

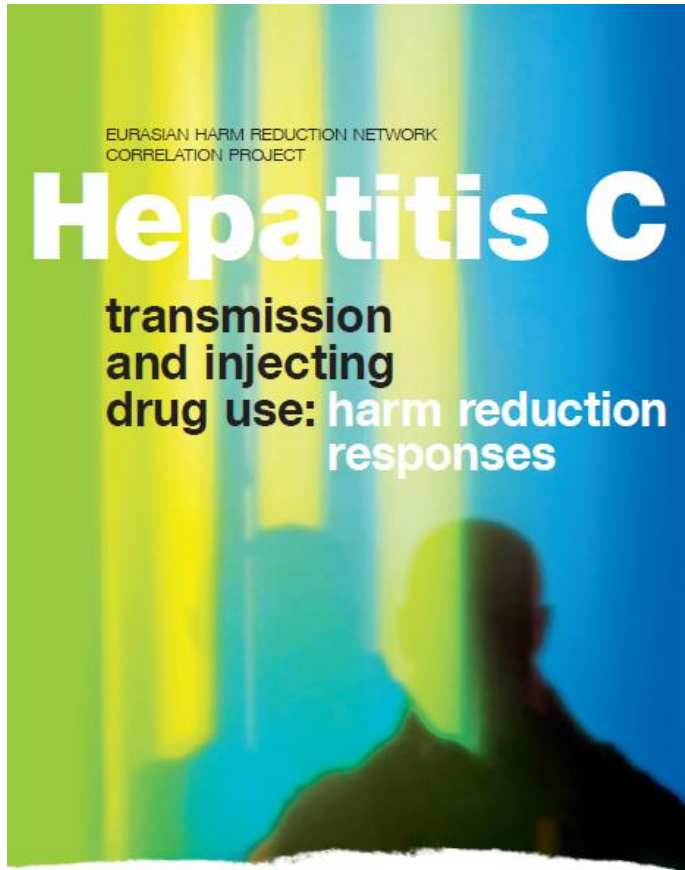
The work on HCV and Drug Use in Europe

Eberhard Schatz

hepc

European Initiative
Hepatitis C and Drug Use

initiative



Correlation

European Network
Social Inclusion & Health

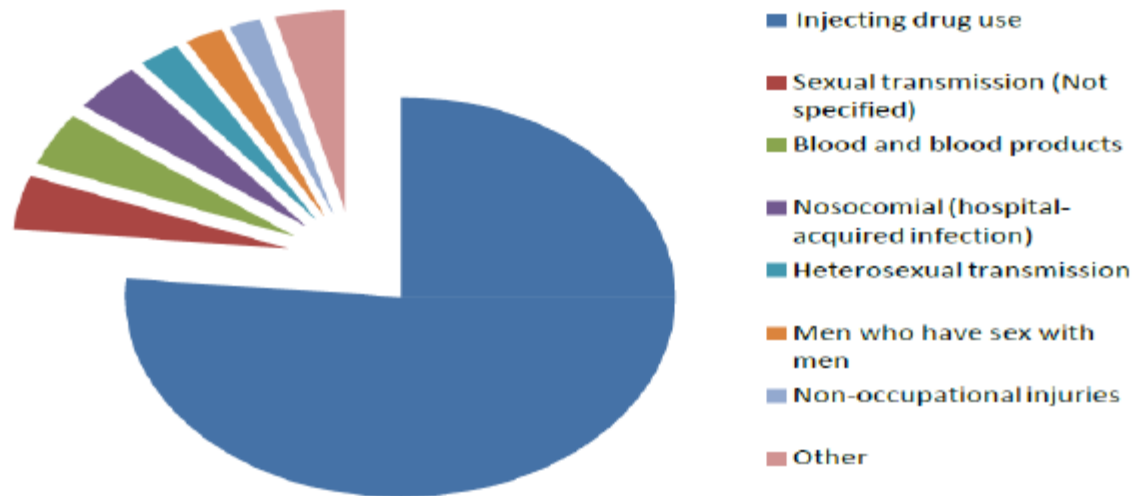


Why an European Initiative particular for HCV and HR?

