

HCV in people who inject drugs: a neglected epidemic



Despite the serious health implications of hepatitis C virus (HCV), especially in the context of concurrent HIV infection, its prevention and management has not been a national health priority in India. With the advent of highly efficacious direct acting antiviral drugs for HCV that can be administered orally once daily,¹ and activism around the reduction of treatment costs, HCV treatment might be added to the national health mission plan, which is especially important for people who inject drugs, the population most affected by HCV. Relevant epidemiological information is important to inform policy makers at this opportune moment.

Sunil Solomon and colleagues² report the results of a multisite community-based assessment in which 14481 people who inject drugs were recruited from 15 cities in 11 Indian states—five cities were from the north and northwestern part of the country, seven were from northeast India, and the other cities were from central, east, and western India; no cities from south India were included. Overall weighted anti-HCV antibody (HCVAb) prevalence in people who inject drugs in this assessment was 37%, with the lowest and highest prevalence being recorded from the northeast. The overall weighted prevalence of anti-HIV antibody (HIVAb) plus HCVAb in people who inject drugs in this study was 13%, with a geographical spread similar to that of HCVAb. This study makes an important and timely contribution to the area of HCV epidemiology.

Several studies have documented HCV prevalence in people who inject drugs during the past two decades with substantial regional variation within India. For example, in Kolkata, an eastern Indian city, the prevalence of HCVAb in people who inject drugs was 18% and in non-injection drug users was 14% during 1994–95, whereas HIV prevalence was 1%.³ In northeast India, a study done in injection heroin users in 1996 in Churachandpur, a district of Manipur bordering Burma, recorded an HCV prevalence of 98% and an HIV prevalence of 75%.⁴ An HCV prevalence of 62% and an HIV prevalence of 30% were reported from Chennai in 2008,⁵ and 49% and 29%, respectively, from Punjab in 2013.⁶ In all these studies, HCV prevalence was higher than HIV prevalence. A similar pattern of high HCV prevalence in people who inject drugs with very low HIV prevalence has been reported in Pakistan.⁷ This finding

is biologically plausible because HCV is more infectious than HIV⁸ and can remain infectious, after drying at room temperature, for up to 6 weeks in blood spots, facilitating HCV transmission using needles or syringes and other paraphernalia.⁹ Furthermore, HCV prevalence reported in these studies is based on serological testing for HCVAbs, and a positive result can represent an acute, chronic, or resolved HCV infection. HCV RNA testing would, therefore, be necessary to arrive at reliable estimates of those with chronic infection needing treatment. Efforts are needed to make these tests more affordable and accessible.

Solomon and colleagues report that only 5% of the HCV antibody positive people who inject drugs were aware of their serostatus.² This finding, in view of the programmatic emphasis on HIV and neglect towards HCV, is not surprising. Low awareness about HCV in people who inject drugs was recorded in the capital city of Delhi and the northeastern city of Imphal in an earlier investigation done during 2006–07 in which 9% and 46% had heard of HCV, of whom 20% and 37%, respectively, underwent HCV testing.¹⁰ A 2010 systematic review of HIV prevention and care services for people who inject drugs estimated that although 78% of people who inject drugs were covered by HIV prevention and care services in India, the number of needles-syringes distributed per person who injects drugs per year was around 34 (22–58) and there were three oral substitution therapy recipients in 100 people who inject drugs;¹¹ estimates for HIV positive people who inject drugs receiving antiretroviral therapy were not available. Moreover, the assessment from Punjab⁶ showed that people who inject drugs reporting irregular supply of syringes and needles from targeted intervention sites had almost twice the odds of being HCV seroreactive compared with their counterparts. All this evidence underscores the fact that access to prevention, care, and treatment remains a challenge for people who inject drugs. It will be a while before treatment for HCV infection becomes affordable and available through public health programmes. Prevention efforts should therefore consist of awareness about HCV (and hepatitis B), safe injection practices, including an emphasis on clean injection paraphernalia, oral substitution therapy, and sexual risk reduction in

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people who inject drugs. Global evidence is evolving such that quality coverage with comprehensive harm-reduction interventions at a sufficient scale can reduce HCV incidence.¹²

Avina Sarna, *Samiran Panda

Population Council, India Office, Dehli, India (AS); and National Institute of Cholera & Enteric Diseases (ICMR), Kolkata, West Bengal, India 700010 (SP)
pandasamiran@gmail.com

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