Advancing Health Equity in viral hepatitis elimination among PWID

Danjuma Adda
President, World Hepatitis Alliance
24/01/2023
Burden of HBV infection (HBsAg) in the general population by WHO region, 2019:

Global: 295,852,053 (228,228,727 - 422,645,790)

Region of the Americas: 5,358,907 (3,062,233 - 12,248,931)

Region of the Americas:
- African Region
- Region of the Americas
- South-East Asia Region
- European Region
- Eastern Mediterranean Region
- Western Pacific Region
- Not applicable

Regional distribution:
- African Region: 82,302,393 (62,064,250 - 114,683,941)
- Eastern Mediterranean Region: 18,243,217 (14,373,443 - 23,771,464)
- South-East Asia Region: 60,458,777 (45,344,083 - 120,917,554)
- European Region: 13,604,235 (10,203,176 - 22,106,882)
- Western Pacific Region: 115,749,203 (95,213,054 - 141,886,119)

*Global Progress Report on HIV, viral hepatitis and sexually transmitted infection, 2021: https://www.who.int/publications/i/item/9789240027077
*WHO, Interim guidance for country validation of viral hepatitis elimination, 2021: https://www.who.int/publications/i/item/9789240028395
GLOBAL HCV EPIDEMIC

WHO (2019 data)

HCV: 58M people living w/chronic HCV and 290,000 deaths per year

Est. 2.3M HIV/HCV coinfection globally

Africa: Over 10M people living with HCV

Global HCV burden among people who inject drugs:

Est. 15.6M people who inject drugs

Est. 3.2M women who inject drugs

Est. 8.2M people who inject drugs test are HCV antibody positive (52.3%)

Of those, 2.8M are also living HIV+ (17.8%)

# Global Hepatitis Elimination Goals 2022-2030: Are these achievable? PEPFAR could support the goals

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline – 2020*</th>
<th>Targets - 2025</th>
<th>Targets - 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis C mortality</td>
<td>360,000 4.7/100K -10%</td>
<td>240,000 3.1/100K -40%</td>
<td>140,000 1.8/100K -65%</td>
</tr>
<tr>
<td>Hepatitis B cascade (Testing/Treatment)</td>
<td>30%/30%</td>
<td>60%/50%</td>
<td>90%/80%</td>
</tr>
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<td>90%/80%</td>
</tr>
<tr>
<td>Hepatitis B vaccine birth dose (PMTCT)</td>
<td>50%</td>
<td>70%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Coverage**

*Sources: WHO GHHS 2016-2021; Activist Guide to HCV Diagnostics*
# GLOBAL HEPATITIS ELIMINATION GOALS 2022-2030: Are these achievable?

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Indicator</th>
<th>Baseline – 2020*</th>
<th>Targets - 2025</th>
<th>Targets - 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>Percentage of countries with costed Hepatitis Elimination Plans</td>
<td></td>
<td>30</td>
<td>50</td>
</tr>
<tr>
<td>Surveilllance</td>
<td>Percentage of countries reporting burden and cascade annually</td>
<td>130</td>
<td>150</td>
<td>170</td>
</tr>
<tr>
<td>HCV drug access</td>
<td>Percentage reduction in prices (to equivalent generic prices by 2025)</td>
<td>20%</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>HBV drug access</td>
<td>Percentage reduction in prices (alignment with HIV drug prices by 2025)</td>
<td>20%</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>Elimination</td>
<td>Number of countries validated for elimination of HCV</td>
<td>0</td>
<td>5</td>
<td>20</td>
</tr>
</tbody>
</table>

**Sources:**
- WHO GHSS 2022-2030: last available data as of end 2020
We won’t achieve viral hepatitis elimination without addressing health equity.

We have the tools.
We can screen, vaccinate, and treat hepatitis with medication & cure.
But the people most at-risk don’t have access.
Screening and Linkage to Care

The development of effective and well-tolerated direct acting antiviral (DAA) therapy has made the goal of HCV elimination possible.

