

HCV is the most common infectious disease among people who inject drugs. It is more infectious than HIV and can be transmitted both through the sharing of needles and syringes, and also of other injecting-related equipment.⁵ A recent review of HCV prevalence among people who inject drugs worldwide found reports of prevalence rates of over 50% in forty-nine countries or territories.⁶ In numerous countries - including Indonesia, Thailand, Pakistan, Mauritius, Estonia, Lithuania, Russia, Ukraine, Luxembourg and Switzerland - almost everyone who injects drugs is living with hepatitis C.⁷

Liver disease associated with HCV is now a leading cause of morbidity and mortality among PLHIV, particularly in Asia and Eastern Europe. As is the case

¹ UNAIDS/WHO/UNICEF (2008) Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector. 2008 Progress Report.

² Walsh, N., Higgs, P. & Crofts, N. (2007). Recognition of hepatitis C virus coinfection in HIV-positive injecting drug users in Asia. *J Acquir Immune Defic Syndr*, 45, 363-5.

³ Aceijas, C. and Rhodes, T. (2007) Global Estimates of Prevalence of HCV Infection among Injecting Drug Users. *International Journal of Drug Policy* 18: 352-358.

⁴ Alter, M.J. (2006). Epidemiology of viral hepatitis and HIV co-infection. *J Hepatol*, 44, S6-9.

⁵ Eurasian Harm Reduction Network (2007) Hepatitis C among Injecting Drug Users in the New EU Member States and Neighbouring Countries. Situation, Guidelines and Recommendations. Vilnius: EHRN.

⁶ Aceijas, C. and Rhodes, T. (2007) Global Estimates of Prevalence of HCV Infection among Injecting Drug Users. *International Journal of Drug Policy* 18: 352-358.

⁷ Cook, C & Kanaef, N (2008) The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics. International Harm Reduction Association.

with HIV, the lack of symptoms of HCV can leave people unaware that they have the virus, and therefore less likely to seek treatment. In the absence of HIV, untreated HCV leads to chronic infection in about 80% of cases. Of these, liver cirrhosis and liver cancer will develop in between 1% and 20% of people.⁸ However, there are additional health implications for people living with both HIV and HCV. Those who have both viruses are much more likely to develop chronic HCV than people with negative HIV serostatus. HIV/HCV co-infection accelerates the progression of HCV and also complicates the treatment of HIV.⁹ End-stage liver disease caused by HIV/HCV co-infection has become one of the leading causes of death among people living with HIV around the world.¹⁰

Global access to hepatitis C treatment

Hepatitis C can be effectively treated with pegylated interferon and ribavirin combination therapy. For people living with HIV, the recommended treatment lasts 48 weeks. The current cost of pegylated interferon is so high that the treatment is not available for most people who need it in low and middle income countries. In 2009, research by the Open Society Institute found that a course of treatment could cost more than US \$20,000 in Eastern Europe.¹¹ Pharmaceutical companies hold patents on the drugs¹² and there are currently no generic versions available. The WHO, UNAIDS and UNODC target setting guidelines for countries now include treatment for Hepatitis B and C as part of the comprehensive package of services for drug users,¹³ but countries cannot make this treatment available while it is so expensive.

It is across Asia and Eastern Europe – where the highest prevalence rates of HIV/HCV coinfection are found – that increased access to HCV treatment is most urgent. Low threshold HCV diagnosis is largely unavailable. Cost and exclusion criteria for drug users in practice prohibit the majority of people that require HCV treatment from accessing it. In several countries, national treatment guidelines explicitly exclude people that inject drugs from HCV treatment, despite this being contrary to treatment protocols of the WHO.¹⁴ In some, a period of abstinence is required before treatment can be initiated. In others, it is left to the discretion of the doctor.

Where treatment is not provided free at the point of access, cost remains a substantial barrier for most people. In most low and middle income countries, information on the availability of HCV treatment is very limited. Many countries are just beginning to develop their response to HCV and this area has received

⁸ World Health Organization, Hepatitis C Factsheet. <http://www.who.int/mediacentre/factsheets/fs164/en/> (date of last access 10 April 2008).

