Hep C

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Central and Eastern European Harm Reduction Network

Hepatitis C Among Drug Users in the New EU Member States and Neighborhood

RECOMMENDATIONS FOR ACTION

We, people living with hepatitis C (HCV), service providers, drug user community representatives, health care professionals, researchers, and human rights activists, who participated in the situation mapping and expert consultation in March 2006 in Vilnius, Lithuania [1], are concerned with current weak political will, a low level of community mobilization and insufficient prevention, testing and treatment efforts to effectively address HCV among injecting drug users (IDUs) in the new European Union (EU) member states and neighborhood.

Action to address hepatitis C is needed NOW:

delay means continuing high rates of infection [2], increased serious health consequences and deaths as well as substantial health care costs in the EU in the near future [3].

Situation: Facts and key issues

Hepatitis C virus (HCV) is more spread than HIV.

- An estimated 200 million people, 3% of world's population, are infected with HCV, with around 170 million of chronic HCV carriers [4].

Injecting drug users (IDUs) and prisoners are most hit by HCV now.

- In the new EU member states and neighborhood, the majority (60-90%) of identified cases of HCV are among people injecting drugs due to sharing of injecting equipment [3];
- HCV prevalence among drug injectors in the EU reaches up to 90%, depending on country and setting [5];
- High proportions of IDUs become infected with HCV in their first years of injecting drugs [6]. Moreover such practices as sharing sniffing equipment also may lead to HCV infection;
- 20–40% of prisoners are living with HCV and the rates of HCV among prisoners who inject drugs are routinely from two to three times higher than among prisoners who have no history of injecting [7]. In the EU HCV prevalence is 100 times higher in prisons than in the community [8];
- After the 1990s, when transmission of HCV in health care settings was effectively eliminated by safer practices, IDUs and prisoners have become the main risk groups for infection.

People do not know about their HCV infection due to low testing availability.

- Large proportions of HCV cases remain undiagnosed until the virus causes serious chronic liver disease because infected people remain mostly asymptomatic (about 90 % of cases) [9];
- Free, anonymous and voluntary testing for HCV at low-threshold facilities is frequently unavailable or limited in the new EU member states and neighboring countries; in Latvia and Slovakia free, low-threshold testing is not available at all;
- In most prisons HCV testing is considered only when symptoms become visible [10]. Access to free hepatitis B (HBV) vaccination for IDUs is available only in the Czech Republic, Slovakia and Slovenia. Access to hepatitis A (HAV) vaccination is even more limited for this population group [11], in spite of the fact that HAV or HBV can be more severe among people co-infected with chronic HCV.

Lack of leadership and low prioritization will result in greatly increased health care costs in the future.

- There is currently poor awareness and political commitment to the issue. In contrast to the issue of HIV, there are neither international/regional political declarations on liver diseases nor national strategies that would mobilize comprehensive responses to HCV;
- It is estimated that in the EU, delays in establishing prevention and treatment programs will lead to increase in treatment costs of additional 1.4 billion euros [3]. Similar cost analysis has never been conducted in the eastern part of Europe.

Targeted prevention services for injecting drug users have insufficient coverage. In many prisons, evidence-based prevention policies and strategies are absent.

- Only 7.6% of IDUs in Eastern Europe have access to evidence-based harm reduction services [12]; better access is seen in Central Europe, namely the Czech Republic and Slovenia;
- In prisons in the new EU member states and neighborhood, with exception of Belarus, there are no needle and syringe exchange programs;
- Only Czech Republic, Poland and Slovenia provide substitution treatment in prisons, though with limited coverage [10]. Pre-trial detention institutions usually do not provide drug and HCV services that exist in the community or in prisons.

Current or past injecting drug use is still used as criteria for exclusion from treatment.

