

1.3 HEPATITIS C



1.3 Hepatitis C

PEOPLE WHO INJECT DRUGS



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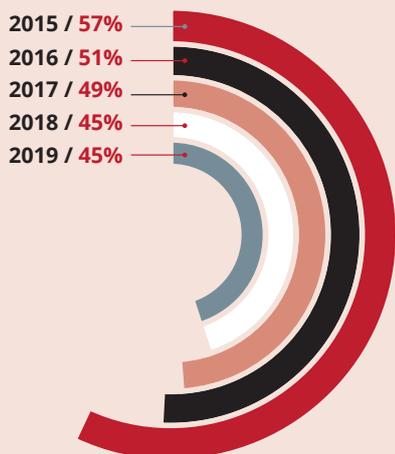
MORE THAN HALF OF ALL PEOPLE WHO INJECT DRUGS ARE ESTIMATED TO **CARRY HEPATITIS C ANTIBODIES**, MEANING THAT THEY HAVE BEEN INFECTED WITH THE HEPATITIS C VIRUS AT SOME POINT IN THEIR LIFETIMES.



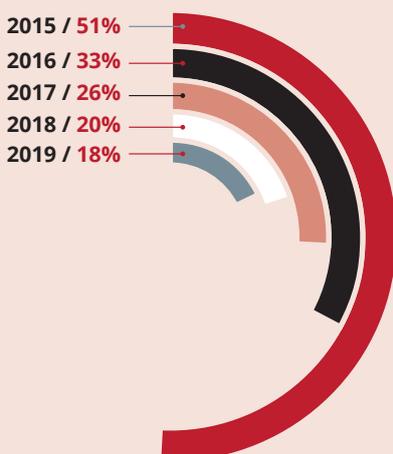
People who use drugs are explicitly excluded from treatment despite unequivocal evidence that treatment is equally effective for people actively using drugs.



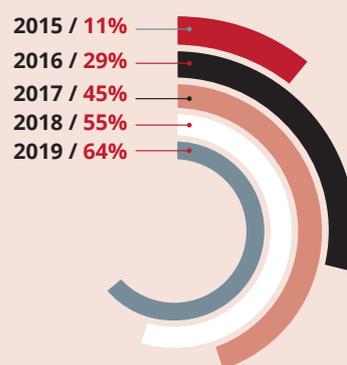
HEPATITIS C-RELATED TRENDS AMONG AUSTRALIAN NSP SURVEY RESPONDENTS 2015-2019^[80]



HEPATITIS C PREVALENCE³



ACTIVE HEPATITIS C INFECTION⁴



LIFETIME HEPATITIS C TREATMENT⁵

³ Hepatitis C antibody prevalence, for further details see p. 37 Table 1.3.1 in Heard, S; Iversen J; Geddes L & Maher, L. (2020). Australian NSP survey: Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees, 25-year National Data Report 1995-2019. Sydney: The Kirby Institute, UNSW Sydney.

⁴ Hepatitis C RNA prevalence, for further details see *ibid.*, p. 40 Table 1.4.1

⁵ Among people who tested HCV antibody positive and did not report spontaneous clearance, for further details see *ibid.*, p. 32 Table 1.1.7

1. Overview

Globally, more than half of all people who inject drugs are estimated to carry hepatitis C antibodies, meaning that they have been infected with the hepatitis C virus at some point in their lifetimes.^[1] People who use drugs but do not inject drugs, such as those who smoke opioids or stimulants, are also at greater risk than the general population.^[2,3] For example, sharing pipes and engaging in higher-risk sexual practices among people who use stimulants are both associated with hepatitis C infection.^[4-6] In the global effort to eliminate hepatitis B and C by 2030,^[7] it is essential that people who use drugs are deemed a priority population for prevention, testing and treatment.

Harm reduction interventions are crucial to the prevention of hepatitis C among people who use drugs. Needle and syringe programmes (NSPs) and the distribution of safer smoking equipment are both means of reducing the sharing of equipment which can lead to viral hepatitis transmission.^[8,9] Opioid agonist therapy (OAT) and drug consumption rooms (DCRs) reduce higher risk injection practices associated with viral hepatitis.^[8,10] These harm reduction interventions also have a crucial role in linkage to care for people who use drugs, and can be a key means of engaging people in hepatitis C testing and treatment.^[8,10]

The World Health Organization (WHO) recommends hepatitis C testing and treatment for all people who inject drugs.^[11,12] Direct-acting antiviral treatments for hepatitis C are capable of achieving either sustained virological response or cure in more than 95% of cases, without the negative side effects associated with previous interferon-based treatments.^[13] The advent of these treatments since 2011 has made the elimination of hepatitis C an achievable goal. However, for this to be achieved, it is essential that treatments are available and accessible to all those who need them, including people who use drugs. Currently, the cost of treatment in many contexts is prohibitively high for most clients and, in some cases, people who use drugs are explicitly excluded from treatment despite unequivocal evidence that treatment is equally effective for people actively using drugs.^[14] Widespread treatment must also be accompanied by testing programmes to identify cases for treatment.

