

ELIMINATE ~~HEPATITIS~~

Global Strategy and European action plan on viral hepatitis. HCV guidelines update.

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WHO Regional Office for Europe

VHPB contry meeting – Russian Federation
26 October 2018, Moscow

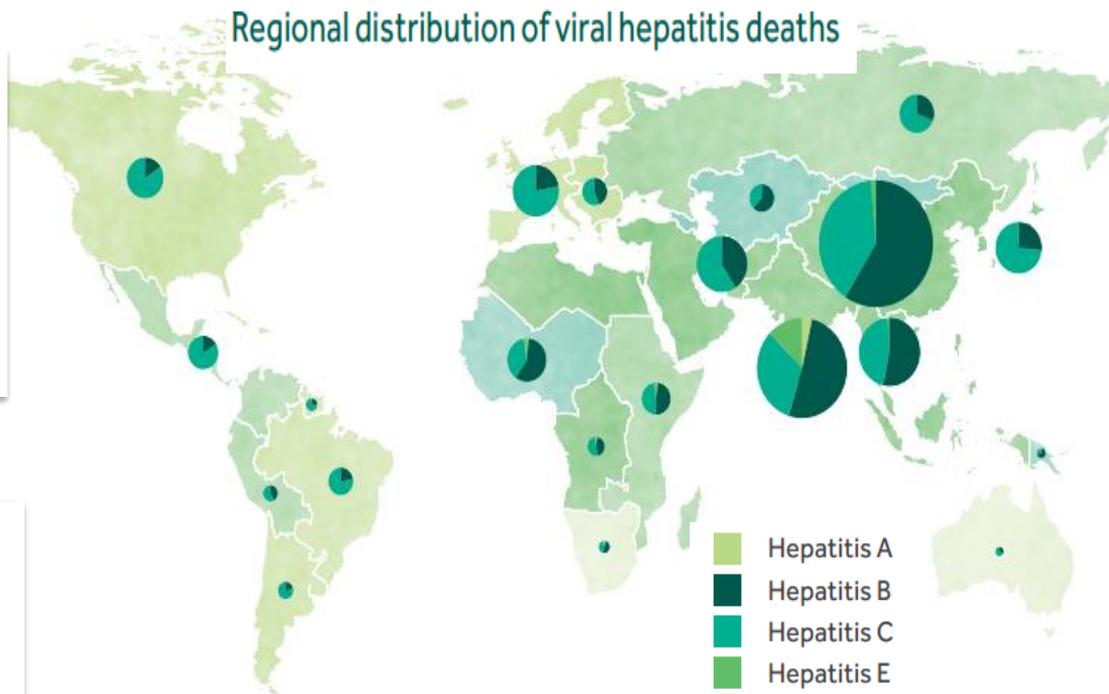


Viral hepatitis: the global epidemic

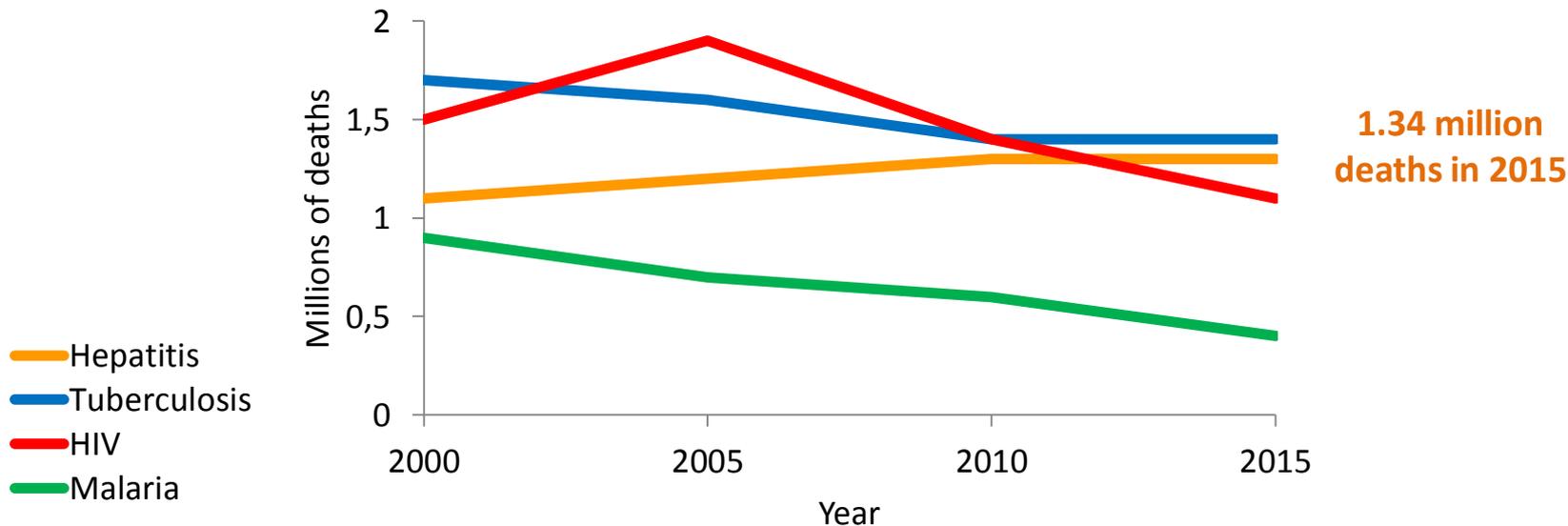
7th

leading cause
of death
globally
(2013)