- 150 million people worldwide are living with chronic hepatitis C virus (HCV), of those infected, nine million are living in the European region.
- Antibody prevalence ranging to over 90% in some European countries. The World Health Organization (WHO) has identified people who inject drugs as a key target group for HCV prevention and treatment.
- In January 2014, the first all oral HCV treatments providing cure rates of up to 98% in clinical trials were approved by the European Commission.
- In spite of European guidelines recommending treatment access for people who use drugs still face considerable barriers to, and are frequently denied, access to the newly approved HCV treatment regimens.
- No european-wide Initiative**

Current transmission route of HCV cases in EU/EEA countries, 2012

- Last decade: new infections not common in general population
major problem people who inject drugs (PWID)



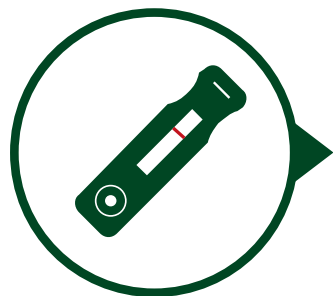
Route of transmission: injecting drug use **78.1%**

*Terrault NA, et al. Hepatology 2013;57:881–9. Thomas SL, et al. Int J Epidemiol 1998;27:108–17
Prati et al, J Hepatol 45 (2006) 607-616. Shepard CW, et al. Lancet Infect Dis 2005;5:558–67.*

Western Europe - Regional Overview

Country/territory with reported injecting drug use	People who inject drugs ^a	HIV prevalence amongst people who inject drugs ^b	Hepatitis C antibody (anti-HCV) prevalence among people who inject drugs ^c	Hepatitis B surface antigen (anti-HBsAg) prevalence among people who inject drugs ^d	Harm reduction response		
					NSP ^{1 e}	OST ^{2 f}	DCR ^g
Andorra	nk	nk	nk	nk	N	N	N
Austria	17,500 (12,000–23,000) ^h	0.7–5.3	43.4–65.3	nk	Y(31)	Y(B,M,O)	N
Belgium	5,125 (3377–7829)	3.4–6 ^(a)	28.1–80j ^(a)	0–2.8 ^(a)	Y(69)(P)	Y(B,H,M)	N
Cyprus	467 (418–539) ^{3 i}	0–1.3	51.3	1.7	Y(1)(P)	Y(1)(B,O)	
Denmark	12,754 (10,066–16,821) ^j	2.1 ^f	52.5	1.3 ^{gk 4}	Y(135) ⁱ	Y(B,H,M)	N
Finland	15,650 (12,200–19,700)	0.7 ^(a)	60.5 ^j	nk	Y(40)	Y(B,M,O)	N
France	122,000 ^m	5.1–8 ^{f (a)}	41.7j ^(a)	4.8 (3.4–6.2) ^{n 4}	Y(532)(P)	Y(19,484)(B,M,O)	N
Germany	94,250 (78,000–110,500) ³	3.4 ^h	75 ^o	7.2 (6–8.4) ^{p 4}	Y(250)	Y(2,786–6,626)(B,H,M)	Y (27)
Greece	9439 (8110–11,060) ^{3q}	0.07–0.8	48.7–68.8	2.9–3.6	Y(6)(P)	Y(17)(B,M,O)	N
Iceland	nk	nk	63 ^{r 4}	nk	N	Y(B,M)	N
Ireland	6289 (4694–7884) ^s	5.8 ^v	74.6 (72.3–76.9) ^{3t}	0 ^{h 4}	Y(32)(P)	Y(332)(B,M,O)	N
Italy	326,000 ^o	11.5	58.5	5.1 (0.9–9.3) ^{u 4}	Y	Y(B,M,O)	N
Luxembourg	1485 (1253–1919) ^g	2.4	71.8–90.7 ^v	3.9 ^v	Y(8)	Y(B,M,O)	Y(1)
Malta	nk	0	36.3		Y(7)	Y(≥2)(B,M)	N
Monaco	nk	nk	nk	nk	N	N	N
Netherlands	2390 (2336–2444) ^{3 w}	0j ^(a)	47.6–67.4 ^(a)	1–13 ^(a)	Y(175)5(P)	Y(B,H,M)	Y(40)
Norway	10,238 (8810–12,480) ³	2.4	69.9	0j ^(a)	Y(29) ^r (P)	Y(B,M)	Y(1)
Portugal	10,950–21,900 ^{3 dd}	4.9–17.2	36.5–83.1	2–3.4	Y(1620)(P)	Y(B,M)	N
Spain	83,972 ^x	32.3	79.6 (73.3–85.9) ^{4 e}	3.6 (1.8–5.3) ^{oo}	Y(2274)(P)	Y(497–2,229)(B,H,M)	Y(7)
Sweden	nk	2j ^(a)	59.7j	2.3 ^t	Y(2)	Y(B,M)	N
Switzerland	31,653 (24,907–38,399)	1.4	78.3 ^{oo z4}	4 ^{oo}	Y(101)(P)	Y(B,H,M,O)	Y(7)
Turkey	nk	0.5	5.3j ^(a)	5.2 ^{oo}	N	N	N
United Kingdom	133,112 (126,852–143,278) ^{3 bb}	0–4.3j ^(a)	26.1–61.2	8.9 (0–17.8) ^{cc 4}	Y(1,523)(P)	Y(B,H,M,O)	N