For those living with HCV, achieving cure is cost-effective and is associated with decreased complications of HCV and improvement in patient related outcomes.
HIV and Hepatitis B and C

- 34 million persons worldwide have HIV
  - 1-3 million PWID

- 240 million persons worldwide have chronic HBV infection
  - 6-26% of all people with HIV co-infected with HBV

- 170 million persons worldwide have chronic HCV infection
  - 25-30% with all people with HIV co-infected with HCV
  - 72-95% of PWID with HIV co-infected with HCV

- ~10 million PWID have HCV (77 countries)

Hepatitis Elimination Financing & Costs

- National elimination plans often not well funded
- Cost of diagnostics & care are not affordable to all (e.g., HCV RNA, HBV DNA diagnostics, variable cost of tx)
- Lack of international funding agency
- World Economic Forum launches Hepatitis Elimination Initiative-failed

Hepatitis Elimination Initiative
Opportunities for Elimination of viral hepatitis

• New Global Fund Information Note to countries to integrate VH into HIV/AIDS programs
• New WHO Consolidated Guidelines on HIV, Viral Hepatitis and STIs prevention/HCV and HIV self Testing guidelines
• A good example is the Thailand PEPFAR program that integrated HCV and HIV self testing

And now PEPFAR
In 2023: PEPFAR must step up in COP to remove health inequity and accelerate access to VH services

- The new COP strategy places emphases on health equity, decentralized community-led approaches.
- Shared approaches for a people-centred response
- PEPFAR should replicate the Global Fund effort and provide financing opportunities for Viral Hepatitis services
- PEPFAR COP should provide financing to support countries in achieving the GHSS 2022-2030 viral hepatitis targets
Why PEPFAR?

• PEPFAR is the largest commitment by any nation to address a single disease in the world; to date, its funding has totaled more than $100 billion, including funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). PEPFAR is credited with saving millions of lives and helping to change the trajectory of the global HIV epidemic.

• HIV, viral hepatitis and sexually transmitted infections share common modes of transmission and determinants, and many of the populations affected by these diseases may overlap.

Perhaps PEPFAR present one of the greatest opportunities for scaling hepatitis elimination across the world.

Despite the burden of disease and existence of cost-effective interventions, there is currently no sign that a new global mechanism for funding viral hepatitis will be implemented to support the expansion of testing and treatment.
PEPFAR’s 4 Guiding Pillars

- **Controlling the HIV Pandemic**

- **Accountability**
  - Demonstrate cost-effective programming that maximizes the impact of every dollar invested

- **Transparency**
  - Demonstrate increased transparency with validation and sharing of all levels of program data

- **Equity**
  - Demonstrate effective efforts to tailor services, close gaps, and address barriers faced by people most vulnerable to HIV

- **Impact**
  - Demonstrate sustained control of the epidemic; save lives and avert new infections

Active Program and Partner Management
It’s time to raise awareness that “Hep Can’t Wait”

- **30s**
  
  Every 30 seconds, someone loses their life to a hepatitis-related illness.

- **People in prison can’t wait**

- **7%**
  
  7% of people living with TB also live with hepatitis C.

- **Pregnant mothers can’t wait**

- **INDIGENOUS PEOPLE CAN’T WAIT**

- **43%**
  
  Only 43% of children receive the hepatitis B birth dose vaccine.

- **2.7m**
  
  2.7 million people live with HIV and hepatitis B.

- **NEWBORN BABIES CAN’T WAIT**

- **Policymakers can’t wait to act**

- **2.3m**
  
  2.3 million people live with HIV and hepatitis C.

- **People who inject drugs can’t wait**

- **1.1m**
  
  more than 1.1 million lives are lost each year to hepatitis B and hepatitis C.

- **REFUGEES CAN’T WAIT**

- **DAVID CAN’T WAIT**

- **RODGER CAN’T WAIT**
Acknowledgements

Dr Funmi Lesi: WHO Geneva:
Dr. Su Wang; Past President WHA
WHA Resource hub
EHRAAI
CDA
THANK YOU
DRUG USE IN PEPFAR RECIPIENT COUNTRIES IN AFRICA: WHAT DO WE KNOW?

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IDPC Africa Consultant
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IDPC is a global network of nearly 200 NGOs promoting drug policy debates and NGO participation. Policies based on evidence, health, social justice, and development.
What do we know?

- In sub-Saharan Africa, approx. 60 million people are chronically infected with HBV, and 10.2 million are chronically infected with HCV.

- The estimated HBsAg prevalence among PWID in sub-Saharan Africa is around 4%.

- People who inject drugs (PWID) are at high risk for hepatitis C (HCV) and hepatitis B (HBV) without accessible harm reduction programmes.
Why this Situation?