- Despite being the group most affected by HCV, many current IDUs and people undergoing drug treatment do not receive HCV treatment and are often explicitly excluded from treatment because of supposedly poor compliance, drug interaction and the possibility of re-infection;
- In contrast, European guidelines clearly state that active drug use should not be an exclusionary criterion per se and that any assessment of treatment eligibility should be made on case-by-case basis [13];
- In some countries, such as Bulgaria, HCV treatment is not accessible overall since it is not reimbursed by state or private insurance;
- People with co-infection of HCV and HIV are treated in the new EU countries, if treatment is accessible at all. However, in some neighboring countries, namely in Russia, having co-infection with HIV is the major guarantee to have access to HCV treatment, since treatment reimbursement mechanism is attached to international funding for HIV.

What works in hepatitis C prevention and management

- **Commitment and support for comprehensive, pragmatic services** among policymakers;
- **A supportive environment** for services that **reduce vulnerability** related to hepatitis C (HCV) and risk behavior;
- **Protection of the human rights and legal interests** of those affected by HCV and the **meaningful involvement of drug users and people with liver disease** are essential components of effective policies and practices;
- Implementation of **evidence-based, targeted preventive measures:** needle and syringe exchange and provision of other injecting equipment; drug treatment, including substitution treatment; education and counseling, including prevention of re-infection and prevention of disease progression; testing and counseling for HCV; peer education and support; vaccination for hepatitis A and B;
- **Free, voluntary and accessible testing with pre- and post-test counseling** using qualitative tests and **equal access to medical examination** by a specialist, which includes evaluation for liver damage;
- **Treatment of chronic HCV with pegylated interferon and ribavirin for all who need it, including drug users and clients of substitution treatment programs. Drug users should not be excluded from HCV treatment** due to drug use status, especially when scientific evidence proves that satisfactory response to treatment among active drug users can be the same as among the non-drug using population. Treatment should be provided to everyone who needs it while eligibility for treatment should be decided on a **case-by-case basis**;
- **Comprehensive care** should be in place to address complications and side effects which can occur during treatment, to maintain quality of life of people in treatment, and to enhance treatment outcome. Comprehensive programs should include cooperation between liver disease doctors, specialists in infectious diseases, social workers, psychologists and psychiatrists, patients, their relatives and peer support organizations;
- The availability of preventive measures **in prisons** should be **equal** to that provided in the community;

It is crucial to implement these measures **simultaneously**, **make them affordable, accessible and effective** taking into account specific needs of drug users.

The following actions are recommended to different stakeholders

Recommendations for policymakers

- Policymakers should acknowledge the need for, and express a greater level of commitment to hepatitis C (HCV) prevention and treatment, developing programs and strategies addressing HCV and liver diseases. Moreover, due to the high prevalence of HCV among drug users, the issue should also be appropriately covered in drug strategies and programs;
- People living with HCV as well as drug users should be involved in development, implementation and evaluation of policies and strategies related to drug use issues and liver diseases;
- Repressive legislation on drug use and drug users should be revised and should reflect a non-stigmatizing approach based in public health and human rights. Public policy should support the implementation and scale up of diverse harm reduction services and ensure access to health and social services for all members of society. The distinction between drug users and drug traffickers is essential, as repression of drug users often restricts their willingness to obtain health services, and increases populations in prisons and pre-trial detention institutions, where preventive services are limited, care is often interrupted or delayed;
- Clear and realistic mechanisms to provide HCV diagnostics and treatment reimbursement in cooperation with insurance and pharmaceutical companies should be developed, taking into account national economic and social conditions;
- More political and financial support for cost-effective drug-related harm reduction measures in the community and in prisons is needed from national and local authorities;
- Policymakers should support good practice dissemination from their countries to neighboring countries and support cross-country collaboration of health care and low-threshold service providers and patient organizations.