This section provides a regional overview of the hepatitis C situation and response as it relates to people who use drugs. National data on hepatitis B and C prevalence among people who inject drugs is available in each regional chapter.

ASIA

There are 1.8 million people with recent injecting drug use living with hepatitis C antibodies in Asia. This accounts for 30% of the global prevalence.^[15] Barriers to care which have contributed to the high number of viral hepatitis cases and deaths among people who inject drugs include over-criminalisation and a lack of testing and harm reduction services,^[16] while regulatory approval is the main barrier to treatment with direct-acting antivirals.^[17,18] Even in high-income countries, costs are prohibitive. In Japan, for instance, a full treatment costs around USD 18,000.^[19] Despite the historic lack of attention to viral hepatitis in the region, particularly in relation to injecting drug use, significant progress has been made in the past few years, with an increasing number of countries sustaining, initiating, or committing to initiate hepatitis programmes. In Japan, the government has continued to subsidise treatment costs on top of free testing for all citizens between 40 and 70 years of age.^[19] In Mongolia, 6,500 people had been treated within 20 months of the public-private Arkhangai project initiated in 2016,^[20] and a 2019 report stated that officials hope to expand it to other sites in the country.^[21] Similar treatment initiatives have been reported in China and Pakistan,^[20] as well as in Bangladesh, where a study found that hepatitis C treatment can be feasibly provided within existing harm reduction services.^[22]

In 2019, India announced a national action plan on viral hepatitis that recognises people who inject drugs as a key population.^[23] Similarly, Malaysia - where direct-acting antivirals have been available since 2017 - included steps related to people who inject drugs in its 'National Strategic Plan for Hepatitis B and C'. This includes the goal of scaling up harm reduction services and "differentiated service delivery for people who inject drugs through engagement with non-governmental organisations."^[24] Taiwan included similar provisions for people who inject drugs in its plan to eliminate hepatitis C by 2025.^[25]

Civil society groups and communities of people who use drugs have also mobilised to enable access to hepatitis C treatment. One notable example is the 'Pengobatan Hepatitis C' in Indonesia, a 'buyer's club' that has been facilitating access to affordable direct-acting antivirals since 2015.^[26]

EURASIA

The prevalence of hepatitis C among people using drugs is very high in Eurasia, varying between 15% and 94%. Hepatitis C prevalence among people who inject drugs is above 50% in 18 countries in Eurasia, up from 16 in 2018 (see regional table, p.82). Russia is one of the four main contributors to the hepatitis C burden among people who use drugs in the world.^[27] The main barriers in the region to reaching the goal of eliminating hepatitis C by 2030^[28] are poor coverage of harm reduction services, restrictive drug policies, criminalisation of drug use, poor access to cost-efficient harm reduction services, low hepatitis C testing, poor linkage to care and treatment, restrictions for accessing direct-acting antiviral therapy and the lack of national strategies and government investment to support elimination goals.^[27, 29]

Over the past few years Armenia, Belarus, Georgia, Kazakhstan, Moldova and Ukraine have adopted national programmes to treat hepatitis C. Kazakhstan has become a notable example of cooperation between civil society and the Ministry of Health, having developed a national roadmap and a national hepatitis C treatment programme which are now among the most progressive in the post-Soviet region.

