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Hep C

Central and Eastern European
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Hepatitis C Among Injecting Drug Users in the New EU Member States and Neighborhood: KEY FACTS AND ISSUES

Hepatitis C virus (HCV) presents an important public health problem globally and particularly in the region of Central and Eastern Europe. Infection with HCV causes chronic infection in about 85% of those infected, and among those chronically infected, cirrhosis may eventually develop in from 5 to 20% (Edlin, 2004). Estimated 250 000 people die annually of HCV-related causes (Lavanchy, 2004). It is already the most common cause of chronic liver disease and the most common reason for liver transplantation in some countries, morbidity and mortality from HCV infection are rising and are expected to continue rising in the coming decades (Edlin, 2004).

The infection spreads rapidly among injecting drug users (IDUs) due to its high infectivity (about 10 times higher than human immunodeficiency virus (HIV)), and—unlike HIV—it can be transmitted by sharing not only needles and syringes but also other injecting equipment (e.g., water, cotton, etc.) which comes into contact with and carries infected blood particles (Hagan, 2001). As a result, international studies suggest that about 50–95% of IDU populations may be infected with HCV (Hagan, 1998). Because HCV and HIV have similar routes of transmission (particularly through needle sharing), HCV/HIV co-infection is also common among IDUs. Co-infection causes further complications, accelerates HCV progression and complicates HIV treatment, which also makes HCV a concern in HIV prevention and HIV treatment advocacy for IDUs.

At the same time, HCV often presents no symptoms, and the vast majority of infected people are not aware of their status. This is even more common among IDUs, since a large part of this group is not reached by services and remains outside of the health care system. Besides, as experiences from different countries show, even if diagnosis and implications for treatment are clear, IDUs are often excluded from HCV treatment, despite recent evidence that HCV treatment is feasible and effective when special needs, such as drug addiction or treatment side-effects, are addressed.

This combination of factors makes HCV prevention and treatment one of the top priorities on the harm reduction agenda all over the world and particularly in the region of Central and Eastern Europe. An effective policy for the control of HCV will require implementing prevention, treatment, care and support programs designed specifically for IDUs.

To help assess the situation related to HCV among IDUs in the region, the Central and Eastern European Harm Reduction Network (CEEHRN) carried out a survey in 13 countries of the European Union (EU) and neighboring countries, looking at the availability of HCV prevention, treatment, care and support for IDUs. The countries assessed were: Belarus, Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Russia, Slovenia, Slovakia, and Ukraine.

The key finding of the report is that in most countries HCV among injecting drug users is a neglected problem. Stigma and discrimination against drug use mean that those with the greatest need for HCV support, treatment and care are often denied these services. Besides, policy and advocacy efforts do not adequately address this issue and significantly more effort is needed in order to bring the issue up on the Public Health policy agenda.

Key findings and issues

- **HCV spreads rapidly among people injecting drugs**

According to various estimates, there could be between 2.1 and 3.3 million IDUs in the 13 countries of the region. Studies among drug injectors from these countries show quite diverse prevalence rate of HCV, varying from 14–97% in different settings.

The rates for HCV are commonly higher in the Eastern part of the region, with the highest rates - from 70% to over 90% - reported in Estonia, Lithuania, Russia and Ukraine.

Significantly lower rates of HCV are reported from countries of Central Europe where HIV prevalence among IDUs is also low – the Czech Republic, Hungary, Romania, Slovenia and Slovakia. However, HCV prevalence of more than 60% was found in studies from Bulgaria, Poland and Romania, showing that in fact HCV prevalence is high among IDUs compared to HIV prevalence throughout the region.

A study among people living with HIV and AIDS (PLWHA) seeking care showed that prevalence of HCV (over 50%) is high mainly in Eastern European countries (Estonia - 80%; Latvia - 61%; Russia - 52%; and Ukraine - 77–80%).

