Promoting Interventions for Viral Hepatitis and Harm Reduction in COP 2022

February 3, 2022 [8 AM EST, 3 PM SAST, 4PM WAT]

Facilitator
Hilary McQuie, Treatment Action Group

Speakers (50 min)
- **Prioritizing Hepatitis C Virus (HCV) in PEPFAR COP 2022** – Joelle Dountio Ofimboudem, Treatment Action Group
- **Hepatitis B Integration for PEPFAR –** Danjuma Adda, World Hepatitis Alliance
- **Drug Use in African PEPFAR-Recipient Countries: What Do We Know? –** Maria-Goretti Loglo, International Drug Policy Consortium
- **Where Does PEPFAR Stand on People Who Use Drugs: Recommendations For and By People Who Use Drugs** – Aditia Taslim, International Network of People who Use Drugs
- **Failure to Fund** – Colleen Daniels, Harm Reduction International

Discussion & Q&A (30 min)

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PRIORITIZING HEPATITIS C VIRUS (HCV) IN PEPFAR COP 2022

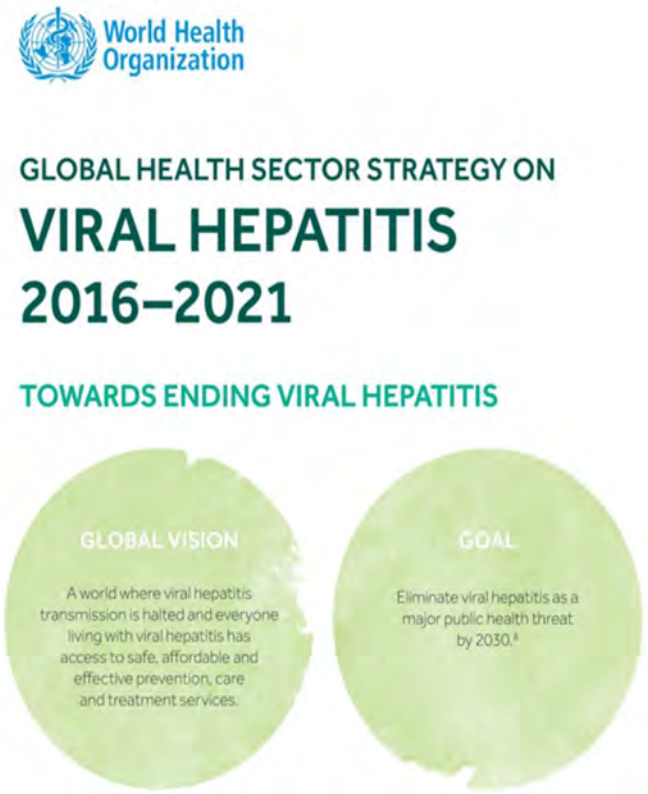
JOELLE DOUNTIO O.

COMMUNITY ENGAGEMENT OFFICER, HCV PROJECT

TREATMENT ACTION GROUP (TAG)

Feb. 03, 2022

GLOBAL HEPATITIS ELIMINATION GOALS?



- 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**

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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

Est. 2.3M HIV/HCV coinfection globally

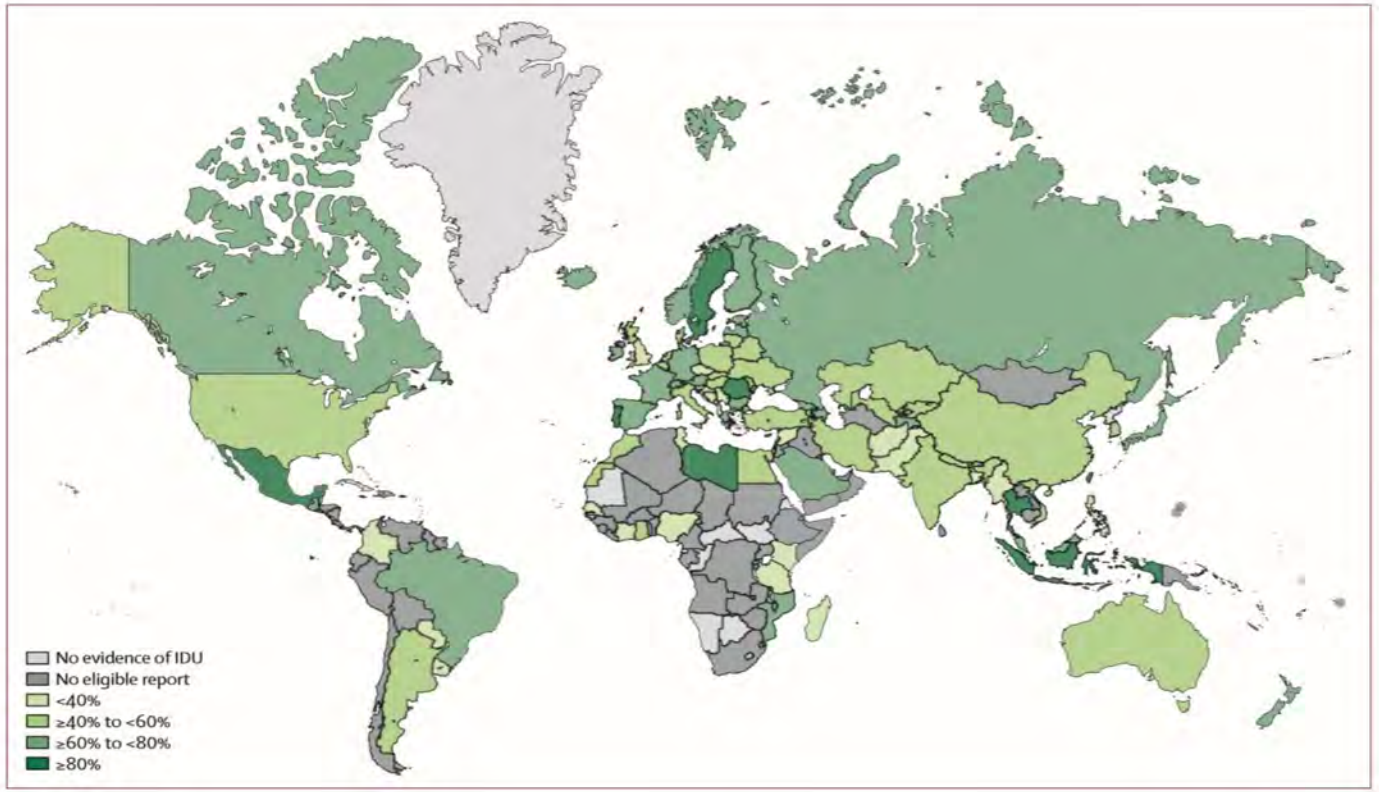
Africa: Over 10M people living with HCV

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%)



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Sources: Degenhardt L, et al. 2017; WHO Progress Report on HIV, Viral Hepatitis, and STIs 2021.

NEW INFECTIONS & MORTALITY BY REGION

GLOBAL

Hepatitis B
New Infection: **1 500 000**
[1 100 000–2 600 000]
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
[220 000–260 000]
Deaths: 77 000
[77 000–140 000]

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

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
[150 000–370 000]
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

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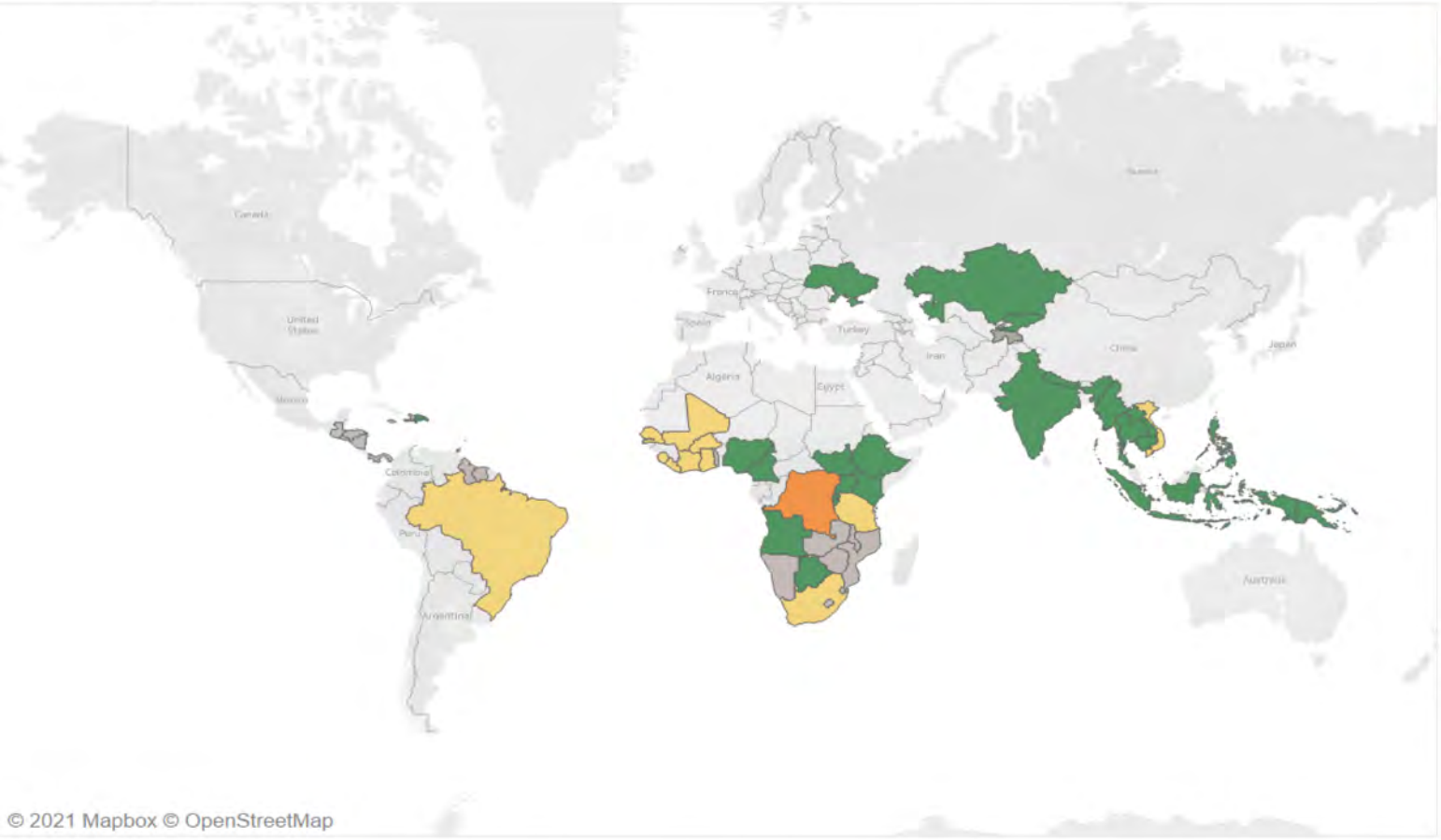
WHY PEPFAR?

- PEPFAR already reaches vulnerable populations and can use its programs to meet people where they are, with what they need, to prevent advanced HIV, chronic illness & 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



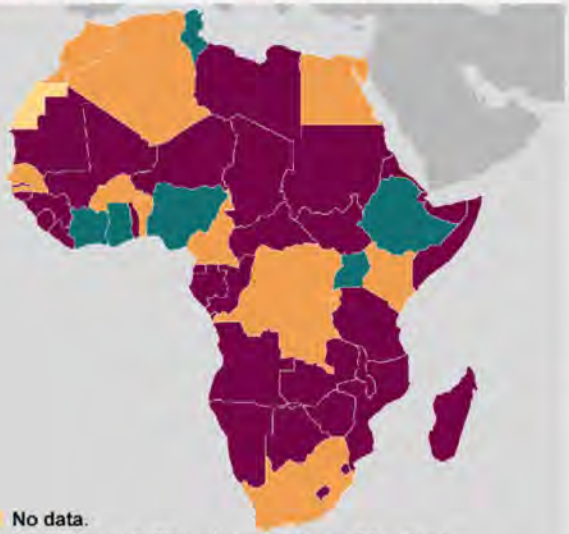
Angola, Botswana
Burundi, Cambodia
Cameroon, Dominican Rep., Ethiopia, India
Indonesia, Kazakhstan
Kenya, Kyrgyz Rep.
Lao PDR, Myanmar
Nepal, Nigeria
PNG, Philippines, Rwanda
South Sudan, Tajikistan
Thailand, Uganda, Ukraine

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

Sources: WHO Policy Brief 2019; MSF Analysis 2019; mapCrowd 2019; Harm Reduction International; WHO: Hepatitis Scorecard for the WHO Africa Region Implementing the hepatitis elimination strategy, 2020.

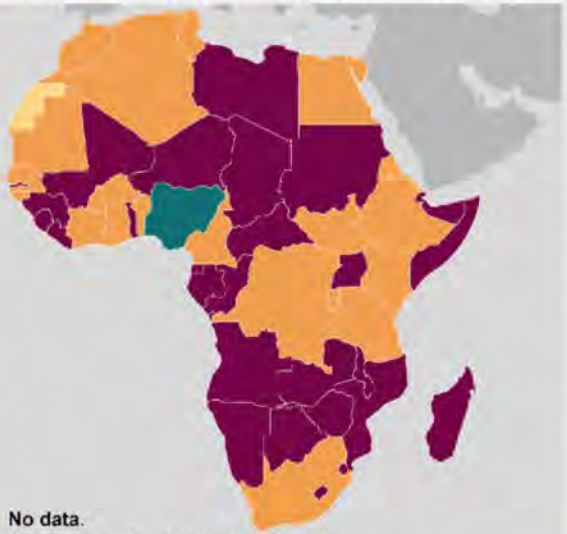
TREATMENT RESTRICTIONS IN AFRICA

Countries with Fibrosis restrictions



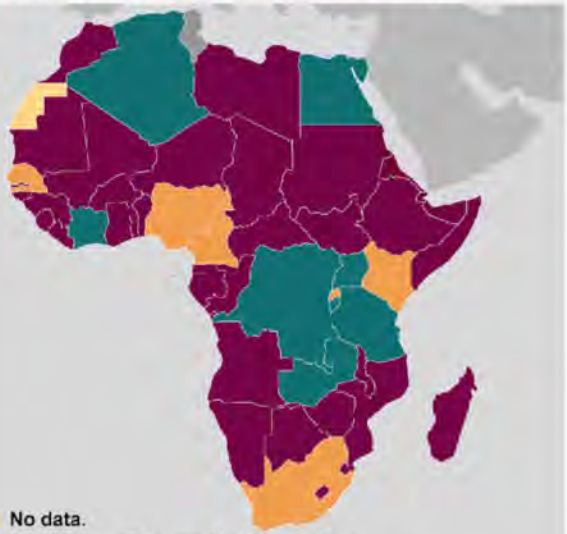
- **No data.**
- **Countries with Fibrosis restrictions:** Côte d'Ivoire, Ethiopia, Ghana, Nigeria, Tunisia, Uganda.
- **Countries with no fibrosis restrictions:** Algeria, Benin, Burkina Faso, Burundi, Cameroon, Congo–The Democratic Republic of, Egypt, Kenya, Mauritius, Morocco, Rwanda, Senegal, South Africa.
- **Countries with no data on fibrosis restrictions:** Angola, Botswana, Cape Verde, Central African Republic, Chad, Comoros, Congo–Republic of The, Djibouti, Equatorial Guinea, Eritrea, Eswatini, Gabon, Gambia, Guinea, Guinea-Bissau, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Sao Tome and Principe, Seychelles, Sierra Leone, Somalia, South Sudan, Sudan, Tanzania, Togo, Zambia, Zimbabwe.