95% of the
burden
from hepatitis
B and C



Hepatitis mortality is increasing



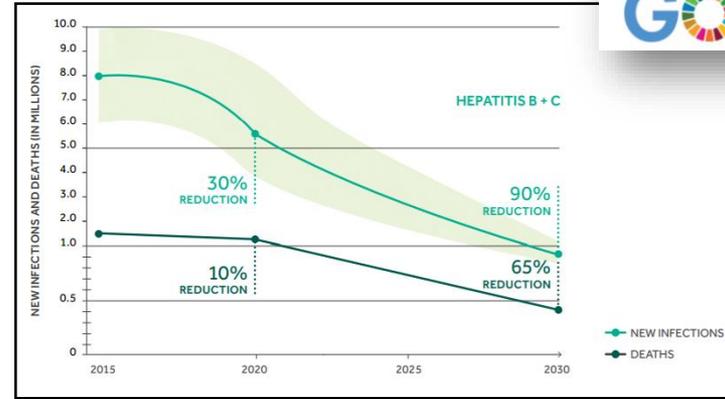
96% hepatitis deaths from HBV and HCV (cirrhosis and hepatocellular carcinoma)



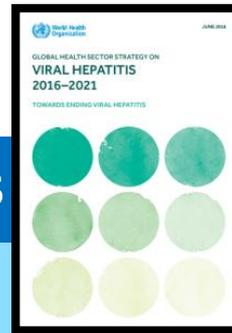
In May 2016, the World Health Assembly endorsed the elimination of hepatitis as a public health threat by 2030



- What does “elimination as a public health threat” mean?
- Incidence reduced by 90%
- Mortality reduced by 65%
- What are the implications?
- Countries formulate plans
- WHO reports on progress



Eliminating hepatitis by 2030: A package of interventions with high impact



| | Interventions | 2030 targets |
|----------------------------|-----------------------------------|--|
| 1. Service coverage | 1. Three dose hepatitis B vaccine | 90% |
| | 2. HBV PMTCT | 90% |
| | 3. Blood and injection safety | 100 % screened donations 90% reuse-prevention devices 100% safe injections |
| | 4. Harm reduction | 300 injection sets/PWID/year |
| | 5. Testing and treatment | 90% diagnosed 80% eligible treated |
| 2. Impact | A. Incidence reduction | 90% |
| | B. Mortality reduction | 65% |

European Action plan on viral hepatitis

Goal: **Eliminate viral hepatitis as a public health threat by 2030**

Five strategic directions:

1. Information for focused action
2. Interventions for impact
3. Delivering for equity
4. Financing for sustainability
5. Innovation for acceleration

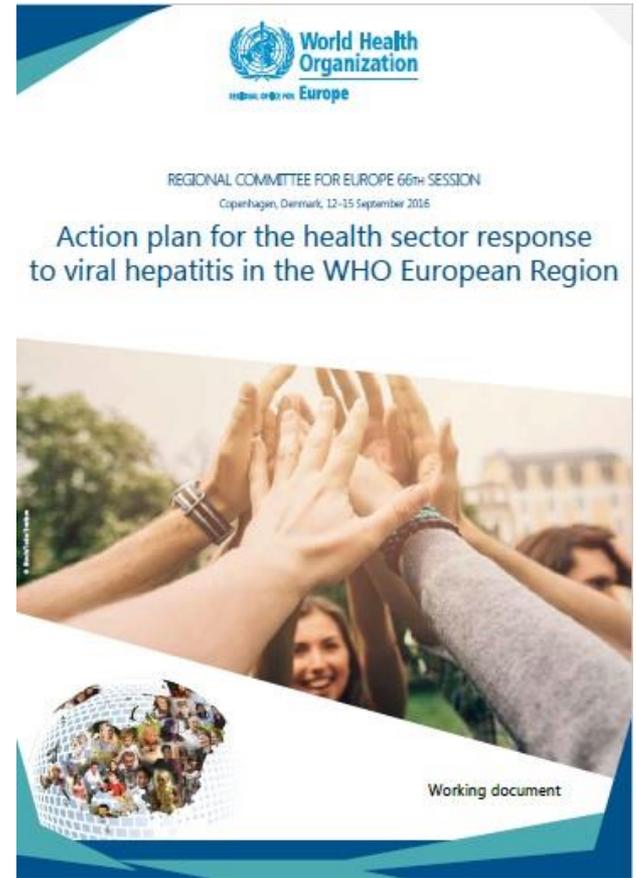
UHC 3 DIMENSIONS

- the «what»
- the «how»
- the financing



September 2016: Resolution (EUR/RC66/Conf.Doc./6)