HCV Care cascade PWID



**HCV
TESTING**

30%



**ASSESS &
MONITOR**

12%



**ENGAGE IN
TREATMENT**

1-2%

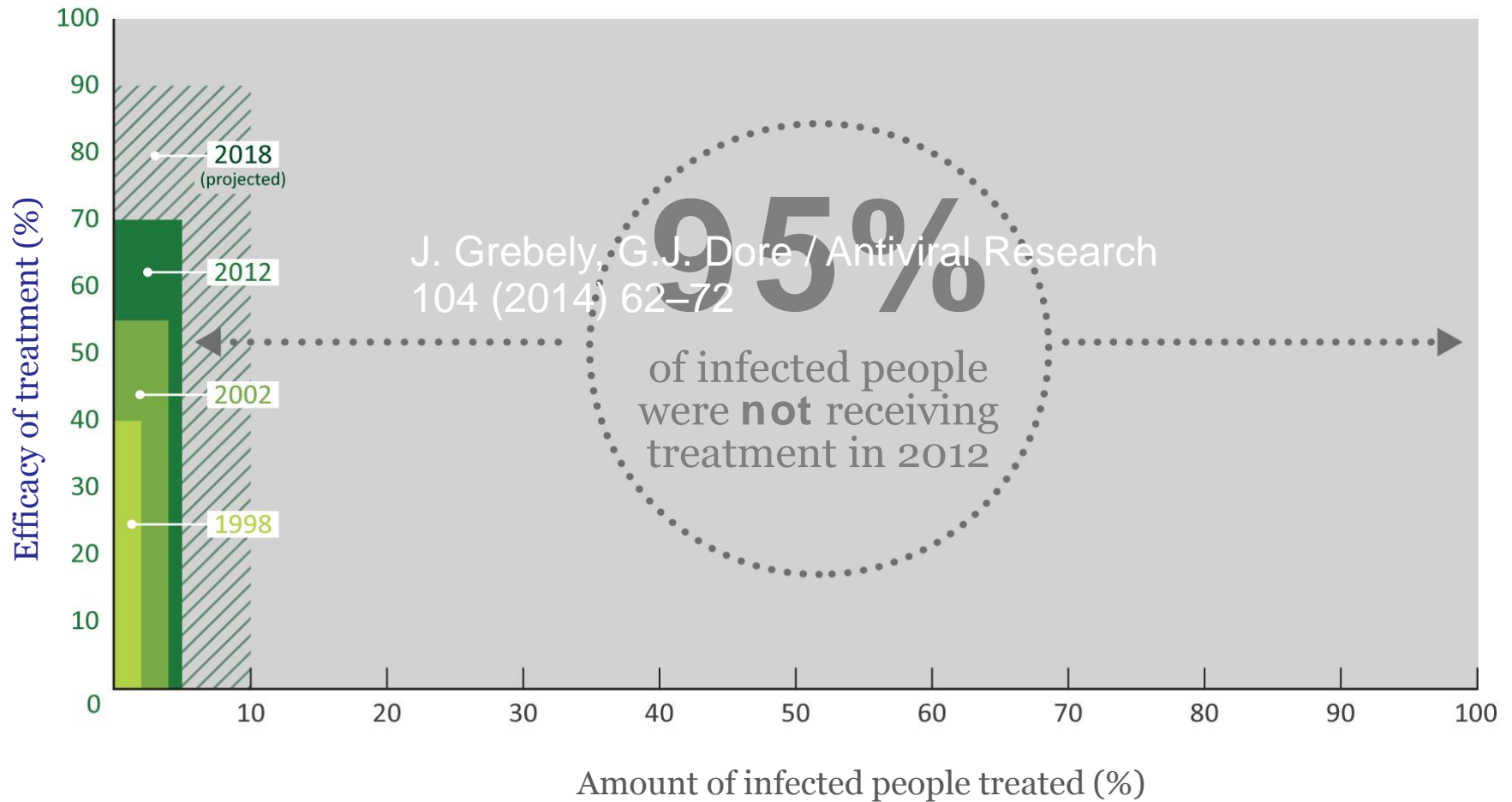


**ENHANCE
RESPONSE**

<1%

Hagan H, *Public Health Rep* 2006; Cullen B *J Public Health* 2012;
Alavi M, *Liv Int* 2013; Iversen, *JVH* 2014

Treatment gap



Barriers in Health Care Setting

- lengths of waiting lists
- lack of comprehensive care and support
- geographic distance
- inflexible appointment policies
- abstinence requirements
- prejudicial attitudes
- communication difficulties between patients and specialists

Recommendation

- eligibility criteria should ensure access for all (drug use is no reason to preclude treatment)
- flexible appointment systems

Harris, M. 2014

Barriers Stigma and Discrimination

- there is evidence that barriers exist:
 - > related to injecting drug use
 - > related to lifestyle
 - > related to health care setting, like discriminatory treatment of medical staff
 - > confidentiality breaches
