



HIV/Hepatitis coinfection in Europe

WHO Response

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Epidemiology of HCV, HBV and HIV

- Global estimates

	HCV (in million)	HBV (in million)	HIV (in million)
Chronic infection	~180	~400	~ 40
HIV coinfection	~ 4-5	~ 2-4	

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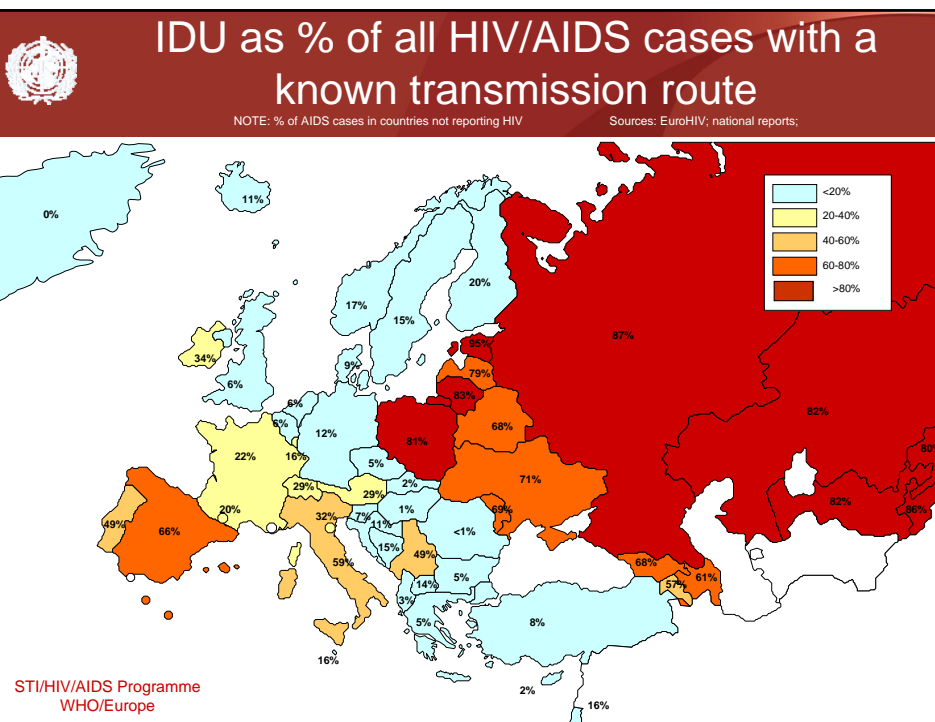


Epidemiology of HCV/HIV

- European prevalence – average 40%, max 90%

HIV infected by RoT	HCV (%)
IDU	70-95
MSM	1-12
Heterosexuals	9-27

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HCV among HIV+ MSM

- **Paris, 2005**
 - 29 cases of acute hepatitis C in HIV+ MSM, 76% asymptomatic (2001-2004)
 - Unprotected traumatic anal sex, mucosal lesions due to STIs
- **Amsterdam, 2007**
 - 1836 MSM (1984-2003)
 - 10 fold increase of HCV incidence in HIV+ MSM
 - Rough sexual techniques (56%), ulcerative STIs (59%), denial of injecting drug use
- **London and Brighton, 2008**
 - Average annual HCV incidence rise in HIV+ MSM 20%
 - Little evidence available of HCV transmission in HIV negative MSM or in MSM with unknown HIV status

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HIV worsens HCV infection

- **Impact of HIV on HCV infection:**
 - Accelerates HCV-associated liver disease
 - Possible immune deficiency in response to HCV
 - Increases risk of HCV transmission
 - MTCT (from 6% to 20%)
 - Sexual transmission (from 0% to 3%)
 - Significantly lowers clearance of HCV
 - Liver disease leading cause of morbidity and mortality
- **Impact of HCV on HIV infection:**
 - Little or no effect on immunological, virological or clinical HIV disease progression or response to ART