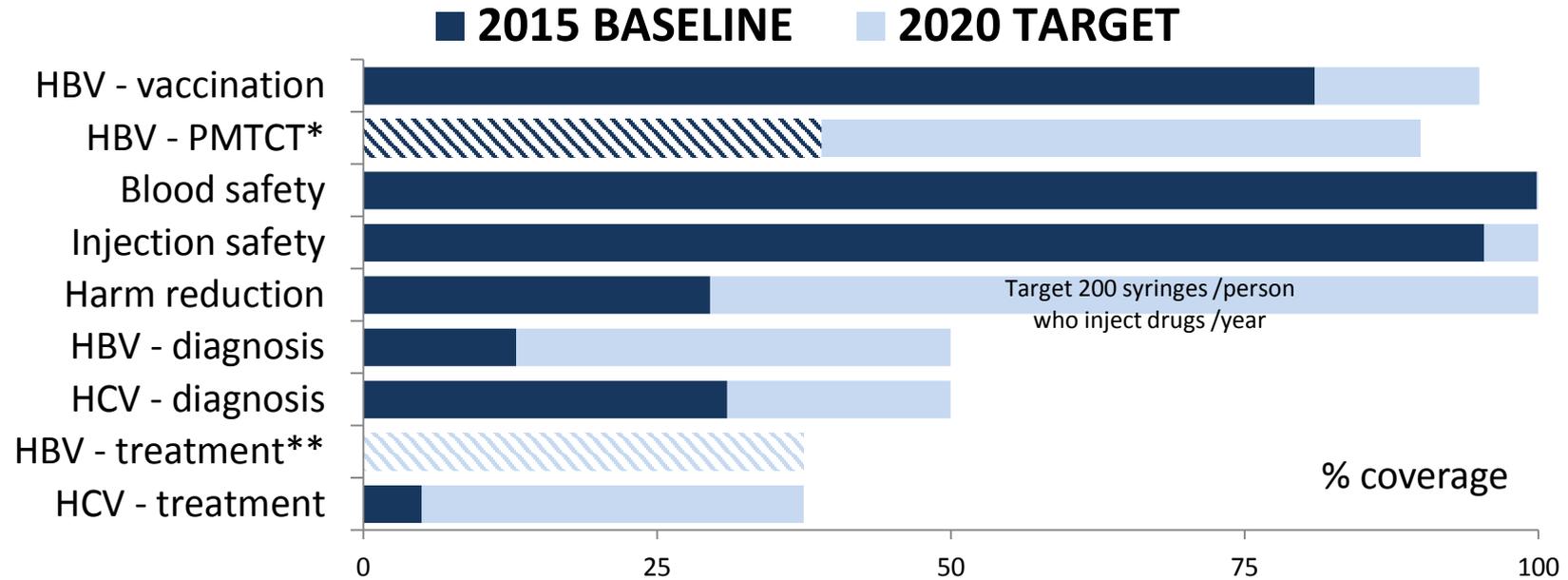
- align national viral hepatitis strategies with the action plan and strengthen public health systems
- target individuals most affected and at risk
- facilitate partnerships to strengthen the response to viral hepatitis and exchange of best practices and experiences
- monitor and report to 69th and 72nd Regional Committees on implementation of the action plan



Targeting populations most affected

- Responses must be based on the epidemiological and social context
- In many countries, transmission of hepatitis B virus and hepatitis C still occurs in health care settings
- Populations exposed through sexual transmission may include young people and adolescents, men who have sex with men, sex workers, transgender people and prisoners
- People who inject drugs are at high risk of hepatitis C and hepatitis B infection because of the shared use of contaminated injecting equipment

Regional “essential” targets by 2020 on the way to elimination of hepatitis

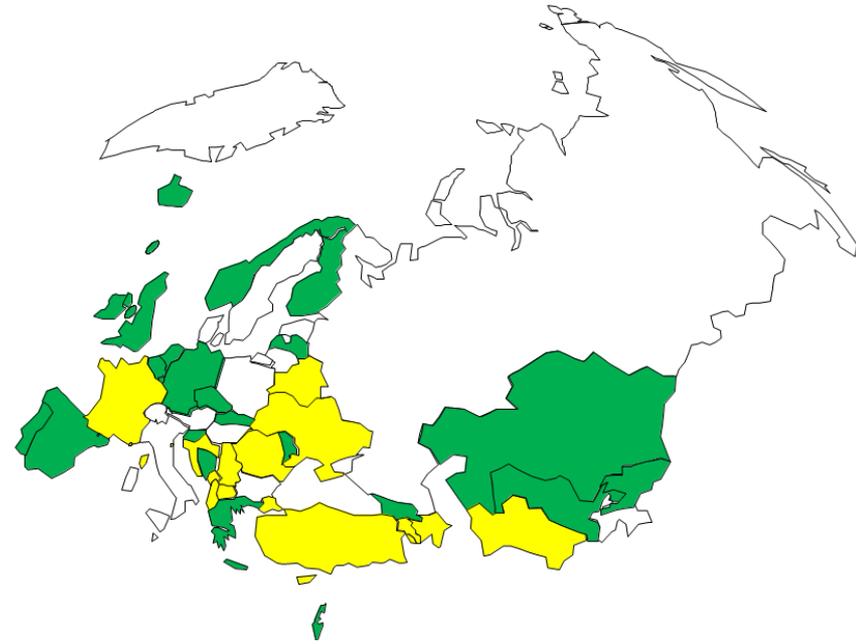


* Measuring the progress on vertical transmission prevention is limited by data on pregnant women screening coverage

