World Health Organization

TOGETHER FOR ELIMINATION

ACCESS TO HEPATITIS C TESTING AND TREATMENT FOR PEOPLE WHO INJECT DRUGS AND PEOPLE IN PRISONS — A GLOBAL PERSPECTIVE

APRIL 2019

POLICY BRIEF

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A. BACKGROUND

WHO estimates that 71 million people worldwide were chronically infected with hepatitis C virus (HCV) in 2017 *(1)*. Left untreated, chronic HCV can lead to cirrhosis, hepatocellular carcinoma and death *(2)*. Over the last 15 years, mortality related to chronic HCV infection has steadily increased to over 400 000 deaths annually *(3)*. This contrasts with the declining number of deaths estimated from other infectious diseases such as HIV, tuberculosis and malaria *(4)*. People who inject drugs (PWID) are disproportionately affected by HCV. Globally, 23% of new HCV infections and one in three HCV deaths are attributable to injecting drug use *(3,5)*. HCV is also a major concern for people detained in prisons and other closed settings – available data demonstrate that one in four detainees are HCV positive (*6)*.

Considering the unprecedented opportunities to act, the WHO *Global health sector strategy on viral hepatitis, 2016–2021* (GHSS) highlights five core areas of interventions needed to eliminate hepatitis as a public health threat by 2030 *(7)*, among them harm reduction for PWID, and treatment with direct-acting antivirals (DAAs). Harm reduction is an evidence-based public health response for PWID – which includes access to sterile injecting equipment through needle and syringe programmes (NSP) and to effective drug dependence treatment, such as opioid substitution therapy (OST). Both of these are critical interventions recommended by WHO.

The WHO targets for the elimination of viral hepatitis are to diagnose 90% and treat 80% of eligible persons. An estimated 5 million people had received DAA treatment for HCV by the end of 2017 (*8)*, and there are evidence-based, simplified models of care that advance access to HCV treatment even in low-income settings *(2)*. However, there is limited understanding regarding the progress of HCV testing and treatment for the most affected populations, such as PWID and people in prisons.

In this policy brief, we highlight the current landscape of country hepatitis policies for harm reduction and HCV testing and treatment in PWID and people in prisons. We aim to capture how governments are translating the GHSS into national plans, and provide a summary of the enablers and barriers to HCV testing and treatment in these populations.

B. METHODOLOGY

This policy brief is based on two sources: a desk review of national and regional policies for hepatitis, and interviews with key informants and stakeholders in seven high-burden countries. The desk review was conducted between January and March 2019. We surveyed the status of existing hepatitis policy documents: draft or completed national hepatitis (strategic or action) plans and clinical management guidelines in 194 countries and territories. Detailed draft or completed national hepatitis plans, whenever accessible, were provided by the WHO Viral Hepatitis and Substance Use Working Group and the WHO regional offices. A secondary search for regional or country policy documents was performed on Google Web Search, the Health in Prisons databases (HIPED, WEPHREN) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). We classified national plans into those that adopted recommendations of the GHSS for PWID and people in prisons, including harm reduction, HCV testing and treatment.

Two key elements were considered for selecting countries to interview: (a) the estimated total burden of HCV in PWID and people in prisons, and (b) geographic and income-level diversity. One country from each WHO region with a significantly high number of PWID living with HCV were thereby selected – namely China, India,

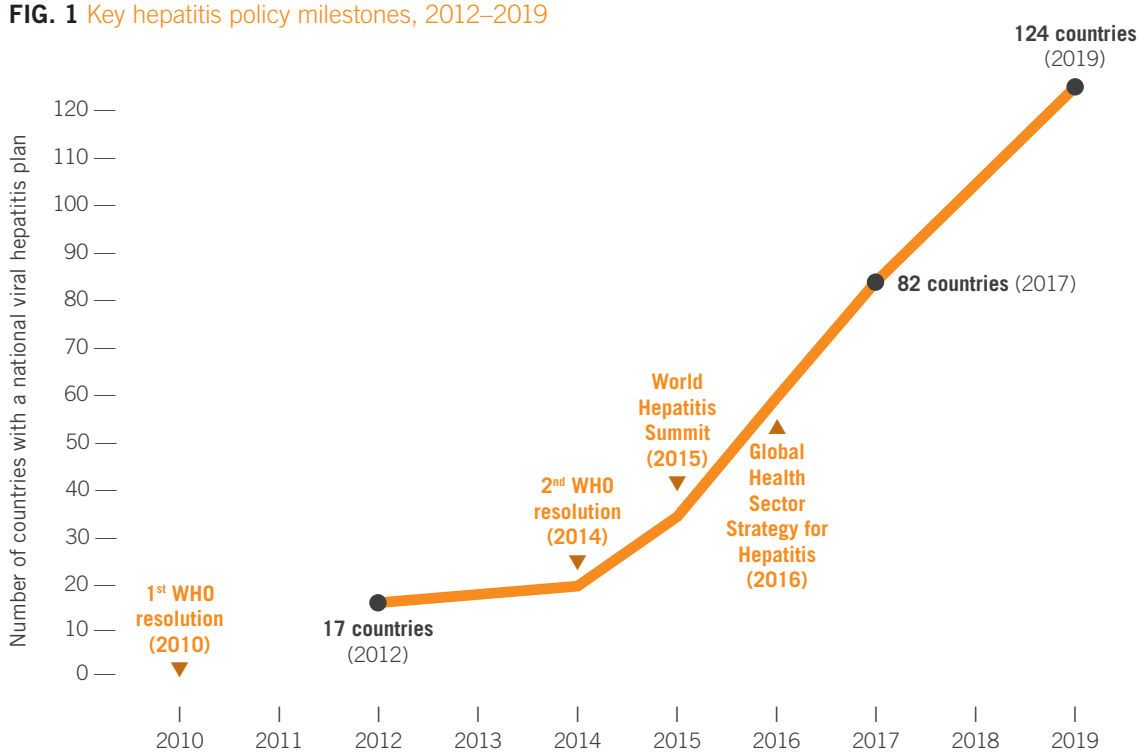
the Islamic Republic of Iran, Nigeria, Ukraine, and the United States of America (USA) *(5)*. Interviews were conducted with representatives from notable NGOs, civil society and community-based organizations in each country. These interviews centered on the main challenges faced in increasing access to HCV services among PWID and people in prison, and elements that catalyse HCV testing and treatment. The interviews took place in March and April 2019.