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HIV worsens HBV infection

- Impact of HIV on HBV infection:
 - HBV infection is more severe
 - Higher HBV replication, more severe liver fibrosis, greater risk of cirrhosis and rapid progression to ESLD
 - More aggressive HCC, and develops at earlier age
 - HIV risk factor for reactivation of hepatitis B in patients who have developed HBsAb
 - Increased risk for liver-related mortality
- No proof of HBV impact on HIV disease progression

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Surveillance of HCV and HBV in Europe (1)

- Routine surveillance in majority of countries introduced recently, including in EU
- Lack of standardization of hepatitis surveillance in the following:
 - Populations being tested
 - Mandatory or voluntary reporting
 - Case definition (varies within the region)
 - Case reporting (differs in acute and/or chronic, confirmed or not confirmed)
 - Sources of case reports differ or unclear (clinics and/or laboratories, govt and/or private sector or other)

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Surveillance of HCV in Europe (2)

- Inadequate data to describe the true HCV infection trend and disease burden
- HCV represents the most common form of viral hepatitis in the EU

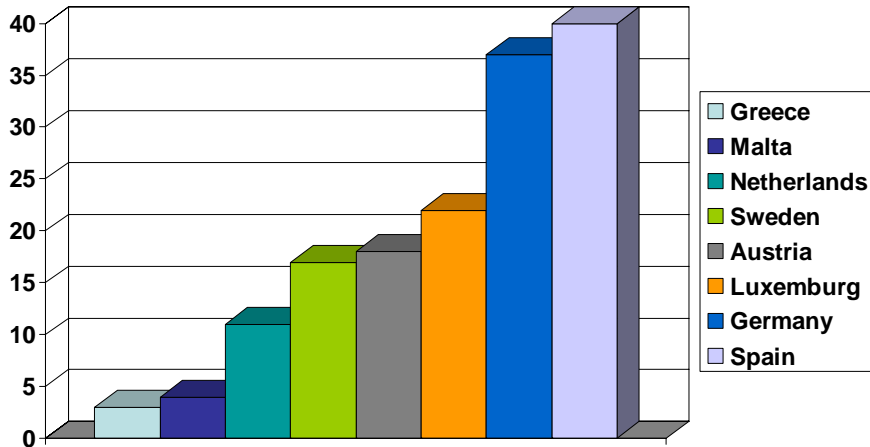


WHO EURO data collection

- Annual survey of the health sector response to HIV/AIDS:
 - Number of PLHIV tested for hepatitis C
 - Number of PLHIV coinfecting with HCV
 - Number of PLHIV with chronic hepatitis C
 - Number of PLHIV receiving treatment for hepatitis C
- Survey 2006, 2008
 - Access to laboratory diagnosis and treatment



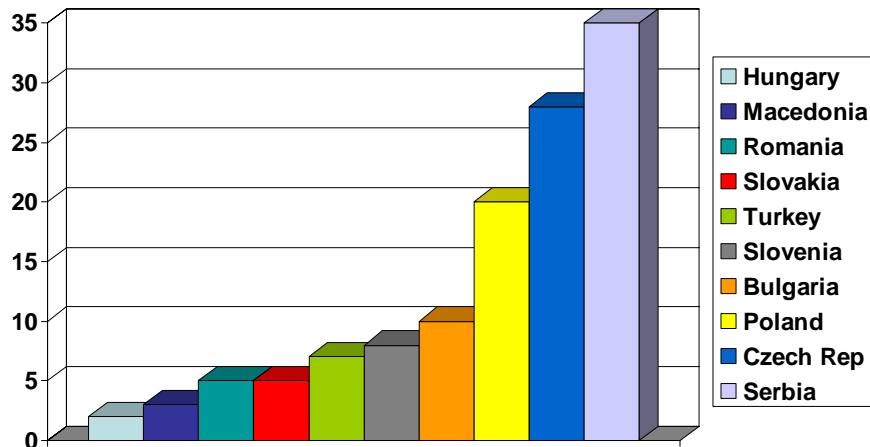
HIV/HCV coinfectd (%) western Europe, end 2006