⁹ Eurasian Harm Reduction Network (2007) Hepatitis C among Injecting Drug Users in the New EU Member States and Neighbouring Countries. Situation, Guidelines and Recommendations. Vilnius: EHRN.

¹⁰ UNAIDS/WHO/UNICEF. *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector*. 2008 Progress Report.

¹¹ Open Society Institute (2009) Unpublished data.

¹² Schering Plough's patent on pegylated interferon a2b expires in 2015, while Roche's patent on pegylated interferon a2a expires in 2017.

¹³ WHO, UNODC, UNAIDS (2009) Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.

¹⁴ See www.who.int for guidelines.

very little attention from NGOs and governments alike in comparison to the HIV response.¹⁵

In some countries, small numbers are able to access treatment through programmes funded by international agencies, for example through the GFATM in Belarus and the World Bank in Ukraine.¹⁶ In Iran, where harm reduction services have been dramatically scaled up in recent years, HCV testing and treatment is becoming available to some. Similarly in South Africa these services are available but the degree to which PLHIV have access to them is unknown. In Brazil, HCV treatment is accessed by people that inject drugs but elsewhere in Latin America and the Caribbean these services appear limited.¹⁷

Elevated prevalence of injecting drug use, HIV and HCV is often found among prison populations, but access to HCV diagnosis and treatment is generally poorer in prisons than outside.¹⁸

The prohibitive cost of HCV treatment is undermining progress towards universal access to HIV prevention, treatment and care. Reducing the cost of pegylated interferon could enable low and middle income countries to integrate HCV diagnosis and treatment within existing HIV services. This action will protect millions of people living with HIV from fatal liver disease.

¹⁵ Cook, C & Kanaef, N (2008) The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics. International Harm Reduction Association.

¹⁶ Eurasian Harm Reduction Network (2007) Hepatitis C among Injecting Drug Users in the New EU Member States and Neighbouring Countries. Situation, Guidelines and Recommendations. Vilnius: EHRN

¹⁷ Cook, C & Kanaef, N (2008) The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics. International Harm Reduction Association.

¹⁸ Ibid.

Table 1: HIV/HCV coinfection prevalence rates in selected countries¹⁹

Country or area	Adult HIV/HCV prevalence rates
Togliatti, Russia	93% among PLHIV
Bialystok, Poland	90% among PLHIV
Ukraine	80% of PLHIV seeking treatment
Estonia	80% of PLHIV seeking treatment
Latvia	61% of PLHIV seeking treatment
Czech Republic	One-third of IDUs living with HIV
China	0-99.3% among PLHIV
Thailand	4.8-98.8% among PLHIV
Vietnam	98.5% among PLHIV
Indonesia	10-40% among PLHIV
Manipur, India	79.1% among PLHIV
Spain	95% of IDU living with HIV
Switzerland	91% of people who inject drugs
Puerto Rico	95.2% of IDU living with HIV
Buenos Aires, Argentina	84.8% of IDU living with HIV
U.S.	50-90% of PLHIV who inject drugs
Zanzibar	40% of people who use drugs (both injecting and non-injecting)

Table 2: HCV prevalence among people who inject drugs and prison populations in selected countries²⁰

Country or territory	Adult HCV prevalence among people who inject drugs	HCV prevalence among prisoners
Bahrain	81%	nk
Brazil	39.5–69.6%	nk
Czech Republic	21–59%	18–78%
Estonia	90%	82–97.4%
Germany	75%	80% (prisoners with a history of injecting, Berlin)
India	92%	nk
Indonesia	60–98%	nk
Iran	35%	18.7%
Japan	55.1–60%	nk
Kazakhstan	65.7%	nk
Mauritius	95%	nk
New Zealand	70%	80% (prisoners with a history of injecting)

¹⁹ Original sources for this data are available in Cook, C. & Kanaef, N. (2008) Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics. International Harm Reduction Association.

