



Editorial

Strategies for achieving universal access to hepatitis C virus prevention and care for people who inject drugs



Globally, control of hepatitis C virus (HCV) infection among people who inject drugs (PWID) will require targeted strategies to enhance HCV diagnosis, link individuals into HCV care, increase treatment uptake and enhance viral cure, collectively termed the “HCV cascade of care”. A major challenge will be to develop and implement programs appropriate for different settings, including low- and middle-income countries. In this issue of the journal, we include a cluster of guest-edited papers focused on the theme of achieving universal access to HCV prevention and care for PWID. This follows the linked guest-edited special issue of the journal (Volume 26, Issue 10) which collated together research articles, systematic and expert reviews, and commentaries on the broader topic of “Expanding access to prevention, care and treatment for HCV infection among PWID” (Grebely et al., 2015a, Martinello and Matthews, 2015, Smith et al., 2015, Meyer et al., 2015, Whiteley et al., 2015, Larney et al., 2015, Hellard et al., 2015, Harris et al., 2015, Artenie et al., 2015, Alavi et al., 2015, Marshall et al., 2015, Treloar et al., 2015, Keats et al., 2015, Mason et al., 2015, Litwin et al., 2015, Milne et al., 2015, Grebely et al., 2015b). Both this themed issue of papers and the special issue were commissioned by the journal in collaboration with the International Network for Hepatitis in Substance Users (INHSU), an international organization dedicated to scientific knowledge exchange, knowledge translation, and advocacy focused on HCV prevention and care among PWID.

International guidelines from the American Association for the Study of Liver Disease (AASLD)/Infectious Diseases Society of America (IDSA), the European Study for the Association of the Liver (EASL), and the International Network for Hepatitis in Substance Users, all recommend treatment for HCV infection among people who use drugs (AASLD/IDSA, 2015; European Association for Study of Liver, 2014; Robaeyns et al., 2013) (Grebely et al., 2015b). In fact, international recommendations also suggest that PWID should be a priority population, given the potential prevention benefits of treatment (AASLD/IDSA, 2015) (Grebely et al., 2015b).

As highlighted by Doyle et al., in 2014, the first global HCV guidelines released by the World Health Organization have also recently advocated targeted HCV testing for PWID (WHO, 2014), assessment of liver disease, and support for alcohol reduction during care (Doyle et al., 2015) (WHO, 2014). They also strongly advocate treatment using currently licenced DAA-based treatment for all individuals, in particular PWID as a key affected population (WHO, 2014). As Doyle and colleagues suggest, national and international policy must facilitate the rapid scale-up of treatment and include PWID specifically in treatment access campaigns (Doyle et al., 2015).

Globally, Scotland has been a leader in development of strategies to achieve universal access to HCV prevention and care among PWID. As described by Hutchinson et al., the first phase of the Scottish Hepatitis C Action Plan was launched in 2006, while the second phase, saw serious commitment from Scottish Government to deliver actions designed to dramatically improve prevention, diagnosis and treatment services

throughout the country, with a specific focus on PWID (by 2015, around £100 million will have been invested in HCV) (Hutchinson et al., 2015). The plan sought to improve services to prevent HCV transmission, particularly among PWID, identify those infected and ensure those infected receive optimal treatment. Achievements include around 50% increase in the proportion of the infected population diagnosed (38–55%); a sustained near two-and-a-half fold increase in the annual number of people initiating therapy, with more pronounced increases among PWID and prisoners, and reversing of an upward trend in the overall number of people living with chronic infection. The Action Plan has demonstrated that a Government-backed, coordinated and invested approach can transform services and rapidly improve the lives of thousands. Cited as “an impressive example of a national strategy” by the Global Commission on Drug Policy (GCDP, 2013), the Scottish Plan has also provided fundamental insights of international relevance into the management of HCV among PWID and serves a model for other countries globally.

A major challenge for achieving universal access to HCV prevention and care for PWID will require the expansion of services in low- and middle-income countries. Despite a number of effective available harm reduction strategies [e.g. needle and syringe program (NSP) and opioid substitution treatment (OST)], access to and uptake of HCV prevention strategies globally remains suboptimal (Mathers et al., 2010). In a systemic review of available prevention strategies for PWID among 200 countries globally, only 41% ($n = 82$) of countries had implemented NSPs and 35% ($n = 70$) had implemented OST (Mathers et al., 2010). Further, as highlighted by Luhman et al., HCV testing, linkage to care and treatment uptake remain very low in many countries, with few countries having national policy plans with specific strategies to address prevention and treatment in PWID (Luhmann et al., 2015). Drawing on lessons learnt from scaling up access to HIV treatment in low and middle income countries, in this issue, Ford et al. outline ten key priorities for expanding access to HCV prevention and treatment for PWID, including: (1) Affordable access to interferon-free HCV treatment; (2) increased awareness and testing; (3) standardization of treatment; (4) simplification of service delivery; (5) integration of services; (6) peer support; (7) treatment within a framework of comprehensive prevention (including NSP and OST); (8) tracking progress; (9) funding; and (10) enabling policies (Ford et al., 2015).

As highlighted by Wolfe et al., these are all changes that can be developed with – rather than “to” or “for” – PWID (Wolfe et al., 2015). Human rights principles of participation, accountability, non-discrimination and transparency are consonant with the long history of work by PWID to make HIV services more responsive to their needs (Friedman et al., 2007), and with recent community calls urging that HCV treatment leave no one, including PWID, behind (MDM & INPUD, 2015). Whether or not framed explicitly in a ‘rights-based’ language, reform of HCV treatment should be grounded in a fundamental human rights claim: that injection of illicit drugs no longer be a criminal act and should not

mean exclusion from citizenship, participation or quality, affordable, accessible care.

Conclusions

This is an exciting era for the field of HCV. As newer IFN-free DAA agents become available, strategies to address HCV infection among PWID will need to be integrated into existing foundations for prevention and health care for PWID, in partnership with the affected community and with a commitment to tackling stigma and discrimination associated with injecting drug use and HCV. However, as we move forward, and as the themed papers in this issue highlight, it will be important to consider how HCV testing, linkage to care and treatment can be expanded globally to achieve universal access to HCV therapy for PWID and strive towards control of HCV worldwide.

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