

Global Declaration to Eliminate Hepatitis C in People Who Use Drugs

A call for political leaders to take action

We, members and representatives of the community working to eliminate hepatitis C — a community that includes people living with viral hepatitis, people who use drugs, advocates, health care providers, programme managers, harm reduction experts, researchers, the pharmaceutical industry, and policy-makers — are concerned with the gap between the global impact of hepatitis C 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.

Globally, morbidity and mortality due to hepatitis C infection continue to rise¹. People who use or inject drugs represent a priority population, given the high prevalence and incidence of hepatitis C infection resulting from inadequate access to sterile injecting equipment²⁻⁵. Globally, it is estimated that among the 15.6 million people with recent injecting drug use, 39% (4.6 million) are living with hepatitis C infection^{6,7} and 1.4 million with hepatitis C and HIV⁸. Sharing of needles and syringes among people who use drugs is estimated to account for 23% of new infections globally⁹.

Opioid substitution therapy with methadone or buprenorphine is effective for the prevention of hepatitis C and HIV infection¹⁰⁻¹⁵. Combination opioid substitution therapy and high-coverage needle and syringe programmes (adequate needles/syringes to cover all injecting episodes) can reduce hepatitis C incidence by up to 80%¹⁵⁻²⁰. Needle and syringe programmes also prevent HIV infection²¹.

However, the coverage of needle and syringe programmes and opioid substitution therapy vary substantially globally. 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 services²². Access to services to prevent hepatitis C is a human right and has significant public health benefits.

The availability of direct-acting antiviral therapies that cure >95% of people with hepatitis C infection is one of the greatest medical advances^{23,24}. This has brought considerable optimism to people living with hepatitis C and people working in the field. This has led United Nations Member States to include hepatitis as a target of the Sustainable Development Goals, and the World Health Organization to set viral hepatitis elimination as the goal of its first Global Health Sector Strategy on Viral Hepatitis²⁵. To achieve elimination by 2030 (from 2015 levels) the World Health Organization set targets that include²⁵:

- reducing new hepatitis C infections by 80%
- 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%.

These goals should also be applied equitably to all affected populations, including people who use drugs²⁶.

However, testing and treatment for hepatitis C among people who use or inject drugs remains suboptimal globally²⁷⁻³⁰. Some countries continue to restrict access to hepatitis C therapies for people who have recently used drugs^{31,32} 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^{33,34}. The rate of hepatitis C reinfection among people who inject drugs is low³⁵⁻³⁷. There is no scientific evidence to deny people who use drugs access to a cure for hepatitis C.

Ensuring access to interventions such as low-threshold needle and syringe programmes, opioid substitution therapy, and hepatitis C treatment are essential to reduce hepatitis C incidence and prevalence among people who use drugs^{17,20}. These interventions are in line with United Nations technical guidance³⁸ and are cost-effective^{39,40}. Consistent evidence also 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 drugs⁴¹.

We, the community of people working to eliminate hepatitis C, whole heartedly support the commitment by United Nations Member states to the goal of eliminating viral hepatitis by 2030. In order to achieve that goal, we call on world political leaders to strive towards eliminating hepatitis C infection as a public health threat by 2030 among people who use drugs by achieving the following actions⁴²:

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 health⁴³. 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.

3. Supporting community empowerment and community-based programmes – Programmes must implement interventions to enhance community empowerment, in particular for people who use drugs^{43,44}. 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 pharmaceutical industry, 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, the pharmaceutical industry, funders, and policy-makers must work together to eliminate stigma, discrimination and violence against people who use drugs;

6. Reforming drug policies – 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 substitution 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); and

7. Enhanced funding for 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.

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, the pharmaceutical industry, and policy-makers around the world to work together to make this happen.