 - > Women and migrants

Recommendation

- stigma reducing interventions
- welcoming, not judgemental environment
- personal interaction
- monitor stigma and discrimination and establish procedures



Barrier Criminalisation

- criminalisation
 contrary impact on treatment access and adherence:
- confiscation of medication by police
- interruption of treatment following arrest
- reluctance among PWID's to seek help
- HCV treatment in prison only in few countries

Recommendation

- dedicated HCV services in custodial settings
- ensuring continuity of care
- decriminalisation of drug use





SOVALDI...
SO EXPENSIVE

PILLS COST LIVES
GILEAD COSTS LIVES

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GILEAD'S SOFOSBUVIR
APPROVED BY THE EMA AND FDA
BUT ACCESSIBLE FOR HOW MANY?

\$84,000

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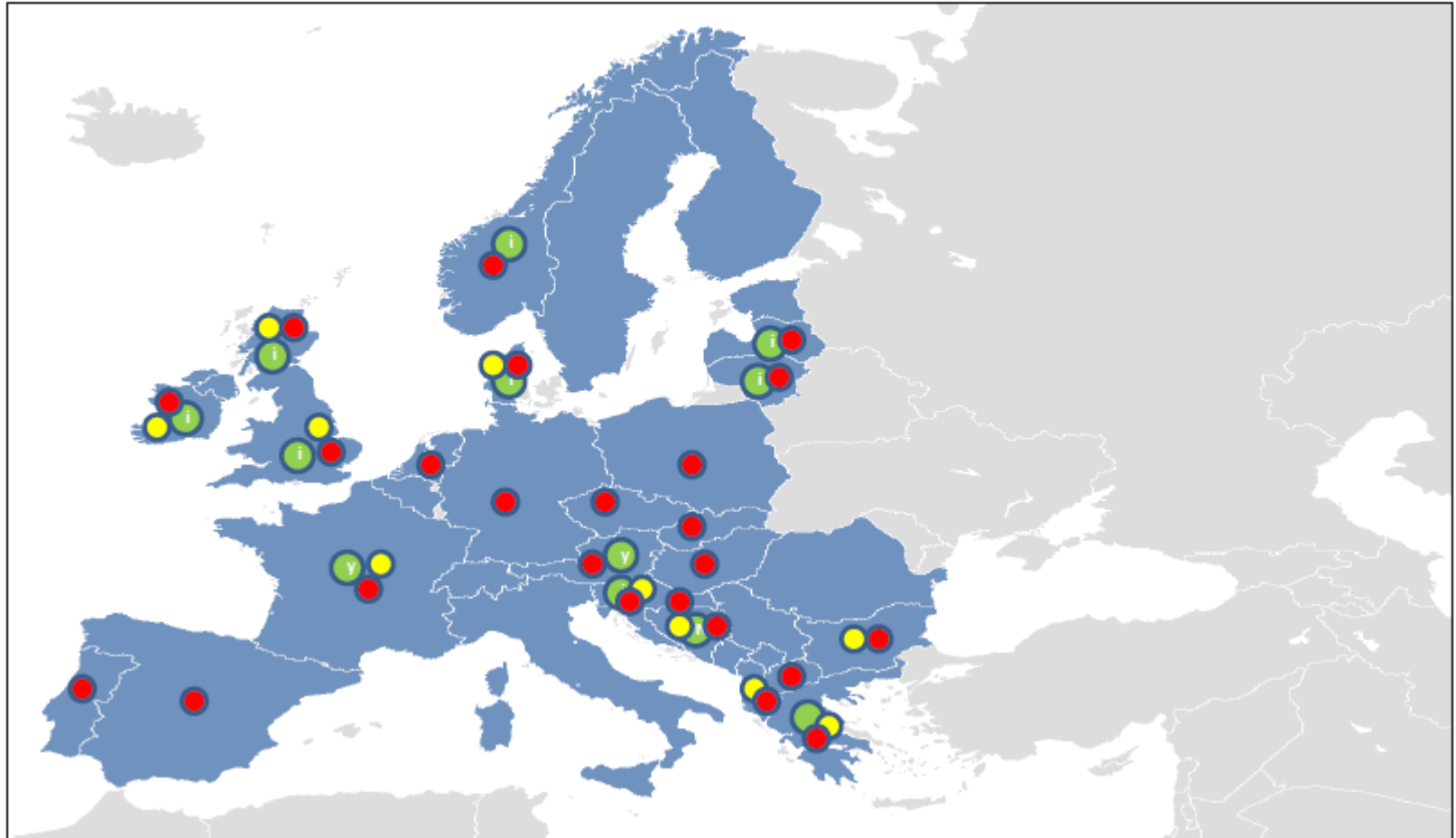
GILEAD'S SOFOSBUVIR
APPROVED BY THE EMA AND FDA
BUT ACCESSIBLE FOR HOW MANY?