While the available data shows that the burden of hepatitis C among people who inject drugs is high, there are still significant gaps in data in many countries. For example, there is currently no systematic collection of data on the hepatitis C cascade of care (the transitions between testing, treatment and cure). National treatment guidelines require abstinence from drug use for between six months and a year in order to enrol into treatment in Bulgaria, Croatia, Hungary and Slovakia. In Romania, a negative drug test is required before starting treatment for hepatitis C patients co-infected with HIV. In Poland, people who are actively 'dependent' on drugs are excluded from treatment.^[30] Slovenia has an integrated national network approach to treatment of hepatitis C among people who use drugs which is implemented with strong coordination between the five clinical centres for viral hepatitis treatment and the 18 drug treatment centres in the country.^[30]

Funding for testing and treatment of hepatitis in most cases comes from national budgets. Consequently, availability of testing and treatment depends on whether it is prioritised by the state (as was done in Belarus, Kazakhstan, Moldova, Slovenia and Ukraine) or not (as in Azerbaijan, Kyrgyzstan

and Uzbekistan). There are no global international donors that support hepatitis C treatment although, after extensive advocacy efforts, the Global Fund to Fight AIDS, Tuberculosis and Malaria started to allow for the inclusion of viral hepatitis within HIV response grants (for example in Ukraine). In Georgia, the launch of the programme in 2015 was sponsored by Gilead and the government contributed to its infrastructure.

LATIN AMERICA AND THE CARIBBEAN

In line with WHO recommendations, the integration of viral hepatitis services with HIV services is common in Latin America.^[52-56] However, their integration with harm reduction services is sporadic. Such integration is only present in northern Mexican cities and those cities in Colombia where injecting drug use is more prevalent.^[57,58] Some harm reduction services in Brazil for people who use crack cocaine also integrate those services.^[58,59] E de Lei in Brazil provides hepatitis C, hepatitis B and HIV prevention in its harm reduction services.^[53] In Buenos Aires, Argentina, the Casa Masantonio project continues integrating hepatitis C treatment into harm reduction services for people who use cocaine paste.^[60]

Even though there are national responses implemented in the region to control viral hepatitis outbreaks, the coverage is insufficient because of lack of funding, the cost of rapid tests and the prevalence of late diagnosis.^[54] For people who use drugs, stigma and discrimination are another barrier to accessing diagnosis and treatment.^[57,59,61,62]

In March 2020, hepatitis C treatment with direct-acting antivirals was added to the Puerto Rico Medicaid programme, meaning it is now available for free. Treatment is not conditional on abstinence from illegal drug or alcohol use nor on the extent of liver damage. However, clients are asked to disclose previous drug use and can be directed to drug treatment on entry to hepatitis C treatment.^[63] As a result, stigma and discrimination still act as a barrier to accessing treatment.^[61] A further barrier is that prescription of hepatitis C treatment is restricted to certain liver and infectious disease specialists.^[64]

MIDDLE EAST AND NORTH AFRICA

The WHO Eastern Mediterranean region has one of the highest rates of hepatitis C infection at 62.5 per 100,000 population compared to the global rate of 23.7 per 100,000, with injecting drug use and unsafe health care procedures being the leading modes of transmission.^[55] In the Middle East and North Africa, the mean prevalence of hepatitis C in people who inject drugs is estimated at 49.3% ranging from 21.7% in Tunisia to 94.2% in Libya.^[88] In a recent study, estimates about prevalence of chronically infected people who inject drugs were made and recommendations highlighted the need to expand harm reduction services and adopt innovative strategies to ensure accessibility and availability of hepatitis C testing and treatment.^[88]

The majority of countries in the region have national viral hepatitis programmes or policies. In Morocco, a national strategy was prepared in 2016, however the government is yet to implement it. Currently, civil society organisations organise national campaigns for hepatitis C testing as part of their advocacy plans.^[89] In Tunisia, national campaigns for community testing for HIV are organised by civil society organisations using a multiplex diagnostic platform for HIV and hepatitis B and C.^[90] Although national policies and strategies exist in some countries, the coverage and availability of screening and treatment remains insufficient. Bahrain, Iran, Jordan, Lebanon, Qatar, Syria, and Tunisia do have dedicated units in their ministries of public health working on hepatitis C. However, the ministries do not always fund testing and treatment, and availability of services is limited to nationals and not foreign nationals.^[90-97]

Tailored approaches for people who inject drugs or integrated services with infectious diseases or OAT are not always available. Tunisia reported integrated HIV and hepatitis C services for people who use drugs, however people need to pay for their initial laboratory tests (viral loads and others) which poses a huge barrier to access.^[90] Stigma and discrimination are among the main barriers to testing. People who inject drugs report avoiding visiting centres for testing, recounting many instances of mistreatment. Another barrier to accessing treatment was the cost of additional tests required prior to the initiation of treatment.^[90] The lack of availability of local and regional data and the lack of awareness and advocacy among local communities and people who inject drugs remain a challenge to political commitment and domestic funding of hepatitis C programmes.

