Section 9: Tackling the Hepatitis C epidemic: a global landscape

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Training “Hepatitis C and HR for PWUD”, 19th-24th Sept. 2016, Nairobi, Kenya
Learning objective of the session:
Identifying key elements of the global landscape regarding access to hepatitis C prevention, diagnosis and treatment
Outline of the presentation

1. Global policies related to hepatitis C
2. The access challenge
3. The funding gap
PART 1: GLOBAL POLICIES RELATED TO HEPATITIS C
The World Health Organization (WHO) is a specialized agency of the United Nations that is concerned with international public health.
WHO’s role in public health

» providing leadership

» setting norms and standards

» providing technical support

Once a year, WHO member states meet during the World Health Assembly to discuss and adopt strategic orientations and policies

» WHO has also regional Committees
WHO and Hepatitis C

- May 2014: **World Health Assembly** adopts a Resolution on viral hepatitis that urges member states «to develop and implement coordinated multisectoral national strategies for preventing, diagnosing, and treating viral hepatitis based on the local epidemiological context»

- April 2014: **WHO Guidelines for the screening, care and treatment of persons with hepatitis C infection** (updated in April 2016)
May 2016: World Health Assembly adopts the **Global Health Sector Strategies for viral hepatitis, 2016-2021**

**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.
<table>
<thead>
<tr>
<th>TARGET AREA</th>
<th>BASELINE 2015</th>
<th>2020 TARGETS</th>
<th>2030 TARGETS</th>
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<tbody>
<tr>
<td>Impact targets</td>
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<tr>
<td>Incidence: New cases of chronic</td>
<td>Between 6 and 10 million infections are reduced to 0.9 million infections</td>
<td>30% reduction (equivalent to 1% prevalence of HBsAg¹ among children)</td>
<td>90% reduction (equivalent to 0.1% prevalence of HBsAg among children)¹⁰</td>
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<tr>
<td>viral hepatitis B and C infections</td>
<td>by 2030 (95% decline in hepatitis B virus infections, 80% decline in</td>
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<tr>
<td></td>
<td>hepatitis C virus infections)</td>
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<tr>
<td>Mortality: Viral hepatitis B and</td>
<td>1.4 million deaths reduced to less than 500 000 by 2030 (65% for both viral</td>
<td>10% reduction</td>
<td>65% reduction</td>
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<td>C deaths</td>
<td>hepatitis B and C)</td>
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¹¹ Equivalent to HBsAg among children.
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<th>BASELINE 2015</th>
<th>2020 TARGETS</th>
<th>2030 TARGETS</th>
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<tr>
<td>Service coverage targets</td>
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<tr>
<td>Blood safety</td>
<td>39 countries do not routinely test all blood donations for transfusion-transmissible infections</td>
<td>95% of donations screened in a quality-assured manner</td>
<td>100% of donations are screened in a quality-assured manner</td>
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<td></td>
<td>89% of donations screened in a quality-assured manner³²</td>
<td></td>
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<td>Safe injections: percentage of injections administered with safety-engineered devices in and out of health facilities</td>
<td>5%</td>
<td>50%</td>
<td>90%</td>
</tr>
<tr>
<td>Harm reduction: number of sterile needles and syringes provided per person who injects drugs per year</td>
<td>20</td>
<td>200</td>
<td>300</td>
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<tr>
<td>Viral hepatitis B and C diagnosis</td>
<td>≤5% of chronic hepatitis infections diagnosed</td>
<td>30%</td>
<td>90%</td>
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<tr>
<td>Viral hepatitis B and C treatment</td>
<td>&lt;1% receiving treatment</td>
<td>5 million people will be receiving hepatitis B virus treatment</td>
<td>80% of eligible persons with chronic hepatitis B virus infection treated</td>
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<td></td>
<td></td>
<td>3 million people have received hepatitis C virus treatment</td>
<td>(Both targets are cumulative by 2020)</td>
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<td></td>
<td></td>
<td>80% of eligible persons with chronic hepatitis C virus infection treated</td>
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Providing harm reduction services

A package of harm reduction services for people who inject drugs can be highly effective in preventing the transmission and acquisition of viral hepatitis A, B and C, as well as HIV and other blood-borne infections. Such a package should be integrated into a comprehensive set of services for the prevention and management of substance use disorders. WHO, UNODC and UNAIDS have defined a set of interventions and services that should be included in a comprehensive package for people who inject drugs. Included in the package are five intervention areas that will have greatest impact on hepatitis epidemics: sterile needle and syringe programmes, opioid substitution therapy for opioid users, risk reduction communication, hepatitis B vaccination, and treatment of chronic hepatitis infection.

The hepatitis C virus is more easily transmissible than HIV, therefore harm reduction services should include provision of all injecting paraphernalia, including mixing containers and solutions. This hepatitis strategy calls for a major increase in provision of sterile needles and syringes to people who inject drugs, from an estimated baseline of 20 needles and syringes per person who injects drugs per year to 200 by 2020 and 300 by 2030. Current coverage of these interventions is too low to have a significant impact on hepatitis epidemics. Ensuring sufficient coverage of other harm reduction interventions depends on overcoming legal and societal barriers.