Countries with Sobriety restrictions



- **No data.**
- **Countries with sobriety restrictions:** Mauritius*, Nigeria*.
- **Countries with no sobriety restrictions:** Algeria, Benin, Burkina Faso, Burundi, Cameroon, Congo–Democratic Republic of The, Côte d'Ivoire, Egypt, Eritrea, Ethiopia, Ghana, Guinea-Bissau, Kenya, Mauritania, Morocco, Nigeria, Rwanda, Senegal, South Africa, South Sudan, Tanzania, Tunisia.
- **Countries with no data on sobriety restrictions:** Angola, Botswana, Cape Verde, Central African Republic, Chad, Comoros, Congo–Republic of The, Djibouti, Equatorial Guinea, Eswatini, Gabon, Gambia, Guinea, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Niger, Sao Tome and Principe, Seychelles, Sierra Leone, Somalia, Sudan, Togo, Uganda, Zambia, Zimbabwe.

Countries with Prescriber restrictions



- **No data.**
- **Countries with prescriber restrictions:** Algeria, Burundi, Congo–Democratic Republic of The, Côte d'Ivoire, Egypt, Tanzania, Uganda, Zambia.
- **Countries with no prescriber restrictions:** Cameroon, Kenya, Mauritius, Nigeria, Rwanda, Senegal, South Africa.
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WHAT DOES FINAL COP 2022 SAY ABOUT HCV?

Viral hepatitis/hepatitis mentioned **20 times**; HCV **6 times**; and HBV **8 times**

- **6.3.1.8 Community-based testing:** "Studies show that community-based testing strategies that integrate health assessments and multi-disease screenings can effectively reduce stigma at the community level by normalizing HIV testing as part of routine health care...Among key populations, HIV testing uptake is highest when combined with testing for TB, STIs, FP, and/or hepatitis but somewhat lower when combined with screening for chronic conditions..." Country plans can also integrate HCV self-testing into their HIV self-testing strategies.

- **6.6.1.4 Diagnosis:** "… diagnose and monitor multiple diseases, including HIV and TB but also COVID-19, hepatitis C..." References GeneXpert and other multi-disease diagnostics platforms. Countries can "integrate point-of-care HCV viral load testing where there are HIV point-of-care testing services."

WHAT DOES FINAL COP 2022 SAY ABOUT HCV?

- **2.3.5 Addressing comorbidities (p. 87):** "consider addressing additional comorbidities (…viral hepatitis, noncommunicable disease, mental illness) in a way that is prioritized 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 (SNUs) 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."

PROPOSED LANGUAGE FOR COP 2022

- **We demand a standalone section on viral hepatitis coinfection!**
- **2.3.5 Addressing comorbidities:** "leveraging enduring lab, supply chain, HRH, and information systems, as well as securing partnership and alignment with national health programs for comorbidities such as viral hepatitis is part of optimized HIV care, and services for monoinfection should be offered as part of prevention, screening and testing strategies."
- **6.4 Optimizing HIV Care and Treatment**: With highly effective and safe pangenotypic direct-acting antivirals, people with HCV can effectively be cured and not transmit the virus if accurate, appropriate prevention education and access to harm reduction materials are in place. Linkage to early HCV treatment for people who are HIV/HCV coinfected can prevent further liver damage and liver cancer and improve HIV and health outcomes.

- **PEPFAR should increase 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.
- **Prevention and education activities**
  - **2.3.3 Person-Centered Continuous ART**: include "people who use and inject drugs and their sexual partners"
  - **6.2 Primary Prevention**: Align with WHO hepatitis guidelines "…Prevention services should promote health and treatment literacy about viral hepatitis transmission and prevention, should offer linkage to viral hepatitis testing, DAA treatment, and HBV vaccination for people at highest risk, including people who use and inject drugs. In addition, prevention services should advocate and implement a comprehensive package of harm reduction interventions…"
  - "Addressing viral hepatitis coinfections can prevent liver cancers."
  - "Addressing HBV can prevent hepatitis D" (for which there's no treatment or vaccine).

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PROPOSED LANGUAGE FOR COP 2022

- **6.3 HIV Testing Services Strategies**: PEPFAR can 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, decentralized diagnostics algorithms that include point-of-care testing.
- **6.3.1.8 Targeted Community-based Testing Services**:"Programs should also consider incorporating HIVST [and HCV antibody self-testing] into community-based testing strategies where appropriate."
- **6.4 Optimizing HIV Care and Treatment**: include integration of viral hepatitis into HIV diagnostics algorithm.

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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 patient.

- **"Won't fund needles/syringes (due to federal ban)"**

  Needles/syringes cost pennies. Federal ban is on the brink of being removed in the US. Countries should not be deterred from including NSPs and comprehensive harm reduction programs in their COPs.

QUESTIONS?

Contacts & Social Media

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@treatmentactiongroup

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@hepcoalition_mapcrowd

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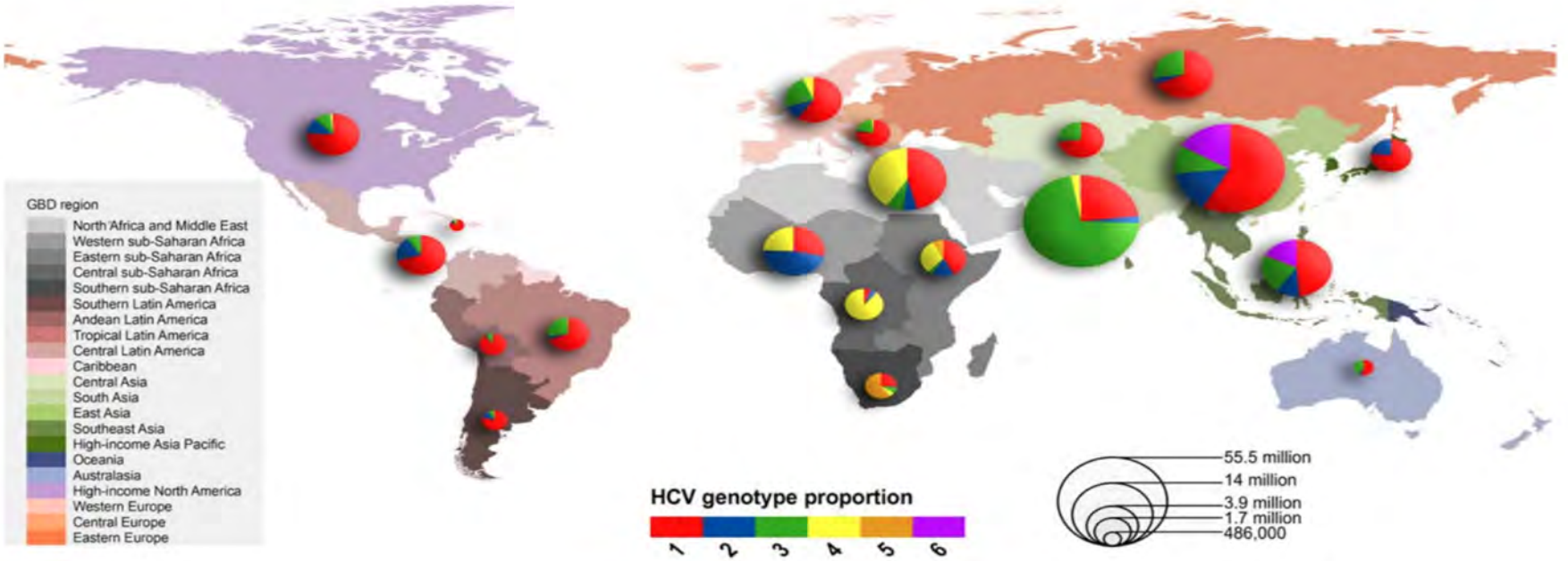
WHY HEPATITIS? WHY NOW?

- 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
- Africa regional plan = We should be demanding investments in viral hep!
- New WHO global guidance expected in 2022; time to align COPs with WHO and UNAIDS / Global Fund strategies/targets

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:
Messina et al. Hepatol. 2015; Aranday-Cortes et al. J. of Inf. D. 2021; Gupta N et Al. Lancet Gastroenterology & Hepatology 2019

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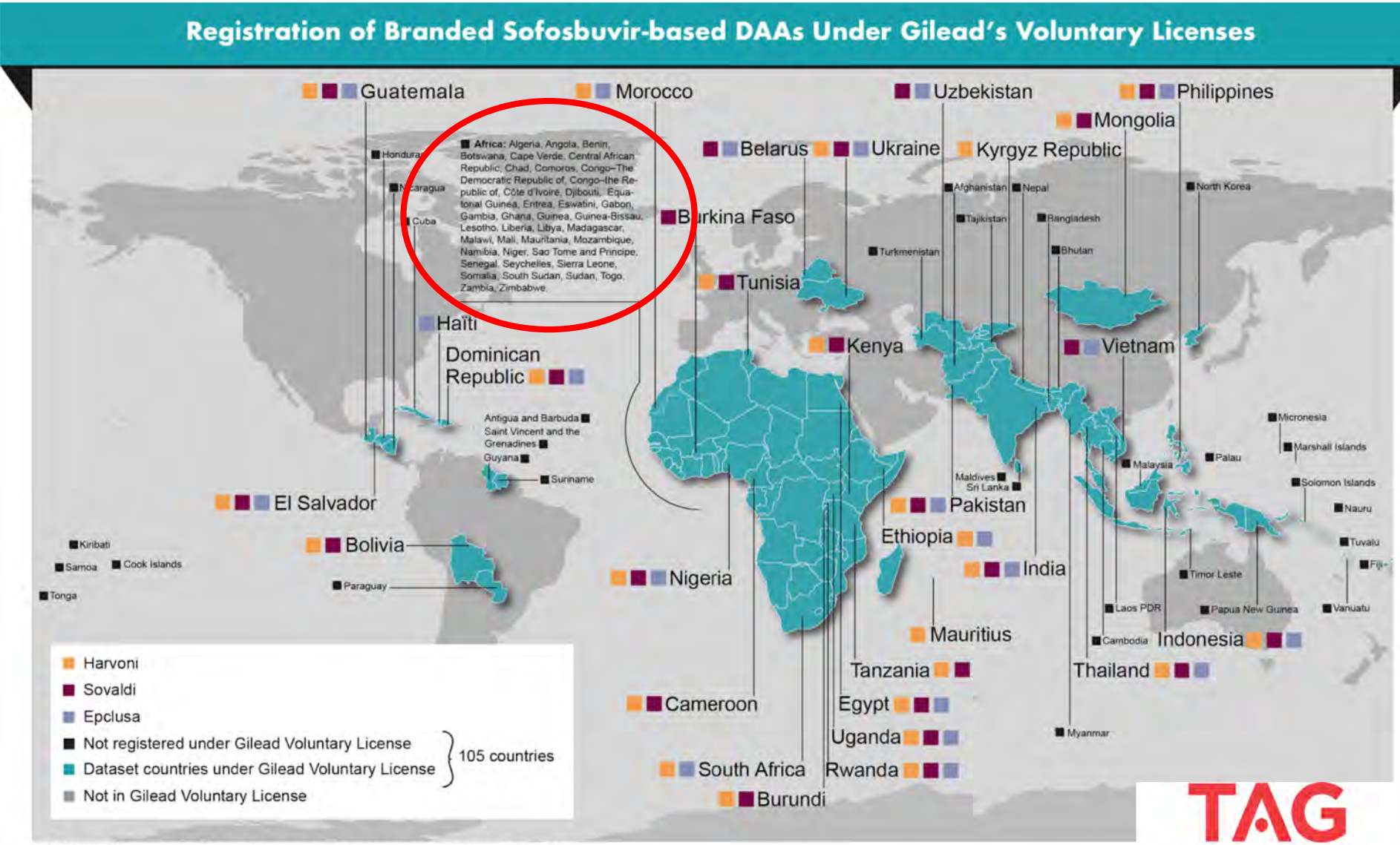
DIRECT-ACTING ANTIVIRAL (DAA) REGISTRATION IN PEPFAR COUNTRIES / AFRICA



Inludes Harvoni, Sovaldi, and Epclusa (105 countries).