C. KEY FINDINGS OF POLICY REVIEW

Planning for the response has significantly increased.

Following development of the GHSS and its endorsement by Member States at the Sixty-ninth World Health Assembly in May 2016, 124 countries have developed national hepatitis plans (Fig. 1). Progress in this area has been notable in several regions. For example in 2015, only three (6%) countries in the WHO African Region (Algeria, Mauritania and Senegal) had national plans for hepatitis; currently, 14 (30%) of the 47 countries in this region have completed national hepatitis plans, and another 10 are in the process of developing such plans.

FIG. 1 Key hepatitis policy milestones, 2012–2019

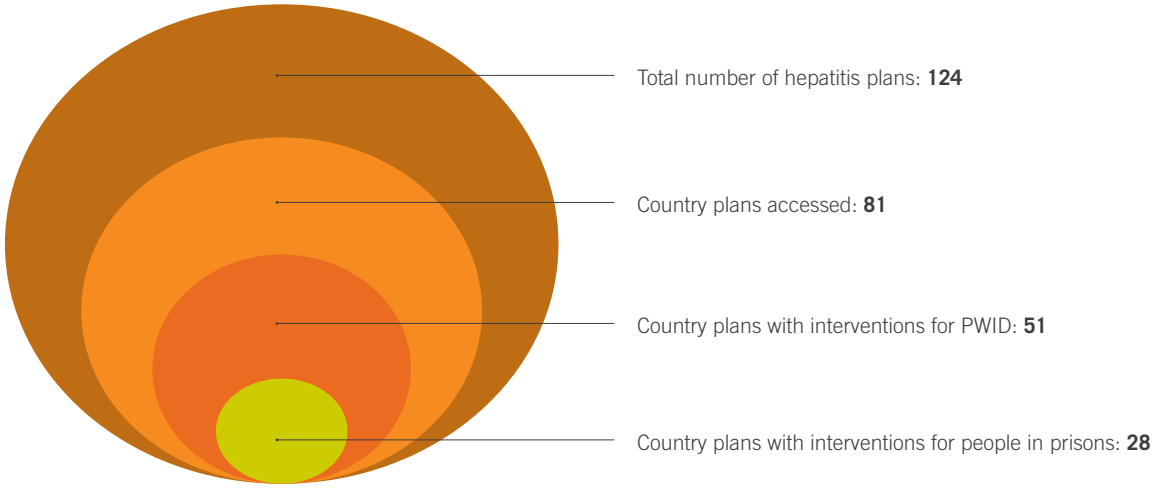


However, planning for hepatitis testing and treatment in PWID and people in prisons remains uneven.

There are significant variations in country responses to the needs of these populations from a national planning perspective (Fig. 2). Of the 124 countries with plans, 81 plans were accessed. 51 (63%) plans included interventions for PWID. 37 (46%) of these country plans outlined necessary interventions for PWID in accordance with the GHSS (Fig. 3). These interventions include HCV testing and treatment, and access to sterile injecting equipment and effective drug dependence treatment as part of a comprehensive package for the prevention of hepatitis and other blood-borne infections.

However, countries with such plans are still in the minority. Thirty national plans (37%) did not reference PWID as a population for interventions, while only 14 plans (17%) indicated a subset of interventions.

FIG. 2 Number of countries with a viral hepatitis plan



Similarly, interventions outlined for people in prisons are uneven. Only 28 national plans (35%) reference HCV testing, treatment or harm reduction for prisoners, highlighting a crucial gap in planning for this population. Of the 28 plans accessed, interventions were comprehensive in 23 (28%) (Fig. 4).