NORTH AMERICA

In both Canada and the United States, hepatitis C causes more years of life lost than any other infectious disease, due in large part to its contribution to liver cancer.^[14,65] Liver cancer is the only cancer with increasing mortality in Canada, and is the fastest growing cancer by number of cases in the United States.^[14,65]

From 2009 to 2018, the number of acute hepatitis C cases in the United States population quadrupled, from 0.3 to 1.2 cases per 100,000 people.^[66] Of the people living with hepatitis C in the country, 61% knew they had the infection.^[67] Among people who inject drugs, a national study found that 44.1% had ever been diagnosed with hepatitis C, and that more than 20% had never been tested.^[67] Millennials (those born between 1980 and 1995) account for more than half of people living with chronic hepatitis C in the United States.^[68]

In Canada, 85% of new hepatitis C infections are among people who inject drugs and 40% of people living with hepatitis C have not been diagnosed.^[65] Nationwide, hepatitis C incidence has increased in recent years, including from 30.5 to 31.7 cases per 100,000 people from 2015 to 2017.^[69] Notably, hepatitis C incidence is five times higher among Indigenous people,^[65] in part due to their overrepresentation in vulnerable populations such as people who inject drugs, people in detention and those with unstable housing.^[70] As in the United States, hepatitis C infections in Canada increased among young people over recent years.^[65]

In Canada, provincial and territorial governments fund viral hepatitis treatment.^[71,72] However, stigma and discrimination towards people who use drugs, as well as unstable housing, poverty, criminalisation and incarceration, all act as barriers to people accessing viral hepatitis testing and treatment.^[65,71,72] Hepatitis C services in Canada are often integrated into harm reduction services to increase accessibility for people who use drugs. However, this is not consistently implemented.^[71] Examples of positive developments since 2018 include the scaling-up of Ontario's Hepatitis C Team Network, which conducts outreach for screening, treatment and prevention for people who inject drugs and people with unstable housing.^[65]

There is no national policy in the United States defining access to hepatitis C treatment under Medicaid, the federal medical assistance programme.^[73] As of 2020, three states

(Arkansas, South Dakota and Texas) continue to limit access to treatment under Medicaid to people with advanced (stage F3 or higher) liver damage (down from 12 in 2017).^[64,74] A period of abstinence from illegal drugs and alcohol before treatment is still required by 16 states (down from 27 in 2017).^[64,74,75] Only eight states now require patients to be abstinent from drugs and alcohol for six months or more.^[74,75]

While this progress is positive, no state should impose these restrictions on access to potentially life-saving treatment. In fact, such limitations on access to treatment violate federal guidance that obliges states to only impose medically necessary restrictions.^[14,76]

OCEANIA

Australia is among the few countries on track to reach the hepatitis C elimination goal by 2030.^[31] Targets included in Australia's National Hepatitis C Strategy 2018–2022 are in line with the global elimination targets set by the WHO.^[77,78] Since 2016, there has been universal access to hepatitis C direct-acting antiviral therapies, including for repeated direct-acting antiviral treatment due to reinfection.^[79,80] According to the Australian NSP data collection, there have been significant improvements since these commitments were made. The prevalence of hepatitis C among people who inject drugs attending Australian NSPs has decreased significantly over the past few years, from 57% in 2015 to 45% in 2019, and lifetime hepatitis C treatment increased substantially from 11% in 2015 to 64% in 2019.^[80] The proportion with active infection³ also declined during this period, from 51% in 2015 to 18% in 2019. According to the most recent data available, illegal drug use was responsible for 75% of the acute hepatitis C burden in the country in 2015.^[81]

Despite the considerable progress in Australia's hepatitis C situation, barriers still exist in access to hepatitis C treatment. Stigma and discrimination experienced by people who use drugs and people living with hepatitis C is the main issue,^[78,79,82] as people who use drugs can be reluctant to engage with the healthcare system because of past bad experiences.^[79] A study among people living with hepatitis C who inject drugs concluded that expanding the models of care on offer beyond hospital settings (outreach clinics, community-based programmes and peer-driven and

other social support throughout the treatment journey) is necessary to ensure that people who inject drugs will come forward for hepatitis C treatment in sufficient numbers to drive elimination.^[83] A study in an urban Aboriginal and Torres Strait Islander primary health care clinic also found that besides low rates of health literacy, feelings of shame and stigma are a barrier to treatment uptake. Connections within the community and family could provide support during the assessment and treatment process; stigma related to hepatitis C infection impacts the individual's desire to seek support and also limits the support available.^[82]

