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AFRICAN DECLARATION TO ELIMINATE HEPATITIS C AND IMPROVE THE HEALTH OF PEOPLE WHO USE DRUGS

Cape Town, South Africa, February 20, 2020 – We, the community of people working to eliminate hepatitis C in the African region express alarm regarding the increasing impact of drug use, hepatitis C, and other viral co-infections (including HIV and hepatitis B) on the health and well-being of people who use drugs and the limited access to evidence-based services effective for the prevention, diagnosis and treatment of hepatitis C infection and for improving the health of people who use drugs.

We are a community that includes people living with viral hepatitis, people who use drugs, advocates, health care providers, programme managers, harm reduction experts, researchers, and policy-makers.

In the African region and globally, we recognize that morbidity and mortality due to hepatitis C infection continue to rise[1]. We acknowledge that people who use or inject drugs represent a priority population, given the high prevalence and incidence of hepatitis C infection. This is a failure of a commitment to harm reduction. This sees people who inject drugs unable to access injecting equipment, and unable to access opioid agonist therapy (e.g. methadone and buprenorphine) despite the evidence that methadone or buprenorphine is effective for the prevention of hepatitis C and HIV infection[2-6]. Further, mathematical modelling has demonstrated that increasing access to opioid agonist therapy, improving retention to opioid agonist therapy, and providing opioid agonist threapy in prison could avert considerable deaths

related to HIV, hepatitis C, and drug overdose[7]. This limited action means that not only are we missing the opportunity to cure and prevent hepatitic C infection, we are missing the opportunity to repond to other health issues for people who inject drugs, including preventing HIV infection[2-6].

We highlight the challenges facing people who use drugs in the African region, including the issues of co-infection with hepatitis B and HIV. We draw attention to the vulnerabilities of women who use drugs, particularly women who are pregnant or may become pregnant. These include the issues of co-infection, mother to child transmission and the impacts of discrimination and stigma around parenting and access to appropriate health care.

We highlight the evidence that shows that the coverage of needle and syringe programmes and opioid agonist therapy vary substantially globally, and the African region is no different. We shine a light on the reality that in most countries, harm reduction coverage is well below the World Health Organization recommended levels, with less than 1% of people who inject drugs living in countries with high coverage of both services[8]. Access to services to prevent hepatitis C is a human right and has significant public health benefits.

We congratulate the innovation that has seen the development of direct-acting antiviral therapies that cure >95% of people with hepatitis C[9,10]. This scientific advance has brought considerable optimism to people living with hepatitis C and people working in the field. We congratulate United Nations Member States to include hepatitis as a target of the Sustainable Development Goals, and the World Health Organization for setting viral hepatitis elimination as the goal of its first Global Health Sector Strategy on Viral Hepatitis[11].

We recognise the Sustainable Development Goals that include a commitment to health and well-being. We affirm the WHO targets to eliminate hepatitis C by 2030 (from 2015 levels) that set targets including[11]:

- reducing new hepatitis C infections by 90%
- reducing the number of hepatitis C deaths by 65%
- increasing the number of sterile syringe/needles distributed for people who inject drugs from 20 to 300 per person per year
- increasing hepatitis C diagnoses from <5% to 90%
- increasing the number of eligible persons receiving HCV treatment from <1% to 80%.

We call for these goals to be applied equitably to all affected populations including people who use drugs across all global regions, with priority given to priority populations in low and middle-income settings, including the African region. We ask the global community to recognise that these targets will not be achieved without increased focus and funding and support the work to achieve these goals in the African region.

We highlight the reality that testing and treatment for hepatitis C among people who use or inject drugs remains suboptimal globally[12-15]. Some countries continue to restrict access to hepatitis C therapies for people who have recently used drugs[16,17] based on unfounded concerns of poor response to therapy and risk of hepatitis C reinfection. This is despite evidence that direct-acting antiviral therapy for hepatitis C infection is effective among people with recent or ongoing drug use[18]. The rate of hepatitis C reinfection among people who inject drugs is low[19], but the availability of opioid agonist therapy and needle-syringe programmes will be critical to reduce the risk of reinfection. There is no scientific evidence to deny people who use drugs access to a cure for hepatitis C.