** Measuring the progress on HBV treatment is now limited by the absence of data on the proportion of persons eligible

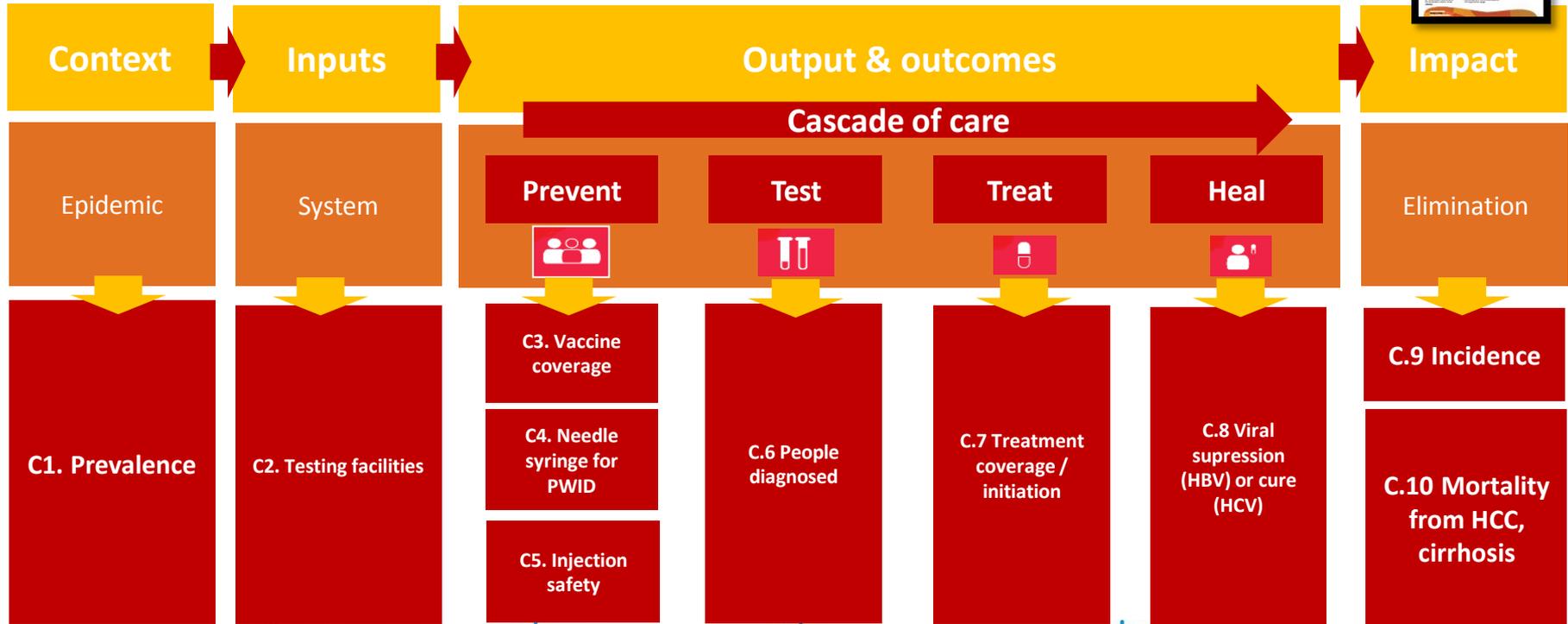
Countries stepping up to eliminate hepatitis

The number of countries with **national hepatitis plans** increased from 13 (in 2013) to 22 (in 2017) in our Region