Recommendations for intergovernmental and international agencies (including the EU and the UN)

- In cooperation with national governments and civil society representatives, initiate and adopt recommendations and/or declarations of commitment to hepatitis with clear accountability mechanisms at international, regional and national levels. In addition, integration of HCV issues in HIV/AIDS, drug use and prison health care agenda is essential for coordinated and cost-effective action;
- Intergovernmental organizations like EU (European Centre for Communicable Disease Control, European Monitoring Centre for Drugs and Drug Addiction), World Health Organization and other relevant UN agencies should collaborate with national governments, service providers and epidemiologists to establish more accurate, specific and sustainable databases to track incidence, prevalence and trends in HCV. Data collection and analysis should also be used to assess risk behaviors, and promote access to evidence based services for drug users in community and among prisoners.

Recommendations for donors (especially in the EU and those providing support to the EU neighborhood)

- Donors, foreign development agencies supporting harm reduction, HIV prevention and other services targeted at injecting drug users (IDUs) and prisoners should include HCV component into their programs forming comprehensive response to challenges posed by drug use and at the same time encouraging funding recipients to include HCV related actions into their services;
- More funding is needed for basic and applied science research in hepatitis and drug dependency fields.

Recommendations for health care authorities

- National meetings of medical professionals delivering HCV treatment should be organized preferably involving drug addiction treatment specialists and drug user activists to agree on HCV treatment and care guidelines (developing new guidelines, or adopting existing European guidelines). Guidelines should be based on results of recent medical research and reflect international good practices which recommend to include drug users in treatment based on clinical criteria, deciding on treatment eligibility on a case-by-case basis;
- Health care institutions should work together with low-threshold service providers to develop systems of referrals from low-threshold facilities to medical care institutions for confirmatory testing for HCV RNA and evaluation of health conditions, in order to establish comprehensive responses to HCV and increase access to care for IDUs and people with liver diseases;
- A course on addiction treatment should be included in graduate and post-graduate education for specialists in infectious diseases and for liver specialists;
- HBV and HAV vaccination should be made widely available, free-of-charge and accessible for IDUs, as a group of high risk especially through low-threshold services and in prisons.

Recommendations for low-threshold and other health service providers

- Drug related harm and risk reduction programs need to be diversified and expanded in order to reach at least 60% coverage [14]. Services should include HCV counseling (on infection and re-infection prevention), needle and syringe exchange, distribution of condoms, cookers and other injection equipment, free, voluntary HCV testing along with counseling, as well as HAV and HBV vaccination, substitution treatment, information and skills building on safer injection and drug use. HIV testing should be always offered to clients with HCV;
- IDUs should be involved in activities implemented by service providers, especially into outreach activities, peer education, service planning and evaluation;
- Strategies to reach young, experimenting and occasional injectors in and out of schools should be developed through primary and other prevention including outreach;

- Program monitoring and evaluation should be done to assess programs' efficiency and impact, with the goal of increasing the effectiveness of HCV prevention and management services over time;
- Disseminate local, regional and international best-practice examples in HCV prevention, testing and treatment for IDUs to health care authorities and policymakers.

Recommendations for pre-trial detention and imprisonment institutions

- Prevention services in prisons should be equivalent to those provided in the community and should include education and counseling on HCV, provision of sterile injecting equipment and other measures to address HCV risk-related practices, such as drug use, tattooing, shaving, piercing and anal sex. If needle exchange is not immediately possible in prisons, bleach or other disinfectants should be provided, alongside relevant training for prisoners and staff on proper sterilization techniques in order to reduce the risk of HCV;
- Prisons and pre-trial detention institutions should develop and implement treatment programs for drug dependent prisoners, including the use of substitution treatment;
- Voluntary testing and counseling on HCV should be widely available in prisons. Voluntary and informed testing should be promoted through counseling to prisoners on admission and upon release. HCV testing, together with hepatitis A and B vaccination should be viewed as part of health care policy in prisons;
- Prison medical staff should receive training on issues related to HCV, drug use and human rights as well as be educated on how to deliver test results to patients, insuring data protection and the confidentiality of prisoners.

