World Hepatitis Alliance

HepHIV 2014
5-7 OCTOBER BARCELONA
HIV and Viral Hepatitis: Challenges of Timely Testing and Care

Testing of Hepatitis: Global and European Perspectives

Charles Gore
World Hepatitis Alliance

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Declaration of conflict of interest

The World Hepatitis Alliance has received funding from:

- AbbVie
- Achillion
- Bayer
- BI
- BMS
- Gilead
- GSK
- Janssen
- Merck
- Roche

I do not receive any personal remuneration from either any part of the pharmaceutical industry or from the World Hepatitis Alliance

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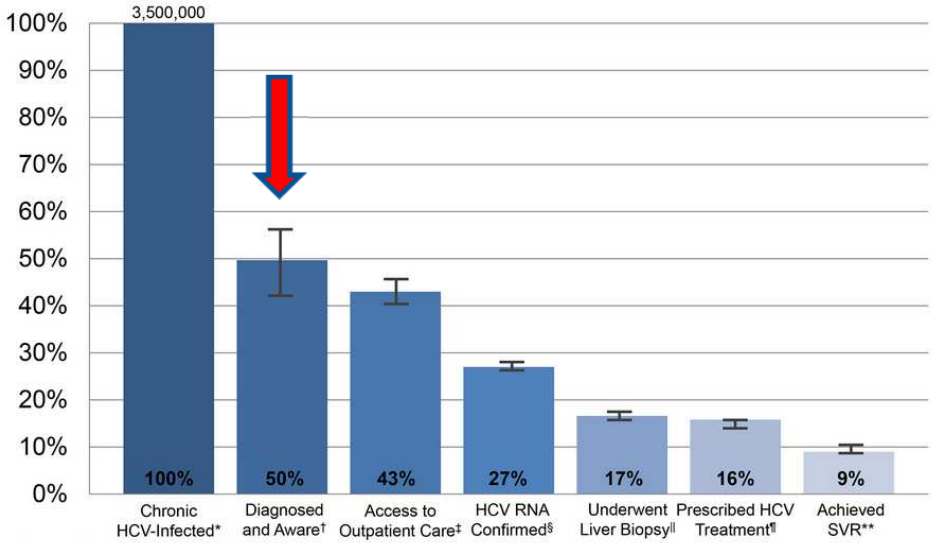
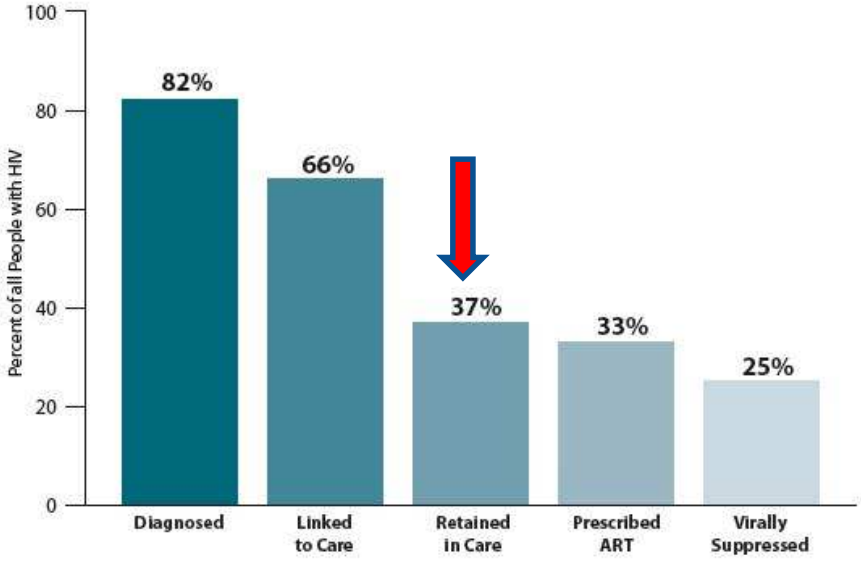
Cascade/continuum of care: HCV and HIV the US example

HCV



* Chronic HCV-Infected; N=3,500,000.
† Calculated as estimated number chronic HCV-infected (3,500,000) x estimated percentage diagnosed and aware of their infection (49.8%); n=1,743,000.
‡ Calculated as estimated number diagnosed and aware (1,743,000) x estimated percentage with access to outpatient care (86.9%); n=1,514,667.
§ Calculated as estimated number with access to outpatient care (1,514,667) x estimated percentage HCV RNA confirmed (62.9%); n=952,726.
‖ Calculated as estimated number with access to outpatient care (1,514,667) x estimated percentage who underwent liver biopsy (38.4%); n=581,632.
¶ Calculated as estimated number with access to outpatient care (1,514,667) x estimated percentage prescribed HCV treatment (36.7%); n=555,883.
** Calculated as estimated number prescribed HCV treatment (555,883) x estimated percentage who achieved SVR (58.8%); n=326,859.
Note: Only non-VA studies are included in the above HCV treatment cascade.