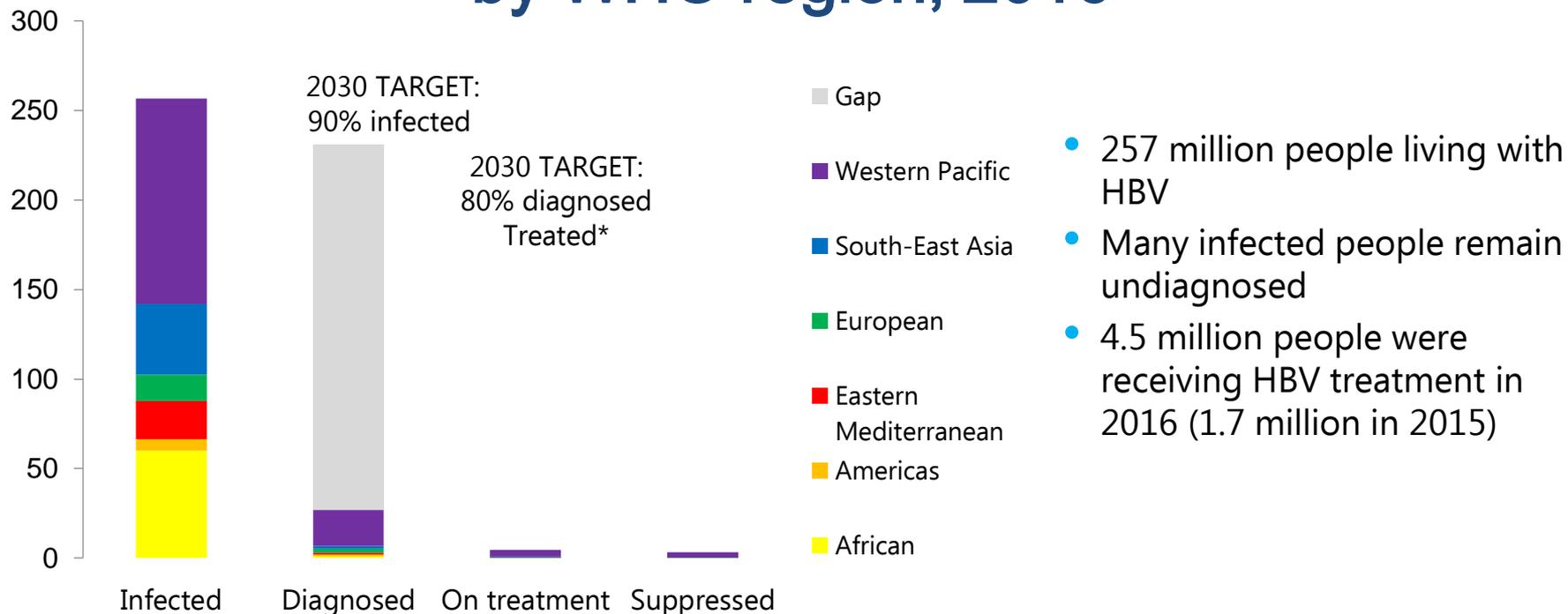


- Endorsed hepatitis action plans (22 countries)
- Developing hepatitis action plans (14 countries)

Monitoring and evaluation framework for HBV and HCV



Cascade of care for HBV infection by WHO region, 2016

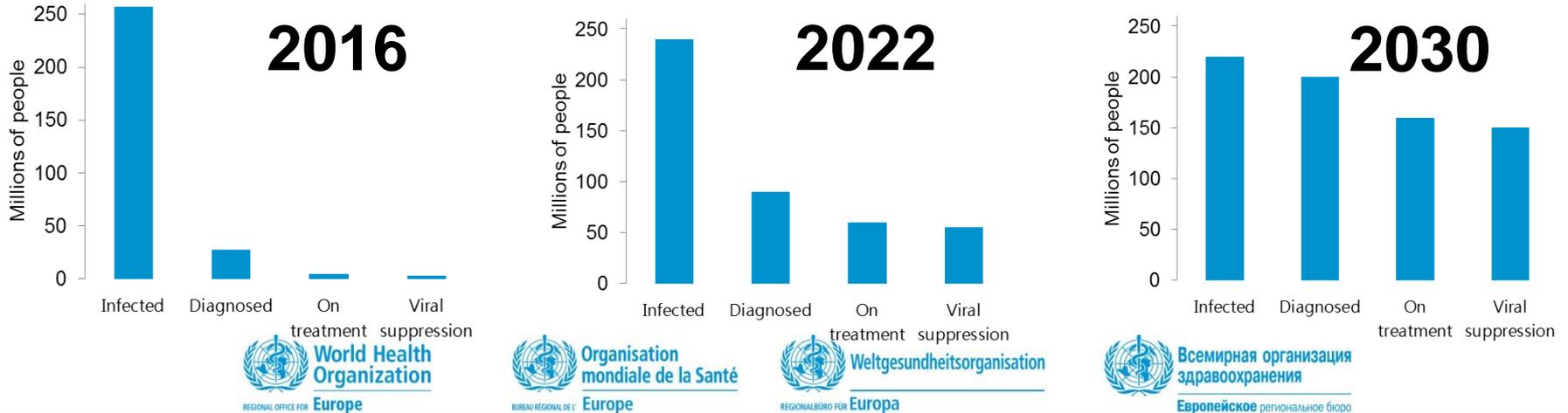


- 257 million people living with HBV
- Many infected people remain undiagnosed
- 4.5 million people were receiving HBV treatment in 2016 (1.7 million in 2015)

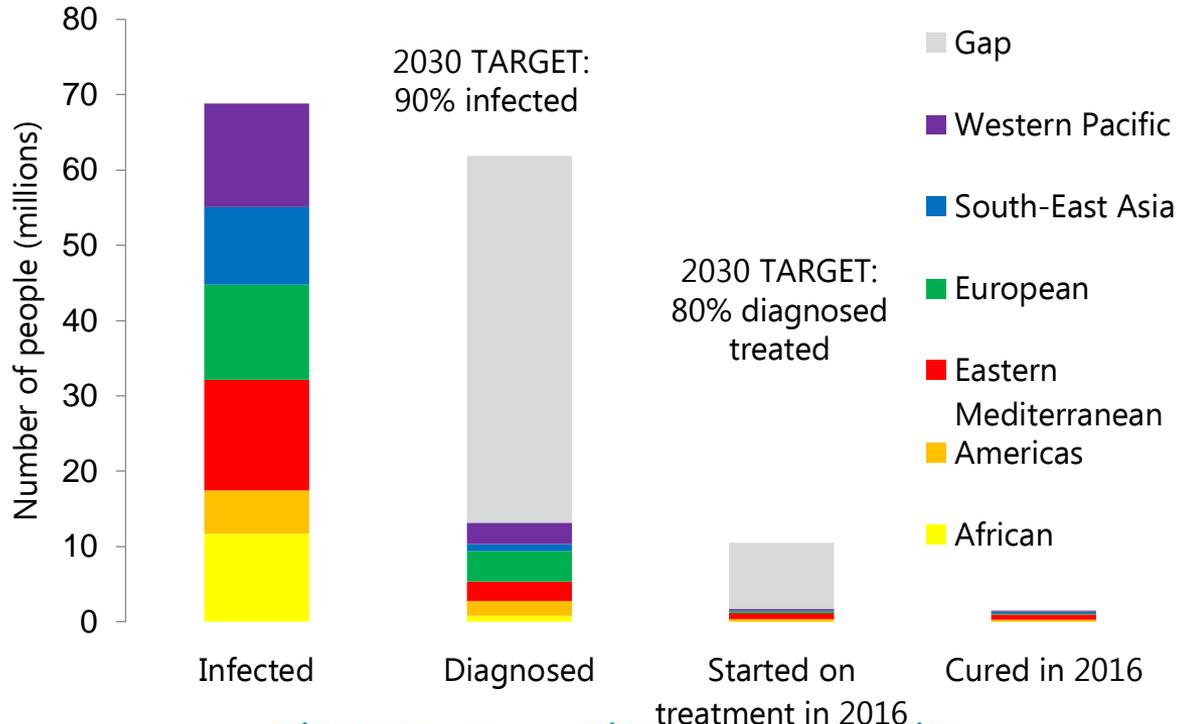
* Measurement of progress on the HBV treatment target is currently limited by the absence of data on the proportion of people who are eligible and the absence of a functional cure.