While data on hepatitis C among people who inject drugs in New Zealand has not been updated since 2018, hepatitis C prevalence among people with lifetime prevalence of injecting drug use is estimated to be 58% according to the latest data available.^[84] Currently, there are an estimated 45,000 people in New Zealand who have been infected with hepatitis C with a significant proportion, approximately 40–50%, being unaware of their status.^[85,86] A significant development is that direct-acting antiviral treatment became publicly funded in February 2019, and is now available at no cost.^[85,87] The public funding of direct-acting antivirals improved access to hepatitis C treatment for people who inject drugs as they are in the focus of testing and treatment measures.^[85] For example hepatitis C service providers are required to work with local organisations including NSPs, community alcohol and drug services, and prisons.^[86] While the New Zealand Needle Exchange Programme (NZNEP) is strongly committed to providing treatment for its clients.^[85] However, there are multiple barriers to accessing hepatitis C treatment. Testing is insufficient in the country, especially onsite at NSPs, with only three having a permanent clinical service onsite.^[85] Client pathways are underdeveloped and also hinder access to treatment. There is no formal plan within the NZNEP to network between NSP services and secondary or primary care and to link NSP clients with appropriate services.^[85]

SUB-SAHARAN AFRICA

In sub-Saharan Africa, mortality and morbidity due to hepatitis C infection is on the rise and injecting drug use contributes considerably to the hepatitis C incidence rates with an estimated 10.2 million people in the region living with chronic hepatitis C.^[54]

³ Hepatitis prevalence rates are based on hepatitis C antibody tests (determining whether the people tested were infected with the virus in the past), while active infection rates can be measured with hepatitis C RNA tests (determining whether the virus itself is present in the tested sample).

Although in many parts of Francophone Africa, detailed and reliable data on viral hepatitis is scarce, available estimates indicate a substantial burden: national prevalence of hepatitis C ranges from 0.7% (in Cameroon) to 3.1% (in Mali) and the prevalence of hepatitis B from 4.4% (Cameroon) to 8.5% (Mali).^[98,99] To establish the extent of viral hepatitis among people who use drugs, systematic population-based prevalence studies should be conducted when developing models of national programmes for the control of hepatitis C.

Policy shifts and discussions are taking shape across the region. Testing for hepatitis B and C is offered in Kenya, Mauritius, Seychelles and Tanzania and is generally affordable. However, the current estimated costs of treatment of chronic hepatitis C are prohibitive in most settings in sub-Saharan Africa.^[100] The International Network on Hepatitis in Substance Users held its conference in Cape Town, South Africa, in February 2020 - the first time the conference had been held in the region. The conference strongly emphasised the need to invest in the fight against hepatitis C among people who use drugs. It reinforced the African Union's 2019 Cairo Declaration on Viral Hepatitis in Africa which commits ministers to provide government leadership; implement hepatitis programmes; develop budgeted national plans; integrate hepatitis C care into existing services; raise awareness; ensure access to hepatitis prevention and treatment for key populations; and accelerate access to new diagnostics and medicines. Despite these developments, most of the governments in sub-Saharan Africa have not yet incorporated the WHO hepatitis C targets into their health sector programmes. The only exceptions are South Africa and Mauritius where a hepatitis C policy exists and has been integrated into health sector programming.

WESTERN EUROPE

The prevalence of hepatitis C antibodies among people who inject drugs varies widely across Western Europe, ranging from 10% in Iceland to 76% in Ireland (as shown in Table 2.3.1). Seven countries in the region are on track to meet WHO hepatitis C elimination targets: France, Iceland, Italy, Netherlands, Spain, Switzerland and the United Kingdom.^[31] The United Kingdom and Iceland have recently reported an encouraging decline in the prevalence of hepatitis C among people who inject drugs following the scale-up of direct-acting antiviral treatment.^[32] Hepatitis strategies are now in

place in 17 EU countries and Norway.^{4[34]} Switzerland also has national guidelines on viral hepatitis for people who inject drugs, developed by Infodrog on behalf of the Federal Office of Public Health.^[35,36] Malta is updating the country's national strategy on hepatitis C and key populations, including people who inject drugs, will have access to testing and treatment.^[37,38] However, one country in the region, Cyprus, continues to restrict access to hepatitis C treatment for people who inject drugs.^[39] Although hepatitis C treatment is free in many countries in the region,^[40-45] cost of treatment remains a barrier to those without health insurance in insurance-based health systems (such as in Austria, Germany, Luxembourg and Switzerland), which negatively impacts upon access for people who inject drugs who are refugees or migrants.^[33,35,44,46]