HIV



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Global diagnosis?

- Very uncertain denominator (i.e. the prevalence)
- Very poor surveillance
- Very few developed countries have diagnosed >50% of HCV
- HCV diagnosis better than HBV
- Global best estimate <20%

The results of low diagnosis

- Low levels of monitoring/treatment
- High rates of mortality

2010 Global Burden of Disease (Lancet Dec 2012)	VIRAL HEPATITIS	HIV/AIDS	TB	MALARIA
ASIA PACIFIC TOTAL	1,012,873	304,628	827,567	106,729
AMERICAS TOTAL	109,025	74,019	25,044	1,268
EUROPE TOTAL	123,818	82,009	35,803	0
AFRICA & MIDDLE EAST TOTAL	198,838	1,004,712	307,576	1,061,501
TOTAL	**1,444,554**	**1,465,368**	**1,195,990**	**1,169,498**

Reasons for low testing/diagnosis in policy

Global

- Screening used to EXCLUDE people, e.g. armed forces, HCW, blood donors
- 48.6% make screening compulsory for HBV
- 45.2% make screening compulsory for HCV
- Very few, very small screening programmes
- Treatment of HBV and HCV not seen as cancer prevention (although HBV vaccination is)
- Hepatitis submerged beneath other priorities

Europe

- Liver disease and/or viral hepatitis has low profile in most countries - liver disease, including HBV and HCV, not part of health check-ups
- Screening programmes, where they exist, limited to certain populations, e.g. MSM, PWID

Reasons for low testing/diagnosis on the ground

Global

- Low demand from those at risk
  - low awareness
  - feeling well OR
  - symptoms ascribed to other things
  - marginalised communities
  - stigma/discrimination

Europe

- Little action from family doctors
  - too busy for case-finding
  - viral hepatitis too rare to engage them in most countries
  - lack of knowledge of symptoms till ESLD
  - lack of understanding about abnormal LFTs

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Why is it so important to change this?

Efficacy of treatment

- HBV treatment prevents disease progression and cancer
- HCV treatment prevents disease progression and cancer and cures HCV

BUT (even affordable) drugs are irrelevant if no-one knows they need them

Momentum and demand

- WHA67.R6 – ‘preventing, diagnosing and treating’
- WHO to assess elimination and establishment of goals
- Link to cancer – IARC: “we cannot treat our way out of the cancer problem. More commitment to prevention … is desperately needed”
- ECDC framework/WHO region
- Patient advocacy

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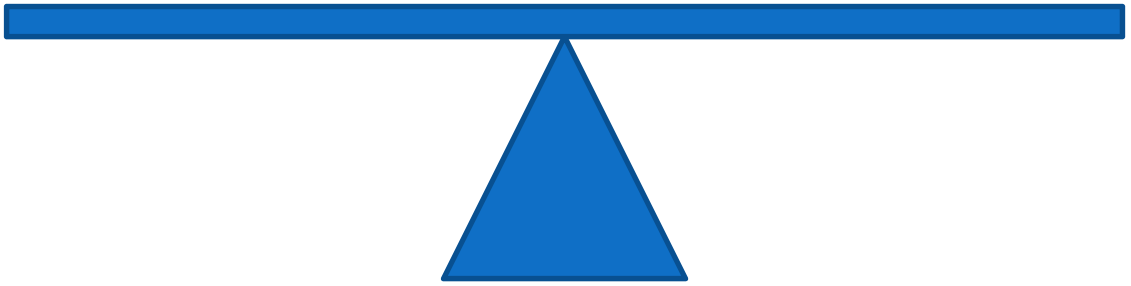
Ethics of testing independent of treatment

A positive diagnosis exposes someone to stigma/discrimination

Without treatment testing burdens someone with knowledge of their status



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Status knowledge is needed to prevent transmission to family/SOs

Reducing alcohol is an effective ‘treatment’