PHOTOGRAPH BY [unreadable]

National level activities on HCV management

A survey of 33 European countries

● National strategy, 12 (10 PWID) ● National action plan, 10 (7 PWID) ● National treatment guidelines, 24 (20 PWID)

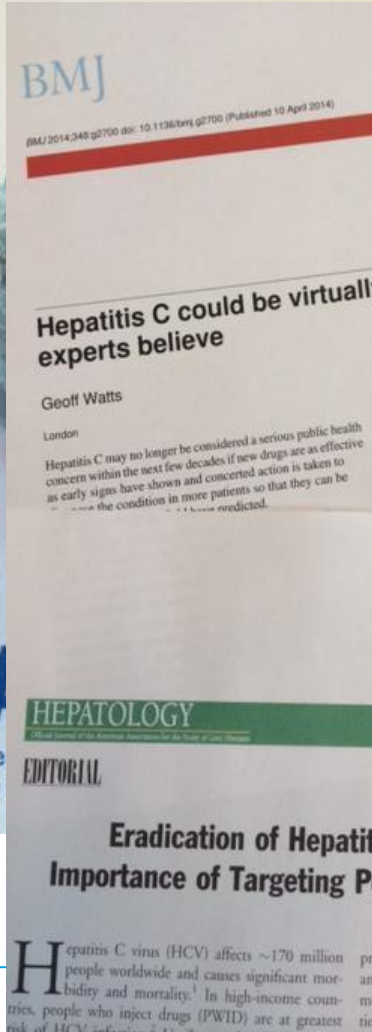


*Scotland was treated separately from UK

Maticic M et al. BMC Infect Dis 2014; 14(Suppl 6): 514-23

EASL Recommendations on Treatment of Hepatitis C

2014



ECDC AND EMCDDA **GUIDANCE**

Prevention and control of
infectious diseases among
people who inject drugs

www.ecdc.europa.eu
www.emcdda.europa.eu



European Association for the Study of the Liver, 2015 Recommendations on treatment of hepatitis C