We highlight the evidence that has proven that access to interventions such as low-threshold needle and syringe programmes, opioid agonist therapy, and hepatitis C treatment are essential to reduce hepatitis C incidence and prevalence among people who use drugs[4,5]. We once again bring attention to the consistent evidence that demonstrates that supervised drug consumption facilities also mitigate overdose-related harms and unsafe drug use behaviours, and may facilitate uptake of other health services, such as hepatitis C testing and treatment, among people who use drugs[20]. We highlight the vital role of civil society to contribute to the efforts to eliminate hepatitis C, and the importance of involving people who use drugs in the efforts to provide appropriate hepatitis C prevention, treatment, care and support.

We congratulate and support the Ministers of Health of the African Union Member States for the drafting of the Cairo Declaration on Viral Hepatitis in Africa, reviewing the progress and challenges on Viral Hepatitis prevention and control in Africa[21]. The declaration commits Ministers to government leadership, implementation of hepatitis programs, developing budgeted national plans, integration of viral hepatis care into existing services, raising awareness, ensuring access to hepatitis prevention and treatment services (including comprehensive care for key populations, including people who inject drugs), accelerate access to new diagnostics and medicines.

We also congratulate African Member states on the adoption of the African Union Plan of Action on Drug Control and Crime Prevention 2019-2023. This recognizes the war on drugs has failed and supports alternatives to crime and punishment.

We, the community of people working to eliminate hepatitis C in the African region, bring our support to the United Nations and African Union Member States working towards the goal of eliminating viral hepatitis by 2030 We call on African political leaders and all global partners to strive towards eliminating hepatitis C infection as a public health threat by 2030 among people who use drugs by achieving the following actions[22].

1. Scaling up harm reduction services – Governments and funders must improve access to harm reduction services and overdose prevention services (e.g. naloxone) by increasing financial support of harm reduction services and protecting funding for programmes;

2. Making health services accessible for people who use drugs – Health services must be made available, accessible and acceptable to people who use drugs, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health[23]. Recent or ongoing drug use should not be a criterion for access to or reimbursement of hepatitis C therapies. Programs already providing services for people who use or inject drugs (e.g. HIV services, drug treatment services, primary care services, harm reduction services, supervised drug consumption facilities, prisons, pharmacies, and homelessness settings) should provide services for hepatitis C. Health responses must be integrated with the holistic health needs for people who use drugs. Highly marginalized groups including women who use drugs should be provided with tailored and specific services that meet their needs, and the needs of their children.

3. Supporting community empowerment and community-based programmes – Programmes must implement interventions to enhance community empowerment and promote involvement in particular for people who use drugs[23,24]. People who use drugs must be included in efforts to strengthen health systems and shift tasks in scaling up hepatitis C testing and treatment services. Governments and funders must also improve access to peer-based and

community-based programmes designed by, led by and for people who use drugs by increasing financial support and protecting funding for such programmes;

4. Improving access to affordable diagnostics and medicines – The affected community, advocates, researchers, health care providers, programme managers, harm reduction experts, researchers, the funders, and policy-makers must work together to negotiate better prices for diagnostics and treatments and work towards broadened access;

5. Eliminating stigma, discrimination, and violence – The affected community, advocates, researchers, health care providers, programme managers, harm reduction experts, researchers, funders, and policy-makers must work together to eliminate stigma, discrimination and violence against people who use drugs;

6. Reforming drug policies – In line with the commitment to ensure drug policies improve the health, safety, security and socio-economic well-being of people that is contained in the African Union Plan on Drug Control and Crime Prevention 2019-2023, countries must urgently consider drug policy reforms. This includes the decriminalization of drug use and/or possession; developing policies and laws that decriminalize the use or possession of sterile needles/syringes (thereby permitting needle and syringe programmes); and reducing barriers to, and stigma around the delivery of opioid agonist therapy and overdose prevention (e.g. naloxone) in the community and in prison. These drug policy reforms would potentially reduce incarceration and transmission of hepatitis C and HIV related to the sharing of unsterile needles and syringes (which are rarely available in prisons). This would be facilitated by a regional framework for the African Union; and

7. Enhanced funding for harm reduction approaches and hepatitis C elimination efforts – Government and global donors need to provide funding for national programmes to eliminate hepatitis C in line with the WHO goal they have all adopted. This would also be facilitated by a regional framework for the African Union. Governments at all levels need to introduce sustainable funding models to support these efforts.

The ambitious targets for hepatitis C elimination set by the World Health Organization are achievable, but will require a community that includes people living with viral hepatitis, people who use drugs, advocates, health care providers, programme managers, harm reduction experts, researchers, and policy-makers around the world to work together to make this happen.

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