

# Viral Hepatitis Prevention Board

**Highlight underserved groups for screening, prevention and treatment of viral hepatitis B and C in Europe**

**LJUBLJANA, SLOVENIA**

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# Objectives

- To define and identify underserved groups for screening, prevention and treatment
- to identify, describe and discuss lessons learnt from initiatives in various countries
- to uncover lost opportunities in existing public health settings for improving screening, prevention and treatment in underserved groups
- to discuss strategies for improving access to hard-to-reach and underserved groups to programmes for screening, diagnosis, treatment and immunization
- to discuss the consequences of both neglecting and highlighting underserved groups for public health
- to identify challenges for research, advocacy and policies for these underserved groups

# Context

- Several diverse, hard-to-reach and underserved populations are at risk of or have chronic hepatitis B and C in Europe, including people who inject drugs (PWIDs), prisoners, migrants, Roma, MSM, sex workers and other vulnerable populations
- Strategies, policies, guidelines: WHO is formulating draft global and regional strategies on viral hepatitis with targets for elimination by 2030; representatives of State and Government adopted the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia; recommendations, manifestos and guidelines have been published; and the European Monitoring Centre for Drugs and Drug Addiction has been issuing warning about the dangers of hepatitis C regularly since 1997
- There is a heterogeneous epidemiological pattern of chronic hepatitis B and C across the European Region, with a NW-SE gradient
- PWIDs are the drivers of both HIV and HCV epidemics in the eastern part of the WHO European Region, but not in western Europe; PWIDs and MSM are at risk of re-infection after treatment
- The new direct-acting antivirals mean that HCV is curable and, combined with the use of vaccines against hepatitis A and B and treatments for chronic hepatitis B, open the door to elimination of viral hepatitis as a public health problem

# Context

- France is a leading country in Europe in tackling viral hepatitis (dubbed the El Dorado for treatment of HCV). It has an estimated 150,000-200,000 HCV patients and a further 75,000 undiagnosed; in 2015 it treated 14,000 patients with direct-acting antivirals.
- Management of HCV: integrated approaches work best – Slovenia described its structure of a National Institute of Public Health and a National Viral Hepatitis Expert Group. Other countries have integrated health systems, with centres for prevention and treatment of drug addiction, municipal services, and multidisciplinary teams. Ukraine for example has multiple centres for screening and treatment organized by the Alliance for Public Health outside the aegis of the health ministry

# Prisons and prisoners

- Europe has about 2 million people incarcerated in a given year, with about 680,000 in the Russian Federation alone, and a high turnover
- High rate of imprisonment of PWIDs; HCV is a major problem, with sometimes much higher rates than in the general population, and transmission within prisons and a high risk of further transmission outside prison after release
- Prisons are thus identified as “disease concentrators”; drug use is common
- Imprisonment is a risk factor for HCV infection in PWIDs; French study identified risks in prison that are not strong risk factors for HCV infection in the general population: drug snorting, sex and sharing toiletries
- Health services are mandatory and some countries have transferred responsibility for prison health to health ministries; international guidelines insist on no discrimination with regard to care and preventive measures, but these recommendations are not in many instances observed: e.g. 0.6% of prisons globally provide needle-exchange services. Screening rates are low.
- A study (2012) in England and Wales showed wide variation in provision of HCV services; low treatment rate for chronic hepatitis C (3%/year) in the general population

# Prisons and prisoners

- An audit of 21 prisons in England and Wales revealed great variation in practices, including training of staff and provision of services for infected inmates, the extent to which testing was offered to all prisoners on entry into the system, and there should be adequate psychosocial support; treatment of HCV should, if possible, be on site. It was recommended that prisons should have written policies. Change in policy in 2013, introducing the possibility of prisoners opting out from the offer to all new entrants into the prison system of being tested for blood-borne viruses. Testing for blood-borne viruses has increased in prisons where the policy has been test, and is being extended to all English prisons.
- Prisons offer an opportunity to provide prevention, testing and care, allowing access to people who could otherwise be contacted only with great difficulty.
- An EU project under way aims to identify infected inmates eligible for treatment of HCV infection.
- Model programmes to improve care exist (in Australia and the USA)
- The need to use proven models of care was identified

# PWIDs

- PWIDs form probably the main groups at risk for HCV infection and disease in Europe – an estimated 3 million are infected with HCV – and are the main drivers of both HIV (as in the Russian Federation and the Ukraine) and HCV epidemics
- Among some 22,000 cases of HCV registered in Europe in 2013, about 80% of the 6000 or so cases of reported infection and for whom an exposure category was identified were PWIDs (although caution needs to be exercised about quality of the data)
- Ukraine has an estimated 300,000 PWIDs; the NGO, Alliance for Public Health, runs one of the largest harm reduction programmes in the world with good results; integrating HCV into harm reduction programmes mobilized communities, raised awareness, and facilitated advocacy for HCV treatment and negotiation of large price reductions for DAAs (to US\$ 900 for a course of sofosbuvir). The NGO's strategy is to use this negotiated price and its treatment model to persuade the Government to follow that lead.
- PWIDs can be treated safely and effectively