Treatment priority	Patient group
Treatment is indicated	<ul style="list-style-type: none"> All treatment-naïve and treatment-experienced patients with compensated and decompensated liver disease
Treatment should be prioritized	<ul style="list-style-type: none"> Patients with significant fibrosis (F3) or cirrhosis (F4), including decompensated cirrhosis Patients with HIV coinfection Patients with HBV coinfection Patients with an indication for liver transplantation Patients with HCV recurrence after liver transplantation Patients with clinically significant extra-hepatic manifestations Patients with debilitating fatigue Individuals at risk of transmitting HCV (active injection drug users, men who have sex with men with high-risk sexual practices, women of child-bearing age who wish to get pregnant, haemodialysis patients, incarcerated individuals)
Treatment is justified	<ul style="list-style-type: none"> Patients with moderate fibrosis (F2)
Treatment can be deferred	<ul style="list-style-type: none"> Patients with no or mild disease (F0-F1) and none of the above-mentioned extra-hepatic manifestations
Treatment is not recommended	<ul style="list-style-type: none"> Patients with limited life expectancy due to non-liver related comorbidities

EASL Recommendations 2015. doi: <http://dx.doi.org/10.1016/j.hep.2015.03.025>



What we did 1

Capacity building:

Peer training manual

•6 modules

Module 1: Understanding

Module 2: HCV prevention

Module 3: HCV testing and diagnosis

Module 4: HCV treatment

Module 5: Living with HCV

Module 6: HCV advocacy and action planning

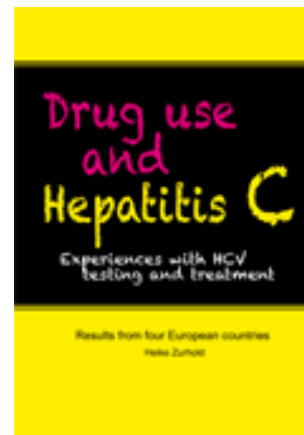
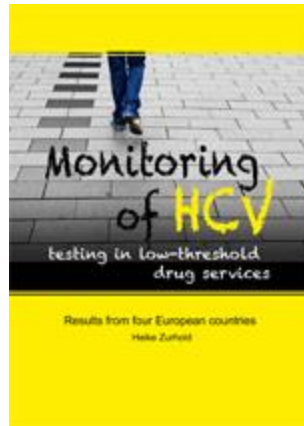


What we did 2

Research:

The scale-up of HCV treatment access to people who inject drugs has the potential to significantly reduce the number of new infections and the prevalence in the population, acting as an effective preventative measure.

Inventory: Hepatitis C testing and treatment barriers among active drug users in 4 European cities: Porto, Helsinki, Frankfurt and Budapest.



What we did 3

Capacity building:
resource centre 250+ entries

Category selection:
approved treatments
epidemiological data
HCV in prison
side effects
clinical trials
policy and guidelines

Alternative Treatments	➤
Burden & Prevalence of HCV	➤
Clinical Trial Data	➤
Cost Effectiveness of HCV Prevention & Treatment	➤
HCV & Drug Use	➤
HCV & Sex	➤
HCV Epidemiological Data	➤
HCV History & Facts	➤
HCV in Prisons	➤
HCV Prevention Interventions	➤
HCV Related Books	➤
HCV Research Including IDUs	➤
HCV Testing Guidelines	➤
HCV Treatment & Prevention	➤
HCV Treatment Side Effects & Interactions	➤
HIV/HCV Co-Infection	➤
Integrating HCV Services	➤
Living with HCV	➤
Peer and Patient Support	➤
Policy Guidelines and Recommendations	➤



Current advocacy priorities for Correlation

Policy priorities

- Advocacy for the implementation of comprehensive national policies
- Advocacy for affordable medicines
- Advocacy for funding of Harm Reduction and HCV services
- Advocacy for meaningful involvement of community members
- Establish synergy with other stakeholders



Declarations and Stakeholders

- World Health Assembly, Resolution 63.18 2010
- World Health Assembly, Resolution 67.6 2014
- Glasgow Declaration on Viral Hepatitis 2015
- HCV Policy Summit Brussels 2016

- WHA, ELPA, EASL, HBCPA, VHPB

- INSHU, EuroNPUD

- EATG, HIV in Europe



Conclusions

- HCV treatment is safe and effective in general population as well as in PWID, with low risk of reinfection in former and current PWID
- International guidelines for the management of HCV in general population and in PWID exist
- National strategies, action plans and clinical guidelines on HCV treatment have not been introduced in all European countries; they are needed for general population as well as for PWID
- Assessment of new drugs on the national level and their introduction for all in need are crucial for future treatment of HCV in Europe
- Europe has been successful in reducing new HIV infections among PWID through evidence-based policies and interventions: we know what works

Thank you!

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