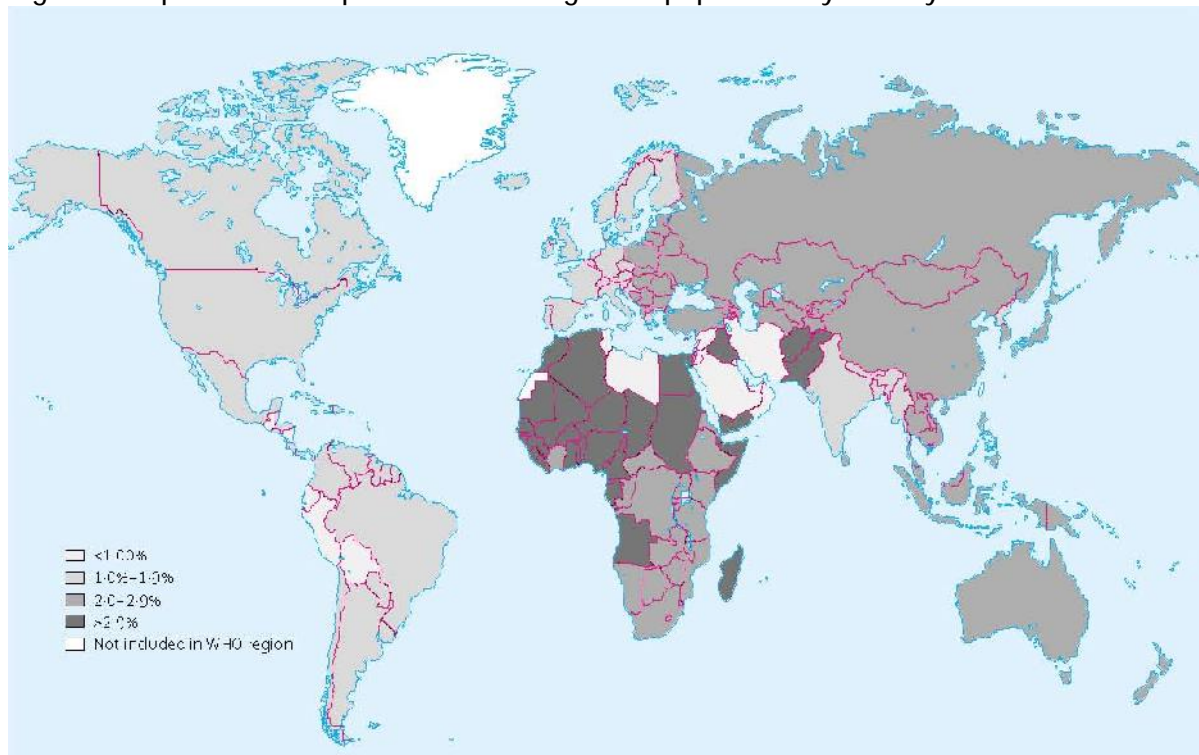
²⁰ Original sources for this data are available in Cook, C. & Kanaef, N. (2008) Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics. International Harm Reduction Association.

Pakistan	89%	nk
Saudi Arabia	69%	nk
Sweden	83.8%	nk
Thailand	90%	nk
Ukraine	70–90%	nk
United Kingdom	41%	30–44% (prisoners with a history of injecting)
United States	50–80%	30–40%

nk = not known

It is estimated that up to 180 million people are living with the hepatitis C virus globally, the majority of whom are in low and middle income countries.²¹ Common transition routes include unsterile medical injections, blood transfusions, blood exchange during cultural practices and injecting drug use. Approximately 90% of *new* HCV infections are transmitted through injecting drugs.²² Figure 1 below shows the global situation in terms of HCV prevalence among the general population.

Figure 1: Hepatitis C virus prevalence in the general population by country²³



²¹ World Health Organization. Hepatitis C.

http://www.who.int/vaccine_research/diseases/viral_cancers/en/index2.html (accessed 10.12.09)

²² Hellard M., Sacks-Davis R., Gold J., (2009) Hepatitis C treatment for injection drug users: a review of the available evidence. *Clin Infect Dis*. 2009 Aug 15;49(4):561-73

²³ Shepard, C. W., Finelli, L. & Alter, M. J. (2005) Global epidemiology of hepatitis C virus infection. *Lancet Infect Dis*, 5, 558-67.