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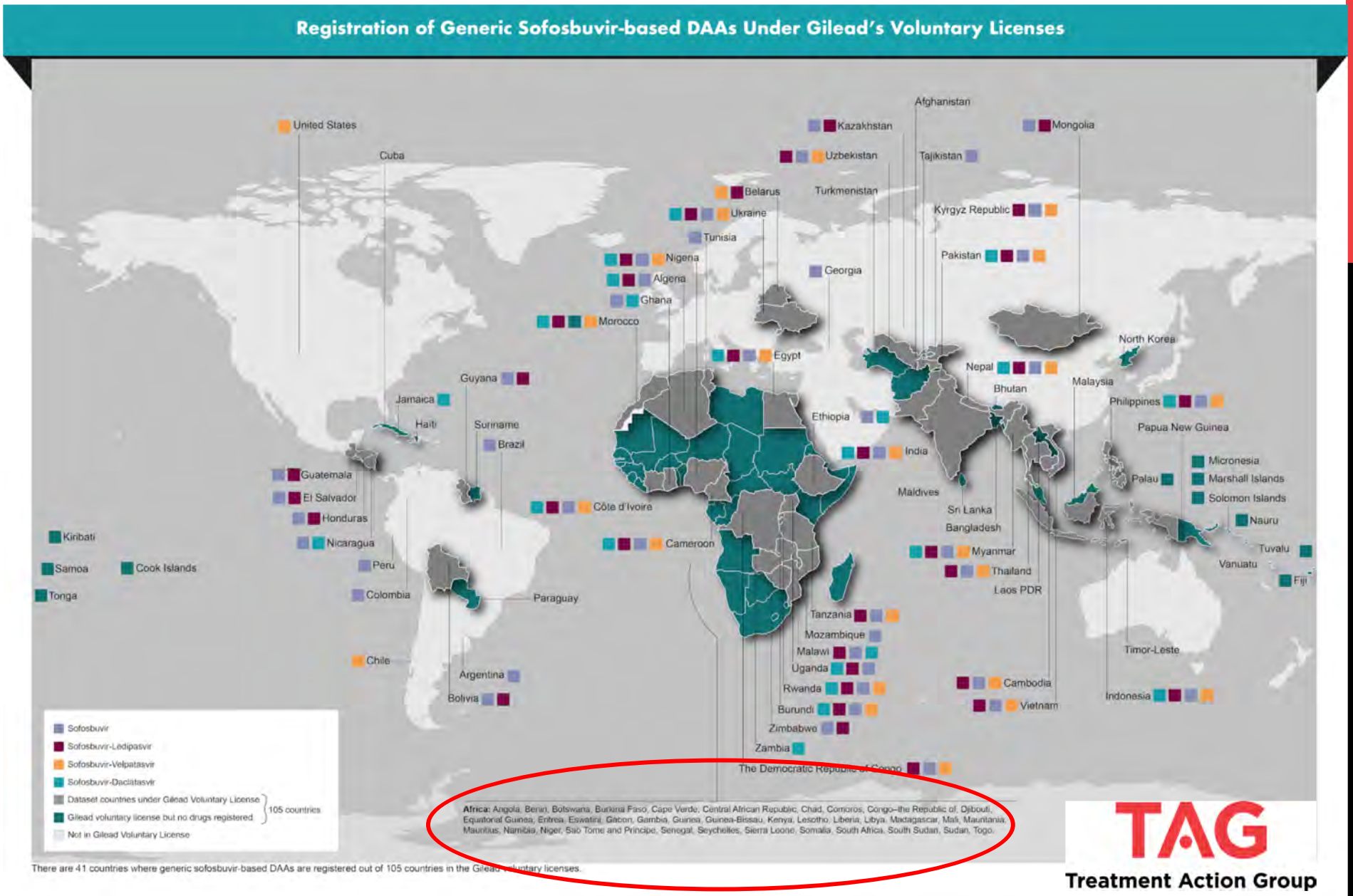
DIRECT-ACTING ANTIVIRAL (DAA) REGISTRATION IN PEPFAR COUNTRIES / AFRICA



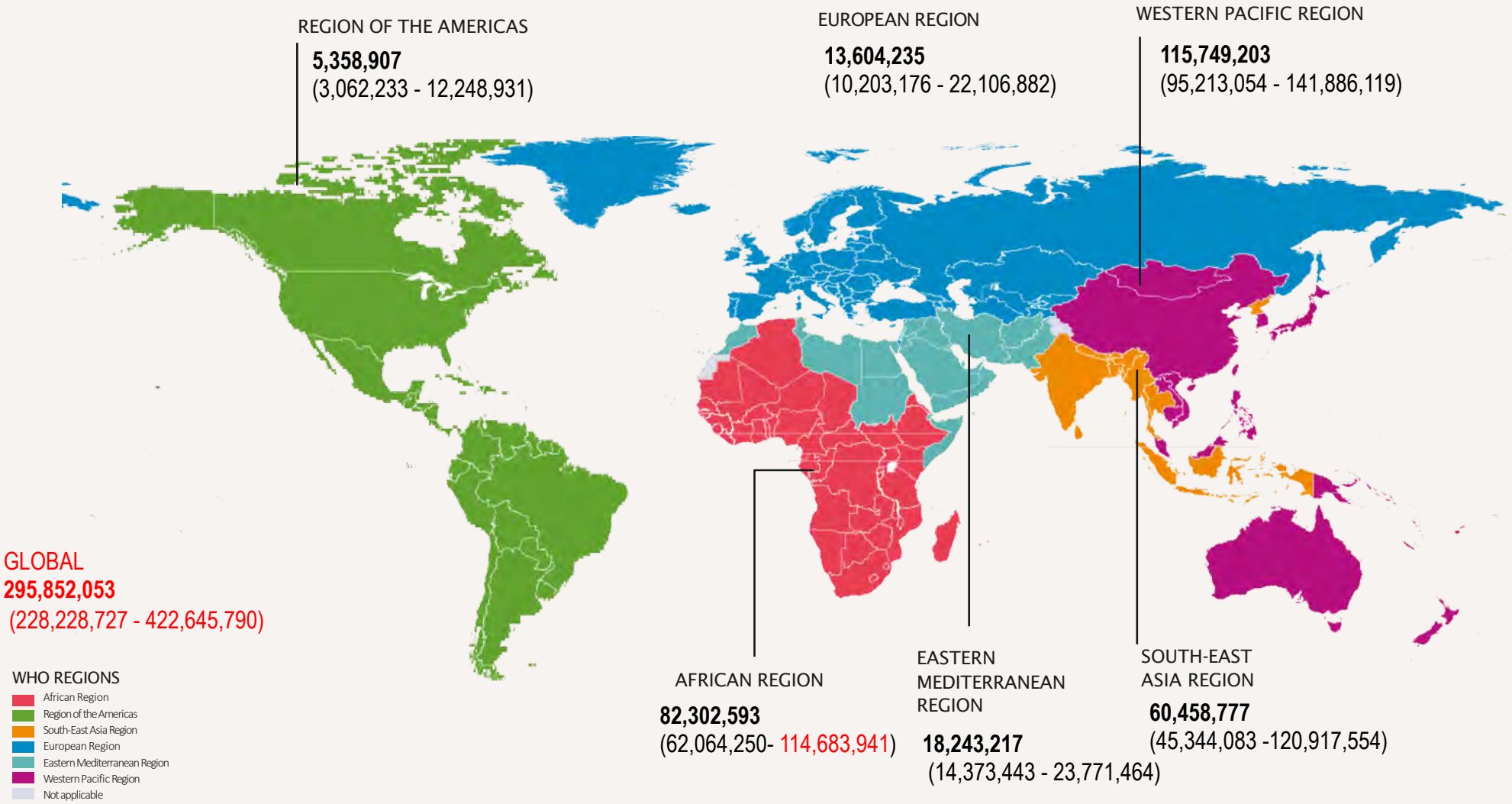
Hepatitis B Integration for PEPFAR

Danjuma Adda
President, World Hepatitis Alliance
03/02/2022

World Hepatitis Alliance

Burden of HBV infection (HBsAg) in the general population by WHO region, 2019:

296 million



World Health Organization

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

World Hepatitis Alliance

Global Epidemiology of Hepatitis B

The burden of hepatitis B infection across WHO regions:

WHO Western Pacific Region: 116 million

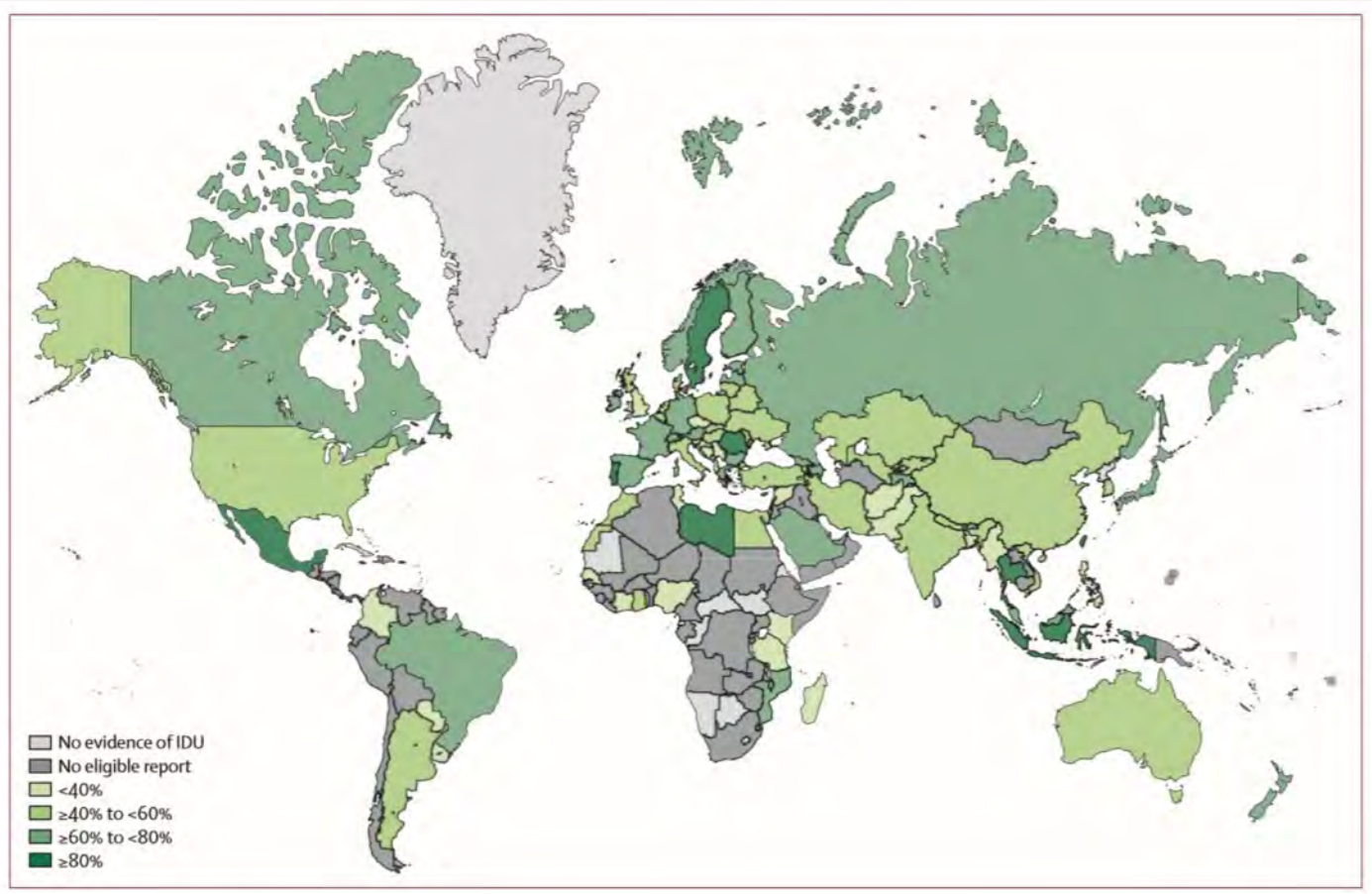
WHO African Region: 81 million people.

WHO Eastern Mediterranean Region: 60 million

WHO South-East Asia Region; 18 million

WHO European Region: 14 million

WHO Region of Americas: 5 million



World Hepatitis Alliance

Sources: World Hepatitis Alliance website 2022

HBV Epidemic in PEPFAR Countries

Botswana: 0
Cote d'Ivoire: 9% (2.9m)
Ethiopia: 8% (7.8m)
Kenya: 1% (558,677)
Mozambique: 8% (2.1m)
Namibia: 0
Nigeria: 8% (20.7m)
Rwanda: 3% (399987)
South Africa: 5% (3.2m)
Tanzania: 4% (2.2m)
Uganda: 6% (2.2m)
Zambia: 3% (539975)

Angola: 10% (2.9m)

Cameroon: 7% 1.6m

Eswatini: 10% (107000)

Haiti: 3% (312000)

Lesotho: 12% (246000)

Malawi: 3% (585474)

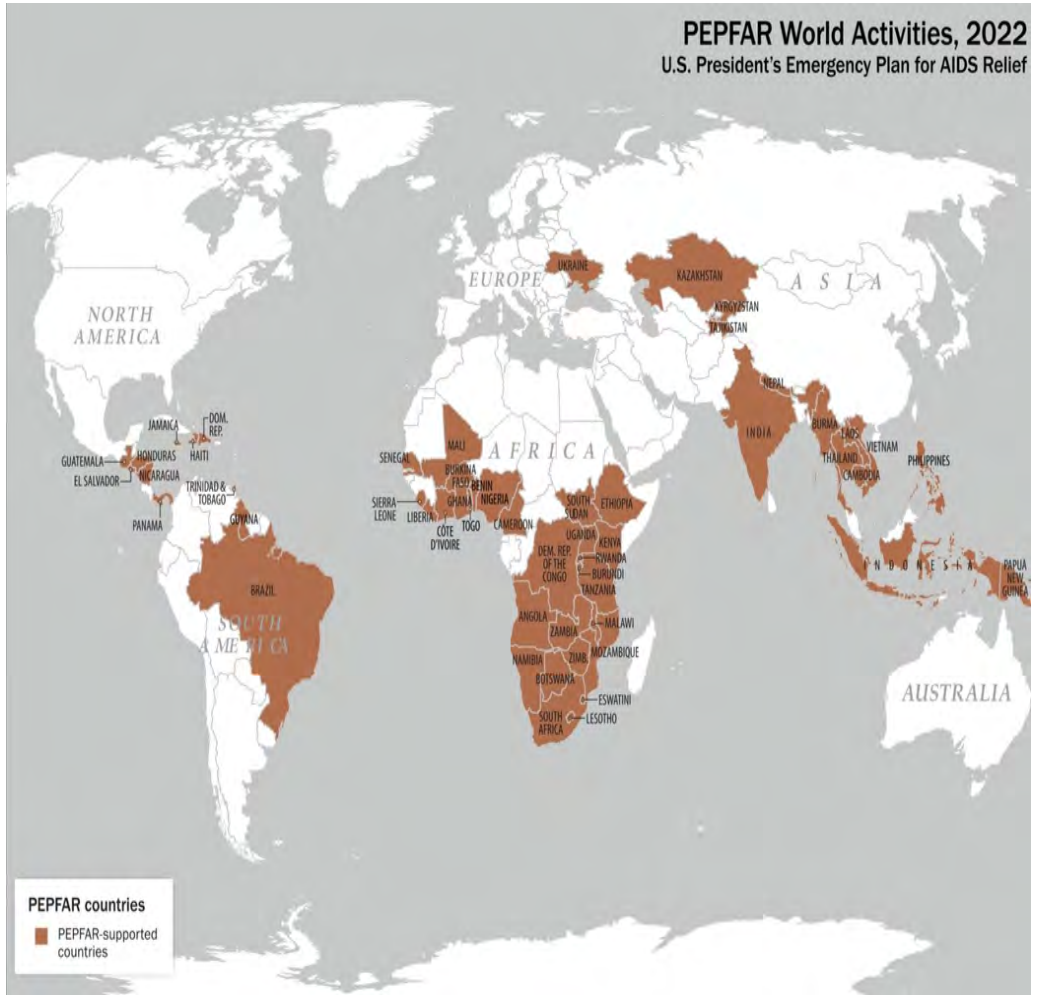
Ukraine: 1% (531000)