Increased risk of HCV can be associated with sharing needles, syringes and other injecting equipment, and a history of imprisonment. The association between HCV infection and duration of injecting or age group is contradictory - a study in Estonia showed higher prevalence among young IDUs and those injecting for less than five years, while the results of testing in Hungary and Slovenia showed the highest HCV prevalence in IDUs who were older than 34 years of age.

- **Limited political commitment**

Most countries have expressed a commitment to fight HIV and have established national programs to prevent and manage HIV and AIDS. However, this is not the case with HCV, and most countries do not have specific strategies to address hepatitis related issues. Despite recommendation of the World Health Organization (WHO) to adopt national plans for HCV, only 2 of the 13 countries (Romania and Slovakia) have specific national documents that address hepatitis.

Political commitment at the international level is also low. Regionally, there is no EU strategy or recommendations on standardizing diagnostics and treatment practices among EU countries, and improving access to prevention, diagnostics, treatment and support for those in need.

- **Limited availability of low threshold testing for IDUs**

HCV anitibody testing by general practitioners (GPs) or specialists is widely available, but this is often considered to be high threshold form of testing, which is less accessible for IDUs. Anonymous and free-of-charge testing remains limited throughout the region.

HCV testing and counseling is poorly linked to already established services for IDUs such as needle and syringe exchange programs (NEPs) and opioid substitution therapy (OST) programs. Testing at either NEPs or ST sites provided in 5 of the 13 countries assessed in this study. In some countries (the Czech Republic, Slovakia and Slovenia) testing for HCV is provided upon entrance to drug treatment and in Latvia free HCV testing is offered as part of primary HIV diagnostics.

IDUs have low level of knowledge about HCV. Service providers from different countries noted that many IDUs who are tested for HCV assume that they are chronically infected, and many remain uninformed or misinformed about the virus due to lack of proper pre- and post-test counseling. This may result in high-risk behaviors among IDUs.

- **Low prioritization of HCV testing among prisoners**

In most countries assessed HIV testing is suggested upon admission to prison. However such testing for HCV is provided only in some prisons in 3 of 13 countries - the Czech Republic, Poland, Slovakia. Most commonly HCV testing in the region is provided only when symptoms occur. In Slovakia, HCV testing is offered to all suspected, diagnosed and self-reported drug users. And in Slovenia it is available for PLWHA or those testing positive for HIV in prison. In most countries, testing is voluntary. From countries surveyed only in the Czech Republic testing is mandatory for all suspected or self-reported drug users and those diagnosed with addiction.

Despite limited availability of HCV testing in prisons, sometimes they provide the only opportunity for drug users to get tested due to the lack of anonymous and free of charge testing in community settings.

- **Falling short in prevention measures**

In the new EU Member States and neighboring countries governments and health care providers are still not committed to provide prevention services that target IDUs. Established HIV prevention measures such as NEPs in many countries can provide only a small part of the necessary clean syringes. However the coverage of NEPs between countries differs substantially reaching up to 50–60% of the IDU population in the Czech Republic and Estonia, but less than 10% of IDUs in Belarus and Russia. Only a few countries provide sterile injecting equipment other than needles and syringes, and none of the new EU countries have needle and syringe programs in prisons.

OST in community settings (outside prisons) is available in 12 countries (out of 13), but the coverage varies. For example, in Hungary in 2005, a mere 4% of all addiction treatment providers offered methadone maintenance (Gerevich, 2006), while the major OST program stopped enrolling new clients in 2006. There are only two OST programs in Romania and they are limited to the capital Bucharest.

OST in prisons is legal in about half of the countries surveyed but with the exception of the Czech Republic, Poland and Slovenia it is neither widely available nor accessible for most drug-dependent inmates.

- **Availability of antiviral treatment for HCV**

In accordance with international guidelines all 13 countries offer treatment by genotype and with the exception of Belarus and Romania indicate availability of treatment with pegylated interferon (PEG-IFN) and ribavirin (RBV).