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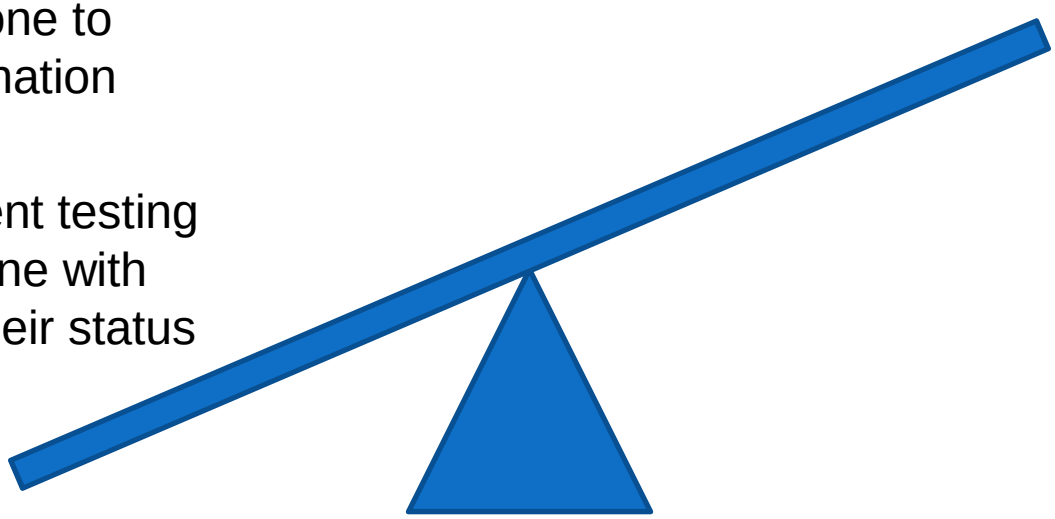

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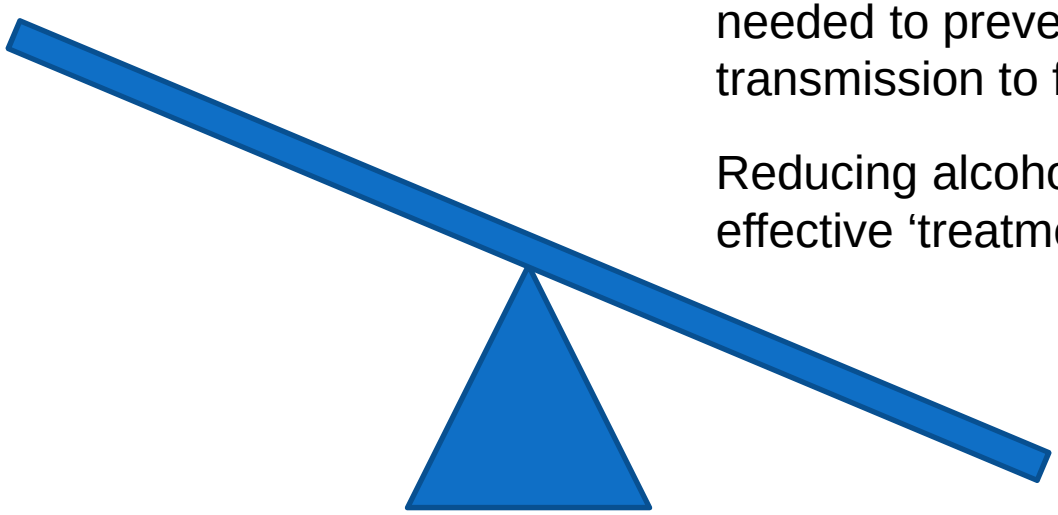

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Options to increase diagnosis

Increase demand from those at risk

Issue

- Low demand from those at risk
  - low awareness
  - feeling well OR
  - symptoms ascribed to other things
  - marginalised communities
  - stigma/discrimination

Solution?

- General awareness campaigns

BUT depends on epidemiology, culture, cost, willingness to take action

- Targeted awareness campaigns

BUT depends on willingness to take action

Options to improve testing/diagnosis

Increase case-finding

Issue

- Little action from family doctors
  - too busy for case-finding
  - viral hepatitis too rare to engage them in most countries
  - lack of knowledge of symptoms till ESLD
  - lack of understanding about abnormal LFTs

Solution?

- Incentivise testing or make it a national priority

BUT can this be justified in most countries?

- Train them

BUT a long-term solution only

Options to improve testing/diagnosis

Screening

Issues

- Effectiveness of screening (and linkage to care)?
- Cost and cost-effectiveness (includes cost of treatment)?
- Who to screen?
- Stigma?

Solutions?

- Involvement of civil society
- Find ways to lower cost (e.g. combining with other tests, HCV with HBV and HIV in pregnant women)
- Define the groups with the highest prevalence and those with most need (likely to be most cost-effective)
- Non-stigmatised screening, e.g. by age (US ‘baby-boomers’ HCV prevalence of 3.3% vs 0.55%), by location (drug services, prisons, HIV clinics, community centres, mosques, ante-natal clinics), by region of origin

Screening

We need to stop asking
IF we can increase diagnosis and IF it's cost-effective

And ask instead

HOW we can increase testing and HOW we can make it cost-effective

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Thank you

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