Hepatitis B cascade of care: people stay on treatment and HBV replication is suppressed

- Lifelong treatment suppresses replication (similar to HIV)
- **Cascade indicators:**
 - People tested and diagnosed (C6)
 - Treatment coverage (C7)
 - Those receiving treatment with suppressed viral loads (C8)



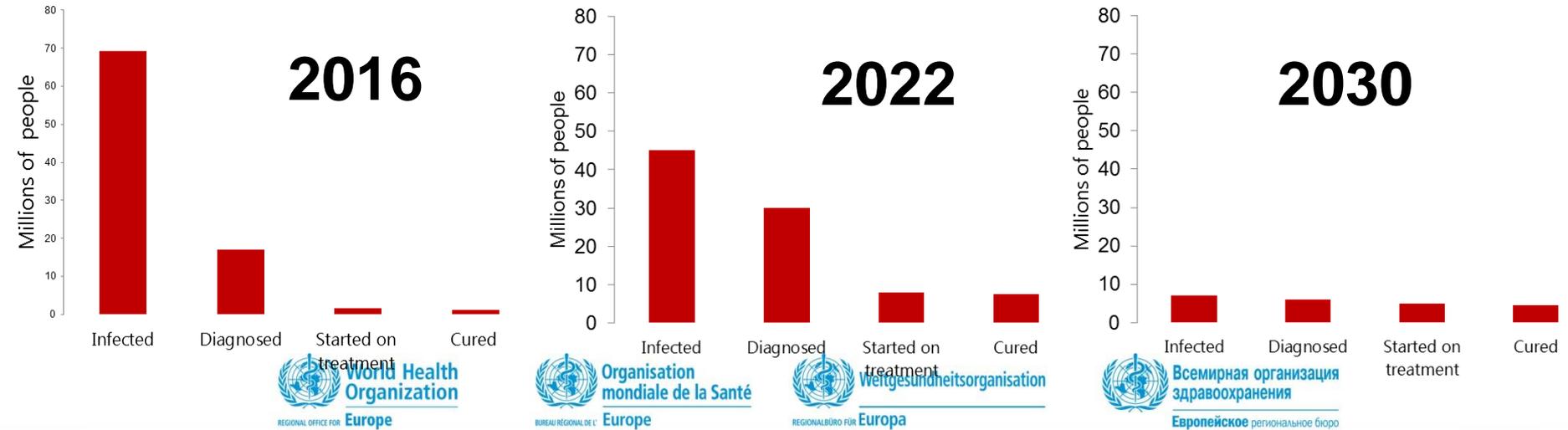
Cascade of care for HCV infection by WHO region, 2016



- 71 million people with chronic HCV
- Major gaps in diagnosis
- 1.76 million people started HCV treatment in 2016 (1.10 million in 2015)
- Total: about 3 million (2017)

Hepatitis C cascade of cure: the number of people infected progressively declines

- Short, curative treatment (similar to tuberculosis)
- **Cascade indicators:**
 - People tested and diagnosed (C6)
 - Treatment initiation rate (C7)
 - Proportion cured among the people finishing treatment (C8)