# PWIDs

- A programme in Copenhagen (Denmark) aims to add value through a more centralized HCV treatment service based on a municipal drug treatment centre; it demonstrated the value of: outreach, providing testing and care at one centre, the use of a mobile Fibroscan and tailored database applications for all patients
- Generally HIV infections in PWIDs have fallen through preventive interventions but the incidence of HIV is still high in eastern Europe and Russian Federation: although there have been outbreaks in western Europe, the European Union has been a success story for HIV reduction.
- Hepatitis C prevalence is rising in 9 countries in the EU, implying a growing risk of a corresponding rise in HIV incidence as the HCV rise is linked to injection.
- Needle exchange programmes and opiate substitution therapy are suboptimal in parts of eastern and western Europe.
- Data on HCV in PWIDs are sparse or lacking

# PWIDs

- Many PWIDs in Catalonia are new injectors, who are young and often migrants; they become infected with HCV soon after starting to inject drugs; many have HIV and HCV co-infections and many, especially migrants, are unaware of their infections
- Prevention, including harm reduction programmes (such as opiate substitution therapy and needle exchange programmes), needs strengthening; an innovative peer-based educative intervention (France) decreased injection practices that contributed to HCV infection and increased HCV testing – the intervention is covered by the French health law promulgated in 2015, meaning that thereby it is potentially replicable in other settings. NGOs are active in Albania but the only needle-exchange programme has ceased because of lack of funds
- Collaboration between clinicians and liver specialists on the one hand and drug specialists and service providers on the other needs to be encouraged and made more effective

# Migrants

- Unprecedented influx of refugees, asylum-seekers and migrants (1.02 million in 2015 and nearly 150,000 so far in 2016 – UNHCR data); legal and illegal immigrants
- Risks of outbreaks of disease, e.g. hepatitis A, in camps and susceptible populations in host countries
- Hepatitis B and C rates reflect those in countries of origin, where vaccination coverage is expected to be good
- WHO does not call for obligatory screening but strongly recommends that health checks be offered
- Examples of programmes were presented:
  - Greece – an estimated 1 million migrants with more coming and staying longer
  - Belgium (Antwerp) – HBV prevalent in Asian communities at rates reflecting those in countries of origin; 50% unaware of infection; linkage to care difficult; cultural barriers
  - Netherlands (Arnhem) – Turkish communities and refugees from Middle East and Asian countries: language issues in former; high rates of HBV were found in first-generation migrants from Viet Nam; high HCV rates were reported in people from former Soviet republics
  - The EpiSouth project presented data from 20 countries bordering the Mediterranean on immigrants' access to immunization
- Difficulties include language, mobility of subjects, follow-up and informing subjects of test results

# Other vulnerable groups

- Roma (10-12 million in Europe, about 4 million in the EU, with 1.8 million in Romania, more than 300,000 and maybe even more than 750,000 in Bulgaria and an estimated 150,000-300,000 in Greece): high rates of HBV and HCV; various approaches and projects used in other countries with Roma (e.g. mobile vaccination team in Belgium and collecting data and improving services in Greece) and other moving populations, but poor acceptance of immunization. Need for information in multiple languages; successful use of trained cultural and health mediators
- Albania has a national action plan whose focus includes health, and health services are offered to the whole population including Roma, but not paying health insurance they do not benefit fully from health services; high rate (10%) of HBsAg, and HCV is present in Roma
- MSM – outreach programme for gay sauna users (some sex workers) in Barcelona – a hidden group with limited access to health services; the programme helped in hepatitis A outbreak but no impact on general MSM population. HCV in MSM is a major problem in Catalonia, and MSM are screened in a programme in Albania
- Sex workers:
  - Belgian programme – the NGO Ghapro provides health and social care, including hepatitis B vaccination, prevention, screening for HCV (few cases found); high mobility is a feature of this population; all new sex workers are tested for HBV markers. Challenges include improving access to care, follow-up and hepatitis C.
  - Clients – a harder to reach population?
- Even tourists to endemic areas

# Screening

- The potential for cure of HCV with new DAAs calls for large-scale screening for chronic HCV infection as a means for global control of the disease
- National plans for viral hepatitis with guidance on screening are vital
- Testing for HCV antibodies is cost-effective in PWIDs, and screening for HBsAg in pregnant women and migrants is also likely to be very cost-effective
- Screening projects: more likely to succeed if personal invitations to participate are issued and key opinion-formers involved; also, close collaboration between all parties dealing with viral hepatitis is vital
- Example of HEPscreen projects from Scotland proved value of using workplace and university settings; success depended on understanding origins of migrants, good planning, flexibility with host organizations, clear information in appropriate language and translators, and rapid delivery of test results
- Value of mobile units (e.g. in France and Greece) was demonstrated
- Need for combined screening for HBV, HCV and HIV