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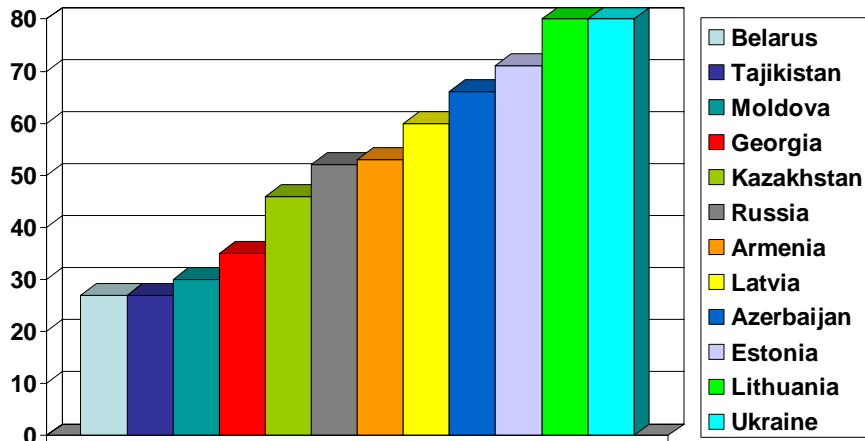
HIV/HCV coinfectd (%) central Europe, end 2006



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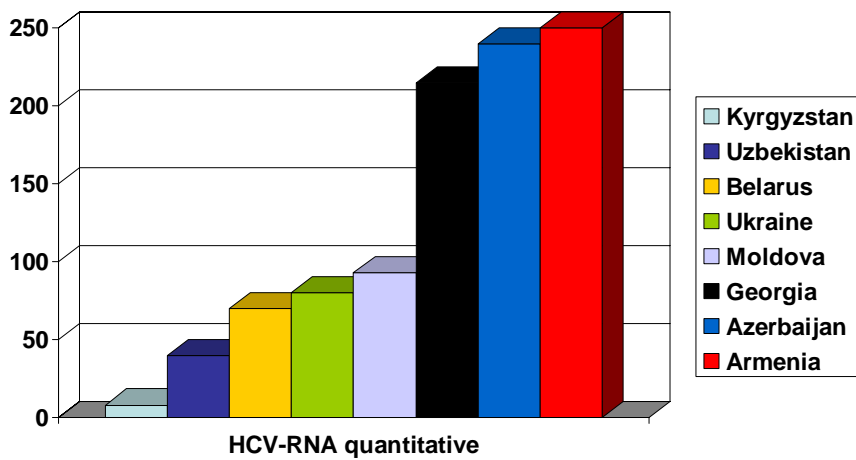
HIV/HCV coinfectd (%) eastern Europe, end 2006



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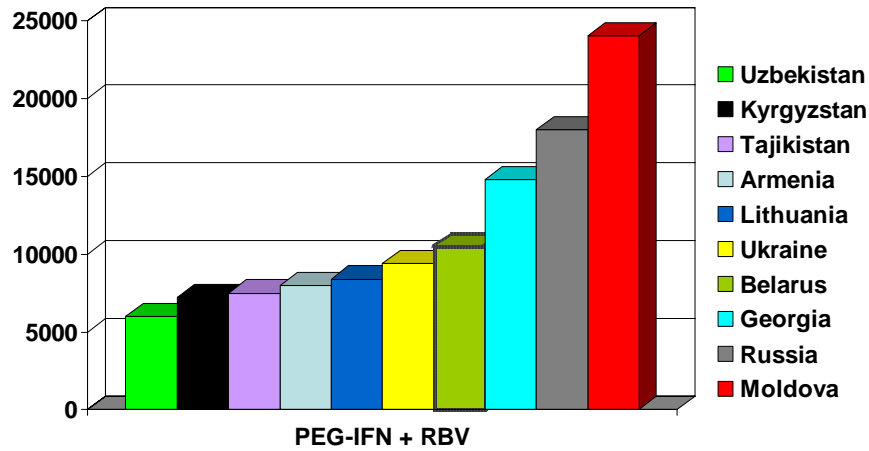
Average HCV laboratory cost (in USD)