Vietnam: 8% (7.7m)

Mali: 5% 935

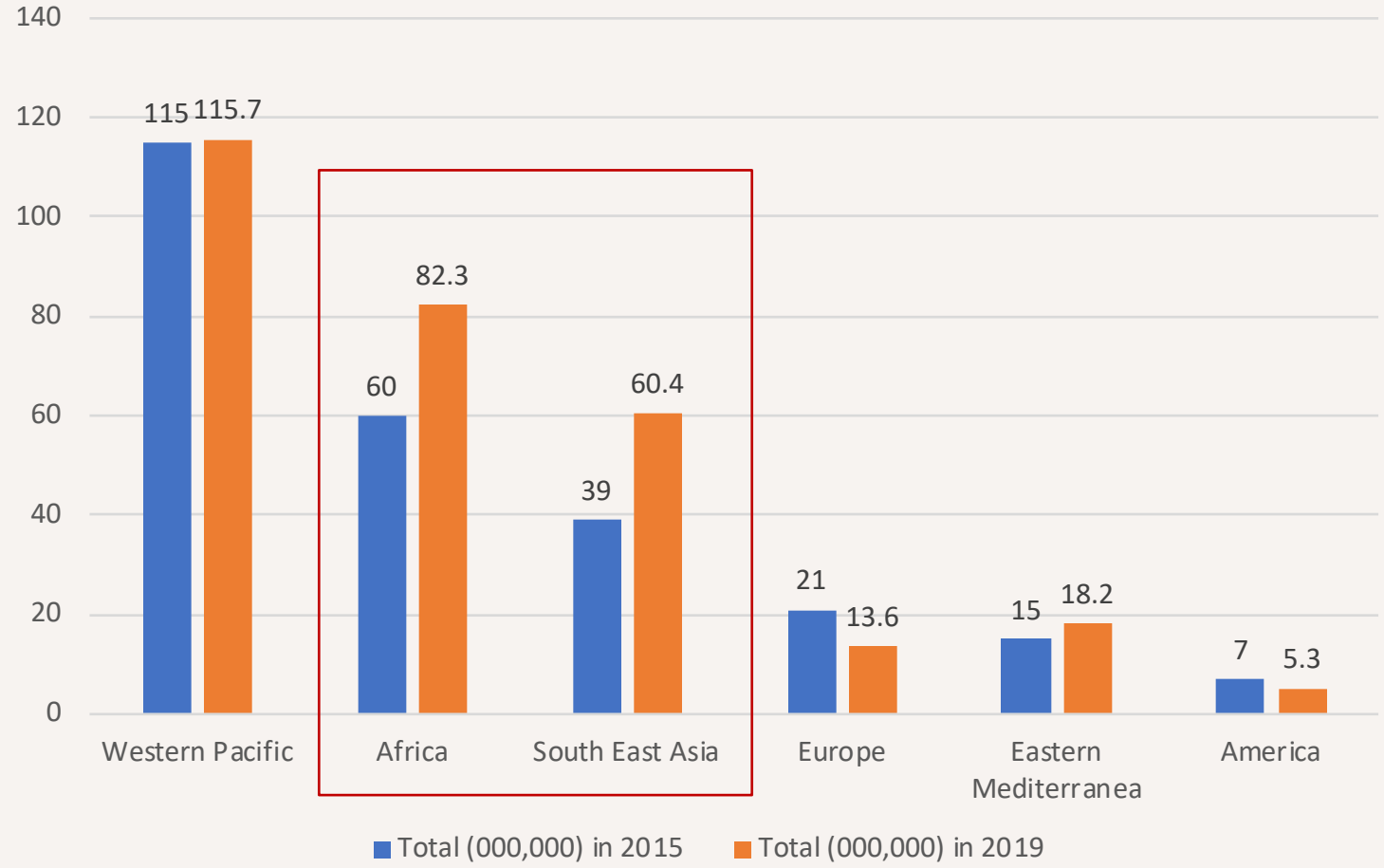
Ghana: 10% 2.8m

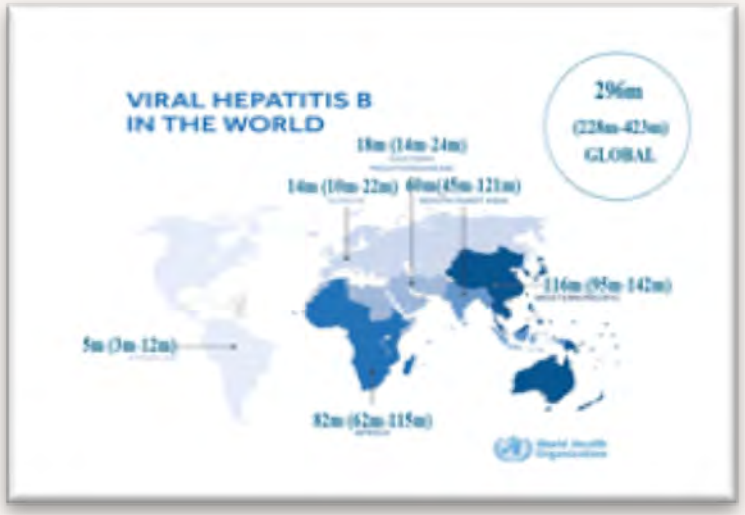
Liberia: 10% (465000)

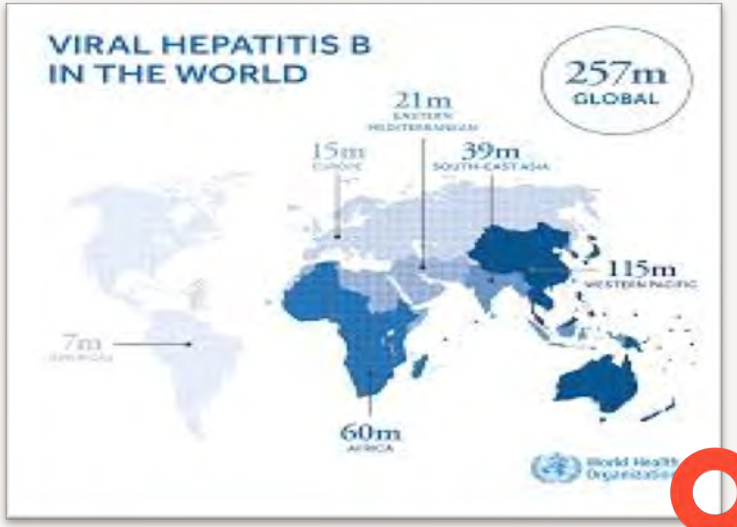


Sources: Centre for Disease Analysis Foundation Polaris Observatory Jan 29 2022

Increased estimated global burden from 257 million(2015) to 296 million (2019)





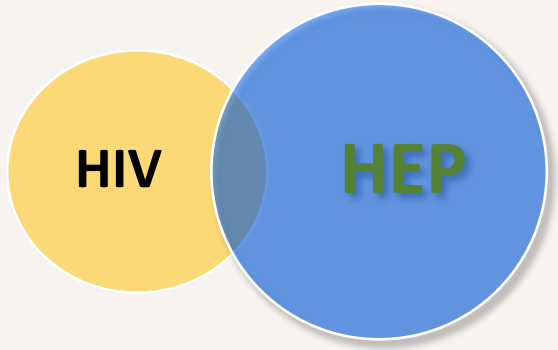


Increased regional burden mostly in AFRO and SEARO accounting for global increase Decreased burden in Europe and the Americas

Sources: Dr Funmi Lesi: WHO Geneva WHA/Hep B United Webinar

World Hepatitis Alliance

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)

WHO (2011), UNAIDS (2011), Ott JJ (2012), Alter MJ 2006, Hoffman CJ (2007), Uneke CJ (2005)

World Hepatitis Alliance

Hepatitis Elimination Financing & Costs

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

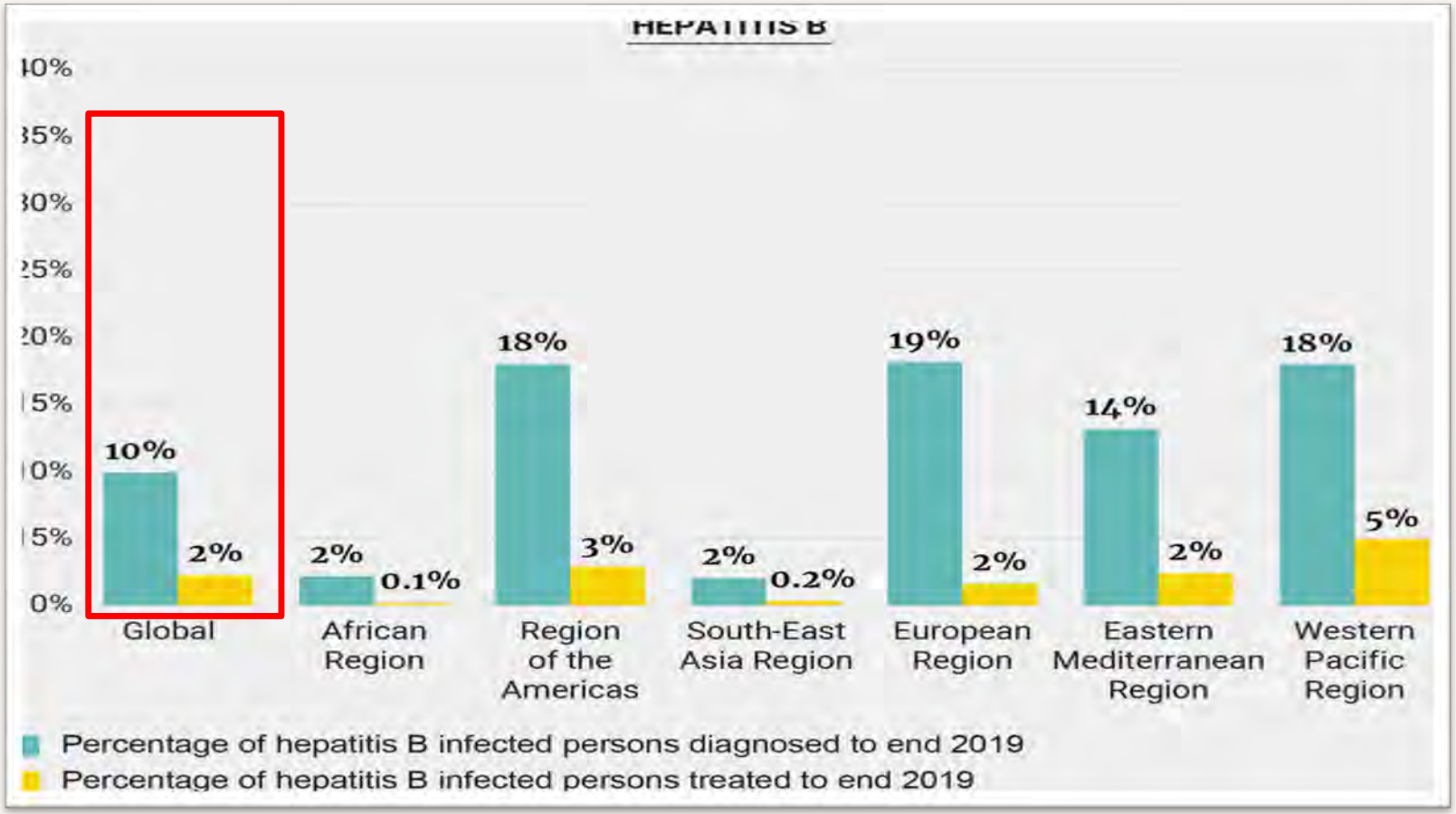
WORLD ECONOMIC FORUM

Hepatitis Elimination Initiative

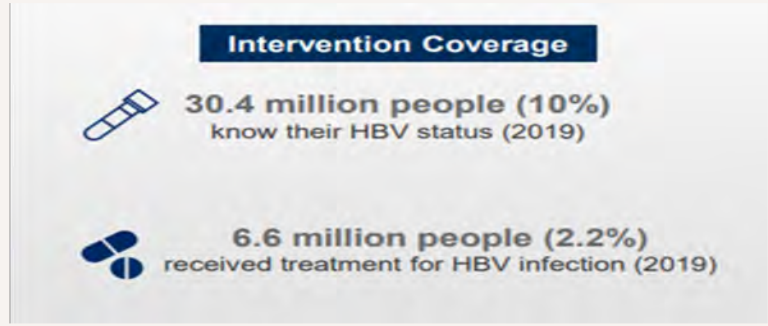
Partners

Abbott Laboratories
Cepheid
Clinton Health Access Initiative
Egypt Government
Roche
The Hepatitis Fund (EndHep2030)
Pharco
World Economic Forum
World Health Organization (WHO)

Major gaps in testing and treatment towards public health elimination



Only 10% of estimated 296 million people with chronic HBV infection were diagnosed in 2019 with variation by regions (only 2% are on treatment)



Progress report on HIV, viral hepatitis and sexually transmitted infections 2021: accountability for the global health sector strategies, 2016–2021: actions for impact. Geneva: World Health Organization; 2021