• African drug policies and treaties have been interpreted as endorsing a “war on drugs.”
Africa’s “War On Drugs” Has Created…

• Injecting drug use reported in over 36 countries
• HCV prevalence is as high as 97.1%!
• Demonisation/marginalisation of people who use drugs
• Lack of availability and accessibility of hepatitis C testing and treatment
• High costs and limited availability means direct-acting
What Are the Challenges?

• Policy and institutional barriers
• Information barriers
• Technical barriers
What Needs to Change?

1. Encouraging strong advocacy for more money for PWUDs in the PEPFAR countries.
2. Providing the space and services for people who use drugs- This creates an opportunity for them to come out of the shadows, thereby providing the best way to get better data on people who use drugs.
3. Developing strong supportive policy.
4. Strengthening Civil society to engage better.
Role of grassroot Activist (1)

1. The need to advocate for more funding despite the paucity of data in these regions.

2. The need to build representative platforms for directly engagement with policy makers at national, regional and international levels.
Role of grassroot Activist (2)

3. Consider civil society ‘audits’ of national delivery against various commitments and obligations.

4. Support or help to establish national and regional networks of people who use drugs.
THANK YOU

QUESTIONS ?
Viral hepatitis, harm reduction and PEPFAR COP 2023
ALMOST 4 IN 10 PEOPLE WHO INJECT DRUGS HAVE ACTIVE HEPATITIS C

1 IN 12 PEOPLE WHO INJECT DRUGS HAVE ACTIVE HEPATITIS B

Source: The Global State of Harm Reduction 2022
VIRAL HEPATITIS DATA REPOSITORY

This repository is publicly available and contains data on the burden of viral hepatitis, with a focus on drug-related hepatitis.
<table>
<thead>
<tr>
<th>Population Size Estimates for People Who Inject Drugs</th>
<th>Prevalence of Inactive Hepatitis B Virus Infection (HBSAg) Among People Who Inject Drugs and the General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Deaths Among People Who Inject Drugs</td>
<td>Percentage of Deaths Among People Who Inject Drugs</td>
</tr>
<tr>
<td>Percentage of New Hepatitis C Infections</td>
<td>Ratio of Hepatitis C Infection</td>
</tr>
</tbody>
</table>
Needle and syringe programmes

2020: 86 Countries
2022: 92 Countries

Source: The Global State of Harm Reduction 2022

Opioid agonist therapy

2020: 84 Countries
2022: 87 Countries

Source: The Global State of Harm Reduction 2022
Supportive references to harm reduction in national policy documents

2020: 87 countries
2022: 105 countries (an increase of 20.7%)

- Eastern and Southern Africa: 9
- Western and Central Africa: 11
- Asia: 13
- Eurasia: 26
- Latin America and the Caribbean: 5
- Middle East and North Africa: 15
- North America: 2
- Oceania: 4
- Western Europe: 20

Total: 105

Source: The Global State of Harm Reduction 2022
GSHR 2022 viral hepatitis reflections

- **Poor access to services** is a major issue in addressing hepatitis C and B among people who use drugs
  - Integrated, person-centred service delivery and prioritising key populations in every setting will improve accessibility
- **Community-based testing and treatment** for people who use drugs is safe and effective
  - Critical role of communities in service delivery and guiding people through health services
- **New supportive global policy and donor developments** for strengthening hepatitis programming for people who use drugs
The funding gap for harm reduction in low- and middle-income countries is widening.

Funding for harm reduction is only 5% of the level required in low- and middle-income countries.

Source: The Global State of Harm Reduction 2022
# PEPFAR and harm reduction

- Second largest donor for harm reduction in LMI countries, provided 12% of donor funds in 2019

<table>
<thead>
<tr>
<th>Year</th>
<th>PEPFAR harm reduction $$</th>
<th>Source</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>8.4 m</td>
<td>HRI, Failure to Fund</td>
<td>Expenditure data provided by PEPFAR (Kenya, Ukraine, Nigeria, Tanzania, South Africa, India)</td>
</tr>
<tr>
<td>2020</td>
<td>7.8 m</td>
<td>AmfAR database</td>
<td>Expenditure data from PEPFAR dashboard (Ukraine, Nigeria, Tanzania, South Africa, Kenya, Mozambique)</td>
</tr>
<tr>
<td>2021</td>
<td>7.5 m</td>
<td>PEPFAR dashboard</td>
<td>Planned allocation to budget code IDUP (Tanzania, Asia Region, Kenya, Ukraine, South Africa, Vietnam, Mozambique)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>PEPFAR prison $$</th>
<th>Source</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>5.0 m</td>
<td>PEPFAR dashboard</td>
<td>79% of which was spent on service delivery (South Africa, Ukraine, Uganda, Kenya, Nigeria and Zambia)</td>
</tr>
</tbody>
</table>
PEPFAR must step up in COP 2023

- **New strategy** emphasizes health equity, community-led approaches and structural interventions.