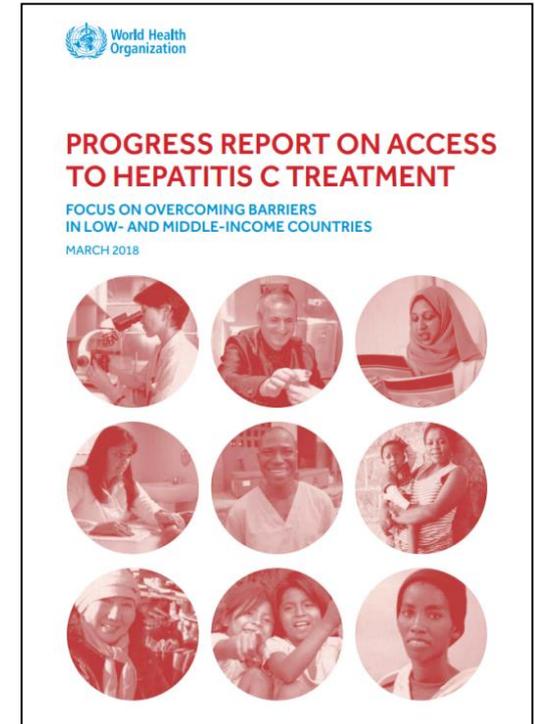
WHO working towards global reporting

1. Prevention indicators are already collected:
No need to duplicate these systems.
2. Aggregation of testing and treatment data needed to monitor the cascade
3. New system to monitor the cascade and other pieces missing:
 - Policy uptake
 - Cascade of care and cure
 - Sequelae
4. Online data entry using DHIS2 tools on WHO servers

Progress Report on Access to Hepatitis C Treatment

Focus on overcoming barriers in low- and middle-income countries

- Launched in March 2018
- Reviews the progress countries have made in expanding access to life-saving DAAs
- Delineates the main challenges countries face
- Describes recent developments in affordability, quality assurance, regulatory approval, government commitment and financing
- Highlights key areas for action by ministries of health and other government decision-makers, pharmaceutical manufacturers and technical partners



Monitoring price reductions for DAAs

Opportunities: Intensifying competition to reduce prices

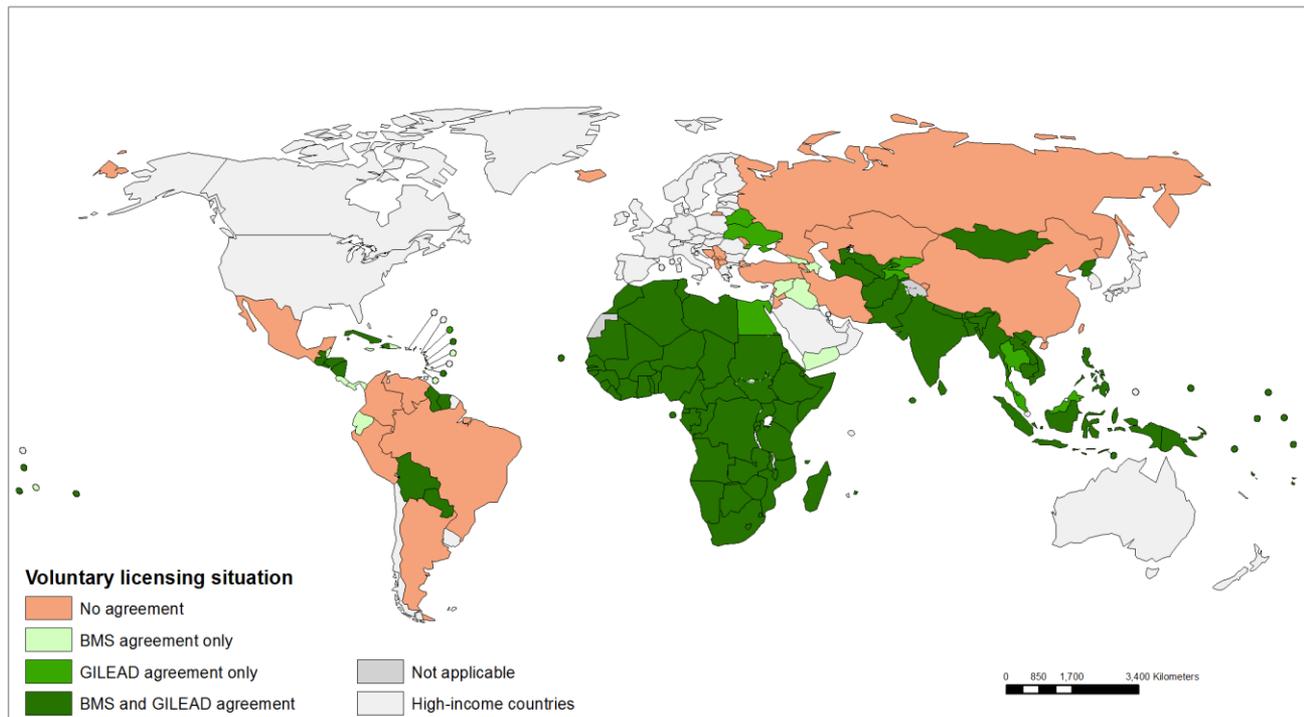
Fig. 3.3. Trends in the lowest reported prices for direct-acting antivirals per 28-day supply, 2016–2017



Note: Prices as reported by DAA producers and countries in the WHO 2016 and 2017 surveys

62% of HCV infected persons live in countries that can currently procure generic DAAs

Voluntary licensing territories for key direct-acting antivirals in low- and middle-income countries, 2017



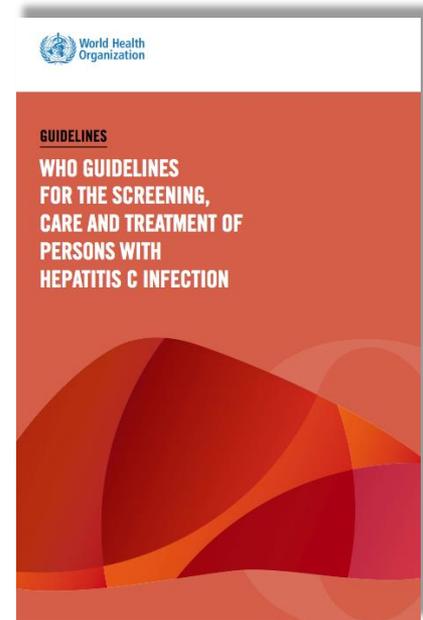
The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Information Evidence and Research (IER)
World Health Organization

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What has happened since release of WHO 2016 guidelines on HCV?