Sources: Dr Funmi Lesi: WHO Geneva WHA/Hep B United Webinar

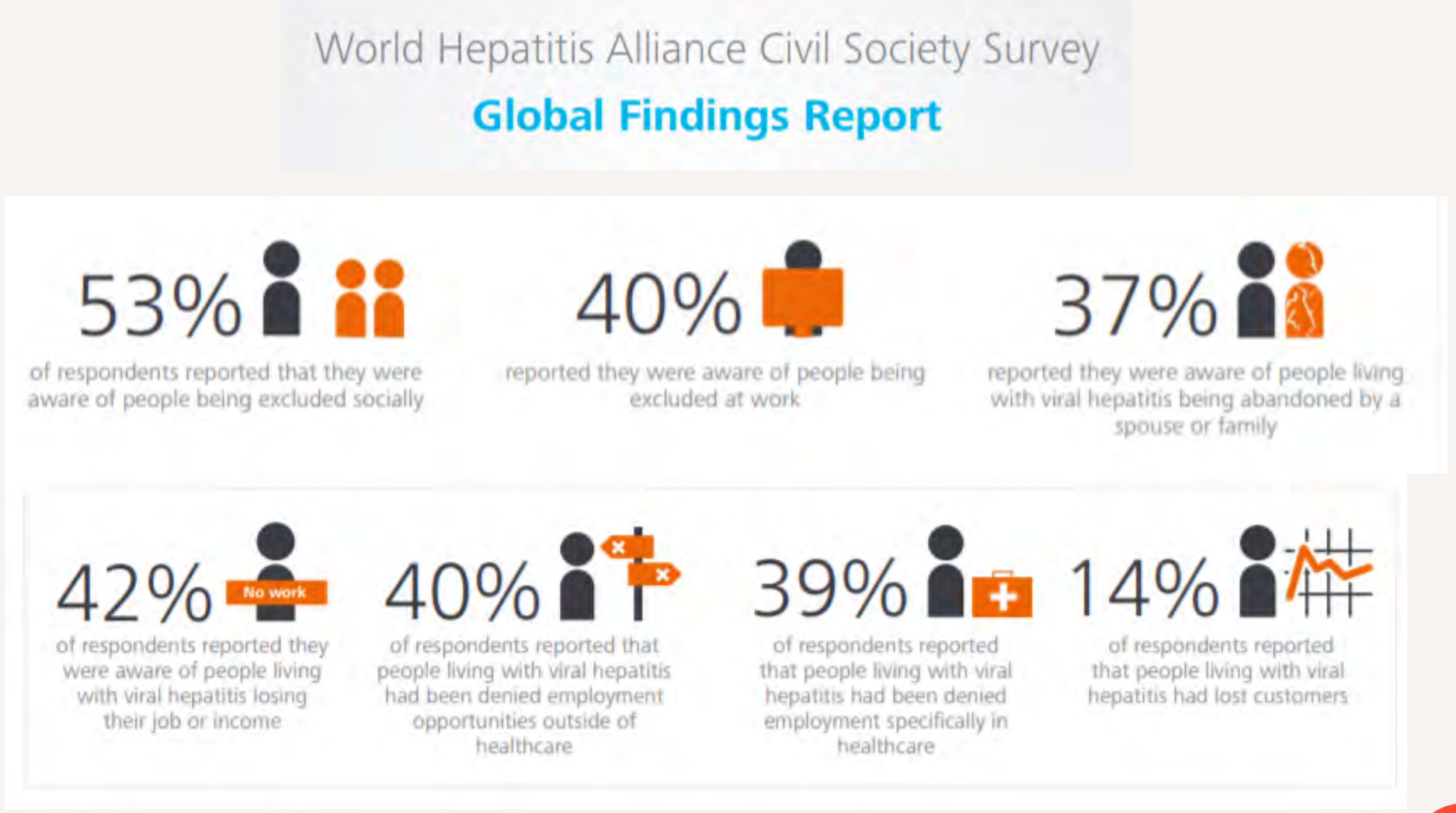
World Hepatitis Alliance

HBV Unmet Needs

- HBV mono-infected patients lack access to Tenofovir (TDF/TAF)
- Out of pocket payment for HBV testing and treatment driving many into poverty
- Poor access to PoC HBV diagnostics systems
- Difficult HBV testing and treatment algorithms
- Poor involvement of patients from Africa in clinical trials for HBV cure
- Poor Hepatitis B BirthDose coverage: GAVI is stalling providing support to countries due to COVID-19 challenges

Poor political will and action by governments and funders

Stigma and discrimination



Holding governments accountable: World Hepatitis Alliance civil society survey global findings report.
World Hepatitis Alliance, London; 2017
http://www.worldhepatitisalliance.org/sites/default/files/resources/documents/holding_governments_accountable_-_civil_society_survey_report.pdf

World Hepatitis Alliance

Form of stigma/discrimination (Percentage of respondents who gave this answer)

72%	Experienced self-stigma/internalised stigma
53%	Social exclusion
52%	Unjust barriers to service provision in health care
50%	Lack of respect
42%	Loss of job or income
40%	Exclusion/ostracism at work
40%	Denial of employment opportunities outside of health care
39%	Denial of employment specifically in health care
38%	Denial of health care
37%	Abandonment by spouse and/or family
32%	Inferior quality of care than given to people who do not have viral hepatitis
30%	Experienced verbal assaults or felt threatened by others
21%	Unable to get married
20%	Mandatory testing
15%	Experienced discrimination from teachers
14%	Lost customers
10%	Denial of childcare
9%	Other
4%	Property loss
5%	No stigma or discrim

Respondent

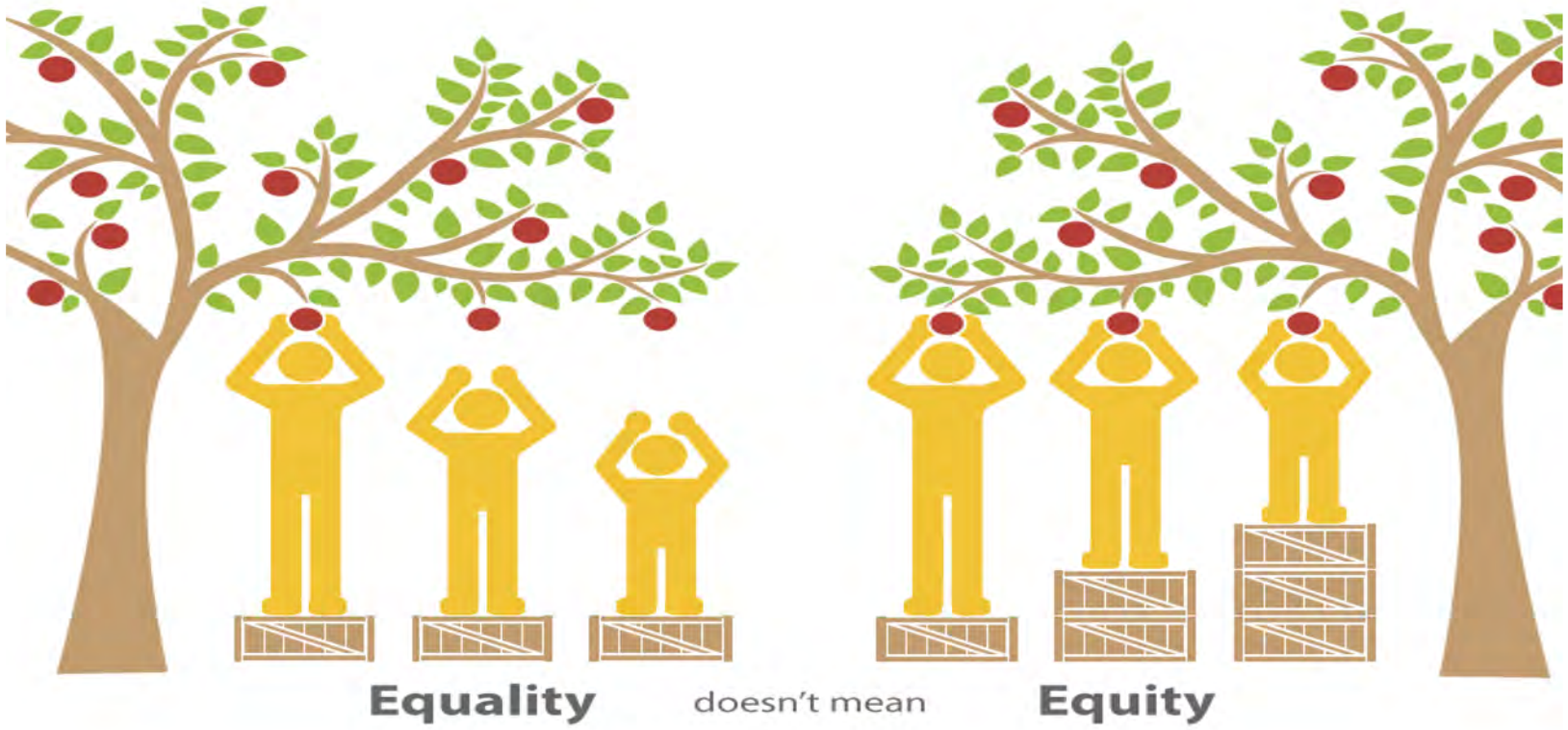
In 2014 WHO Member States at the World Health Assembly adopted resolution 67.6 which urges member states:

(16) to review, as appropriate, policies, procedures and practices associated with stigmatisation and discrimination, including the denial of employment, training and education, as well as travel restrictions, against people living with and affected by viral hepatitis, or impairing their full enjoyment of the highest attainable standard of health;

Holding governments accountable: World Hepatitis Alliance civil society survey global findings report.

World Hepatitis Alliance

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.

World Hepatitis Alliance

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.

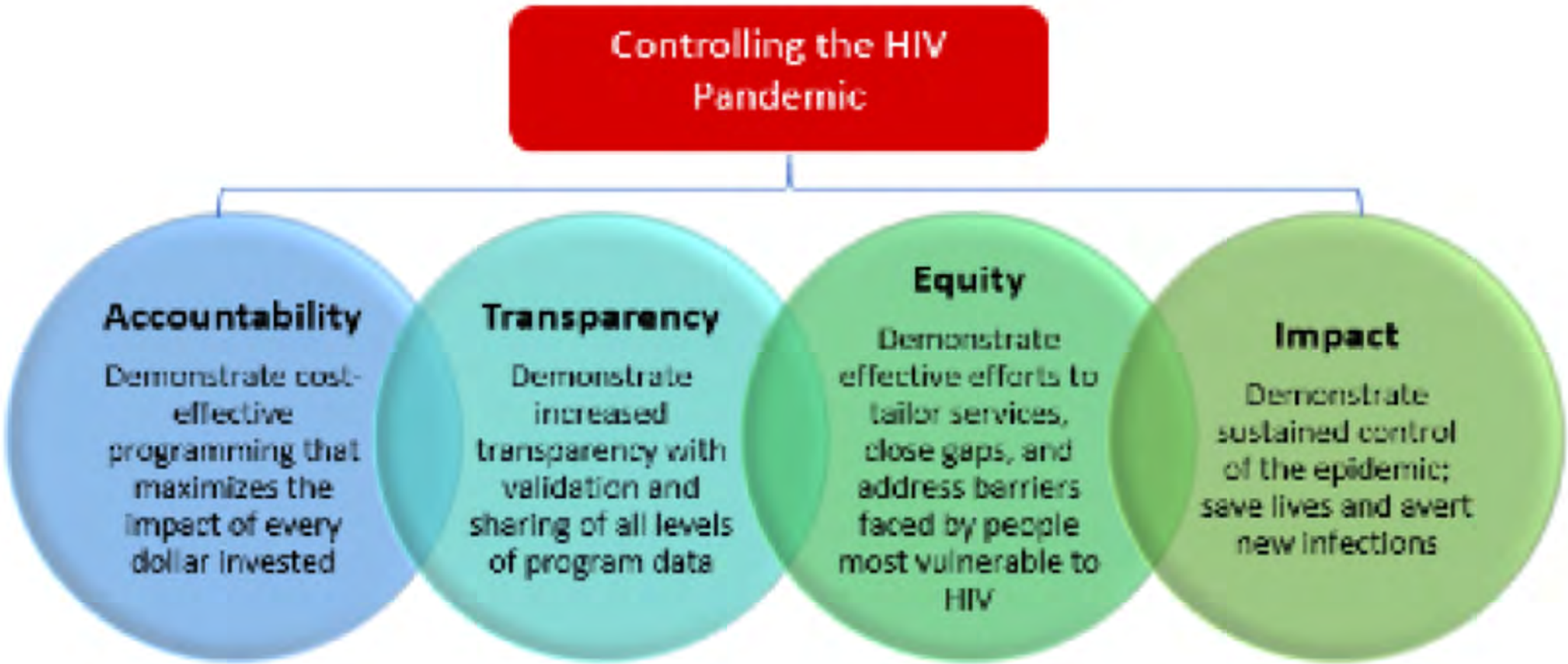
- HIV, viral hepatitis and sexually transmitted infections share common modes of transmission and determinants, and many of the populations affected by these diseases may overlap

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.