However, the availability of PEG-IFN treatment (which can increase the chances of sustained virological response and chances for recovery) is limited in some countries most often because only limited number of PEG-IFN treatment courses can be reimbursed by the state.

- **Discrimination against drug users prevents access to HCV treatment**

International guidelines - such as those issued by the European Association for the Study of the Liver (EASL) on hepatitis and HIV co-infection treatment, and the World Health Organization's protocols on HCV and HIV management - state that drug users cannot be excluded as a group, and the eligibility of drug users for treatment should be assessed on a case-by-case basis, as it is among the non-drug-using population.

HCV treatment guidelines exist in virtually all countries of the region, though in Ukraine guidelines are only at draft stage and in Hungary new guidelines are pending approval. While guidelines in most countries support the provision of qualified and effective treatment, they seldom reflect international guidelines when it comes to treatment access for drug users. In all 13 countries drug use is generally considered a contraindication to treatment and this was found to be the case in practice as IDUs rarely receive treatment. The only exception is Slovenia where drug users with health insurance can access treatment and be treated by multi-disciplinary teams of specialists of infectious diseases and addiction treatment.

Some countries report individual cases when drug users are included in HCV treatment based on the decision of individual doctors. Commonly in all countries abstinence period of at least six months is required.

Though most guidelines do not address the treatment of OST clients, access to HCV treatment is higher for those on OST. In number of countries people stabilized on OST can have access to HCV treatment (in Bulgaria, the Czech Republic, Hungary, Lithuania, Romania, Slovakia, Slovenia). However, most often the treatment is limited and can be refused by doctors. Better access to treatment for OST clients is seen in the Czech Republic where HCV treatment is linked with drug treatment and low threshold services.

Restrictive guidelines present one of the barriers limiting access to HCV treatment for drug users. Often IDUs simply are not a priority or are excluded from treatment due to prejudice on the part of health care providers and lack of training on drug use and addiction treatment among infectious diseases specialists. Other key barriers include:

- stigma and discrimination against IDUs - often negative attitudes of medical professionals towards drug users;
- lack of cooperation between drug treatment and infectious diseases specialists;
- limited access to primary health care for IDUs;
- limited access to additional care and treatment - such as OST and antiretroviral therapy (ART) for people co-infected with HIV.

- **Overall limited availability of HCV diagnostics and treatment**

The cost of HCV treatment in most of the world is relatively high. In the new EU Member States and neighboring countries a 53-week course costs an average of EUR 12 600. As a result, cost is one of the primary barriers to treatment not only for IDUs but also for the general population.

The practices of reimbursement by the state vary from country to country. In 9 (out of 13) countries the treatment costs are fully covered by the state, most often by health insurance. However, the ability and readiness of states to reimburse treatment remains limited. For example, in Bulgaria only 50–60 people can get state-financed treatment. Treatment is partly covered by state in two countries - Belarus and Latvia. However the standards of treatment provided and covered by the state may significantly differ from the European standards, for example in Belarus doctors still prescribe interferon monotherapy. Modern combination therapy is not covered by state in Russia or Ukraine.

In theory, HCV treatment should be available in prisons in Bulgaria, Hungary, Lithuania and Poland. In practice, however, it is rarely available and, although data are limited, it appears that very few inmates receive treatment, which most often is due to lack of funds for treatment and/or diagnostics. More commonly, prisons in most countries have an established practice of providing only symptomatic treatment to HCV patients.

Access to diagnostic tests (confirmatory antibody test, RNA and genotype test) varies across the region and in some cases also is an impediment to access to treatment. Confirmatory tests, RNA and genotype tests are reimbursed in most countries, except Ukraine. In Russia, antibody tests are free of charge for patients with health insurance,

but they must pay for all other tests. In Lithuania diagnostic tests are purchased centrally by the state, therefore a limited number of people can undergo diagnostic tests each year. By the end of 2006 a shortage in tests was reported by medical professionals.

The differences in access in different cities were not assessed but, according to respondents, there are inequalities in access to diagnostics between regions and cities within countries.