- Price reductions and wider availability of generics (*WHO Progress Report on Access to HCV Treatment*, March 2018)
- New pan-genotypic DAA regimens approved:
 - Sofosbuvir/Velpatasvir
 - Glecaprevir/Pibrentasvir
- Accumulating evidence on safety and effectiveness of DAA regimens in real world (e.g., Daclatasvir/Sofosbuvir)
- Further guidance needed on when to start treatment and what treatment to use



Whom to treat and when to start?

- New upcoming WHO guidance looks to **move towards treating all those infected above 12 years of age** (with exception of pregnant women)
 - DAAs lead to high rates of cure (SVR) and SVR is associated with reduced all cause mortality, liver related mortality, and reduced incidence of HCC (*based primarily on IFN data*)
 - SVR is associated with improvement of co-morbidities like diabetes, depression and chronic renal disease
 - Treatment of HCV-infected adolescents is effective and well tolerated

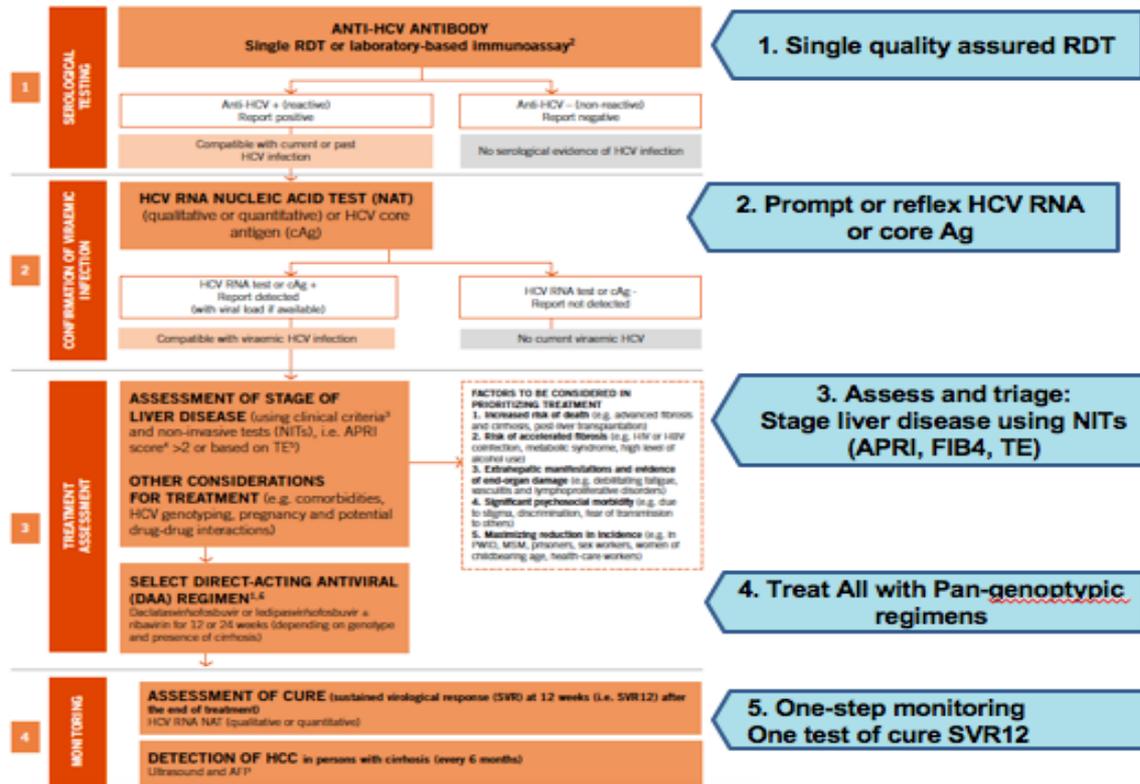
What treatment to use?

WHO is considering the use of pan-genotypic DAA regimens for the treatment of persons with chronic hepatitis C infection aged 18 years and above

- Pan-genotypic DAAs on the market:
 - Sofosbuvir/Velpatasvir
 - Glecaprevir/Pibrentasvir (no access policy yet announced)
 - Daclatasvir/Sofosbuvir (based on real-world observational studies, including MSF data for genotypes 5 and 6)

Simplified testing and management algorithms

FIG.3. Summary algorithm for diagnosis, treatment and monitoring¹ of chronic HCV infection



1. Single quality assured RDT

2. Prompt or reflex HCV RNA or core Ag

3. Assess and triage:
Stage liver disease using NITs (APRI, FIB4, TE)

4. Treat All with Pan-genotypic regimens

5. One-step monitoring
One test of cure SVR12

Five key steps

Acknowledgments

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