World Hepatitis Alliance

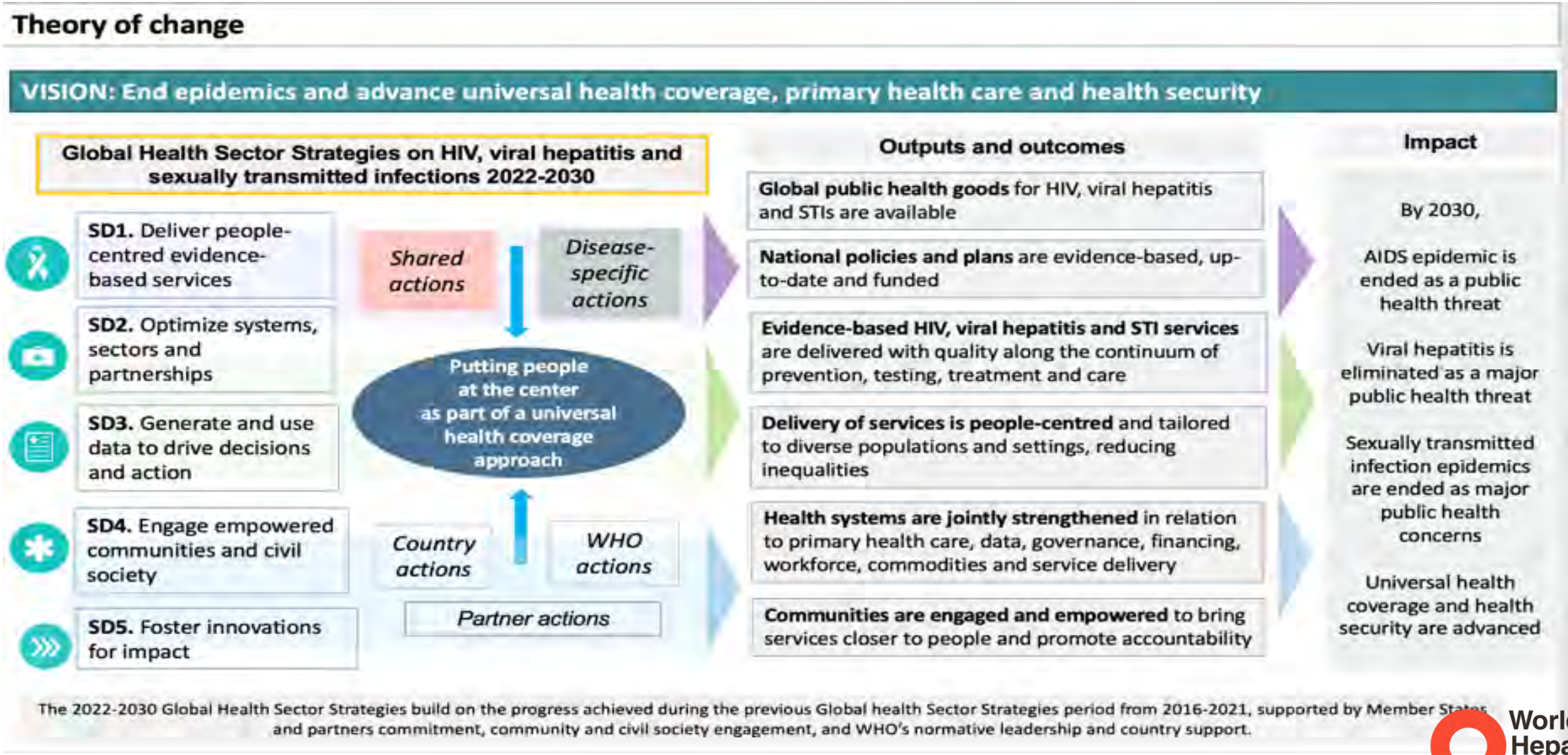
PEPFAR's 4 Guiding Pillars



Active Program and Partner Management

World Hepatitis Alliance

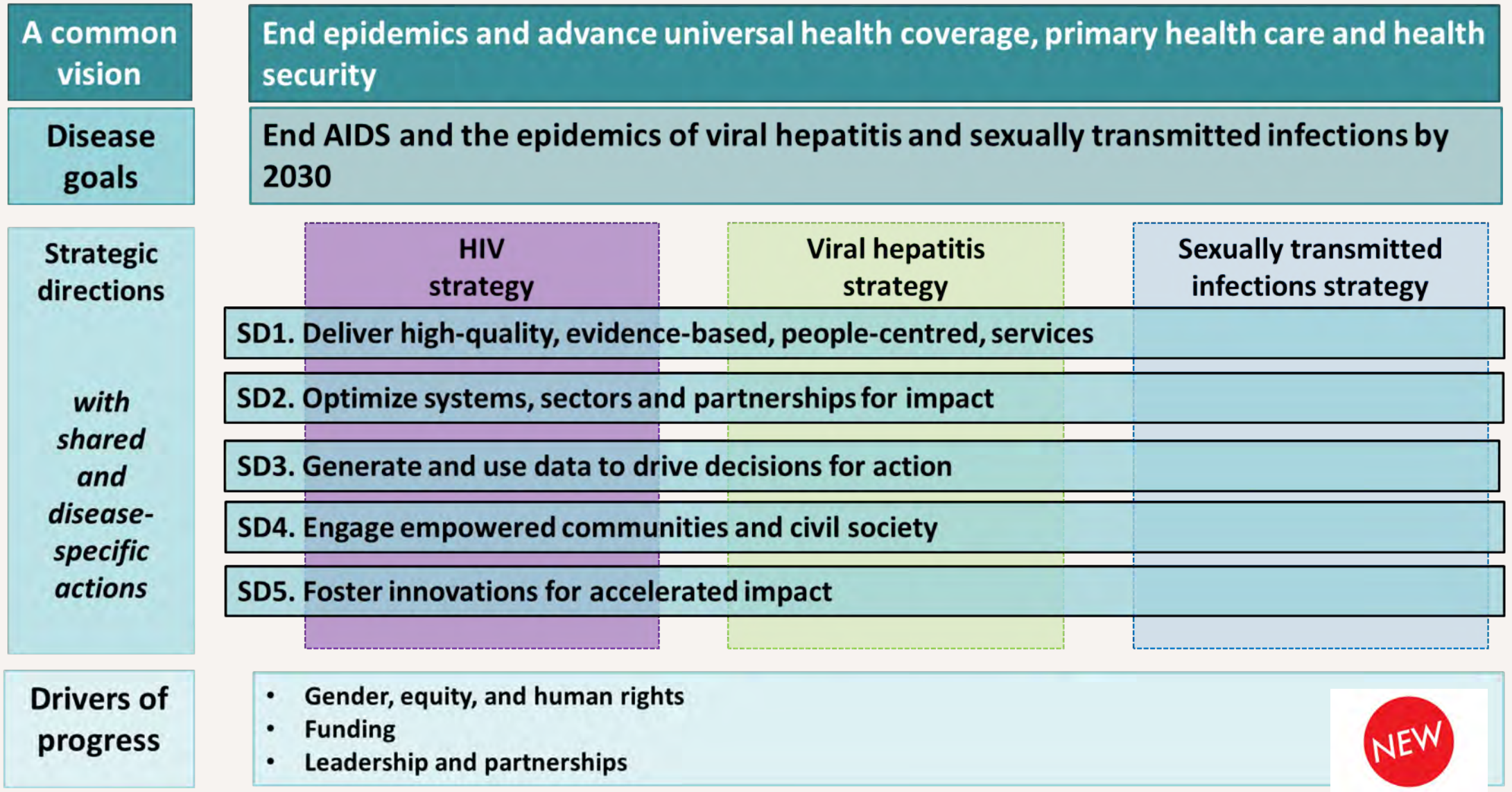
Integrate HBV PEPFAR Plans into WHO GHSS 2022-2030



World Hepatitis Alliance

Vision, goals and strategic directions (GHSS 2022-2030)

World Health Organization



(Current draft)

PEPFAR Guiding Principles: Key areas for focus as stakeholders approach planning for COP22 guidance for implementation in FY2023 include the following:

Plans should ensure that PEPFAR's actions are supporting enduring public health systems and capabilities……which can be adapted for responses to other public health threats and emergencies.

Linkage and Integration: Where beneficial and appropriate, link to and integrate HIV services with other related U.S. government health investments and development priorities to support progress toward achieving UN Sustainable Development Goal (SDG) 3 while also advancing other interdependent SDGs.

Priority populations across HIV, viral hepatitis and sexually transmitted infections

Many of the populations that are most affected by and at-risk for HIV, viral hepatitis and sexually transmitted infections overlap across these disease areas.

Shared approaches for a people-centred response

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.

People-centred approaches that are organized around the needs of affected populations can enhance health care delivery, advance universal health coverage, increase service quality and sustainability, and maximize the impact of available health resources.

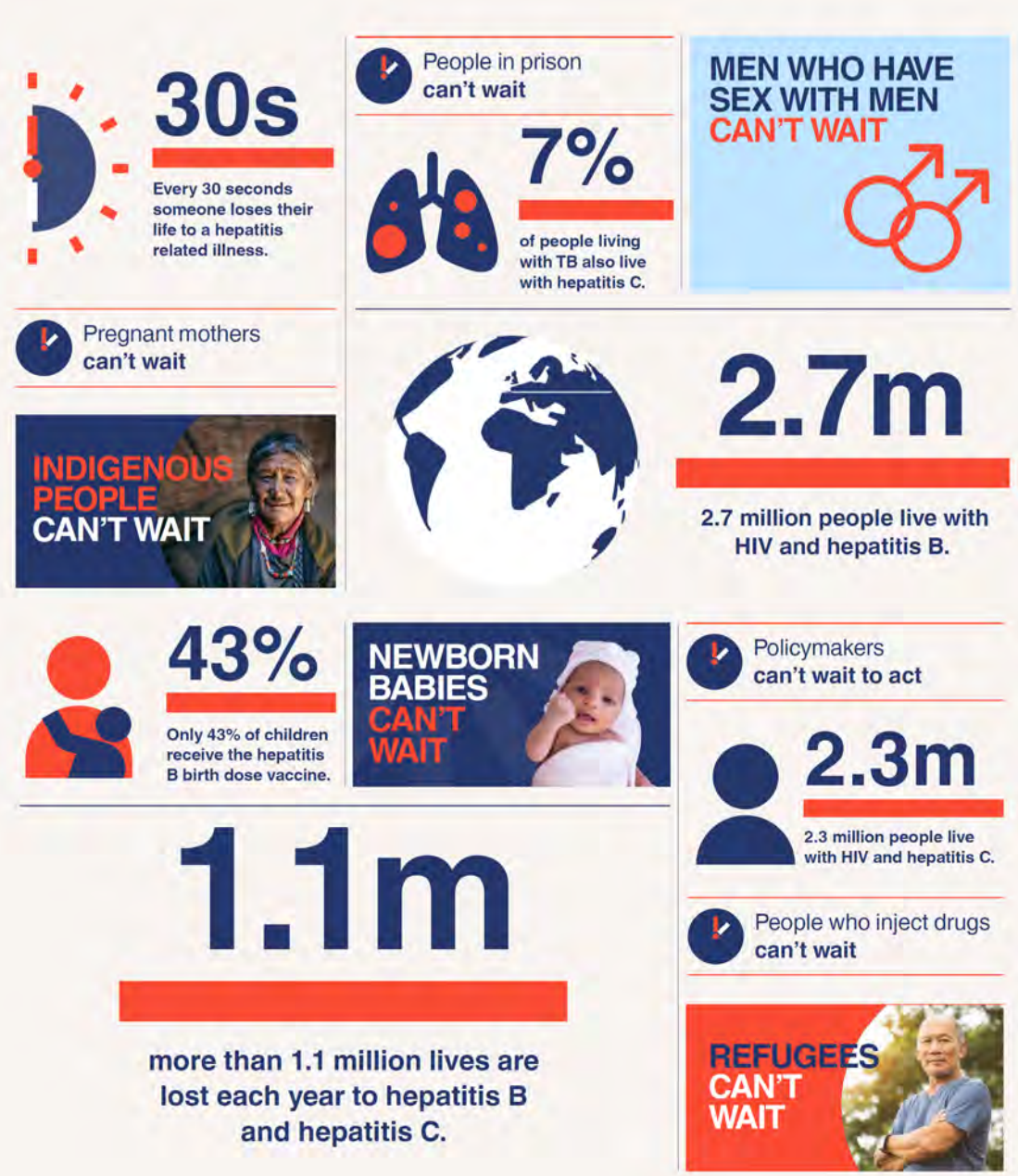
ACTION 15: Universal health coverage. Adopt a health systems-oriented approach to deliver essential HIV, viral hepatitis and sexually transmitted infection services as part of universal health coverage, including through alignment of disease-specific and health system efforts at the policy, programme and service levels

HBV Advocacy Priorities

1. Greater public awareness of the importance of viral hepatitis B and C prevention, testing and treatment
2. Increased financial resources allocated
3. Scale-up of universal access to hepatitis B birth dose vaccine and improved services for prevention of vertical transmission
4. Continuous investment in primary prevention
5. Greatly increased access to hepatitis B and C virus testing and treatment
6. Simplified and decentralized service as well as integrated service delivery
7. Strengthened community and civil society
8. Innovations to accelerate action (incl HBV cure)

World Hepatitis Alliance

It’s time to raise awareness that “Hep Can’t Wait”



In the context of rights to health: HBV mono infected patients needs to seat at the table

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Acknowledgements

Dr Funmi Lesi: WHO Geneva:
Dr. Su Wang; Past President WHA
WHA Resource hub
EHRAAI
CDA

THANK YOU

World Hepatitis Alliance

www.idpc.net

International Drug Policy Consortium
A global network promoting objective and open debate on drug policy

DRUG USE IN PEPFAR RECIPIENT COUNTRIES IN AFRICA : WHAT DO WE KNOW?

Maria-Goretti Loglo
IDPC Africa Consultant
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idpc
www.idpc.net

International Drug Policy Consortium
A global network promoting objective and open debate on drug policy

- IDPC is a global network of nearly 200 NGOs
- Promoting drug policy debates and NGO participation
- Policies based on evidence, health, rights and development

NATURE OF DRUG POLICIES IN AFRICA

- The treaties have been interpreted as endorsing a **"war on drugs"**
  - a Western construction which was imported into this continent

- Most Western governments have started shifting towards more humane policies
  - a clear indication of an error of their ways

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www.idpc.net

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Africa's "War On Drugs" Has Created…

- Injecting drug use reported in 36 countries
- Estimated 645,000 - 3 million people who inject drugs
- HIV prevalence as high as 46.3% in some countries
- HCV prevalence as high as 97.1%!
- Public health crises and widespread violence
- Systemic human rights violations
- Overburdened prisons




DRUG USE IN AFRICA

- UNODC estimates that by 2030 the number of people who use drugs in the continent will rise by 40%

- 30% of people who inject drugs in the region are estimated to be living with HIV.

DRUG USE IN AFRICA (CONTINUE)

- People who use drugs in Africa continue to face stigma and discrimination
- Lack of availability and accessibility of hepatitis C testing and treatment

- High costs and limited availability means direct-acting antivirals remain out of reach to many.