- **Draft guidance** provides for funding comprehensive package of interventions for people who use drugs, except for NSP.

- **Epidemiological case** for far greater investment in harm reduction in PEPFAR countries.

- **Evidence of impact** - powerful case for investment

- **Programme efficiencies** - e.g. take-home OAT doses would reduce cost and improve retention.

- **Growing precedence** for integrated viral hepatitis programme support (see strategic direction 2022 reports e.g. South Africa, Thailand, Tajikistan)
Harm reduction priorities for COP 2023

- PEPFAR must play a much larger role in filling **programming gaps** – e.g. low OAT coverage, minimal provision of naloxone for overdose prevention, very limited harm reduction in prisons, integrated viral hepatitis test and treat services
- Increase and track **funding for community-led organisations** to strengthen response and meet GAS 30-80-60 targets
- Increase **funding for advocacy** to address structural barriers and to decriminalise drug use
- Increase **funding for advocacy to increase domestic public financing for harm reduction**
- Support PEPFAR countries to **introduce social contracting mechanisms** that enable government funds to reach community-led, community-based and civil society organisations.
The Global State of Harm Reduction 2022

"The overall increase in the commitment to and implementation of harm reduction is a testament to the dedication, resilience and strength of communities, civil society and international organizations, which have successfully advocated for a health and human rights-based approach to drug use despite extremely limited resources."
PRIORITIZING HEPATITIS C VIRUS (HCV) IN PEPFAR COP 2023

JOELLE DOUNTIO O.
ACTING HCV PROJECT DIRECTOR
TREATMENT ACTION GROUP (TAG)
Jan. 24, 2023
GLOBAL HEPATITIS ELIMINATION GOALS?

GLOBAL HEALTH SECTOR STRATEGY ON VIRAL HEPATITIS 2016–2021
TOWARDS ENDING VIRAL HEPATITIS

GLOBAL VISION
A world where viral hepatitis transmission is halted and everyone living with viral hepatitis has access to safe, affordable and effective prevention, care and treatment services.

GOAL
Eliminate viral hepatitis as a major public health threat by 2030.³

- 90 percent reduction in incidence; *
- 65 percent reduction in mortality;
- 90 percent of people infected with hepatitis C to be diagnosed; and
- 80 percent of people diagnosed to be treated.³

* All targets relative to 2015 baselines

Sources: WHO GHHS 2016-2021; Activist Guide to HCV Diagnostics
GLOBAL HCV EPIDEMIC

WHO (2019 data)

HCV: 58M people living w/chronic HCV and 290,000 deaths per year

Africa: Over 10M people living with HCV

Global HCV burden among people who inject drugs:

Est. 2.3M HIV/HCV coinfection globally

Est. 15.6M people who inject drugs

Of which 8.2M people who inject drugs test are HCV antibody positive (52.3%)

Est. 3.2M women who inject drugs

NEW INFECTIONS & MORTALITY BY REGION

GLOBAL
Hepatitis B
New Infection: 1,500,000
[1,000,000–2,600,000]
Deaths: 820,000
[450,000–950,000]

Hepatitis C
New Infection: 1,500,000
[1,300,000–1,800,000]
Deaths: 290,000
[230,000–580,000]

REGION OF THE AMERICAS
Hepatitis B
New infections: 10,000
[5,100–26,000]
Deaths: 15,000
[8,500–23,000]

Hepatitis C
New infections: 67,000
[63,000–73,000]
Deaths: 31,000
[19,000–84,000]

EUROPEAN REGION
Hepatitis B
New infections: 19,000
[9,400–38,000]
Deaths: 43,000
[34,000–51,000]

Hepatitis C
New infections: 300,000
[240,000–320,000]
Deaths: 64,000
[39,000–72,000]

WESTERN PACIFIC REGION
Hepatitis B
New infections: 140,000
[96,000–210,000]
Deaths: 470,000
[200,000–490,000]