# Screening

- A major benefit of screening is the eventual reduction in the burden of morbidity and mortality due to cirrhosis and liver cancer, the outcomes of long-term disease progression
- Conclusions from the VHPB Budapest meeting on screening in 2010 remain valid:
  - The list of risk groups has not changed for nearly two decades
  - There is no one-fits-all action plan
  - Define the purpose of screening
  - Do not start screening programmes until preparations for the steps to follow are in place – feasibility proven, access, patient management, treatment and follow-up
- As with programmes for treating HCV – prepare a costed strategy first

# Testing

- Point-of-care testing, with rapid diagnostic tests such as dried blood spots and saliva tests, are proving useful with good sensitivity and specificity
- HCV antibody test results need to be followed up with sensitive RNA tests
- Non-invasive testing such as assessment of fibrosis are valuable and effective; advantages in combining multiple such approaches
- Innovative Internet and mass media project in Netherlands includes online risk assessment: well-used and accepted; gave higher uptake of advice for testing than similar projects but uptake is not yet optimal; involvement of general practitioners was successful in raising uptake rates. Need for better validation
- Birth cohort approach did not work in Netherlands

# Prevention and treatment

- Harm reduction programmes are essential; in Slovenia early introduction resulted in low prevalence of HCV in PWIDs
- Online survey in 6 EU countries of policies for hepatitis B vaccination practices for migrants from areas endemic for hepatitis B and in specific vulnerable populations, including pregnant women revealed numerous instances of lack of adherence to recommendations; improved response need clear policies, identified responsibility for implementing those policies, free for those at risk, and better education of medical professionals
- A survey of 33 countries in the WHO European Region (62%) showed that not all countries have or are implementing national plans and clinical guidelines
- Reaching people for vaccination and treatment depends on access to care, cost, trust, tailored information, good communication and political will (and, if possible, strong or charismatic leadership); example of mobile vaccination team in Flanders whose targets include private schools, homeless people, and victims of human trafficking
- A “toolbox” for tailoring communication about immunization for hard-to-reach communities being developed and supported by WHO EURO (its deployment in Sweden was described, demonstrating that its principles applicable to other countries
- International guidelines on management of patients have been published (e.g. those of EASL) and those on management of PWIDs call for treatment

# Treatment

- DAAs are crucial for management of HCV in PWIDs and are effective in those on opiate substitution therapy; continued injection during treatment does not affect disease progression or outcome
- Negotiations with pharmaceutical companies are producing large discounts (examples: the French Government and the Alliance for Public Health in Ukraine)
- Many questions remain unresolved. When and who to treat? At what stage of liver disease (F0/F1 or F2-F4) should treatment start? Should certain subgroups with HCV be prioritized for treatment? These questions provoked an extensive debate on the ethics of screening and possibly not treating. Is it better to prioritize for treatment those with moderate or severe disease or those with the potential to transmit infections but in the early stages of disease progression?

# Concluding remarks

- Data are still often of poor quality or absent; need for better validation, quantification of population denominators, incidence and prevalence rates, prevalence and treatment of HCV in PWIDs and prisoners, etc
- Access to care and services for all underserved people (from prison inmates to illegal migrants) is hindered by numerous factors such as ignorance, misperceptions, distrust, fear of authorities, and stigmatization and discrimination; more work needed on migrants
- Prevention of re-infection: one lesson from HIV/AIDS is to invest in health education after treatment and harm reduction programmes for PWIDs
- Early interventions for PWIDs, migrants and homeless with education and access to services are needed, including increasing access to new HCV prevention tools and HCV treatment in prison settings. More attention needs to be paid to the role of alcohol and cannabis (on disease progression) and ability to understand information

# Concluding remarks

- Value of mobile service provision
- Need to find ways to persuade policy-makers to promote testing and treatment with a general policy that covers all those at risk of infection with HCV
- Utility of legislation (e.g. from France on outreach and Albania on immunization)
- Think globally, act locally. There are many examples of what works, including the use of existing networks and enactment (and application) of laws to facilitate provision of services and access to care, and what works should be broadly implemented
- Better and tailored communication strategies are needed to reach underserved populations and decision-makers (and the public to dispel misperceptions) as well as marketing and business plans for projects
- Vital to invest in careful preparatory work before the initiation of programmes, whether for screening, mobile immunization teams, or tailored communication programmes

# Concluding remarks

- Recognize barriers to reaching hidden populations within hard-to-reach groups: language, culture, lack of knowledge about health, vaccines, diseases, lack of collaboration with traditional care services, costs, time and staff investment; recognize also the role of community leaders and find new ways to reach these populations
- Some interventions are known to work – they need to be implemented
- Start with demonstration projects and scale up to the operational level; successful projects then need to be scaled up and generalized at country level
- Key success factors identified included:
  - Free and easy access to services (e.g. screening, counselling and treatment)
  - Rapid provision of results of screening tests
  - Availability of mobile teams – taking the services to the clients
  - Integrate screening programmes and integrate work on multiple risk dimensions within programmes (e.g. migrants in prisons)