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**HARM REDUCTION**

**PRIORITY ACTIONS FOR COUNTRIES**

- Implement a comprehensive package of harm reduction services, where appropriate, based on the WHO package of evidence-based harm reduction interventions for people who inject drugs, taking into account the domestic context, legislation and jurisdictional responsibilities.
- Address legal and institutional barriers to the provision of harm reduction services.
- Link hepatitis and harm reduction services to facilitate integrated prevention, treatment and care for people who use drugs.

**PRIORITY ACTIONS FOR WHO**

- Develop and update policies and guidance on evidence-based prevention and management of viral hepatitis B and C infection for people who inject drugs and for non-injecting drug users, including people who use cocaine and amphetamine-type stimulants.
- Provide advocacy and technical support to countries to mobilize commitment and resources for recommended harm reduction interventions.
Prevention, Care and Treatment of Viral Hepatitis in the African Region: Framework for Action, 2016–2020

Adopted by WHO Regional Committee for Africa on 21st August 2016 to guide Member States in the African Region to implement the Global Health Sector Strategy on viral hepatitis.

“By 2020, all 47 countries of WHO AFRO have developed national action plans for the prevention, care and treatment of viral hepatitis”
UN Sustainable Development Goals

On September 25th 2015, countries adopted a set of goals to **end poverty, protect the planet, and ensure prosperity for all** as part of a new sustainable development agenda.

Each goal has specific targets to be achieved over the next 15 years.
Goal 3: Ensure healthy lives and promote well-being for all at all ages

- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
- **By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.**
- By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- By 2020, halve the number of global deaths and injuries from road traffic accidents
- By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective,
Summary of the policies landscape

» Global dynamic to tackle hepatitis C epidemic
» Countries will start developing national action plans
PART 2: THE ACCESS CHALLENGE
Globally, access to hepatitis C treatment is very low
Figure 6. Estimated number of people treated with SOF, SOF/LDV or SIM by region (Q4 2013–Q4 2014)

Access to medicine?

= 3 elements
1) Availability

» Registration is a national procedure of reviewing the safety and efficacy of a new drug

» Certificate of Registration allows the drug to be legally marketed in the Country

» In Kenya, drugs are registered by the Pharmacy and Poisons Board (PPB)
2) Affordability = price
Figure 5. Prices of sofosbuvir in different countries. *Price in Brazil based on expert opinion

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<th>Brand name</th>
<th>Gilead License</th>
<th>Manufacturer</th>
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*Printed prices were obtained from other locations and through other Rupees.

TBD - to be determined; N/A - not applicable.


* Lowest price available in India (mapCrowd)
Affordability issue also concerns diagnosis
3) Quality

» Ensuring bioequivalence of generic versions of DAAs

» In 2015 WHO expanded its prequalification program to HCV DAAs.

» No generic DAA prequalified yet
REDEMPTION-1 Study presented during International Liver Congress 2016: cure rates in branded medicines treatment and low-cost generic DAA treatment are very similar.

REDEMPTION-1 Overall SVR4 Results For Generics

Note: Some small percentage loss of SVR is expected during the SVR4 to SVR12 period.
Summary of the policies landscape

» Quality generic versions of HCV DAAs are available, and price are expected to further decrease;

But…

» DAAs are not yet registered in most LMICs
» Diagnosis test remains expensive
PART 3: THE FUNDING GAP
Viral hepatitis, the « silent epidemic » originally suffers from a lack of attention and funding.

No specific donor institution funding work on hepatitis

Context of constraint due to economical crisis in donors countries

Number of deaths per diseases and per year 2010

WHO 2012 - Budget allocation compared to # of deaths

2014: UNITAID approved 2 grants to reduce barriers preventing access to new treatment of hepatitis C in low- and middle-income countries.

- MSF grant to screen, diagnose and treat patients living with HIV/HCV coinfection in India, Iran, Kenya, Mozambique, Myanmar, and Ukraine to catalyse demand for newly-available medicines.

But…

- Only for people living with HIV/HCV coinfection
- UNITAID only finances « demonstration interventions »
April 2015: Global Fund Board approves a new framework for financing co-infections and co-morbidities of HIV/AIDS, tuberculosis and malaria (GF/B33/11) allowing countries to use some of their allocations to fund hepatitis C interventions.

Like UNITAID Global Fund is only considering hepatitis C under the approach of HIV/HCV coinfection.

But a substantive part of the investments required to develop access to HCV services (technical labs, training of physicians, procurement chains, etc.) could be done with this funding?
Summary

» Limited international funding for hepatitis C. No specific funding mechanism to finance hepatitis C services scale up.

» WHO strategy recommends the scale up towards universal health coverage. Need for increased public domestic funding (tax revenues and allocation of a greater share of government funds to health).

» Low- and lower middle-income countries will still rely on external funding to expand their hepatitis responses.
This presentation was produced with the financial support of the French development agency (AFD – Agence Française de développement). The ideas and opinions it contains are those of Médecins du Monde and do not necessarily represent those of AFD.