Recommendations for researchers

- Researchers, scientists and research organizations should cooperate with service providers and heath care authorities and jointly seek additional research funding, using national and international resources and programs, such as the EU Community Programme for Research and Development to track HCV incidence, determine prevalence among IDUs and HCV impact on public health, economics, public finance, and other areas;
- Cost effectiveness analysis comparing (1) early treatment vs. late treatment in IDUs and (2) treatment vs. non-treatment in IDUs should be conducted, taking into consideration different national health insurance/treatment schemes and epidemiologic trends;
- Closer collaboration with service providers in order to assess the impact of drug policy on the HCV epidemic and service provision is needed;
- Developing innovative prevention and treatment strategies for HCV and drug dependency (including vaccines, new HCV treatment medications with lower toxicity, fewer side effects and greater efficacy, and drug treatment methods especially in regard to amphetamine type stimulants and poly-drug use).

Sources:

[1] Mapping of situation with hepatitis C among drug users covered thirteen countries of Central and Eastern Europe, mainly targeting new EU member states (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovenia, Slovakia, Bulgaria, Romania, Belarus, Russia and Ukraine) and was done by Central and Eastern European Harm Reduction Network (CEEHRN) in January-March 2006. Regional consultation "Hepatitis C and Drug Use: Towards Awareness and Action" gathered representatives from heath care institutions, drug users' community, service providers, researches and people living with HCV from Europe and US and took place on March 10 – 11, 2006 in Vilnius, Lithuania.

[2] WHO estimates that from 3 to 4 million persons are newly infected with hepatitis C each year. WHO (2000) "Hepatitis C" World Health Organization Fact sheet No. 164. Available at: http://www.who.int/mediacentre/factsheets/fs164/en/.

[3] EMCDDA (2003) "Hepatitis C: A hidden epidemic" Drugs in focus No. 11. European Monitoring Center for Drugs and Drug Addiction, Lisbon, 2003.

[4] WHO. Initiative for Vaccine Research.
Available at: http://www.who.int/vaccine_research/diseases/hepatitis_c/en.

[5] EMCDDA (2005) Statistical Bulletin. Available at www.emcdda.eu.int.

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[7] WHO (2005) Status Paper on Prisons, Drugs and Harm Reduction, World Health Organization Regional Office for Europe, Copenhagen, 2005.

[8] Stover, Heino (2005) Harm Reduction in European Prisons. Presentation at the 8th European Conference on Drugs and Infections in Prison Unlocking Potential – Making Prisons Safe for Everyone, July 7-9, 2005, Budapest, Hungary.

[9] Desenclos J. C (2003) "The challenge of hepatitis C surveillance in Europe" in Euro Surveillance Monthly 2003, 8 (5).

[10] Mapping of situation with hepatitis C (HCV) among drug users in countries of Central and Eastern Europe (CEE) done by Central and Eastern European Harm Reduction Network (CEEHRN) in January-March 2006.

[11] Eurohep.Net, Surveillance and Prevention of Vaccine Preventable Hepatitis (2004) Data on surveillance and prevention of hepatitis A and B in 22 countries 1990's-2001, Centre for the Evaluation of Vaccination, Department of Epidemiology and Social Medicine at University of Antwerp. Available at http://www.eurohep.net/default.asp?p=93&l=06.04.

[12] Intensifying HIV prevention (2005) UNAIDS Policy Position Paper, Geneva, 2005. Available at: http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf.

[13] EASL (2005) European Association for the Study of the Liver: Short statement of the first European Consensus Conference on the Treatment of Chronic Hepatitis B and C in HIV Co-infected Patients, in Journal of Hepatology 42 (2005).

[14] UNAIDS estimates that effective prevention efforts need to cover 60 % of IDUs in order to effectively contain injection-driven epidemics (primary targeted at HIV prevention).

For reference:

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