Country/territory with reported injecting drug use[a]	People who inject drugs	HIV prevalence among people who inject drugs(%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs(%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs(%)	Harm reduction response		
					NSP[b]	OST[c]	Peer-distribution of naloxone
Benin	nk	5.1[1]	nk	nk	×	×	×
Burkina Faso	nk	nk	nk	nk	×	×	×
Burundi	nk	nk	nk	nk	×	×	×
Côte d'Ivoire	500[1][d]	5.3[1]	1.8[1]	10.5[1]	×	✓[12]	×
Democratic Republic of the Congo	3,500[1]	13.3[1][e]	nk	nk	×	×	×
Ghana	6,314[3]	nk	40.1%[1]	nk	×	×	×
Kenya	30,500[1]	42[1]	16.4[1]	5.4[1]	✓19[12]	✓7[4,5]	×[f]
Lesotho	2,600[6]	nk	nk	nk	×	×	×
Liberia	457[7][g]	3.9[8][h]	nk	nk	×	×	×
Madagascar	15,500[1]	4.8[1]	5.5[1]	5%[1]	×	×	×
Malawi	nk	nk	nk	nk	×	×	×
Mali	nk	5.1[9]	nk	nk	✓[1]	×	×
Mauritius	11,667[10]	45.5[1]	97.1[1]	6.1[1]	✓46[1][i]	✓42[1][i](B, M)	×
Mozambique	29,000[1]	46.3[1]	67.1[1]	nk	✓1[12]	×	×
Nigeria	44,515[9]	3.4[13]	5.8[1][k]	6.7[1]	×	×	×
Rwanda	2,000[1]	nk	nk	nk	×	×	×
Senegal	1,324[14]	9.4[1]	38.9[1]	nk	✓5[15,16]	✓1[16]	×
Seychelles	2,560[17][m]	12.7[17]	76[17]	1[17]	×	✓[n]	×
Sierra Leone	1,500[1]	8.5[1]	nk	nk	×	×	×
South Africa	76,000[1]	14.2[1]	54.7[18][o]	5[19][p]	✓4[20]	✓<11[20][q] (M, B, B-N)	×[r]
Tanzania	30,000[21][s]	35[22]	57[23]	1.1[1]	✓	✓6[24]	×
Tanzania (Zanzibar)	3,000[25]	11.3[26]	25.4[26]	5.9[26]	×[t]	✓[27]	×[u]
Togo	2,500[28]	nk	nk	nk	×	×	×
Uganda	nk	17-20[29][v]	nk	nk	✓2[30]	×	×
Zambia	nk	nk	nk	nk	×	×	×
Zimbabwe	nk	nk	nk	nk	×	×	×

nk – not known

WHAT ARE THE CHALLENGES ?

- Policy and institutional barriers
- Information barriers
- Technical barriers
- Financial barriers
- Ideological 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 best way to get better data on people who use drugs
3. Developing strong supportive policy
4. Strengthening Civil society to better engage

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

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 dugs

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THANK YOU

QUESTIONS ?

Where do PEPFAR stand on people who use drugs? Recommendations for and by people who use drugs

ARGUING HARM REDUCTION SERVICES & PROGRAMME

- PEPFAR is the second largest donor for harm reduction, yet it only allocates 1% for PWID
- Funding for harm reduction remains stagnant, despite renewed commitments (Global Prevention Coalition in 2018)
- With only less than 16% allocated annually for prevention in the last 5 years, 1% went to PWID and only less than half of the 1% was led by NGOs/CSOs
- New targets and commitments (Global AIDS Strategy and Political Declaration) on 10-10-10 and 30-60-80
- Lack of data availability further led to funding reduction and ignorance

COP22: WHAT IS AND ISN'T THERE?

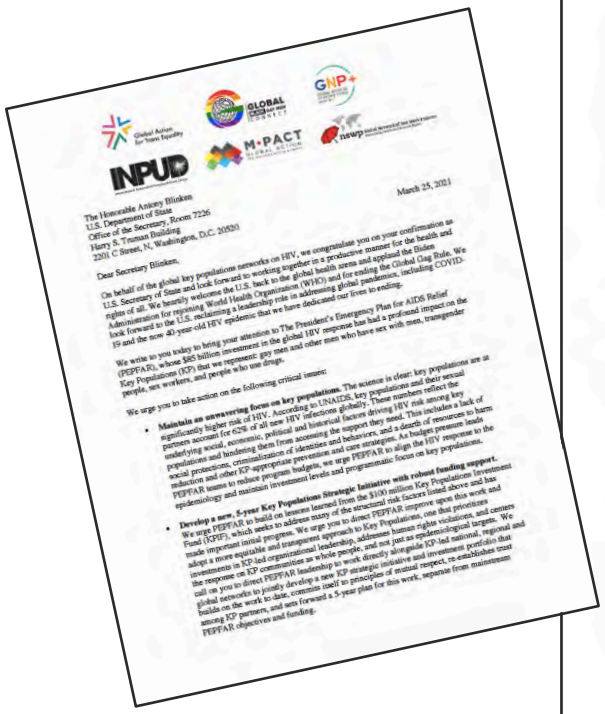
COP22 only specifies OAT, although it also includes **specific areas of harm reduction to focus on**	➡	Advocate for **wide-range of services** buprenorphine, access to needles & syringes, condoms, overdose prevention, take away dose, community-led drop-in centres, HCV services
Clearer focus, strategy and approach on KP, but lack clarity on **commitment towards investment on KP-led** (vs KP-competent)	⇨	Stronger commitment and recognition on the important roles of KP-led, including **clear definition** of KP-led
Community-Led Monitoring is in the core of PEPFAR	➡	PEPFAR recognises **the challenge in data availability on KP**
COP22 emphasises more on **the need to address structural barriers, including policy reform**. However, there is not budget earmarked for structural interventions	⇨	PEPFAR recognises that without addressing the **underlying factors of structural barriers**, epidemic control will not be achieved
Meaningful involvement of KP throughout the design, implementation and monitoring is key in COP22 processes	➡	Strong emphasis in **ensuring KP are represented** throughout the processes

COP22: OUR RECOMMENDATIONS

- Advocate for **comprehensive harm reduction services**, aligned with WHO Guidelines
- Advocate for **transparent and inclusive** COP22 processes. Work with PEPFAR Country Team to provide the opportunity for competent KP-led for funding, and/or develop clear timeline and milestones in in **building the capacity of KP-led organisations** to receive funding from PEPFAR.
- Continue advocating for **dedicated funding stream for KP** (both globally and locally)
- Use **community data** to complement the lack of data on PWID estimates, services and programmes
- Advocate for **minimum funding allocation on structural interventions** and link to the 10-10-10 targets on decriminalisation of KP, particularly on the possession of small amount of drugs.
- Ensure **adequate allocation** of small grant under COP22 that can support structural interventions
- Ensure PEPFAR Country Team uses **IDUIT** (and other tools such as MSMIT, SWIT, and TRANSIT) in **planning and designing** their programmes, including across all implementing partners
- Explore the possibility of using the **Discretionary Budget Requirements** to cover HCV services and to advocate HCV as integral part of services for PWID

PEPFAR VISION 2025: OUR DEMANDS

- Introduce and scale up comprehensive harm reduction programmes for people who use drugs; ensuring its availability, accessibility, and affordability; and to meet the target of $9.8 billion for HIV prevention by 2025
- Define and promote community-led responses and organisations, and key population-led responses and organisations, including those led by women and young people, aligned with UNAIDS definition
- Guarantee funding to achieve the targets on societal enablers (10-10-10)
- Guarantee funding to achieve the targets on community-led responses and organisations (80-60-30), including the CLM
- Building from the experience in KPIF, create a dedicated funding stream for key population that is more accessible, transparent, and inclusive



March 25, 2021

The Honorable Antony Blinken
U.S. Department of State
Office of the Secretary, Room 7226
Harry S. Truman Building
2201 C Street, N, Washington, D.C. 20520

Dear Secretary Blinken,

On behalf of the global key populations networks on HIV, we congratulate you on your confirmation as U.S. Secretary of State and look forward to working together in a productive manner for the health and rights of all. We heartily welcome the U.S. back to the global health arena and applaud the Biden Administration for rejoining World Health Organization (WHO) and for ending the Global Gag Rule. We look forward to the U.S. reclaiming a leadership role in addressing global pandemics, including COVID-19 and the now 40-year old HIV epidemic that we have dedicated our lives to ending.

We write to you today to bring your attention to The President's Emergency Plan for AIDS Relief (PEPFAR), whose $85 billion investments in the global HIV response has had a profound impact on the Key Populations (KP) that we represent: gay men and other men who have sex with men, transgender people, sex workers, and people who use drugs.

We urge you to take action on the following critical issues:

- **Maintain an unwavering focus on key populations.** The science is clear: key populations are at significantly higher risk of HIV. According to UNAIDS, key populations and their sexual partners account for 62% of all new HIV infections globally. These numbers reflect the underlying social, economic, political and historical factors driving HIV risk among key populations and hindering them from accessing the support they need. This includes a lack of social protections, criminalization of identities and behaviors, and a dearth of resources to harm reduction and other KP-appropriate prevention and care strategies. As budget pressure leads PEPFAR teams to reduce program budgets, we urge PEPFAR to align the HIV response to the epidemiology and maintain investment levels and programmatic focus on key populations.

- **Develop a new, 5-year Key Populations Strategic Initiative with robust funding support.** We urge PEPFAR to build on lessons learned from the $100 million Key Populations Investment Fund (KPIF), which seeks to address many of the structural risk factors listed above and has made important initial progress. We urge you to direct PEPFAR improve upon this work and adopt a more equitable and transparent approach to Key Populations, one that prioritizes investments in KP-led organizational leadership, addresses human rights violations, and centers the response on KP communities as whole people, and not just as epidemiological targets. We call on you to direct PEPFAR leadership to work directly alongside KP-led national, regional and global networks to jointly develop a new KP strategic initiative and investment portfolio that builds on the work to date, commits itself to principles of mutual respect, re-establishes trust among KP partners, and sets forward a 5-year plan for this work, separate from mainstream PEPFAR objectives and funding.

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Failure to Fund

Colleen Daniels
Deputy Director
Harm Reduction International

HARM REDUCTION INTERNATIONAL
www.hri.global

Global State of Harm Reduction 2021

- The number of countries providing harm reduction services has effectively stalled since 2014, and there are major gaps in global health response to overdose, HIV, hepatitis C crises
- Approximately half of the countries with injecting drug use do not provide any sterile needle and syringe programs or opioid agonist therapy such as methadone and buprenorphine. The number of countries implementing these life-saving harm reduction services has decreased, after stalling for years.

Global State of Harm Reduction 2021

HARM REDUCTION IMPLEMENTATION HAS WORSENED SINCE OUR LAST REPORT IN 2018, AFTER HAVING STALLED SINCE 2014.

87↑

↑86

IN 2021, THE TOTAL NUMBER OF COUNTRIES IMPLEMENTING NEEDLE AND SYRINGE PROGRAMS (NSP) HAS INCREASED BY JUST ONE, FROM 86 TO 87.

THE TOTAL NUMBER OF COUNTRIES IMPLEMENTING OAT IN 2021 IS 86 (UP FROM 84 IN 2020).

HARM REDUCTION INTERNATIONAL

Global State of Harm Reduction 2021

- In 2021, the total number of countries implementing needle and syringe programs (NSP) has increased by just one, from 86 to **87**. The new country is Uganda along with Algeria, Benin, Nigeria and Sierra Leone which opened new syringe programs in 2019-2020, while Palestine, Jordan, Mongolia and Uganda closed their programs)

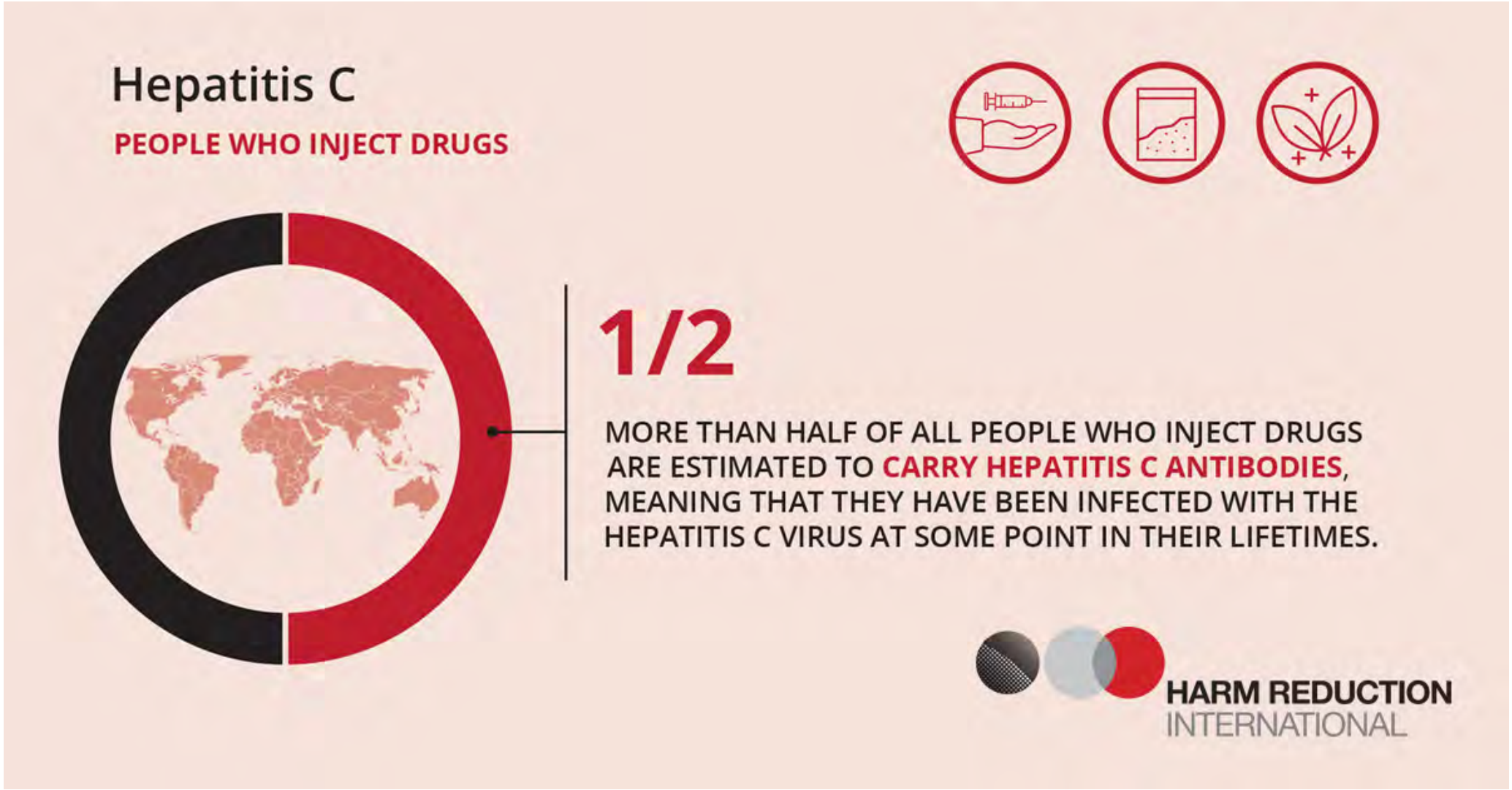
- Two new countries (Uganda and Mozambique) have begun implementing opioid agonist therapy (OAT) programs since 2020. The total number of countries implementing OAT in 2021 is **86** (up from 84 in 2020). (Burkina Faso introduced the treatment while Costa Rica, Bahrain and Kuwait suspended treatment provision)

- There were no reports of countries ceasing implementation of NSP, OAT, peer distribution of naloxone or shutting down drug consumption rooms in 2021.
- New search strategies identified an additional 11 countries with explicit supportive references to harm reduction in national policy documents. The total number in 2021 is **98**.