While hepatitis C testing and counselling are offered by harm reduction services, treatment provision is an area where the region lags behind. A study found that treatment prescription is available in services for people who use drugs in Cyprus, Denmark, Germany, Luxembourg and England,^[47] and several NSPs offering hepatitis C treatment in Sweden.^[48] However, a wide range of best practices and innovative models of care in harm reduction services are present in the region. There are at least eight countries where hepatitis C treatment in low-threshold settings, peer support and community-based programmes, and multidisciplinary treatment provision integrated to OAT and NSP are present.^[49]

According to reports, the availability of hepatitis C testing in the region is high, with Cyprus being the only country where testing is not offered in harm reduction services.^[47] In the United Kingdom, hepatitis C testing has been scaled up significantly and has been made available in harm reduction services, drug treatment services, pharmacies, health clinics and general practitioners.^[41] Despite the availability of rapid hepatitis C tests in harm reduction services in Italy, uptake of testing is very low, with less than a fifth of drug service clients being tested. Low testing is attributed to insufficient information on the availability of testing among the clients.^[50] There is also insufficient test uptake in Switzerland. However, the overall coverage of harm reduction services is the main barrier to access. It is estimated that coverage of OAT services is about 70%, and 75% of people who inject drugs are in NSPs.^[35]

⁴ Although Denmark does not have national hepatitis C treatment guidelines, it has a number of strong policy documents regarding hepatitis C care for people who inject drugs. Therefore, the European Monitoring Centre for Drugs and Drug Addiction counts Denmark as 'having a policy'.^[39]

The placement of hepatitis testing in inappropriate settings is consistently reported as a barrier to testing and treatment. In Germany, for example, hepatitis C testing is mainly available in medical settings (doctor's offices, hospitals), which does not sufficiently meet the needs of people who inject drugs. In order to effectively increase hepatitis C testing,^[46] targeted harm reduction measures are needed to reach vulnerable subpopulations of people who inject drugs.^[51] In the Netherlands, a specialised outreach project was launched to provide hepatitis C testing at drop-in centres and homeless shelters to reach those who would not normally attend the municipal health services for testing.^[43] Although there are some informal arrangements to provide community-based testing in Portugal, most testing and treatment is hospital-based; health services are not adapted to the needs of people who inject drugs, and stigma and discrimination are still an issue.^[40] Civil society actors also identify the fear of stigmatisation and discrimination from medical professionals as a major barrier in being able to access hepatitis C care in Austria.^[44]

Recommendations

VIRAL HEPATITIS SERVICES MUST BE AVAILABLE FOR FREE OR AT LOW COST TO ALL PEOPLE WHO NEED THEM WITH NO REQUIREMENT FOR ABSTINENCE FROM DRUG USE.

The elimination of hepatitis B and C will not be possible unless testing and treatment (including repeated treatment due to reinfection) is widely available and accessible. This requires eliminating barriers that prevent people from accessing services such as clinical restrictions on drug use or liver damage and upfront or out-of-pocket costs to the client.

VIRAL HEPATITIS TESTING AND TREATMENT MUST BE INTEGRATED WITH OTHER HARM REDUCTION SERVICES.

In order for harm reduction services to meet their potential as sites of linkage to care for viral hepatitis, they must be integrated with services providing viral hepatitis testing and treatment. This can also mitigate the impact of stigma and discrimination.

VIRAL HEPATITIS SERVICES FOR PEOPLE WHO USE DRUGS MUST BE NON-JUDGEMENTAL AND COMPASSIONATE TO LIMIT THE EFFECTS OF REAL AND PERCEIVED STIGMA.

Stigma and discrimination towards people who use drugs, who may also belong to other stigmatised groups, are consistently reported as a barrier to viral hepatitis services in every world region. Ways of addressing this include the employment of peers as service providers, the integration of harm reduction and viral hepatitis services, and increased community outreach.

STATES MUST INCREASE EFFORTS TO GATHER ROBUST DATA ON HEPATITIS C AMONG PEOPLE WHO USE DRUGS TO INFORM THE RESPONSE, INCLUDING BY INCREASING TESTING.

The significant number of people living with hepatitis C who are not aware of their condition represents a challenge for elimination efforts. It is essential that states expand efforts to understand the epidemic in their territories, and ensure that testing is available to all those who are at risk.

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