Hepatitis C
New infections: 230,000
[220,000–240,000]
Deaths: 77,000
[77,000–140,000]

AFRICAN REGION
Hepatitis B
New infections: 990,000
[660,000–1,600,000]
Deaths: 80,000
[47,000–110,000]

Hepatitis C
New infections: 210,000
[150,000–270,000]
Deaths: 45,000
[23,000–72,000]

EASTERN MEDITERRANEAN REGION
Hepatitis B
New infections: 100,000
[79,000–140,000]
Deaths: 33,000
[26,000–60,000]

Hepatitis C
New infections: 470,000
[240,000–520,000]
Deaths: 31,000
[31,000–74,000]

SOUTH-EAST ASIA REGION
Hepatitis B
New infections: 260,000
[180,000–590,000]
Deaths: 180,000
[140,000–300,000]

Hepatitis C
New infections: 230,000
[200,000–430,000]
Deaths: 38,000
[37,000–130,000]

Source: WHO Progress Report on HIV, Viral Hepatitis, and STIs 2021
WHY PEPFAR?

• PEPFAR already reaches vulnerable populations. Existing programs can be used to meet people where they are, with what they need, to prevent advanced HIV, chronic illness including liver cancer, and death.

• Using the same blood sample, existing HIV diagnostics infrastructure in PEPFAR programs can test and diagnose HBV and HCV.

• Tenofovir (TDF) which is covered by global donors (including PEPFAR) for HIV is not available for HBV. Advocates can push it to be made available for HBV treatment.
24 PEPFAR COUNTRIES WITH NATIONAL HEPATITIS PLANS

Angola, Botswana, Burundi, Cambodia, Cameroon, Dominican Rep., Ethiopia, India, Indonesia, Kazakhstan, Kenya, Kyrgyz Rep., Lao PDR, Myanmar, Nepal, Nigeria, PNG, Philippines, Rwanda, South Sudan, Tajikistan, Thailand, Uganda, Ukraine

Other Countries: Algeria, Argentina, Australia, Brazil, Colombia, Egypt, Ethiopia, Georgia, Ghana, India, Mexico, Pakistan, Paraguay, Peru, Philippines, South Africa, Tanzania, Türkiye, USA, Burundi, Myanmar, Senegal

WHAT DOES DRAFT COP 2023 SAY ABOUT HCV?

Viral hepatitis mentioned 2 times (down from 20 times in 2022)
HCV 2 time (down from 6 times in 2022)
HBV 0 times, (down from 8 times in 2022)

3.1.3.5. Laboratory systems – ‘... there have been strong recommendations to shift from silo testing to integrated diagnostics and multiplex use of platforms. Several technologies, ... can be used to diagnose and monitor multiple diseases (e.g., HIV TB, COVID-19, hepatitis C, human papillomavirus (PPV), etc.). ... [PEPFAR] recommend that ... programs incorporate these tools to address HIV testing inequities and to fill other global health diagnostic gaps’

3.1.1.3 Key populations
PEPFAR teams should ‘... develop specific strategies and goals to reach and provide differentiated prevention and treatment services to underserved key populations based on available data and in alignment with WHO consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment, and care for key populations.'
We demand a standalone section on viral hepatitis coinfection in COP

Aligned with WHO consolidated guidelines on HIV, viral hepatitis and STI prevention diagnosis, treatment, and care for key populations to provide comprehensive health services. Unethical to demand that people get diagnosed without linkage to care.

We demand inclusion of 2.3.5 of COP 2022 which required that in addressing comorbidities:
“consider addressing additional comorbidities (…viral hepatitis, noncommunicable disease, mental illness) … based on their impact on HIV treatment and the health of the clients. Addressing additional comorbidities using funds from the COP envelope should only be proposed if it is built on a solid PEPFAR HIV service delivery platform and can be done without adverse impact on HIV services; it is discouraged if epidemic control has not been achieved equitably across regions and populations…(Goal 1). It should also be designed with Goals 2 and 3 in mind—for example, leveraging enduring lab, supply chain, HRH, and information systems, as well as securing partnership and alignment with national health programs…. ” More specifically, within PEPFAR OUs, districts (SNU) that have demonstrated equitable achievement of the 95/95/95 goals may offer, as part of operational plan strategy, funding for more comprehensive services for people living with HIV, such as diagnosis and treatment of hepatitis B and C If these additional services are funded in the COP as PEPFAR programming, they must be offered equitably and without discrimination… Programs should refer to the updated WHO recommendations on hepatitis B and C testing.”
To optimize HIV Care and treatment outcomes, early linkage to HCV treatment for people who are HIV/HCV coinfected is critical. This can prevent further liver damage and liver cancer and improve HIV and health outcomes. Highly effective and safe pangenotypic direct-acting antivirals (DAAs) to cure HCV and prevent transmit. Appropriate prevention education and access to harm reduction services also prevents HCV.