Organizations that Support the Declaration



References

1. Stanaway JD, Flaxman AD, Naghavi M, et al. The global burden of viral hepatitis from 1990 to 2013: findings from the Global Burden of Disease Study 2013. *Lancet* 2016; **388**(10049): 1081-8.
2. Wiessing L, Ferri M, Grady B, et al. Hepatitis C virus infection epidemiology among people who inject drugs in Europe: a systematic review of data for scaling up treatment and prevention. *PLoS one* 2014; **9**(7): e103345.
3. Hagan H, Pouget ER, Des Jarlais DC, Lelutiu-Weinberger C. Meta-regression of hepatitis C virus infection in relation to time since onset of illicit drug injection: the influence of time and place. *American journal of epidemiology* 2008; **168**(10): 1099-109.
4. Page K, Morris MD, Hahn JA, Maher L, Prins M. Injection drug use and hepatitis C virus infection in young adult injectors: using evidence to inform comprehensive prevention. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America* 2013; **57** Suppl 2: S32-8.
5. Morris MD, Shiboski S, Bruneau J, et al. Geographic Differences in Temporal Incidence Trends of Hepatitis C Virus Infection Among People Who Inject Drugs: The InC3 Collaboration. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America* 2017; **64**(7): 860-9.
6. Grebely J, Larney S, Peacock A, et al. Global, regional, and country-level estimates of hepatitis C infection among people who have recently injected drugs. *Addiction* 2018.
7. Degenhardt L, Peacock A, Colledge S, et al. Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review. *Lancet Glob Health* 2017; **5**(12): e1192-e207.
8. Platt L, Easterbrook P, Gower E, et al. Prevalence and burden of HCV co-infection in people living with HIV: a global systematic review and meta-analysis. *The Lancet Infectious diseases* 2016; **16**(7): 797-808.
9. WHO. Global Hepatitis Report 2017. . Geneva: World Health Organization, 2017.
10. Grebely J, Robaeks G, Bruggmann P, et al. Recommendations for the management of hepatitis C virus infection among people who inject drugs. *The International journal on drug policy* 2015; **26**(10): 1028-38.
11. Nolan S, Dias Lima V, Fairbairn N, et al. The impact of methadone maintenance therapy on hepatitis C incidence among illicit drug users. *Addiction* 2014; **109**(12): 2053-9.
12. Aspinall EJ, Weir A, Sacks-Davis R, et al. Does informing people who inject drugs of their hepatitis C status influence their injecting behaviour? Analysis of the Networks II study. *The International journal on drug policy* 2014; **25**(1): 179-82.
13. White B, Dore GJ, Lloyd AR, Rawlinson WD, Maher L. Opioid substitution therapy protects against hepatitis C virus acquisition in people who inject drugs: the HITS-c study. *Med J Aust* 2014; **201**(6): 326-9.
14. Tsui JI, Evans JL, Lum PJ, Hahn JA, Page K. Association of opioid agonist therapy with lower incidence of hepatitis C virus infection in young adult injection drug users. *JAMA internal medicine* 2014; **174**(12): 1974-81.
15. MacArthur GJ, van Velzen E, Palmateer N, et al. Interventions to prevent HIV and Hepatitis C in people who inject drugs: a review of reviews to assess evidence of effectiveness. *Int J Drug Policy* 2014; **25**(1): 34-52.
16. Degenhardt L, Mathers B, Vickerman P, Rhodes T, Latkin C, Hickman M. Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed. *Lancet* 2010; **376**(9737): 285-301.
17. Hagan H, Pouget ER, Des Jarlais DC. A systematic review and meta-analysis of interventions to prevent hepatitis C virus infection in people who inject drugs. *The Journal of infectious diseases* 2011; **204**(1): 74-83.
18. Turner KM, Hutchinson S, Vickerman P, et al. The impact of needle and syringe provision and opiate substitution therapy on the incidence of hepatitis C virus in injecting drug users: pooling of UK evidence. *Addiction* 2011; **106**(11): 1978-88.
19. van den Berg CH, Smit C, Bakker M, et al. Major decline of hepatitis C virus incidence rate over two decades in a cohort of drug users. *European journal of epidemiology* 2007; **22**(3): 183-93.
20. Platt L, Reed J, Minozzi S, et al. Effectiveness of needle/syringe programmes and opiate substitution therapy in preventing HCV transmission among people who inject drugs. *The Cochrane database of systematic reviews* 2016; **2016**(1).
21. Aspinall EJ, Nambiar D, Goldberg DJ, et al. Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. *International journal of epidemiology* 2014; **43**(1): 235-48.
22. Larney S, Peacock A, Leung J, et al. Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review. *Lancet Glob Health* 2017; **5**(12): e1208-e20.
23. Dore GJ, Feld JJ. Hepatitis C virus therapeutic development: in pursuit of "perfectovir". *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America* 2015; **60**(12): 1829-36.
24. Falade-Nwulia O, Suarez-Cuervo C, Nelson DR, Fried MW, Segal JB, Sulkowski MS. Oral Direct-Acting Agent Therapy for Hepatitis C Virus Infection: A Systematic Review. *Annals of internal medicine* 2017; **166**(9): 637-48.
25. WHO. Global health sector strategy on viral hepatitis 2016-2021. 2017. <http://apps.who.int/iris/bitstream/10665/246177/1/WHO-HIV-2016.06-eng.pdf?ua=1> (accessed June 5, 2017).
26. Lazarus JV, Pericas JM, Colombo M, Ninburg M, Wiktor S, Thursz M. Viral hepatitis: "E" is for equitable elimination. *J Hepatol* 2018.
27. Saraswat V, Norris S, de Knecht RJ, et al. Historical epidemiology of hepatitis C virus (HCV) in select countries - volume 2. *Journal of viral hepatitis* 2015; **22** Suppl 1: 6-25.
28. Liakina V, Hamid S, Tanaka J, et al. Historical epidemiology of hepatitis C virus (HCV) in select countries - volume 3. *Journal of viral hepatitis* 2015; **22** Suppl 4: 4-20.
29. Bruggmann P, Berg T, Ovrehus AL, et al. Historical epidemiology of hepatitis C virus (HCV) in selected countries. *Journal of viral hepatitis* 2014; **21** Suppl 1: 5-33.
30. Lazarus JV, Sperle I, Spina A, Rockstroh JK. Are the testing needs of key European populations affected by hepatitis B and hepatitis C being addressed? A scoping review of testing studies in Europe. *Croatian medical journal* 2016; **57**(5): 442-56.
31. Barua S, Greenwald R, Grebely J, Dore GJ, Swan T, Taylor LE. Restrictions for Medicaid Reimbursement of Sofosbuvir for the Treatment of Hepatitis C Virus Infection in the United States. *Annals of internal medicine* 2015; **163**(3): 215-23.
32. Marshall AD, Cunningham EB, Nielsen S, et al. Restrictions for reimbursement of interferon-free direct-acting antiviral drugs for HCV infection in Europe. *Lancet Gastroenterol Hepatol* 2018; **3**(2): 125-33.
33. Grebely J, Hajarizadeh B, Dore GJ. Direct-acting antiviral agents for HCV infection affecting people who inject drugs. *Nat Rev Gastroenterol Hepatol* 2017; **14**(11): 641-51.
34. Hajarizadeh B, Cunningham EB, Reid H, Law M, Dore GJ, Grebely J. Direct-acting antiviral treatment for hepatitis C among people who inject drugs: A systematic review and meta-analysis. *Lancet Gastroenterol Hepatol* 2018; **In Press**.
35. Cunningham EB, Applegate TL, Lloyd AR, Dore GJ, Grebely J. Mixed HCV infection and reinfection in people who inject drugs--impact on therapy. *Nature reviews Gastroenterology & hepatology* 2015; **12**(4): 218-30.