- **Treatment for people co-infected with HIV is a priority**

Most often, co-infected people need treatment more urgently than mono-infected people, and five countries do report having specific guidelines for the treatment of hepatitis/HIV co-infection either within their hepatitis or HIV treatment guidelines or in a separate document. Yet in some countries surveyed, such as Belarus, co-infection is an excluding factor when considering HCV treatment.

In some countries, co-infection with HIV is the only way to get state-funded treatment. In Russia, where free-of-charge treatment is not available, guidelines allow to provide it to people with a disability, which includes people living with HIV (PLWH) registered at AIDS Centre. This usually is also true in practice.

Countries with high HIV prevalence and those receiving international funding from large donor organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), offer a possibility of HCV treatment to PLWH. For example, in Belarus in 2007 it is planned to provide treatment for 40–50 co-infected people as part of the project funded by the GFATM. A pilot program to provide HCV treatment to PLWH is also planned to be implemented in 2007 in Ukraine. The program, which will enroll about 200 people into treatment, will be supported by the World Bank and partly by the state (34–35 people). As of February 2007 the drugs had still not been purchased.

- **Vaccination for hepatitis A and B**

Among the 13 countries surveyed, only Slovenia and Romania have hepatitis A (HAV) vaccination targeting IDUs at no cost. In Romania vaccination for drug users is a part of GFATM funded project.

Hepatitis B (HBV) vaccination is more widely available than HAV vaccination and is provided at some low threshold facilities in the Czech Republic and Romania, also in some cities of Russia and Slovakia upon registration at the Center for the Treatment of Drug Dependencies, but is still limited for drug users.

HAV vaccination in prisons is available only in Slovenia and the Czech Republic; HBV vaccination for drug users in prisons is much more widely available than HAV vaccination. It tends to be more accessible than in communities and in some cases is provided for free in Bulgaria, the Czech Republic, Estonia, Hungary, Lithuania and Slovenia. In Slovakia vaccination at cost can be provided upon request.

Recommendations for further actions:

- Policy-makers should acknowledge the need for, and express a greater level of commitment to, HCV prevention and treatment, developing programs and strategies addressing HCV and liver diseases;
- A supportive environment for services that reduce vulnerability related to HCV and risk behavior should be created, including revision of drug policies which would reflect a non-stigmatizing approach based on public health interests and human rights and greater support for comprehensive, pragmatic prevention, treatment, care and support services;
- Protect the human rights and legal interests of those affected by HCV and meaningfully involve drug users and people with liver disease in developing policies and practices;
- International organizations (like the EU and the United Nations), in cooperation with national governments and civil society representatives, should initiate and adopt recommendations and/or a pan-European strategy on hepatitis with clear accountability mechanisms at international, regional and national levels;
- Guidelines on HCV treatment should be based on results of recent medical research and reflect international good practices which recommend including drug users in treatment programs based on clinical criteria, deciding on treatment eligibility on a case-by-case basis. Drug addiction treatment specialists and representatives of affected communities should be involved in the development of guidelines;
- Health care institutions should work together with low threshold service providers and representatives from communities affected by HCV and IDU to establish comprehensive responses to HCV and increase access to care for IDUs and people with liver diseases;
- Low threshold services, often being the main services in contact with IDUs, should be expanded and include HCV counseling; distribution of needles, syringes and other injecting equipment; free, voluntary HCV testing along with pre- and post-test counseling; HAV and HBV vaccination; and information and skills building on safer injection and drug use;
- The most effective treatment must be made available for all who need it, including IDUs and clients of OST programs;
- Comprehensive care should be provided to address complications and side-effects of treatment, to maintain quality of life of people in treatment, and to enhance treatment outcomes. This involves cooperation between liver disease doctors, infectious disease specialists, social workers, psychologists and psychiatrists, patients, their relatives and peer support organizations;
- Ensure that the availability of preventive measures and treatment, care and support in prisons is equal to that provided in the community.

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