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Average HCV treatment cost (in USD)



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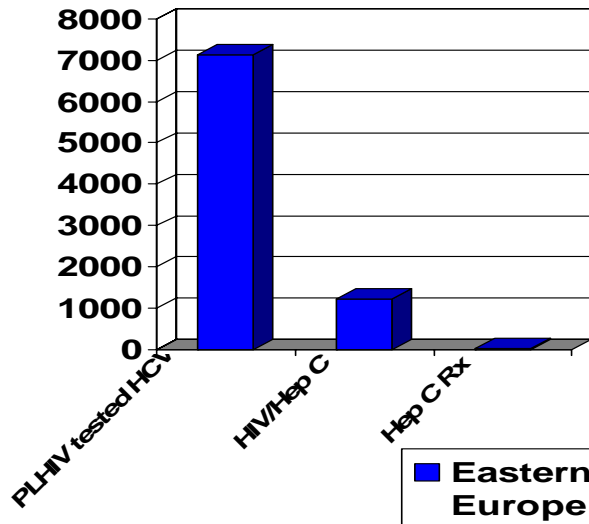
Geographical access

Country	Laboratory	Treatment
Armenia	1	1
Kyrgyzstan	1	1
Tajikistan	N/A	1
Uzbekistan	1	1
Belarus	2	11
Ukraine	33	21

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Hep C treatment in PLHIV



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Reasons for poor access to hepatitis treatment (1)

- Hidden epidemics
 - Poor surveillance
 - Lack of awareness among health care providers and officials
 - Lack of awareness among the general and target populations
 - Lack of strong advocacy at international and national levels

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Reasons for poor access to hepatitis treatment (2)

- Lack of political commitment and available resources for programme responses
- Limited availability and access to diagnostic assays and treatment
- The most vulnerable, active IDUs, have limited access to ART, OST and hepatitis treatment due to health systems, policy issues and discrimination

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WHO EURO response (1)

- Clinical protocols
 - Management of hepatitis C and HIV coinfection
 - Management of hepatitis B and HIV coinfection
 - Prevention of hepatitis A, B, and C and other hepatotoxic factors in people living with HIV/AIDS
- Set of 13 clinical protocols on HIV/AIDS treatment and care
- Found at: www.euro.who.int/aids



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WHO EURO response (2)

- WHO position paper (2004)
 - *Routine vaccination of all infants against HBV infection should become an integral part of national immunization schedules worldwide*

 - *Catch-up strategies targeted at older age groups or groups with risk factors should be considered as a supplement to routine infant vaccination in countries of intermediate or low hepatitis B endemicity*

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WHO EURO response (3)

- Vision: *(draft)* Universal access to hepatitis B and C prevention, treatment and care

- Ultimate goal: *(draft)* To reduce incidence, prevalence, morbidity, and mortality of viral hepatitis in the WHO EURO region

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WHO EURO areas of work

- Policy, strategy and standards
- Advocacy
 - Increase political commitment, resource mobilization, reduction of cost
- Surveillance in collaboration with ECDC
- Expansion of prevention programmes
 - HR, hep B vaccination of VP, safety in health care settings
- Address hepatitis treatment and care and access
- Capacity building of the Member States

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Lessons learned from HIV

- Strong standardized surveillance
- Awareness of the problem (general population, risk groups, health care authorities and providers)
- Advocacy, activism, lobbying from patient led organizations
- Financial resources (GFTAM, donor agencies)
- Price reduction strategy for tests and Rx
- Public health approach to Rx (standardized simplified recommendations), to allow scale-up of access to Rx
- Provider initiated testing
- Investment in research (HAART, fixed dose combinations)

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