We demand inclusion of people who use drugs and their sexual partners in continuous ART to address comorbidities.

PEPFAR should expressly provide funding for harm reduction and comprehensive package of viral hepatitis services (including HBV vaccination, NSP, medications for opioid use disorders (MOUD), naloxone, DAAs as TasP) for people living with or at risk for HIV.

HIV Prevention services should promote health and treatment literacy about viral hepatitis transmission and prevention; offer linkage to viral hepatitis testing, & treatment; & HBV vaccination for people at highest risk, including people who use and inject drugs or share equipment.
3.1.3.5. Laboratory systems:

PEPFAR should fund: the purchase of GeneXpert HCV cartridges; Abbott RealTime; Roche Cobas Taqman HCV diagnostics platforms and tests; sample transport; and laboratory network strengthening to integrate viral hepatitis testing using existing HIV infrastructure. PEPFAR can cover training and support for the National AIDS Program and National Viral Hepatitis Program to update national guidance on diagnostics to move towards simpler, integrated, decentralized diagnostics algorithms that include point-of-care testing.

**Targeted Community-based Testing Services**: Programs should also consider incorporating HIVST [and HCV antibody self-testing] into community-based testing strategies where appropriate.

**Optimizing HIV Care and Treatment**: include integration of viral hepatitis into HIV diagnostics algorithm.

Why push for viral hep diagnosis and treatment in COP 2023?

Liver damage from HCV happens slowly, progresses more quickly in people living with HIV. Treat early!
EXCUSES & COUNTER-ARGUMENTS

• “Not part of PEPFAR’s mission/priorities”
  
  It is part of “reach[ing] the most vulnerable where they are, with what they need.”

• “Asked to do more with less $”

Simple policy shift (use HIV existing infrastructure for HCV testing).

Treating HIV & HCV coinfections is both cost effective & cost saving.

  Early HCV diagnosis & treatment, and comprehensive harm reduction improves health outcomes for both HIV coinfected, monoinfected & people who use & inject drugs; and avoids long term complications (cirrhosis and liver cancer).

• “DAAs are too expensive”

  Thanks to CHAI’s test & treat program = less than $80 per
QUESTIONS?

Contacts & Social Media

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mapCrowd.org
@hepCoalition
@hepcoalition_mapcrowd
WHY HEPATITIS? WHY NOW?

• Viral hep = silent disease

• Causes liver disease & liver cancer

• **Treat early:** Liver damage from HCV happens slowly, progresses more quickly in people living with HIV

• **HIV/HCV coinfection** makes treating HIV more complicated (need to check drug-drug interactions) & can increase liver toxicity

• Check your liver health. **Liver function tests** = opportunities for coinfection testing

• 4% risk of mother-to-child transmission of HCV, yet no clear protocols for screening/testing pregnant womxn or safety of DAAs during pregnancy

• People living with HIV, **taking ARVs**, can reduce risk of HIV & HCV transmission

Sources: WHO 2017; amfAR/TREAT Asia 2019
DIFFICULT TO TREAT SUBTYPES

*NB: Doesn’t cover HCV genotype subtypes: non-1a/1b; 4a, 4k, 4p, 4q, 4r, 4s

Subtypes **GT1l** and **GT4r**, widely distributed across Western, Central, and Eastern Africa respond poorly to SOF/LED and **should be treated with SOF/DAC, or if available SOF/VEL or SOF/VEL/VOX.**

Sources:
DIRECT-ACTING ANTIVIRAL (DAA) REGISTRATION IN PEPFAR COUNTRIES / AFRICA

Registration of Branded Sofosbuvir-based DAAs Under Gilead's Voluntary Licenses

Includes Harvoni, Sovaldi, and Epclusa (105 countries).
DIRECT-ACTING ANTIVIRAL (DAA) REGISTRATION IN PEPFAR COUNTRIES / AFRICA