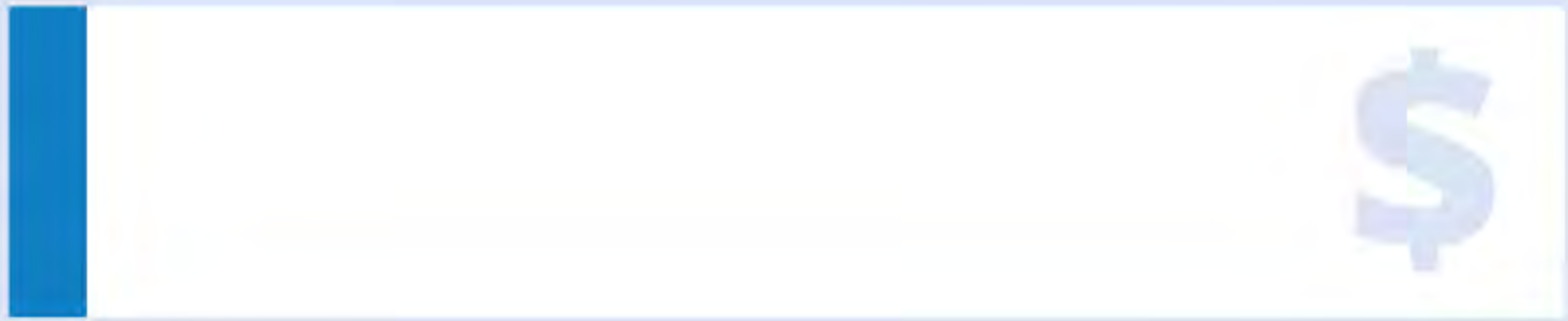
Global State of Harm Reduction 2021

- The use of stimulant drugs such as amphetamines and cocaine is rising around the world
- Punitive drug policies are risking progress in health-based responses to drug use
- Harm reduction services are innovative public health interventions, pivotal in reaching marginalized populations and are key to addressing overdose, HIV, hepatitis and tuberculosis crises

Global State of Harm Reduction 2021



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



HARM REDUCTION INTERNATIONAL

The funding gap for harm reduction

in low- and middle-income countries is widening

13%
of what
is required

5%
of what
is required

HARM REDUCTION
INTERNATIONAL

Global Drug Policy Index – Harm Reduction

Composite measure for harm reduction:

- Harm reduction in national policy documents
- Availability and coverage of harm reduction interventions
- Perception of equity in accessing harm reduction services
- **Sustainable funding for harm reduction**
  - **Resource needs (un)met**
  - **Secure and reliable funding**

GDPI – Harm reduction resource needs met (%)

Adequate (over 70%)	Moderate (50-69%)	Moderately low (30-49%)	Low (10-29%)	Very low (under 10%)
Canada	Australia	Georgia	Indonesia	Afghanistan
New Zealand		Hungary	Kyrgyzstan	Argentina
Norway		Kenya	Nepal	Brazil
Portugal		Morocco	South Africa	Colombia
UK		North Macedonia		Costa Rica
		Senegal		Ghana
		Thailand		India
				Jamaica
				Lebanon
				Mexico
				Mozambique
				Russia
				Uganda

The Global Drug Policy Index

GDPI – Harm reduction funding score (0-100)

Over 70	50-69	30-49	10-29	Under 10
New Zealand	Australia	Georgia	Nepal	Indonesia
Norway	Canada	Morocco	Hungary	Afghanistan
Portugal		North Macedonia	Kenya	Argentina
UK			Senegal	Brazil
			Thailand	Colombia
				Costa Rica
				Ghana
				India
				Jamaica
				Kyrgyzstan
				Lebanon
				Mexico
				Mozambique
				Russia
				Uganda
				South Africa

The Global Drug Policy Index

Harm reduction funding

- **Resource needs are not met** in majority of countries
  - Only 5 out of 30 countries reached ‘adequate’ level of investment
- **Lack of sustainable funding** for harm reduction in majority of countries
  - Current investment considered ‘mostly secure’ in just one country
  - Uncertain or somewhat unstable in 14 countries
  - Budget cuts are seen as likely in 11 countries
  - Severe reductions are anticipated in 4 countries

PEPFAR harm reduction expenditure

- 2019 – USD 8.4 million.
- 12% of international donor funding for harm reduction in2019, making PEPFAR the second largest donor for harm reduction.
- This amount represents only 1% of PEPFAR's HIV prevention funding and 0.15% of PEPFAR's overall HIV funding in 2019.
- Data suggest PEPFAR has reduced its funding for harm reduction since 2016, with reductions noted for Central Asian countries and for Kenya. In 2019, this funding level had decreased by 17% compared to the previous year, and by a further 6% in 2020.
- 2020 – USD 7.8 million.
- PEPFAR's largest harm reduction expenditures in 2019 and 2020 were in **Ukraine, Kenya, Tanzania** and the **Central Asia Regional** Programme. There was an increase in expenditure in **Nigeria** and **South Africa** from 2019 to 2020.

Breakdown of harm reduction expenditure across country and regional programmes 2016-2020.

Country list	2016	2017	2018	2019	2020	Total over period
Asia Regional Program		7,625				$7,625.00
Burma			290,782	-	192,322	$483,104.00
Cambodia	144,277	165,205				$309,482.00
Central America Region		162				$162.00
Central Asia Region	889,248	810,009	1,686,263	1,205,273	-	$4,590,793.00
Ethiopia		50,119				$50,119.00
India	610,400	998,636	254,681	474,469	112,868	$2,451,054.00
Indonesia	168,516	210,475	16,620	73,525	-	$469,136.00
Kazakhstan			-	-	38,119	$38,119.00
Kenya	2,315,852	1,675,583	2,392,835	1,785,294	735,605	$8,905,169.20
Kyrgyzstan			-	-	191,390	$191,390.00
Mozambique	7,375	73,353	213,927	143,079	226,812	$664,546.00
Nigeria	3,103,908	1,674,027	511,903	252,998	910,365	$6,453,201.00
South Africa	522,516	101,935	65,056	369,037	768,802	$1,827,346.00
Tajikistan			-	-	223,012	$223,012.00
Tanzania	1,200,347	1,393,964	1,315,805	1,140,512	838,940	$5,889,568.00
Uganda		45,911	0	0	0	$45,911.00
Ukraine	141,467	119,403	2,668,476	2,769,102	3,584,098	$9,282,546.00
Vietnam	3,149,115	1,461,383	618,874	152,459	0	$5,381,831.00
Zambia		362,359				$362,359.00
Total	**$12,253,021.00**	**$9,150,149.00**	**$10,035,222.20**	**$8,365,748.00**	**$7,822,333.00**	

What interventions for people who inject drugs does PEPFAR support?

- In 2019, the largest areas of spending were OAT (about half of PEPFAR spend went to OAT - USD 4.3 million), and HIV testing and counselling for people who inject drugs (33% - USD 2.8 million).
- In 2019, PEPFAR supported OAT programmes reaching around 17,000 people in eight countries (India, Kazakhstan, Kenya, Kyrgyzstan, South Africa, Tajikistan, Tanzania, and Ukraine), which represents around 2% of the total estimated people who inject drugs in those countries.
- Between 2018-2020, PEPFAR increased the number of countries where people who inject drugs have been reached with services to 31.
- While this includes funding for HIV testing in Vietnam and Ukraine with established harm reduction programmes, this also includes support to many countries with small-scale programmes.
    - For example, PEPFAR has provided support for PrEP programmes reaching people who inject drugs in Brazil, eSwatini, Kenya, Nigeria, South Africa, Tanzania, Uganda, Ukraine, Vietnam, Zambia, Zimbabwe and to one person in Lesotho.

Opportunities

- PEPFAR will continue to be a crucial donor for harm reduction in its focus countries, several of which only have nascent harm reduction responses. PEPFAR can play a vital role in supporting countries to introduce and scale up their harm reduction programmes, as well as through supporting advocacy and policy reform. Overall, if UNAIDS targets are to be met, PEPFAR's contribution to harm reduction must become a much greater component of its funding and a priority within its next strategy.
- PEPFAR's impact on the epidemic must be maximised, including through strategic investments in cost-effective, evidence-based programming for people who use drugs and the procurement and provision of sterile needles and syringes.
- The PEPFAR guidance note from 2010 acknowledges the importance of overdose prevention programmes, and in its 2021 Country Operational Guidance says that it is critical to include naloxone distribution for drug overdose management. However, information on implementation of peer distribution of naloxone is not available.

We cannot end AIDS without communities.

Yet funding for community-led organisations is **less than 7%** of total harm reduction funding from international donors.

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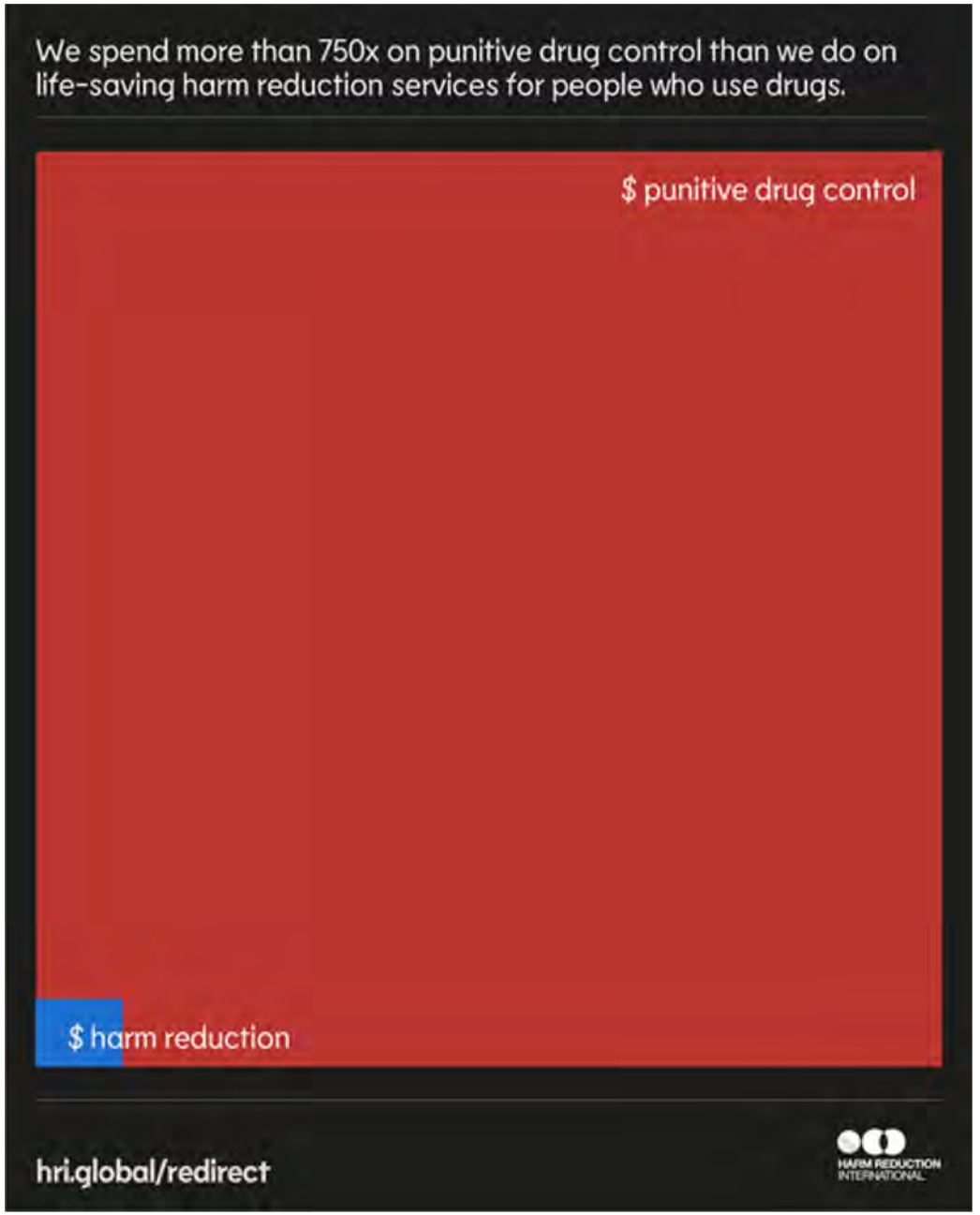
Opportunities

- PEPFAR is transparent about allocation and expenditure through online dashboards. However, it was difficult to disaggregate spending in some areas e.g. community-led services or support for community-led advocacy (while it was noted that funds had gone to community-led organisation in Ukraine this isn't routinely captured in data reporting).
  - We welcome the inclusion of community-led approaches to monitor and address new HIV infections and the objective to strengthen capacity and leadership of communities in the PEPFAR strategy under development.
  - In our feedback we recommended that PEPFAR's strategy articulates its role in ensuring that community-led organisations are funded to carry out this necessary work.
  - We also proposed that the UNAIDS definition of community-led and key population-led responses are proactively included within the PEPFAR Strategy.
  - Funding for civil society and community-led advocacy remains extremely limited and yet the 10-10- 10 targets are highly dependent on this work.
  - PEPFAR's strategy should clearly articulate its role in funding civil society and community-led advocacy, including for the decriminalisation of drug use and personal possession and the removal of laws and policies that impede harm reduction service delivery and access for people who use drugs. (further info in our feedback on strategy https://www.hri.global/files/2021/11/22/Harm_Reduction_International_inputs_on_PEPFAR_Strategy_Draft_Overview_Version_2_0.pdf)

Divest. Redirect. Invest

- Critically assess drug policy spending
- Divest from punitive drug law enforcement
- Redirect this funding towards life-saving, cost-effective and rights-based harm reduction interventions,
- Invest in programmes that prioritise health, community and justice.



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Recommendations

- PEPFAR is transparent about allocation and expenditure through online dashboards. However, it was difficult to disaggregate spending in some areas e.g. community-led services or support for community-led advocacy (while it was noted that funds had gone to community-led organisation in Ukraine this isn't routinely captured in data reporting).
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