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# Prevention and control of viral hepatitis

## Introduction

1. Viral hepatitis is a leading cause of chronic disease and mortality, affecting one in 12 people in the world, mostly as a result of infection with hepatitis B virus (HBV) and hepatitis C virus (HCV). Chronic infection with HBV or HCV leads to hepatic cirrhosis and hepatocellular carcinoma, which are responsible for 1.4 million deaths annually, i.e. 2% of all global burden of disease. In 2014, the Sixty-seventh World Health Assembly in resolution WHA67.6 called for an intensified and expanded global hepatitis response and requested the WHO Secretariat to examine the feasibility of elimination of hepatitis B and C.

2. In the Eastern Mediterranean Region, it is estimated that 170 million people are infected with HBV and 17 million with HCV. Annually, 4.3 million and 800 000 people, respectively, become infected with HBV and HCV. The epidemic of HBV and HCV in the Region presents in different ways in different countries of the Region. The risk of HBV infection is high in five countries (Afghanistan, Pakistan, Somalia, Sudan and Yemen), and moderate in the remaining 17 countries. The national prevalence of hepatitis C is estimated to range between 1% and 3% in the majority of countries and up to 4.8% in Pakistan[1] and 7% (age group 15–59 years) in Egypt[2]. Region-wide, viral hepatitis contributes to 3% of all mortality. In Egypt, 9% of mortality is attributable to hepatitis; in Pakistan, this proportion is about 3% and in most other countries hepatitis accounts for around 1% of total mortality.[3]

3. In the majority of the countries of the Region, new infections with HBV and HCV result from unsafe practices in health care settings. This affects both health care workers and those seeking care. People who inject drugs constitute another population group at very high risk of HBV and HCV transmission due to the sharing of injections and drug injection equipment. Additionally, HBV threatens population groups with high-risk sexual behaviour, such as men who have sex with men and sex workers.

4. Facing the growing threat of viral hepatitis in the Region, in 2009 the 56th session of the WHO Regional Committee for the Eastern Mediterranean endorsed a resolution calling for urgent action by Member States and WHO to prevent and control HBV and HCV.

## Progress and challenges

5. Hepatitis B birth-dose immunization has been introduced in 16 countries of the Region; however, coverage remains low at regional level (24% in 2014). In contrast, the average regional coverage of childhood vaccination with three doses of hepatitis B vaccine has reached 83%, ranging from 42% in Somalia to 99% in Bahrain, Islamic Republic of Iran and Morocco.

6. Ensuring safe blood transfusions and injections remains a challenge to many countries in the Region. Although all countries report having injection safety policies and 20 countries use auto-disable syringes in vaccination services, only three countries explicitly recommend auto-disable syringes for injections in general. Blood transfusions are tested for hepatitis C and B but only two-thirds of countries report uninterrupted supply of test kits.

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[1] Qureshi H et al. Prevalence of hepatitis B and C viral infections in Pakistan: findings of a national survey appealing for effective prevention and control measures. East Mediterr Health J. 2010;16 Suppl:S15–23.

[2] Preliminary results of the Demographic Health Survey 2015..

[3] Global burden of disease database [online database]. Seattle, WA: Institute for Health Metrics and Evaluation, University of Washington; 2014 (available from http://www.healthdata.org/, accessed 1 September 2015).

7. All countries have at least one treatment regimen available for HBV and HCV, except Djibouti, Somalia and Yemen. Pegylated interferon is still widely in use. However, new direct-acting antivirals for HCV treatment are getting registered and prescribed in several countries. Egypt has made a breakthrough in obtaining originator sofosbuvir (Gilead) for a negotiated price of approximately US$ 800 per 12-week treatment course in the public sector. As a result, Egypt is rapidly scaling up treatment of HCV infection with the target of treating 2 million people by 2018. In Pakistan, the private sector has succeeded in reducing the price for a 12-week clinical care package including originator sofosbuvir and viral load testing to approximately US$ 1700. By mid-2015, a voluntary licensing agreement between Gilead and its generic manufacturing partners for sofosbuvir includes the majority of low and lower–middle income countries of the Region. Aiming at further cost reduction, several countries including Egypt, Morocco and Pakistan are opting for local generic production.

## Future directions

8. Responding to the call of the World Health Assembly (WHA) resolution on hepatitis in May 2014 (WHA67.6), the WHO Global Hepatitis Programme is currently developing a global strategy on the prevention and control of viral hepatitis infection in consultation with national, regional and global stakeholders. The strategy positions the health sector response to viral hepatitis within the context of universal health coverage and the post-2015 health and development agenda and targets. It is closely aligned with related global health strategies and plans, including those for HIV, sexually transmitted infections, blood safety and noncommunicable diseases.

9. The current draft strategy sets out an ambitious set of targets for 2030 that pave the way for the elimination of viral hepatitis as a public health problem and identifies the national action required to reach those targets. Specifically the draft strategy aims to achieve by 2030:

- 90% reduction in new cases of chronic hepatitis B and C;
- 65% reduction in hepatitis B and C deaths;
- 80% of treatment eligible persons with chronic hepatitis B and C infections treated.

10. A regional consultation of hepatitis focal points was facilitated by the WHO Regional Office in June 2015 involving national hepatitis focal points, experts and civil society organizations. In this meeting the participants discussed the strategy structure, targets and strategic directions and provided their input into the draft strategy.

11. The global strategy on hepatitis will be presented to the Sixty-ninth World Health Assembly in May 2016 for endorsement. Once it is endorsed, the Regional Office will develop in consultation with Member States a regional action plan for the implementation of the strategy in the Region. Within this framework, WHO will focus its support to countries on establishing national leadership and coordination in hepatitis control, collecting and analysing strategic information that guides the response, developing or revising policies and strengthening services for prevention and treatment of hepatitis, increasing access to affordable medicines and monitoring and evaluating the response.