36. Simmons B, Saleem J, Hill A, Riley RD, Cooke GS. Risk of Late Relapse or Reinfection With Hepatitis C Virus After Achieving a Sustained Virological Response: A Systematic Review and Meta-analysis. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America* 2016; **62**(6): 683-94.
37. Midgard H, Bjoro B, Maeland A, et al. Hepatitis C reinfection after sustained virological response. *Journal of hepatology* 2016; **64**(5): 1020-6.
38. WHO. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users - 2012 revision. Geneva, Switzerland, 2012.
39. Martin NK, Vickerman P, Dore GJ, et al. Prioritization of HCV treatment in the direct-acting antiviral era: An economic evaluation. *Journal of hepatology* 2016; **65**(1): 17-25.
40. Wilson DP, Donald B, Shattock AJ, Wilson D, Fraser-Hurt N. The cost-effectiveness of harm reduction. *The International journal on drug policy* 2015; **26 Suppl 1**: S5-11.
41. Kennedy MC, Karamouzian M, Kerr T. Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review. *Curr HIV/AIDS Rep* 2017; **14**(5): 161-83.
42. Grebely J, Dore GJ, Morin S, Rockstroh JK, Klein MB. Elimination of HCV as a public health concern among people who inject drugs by 2030 - What will it take to get there? *J Int AIDS Soc* 2017; **20**(1): 22146.
43. United Nations Office on Drugs and Crime INoPWUD, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, United Nations Population Fund, World Health Organization, United States Agency for International Development. . Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. . 2017. http://www.unodc.org/documents/hiv-aids/publications/Implementing_Comprehensive_HIV_and_HCV_Programmes_with_People_Who_Inject_Drugs_PRACTICAL_GUIDANCE_FOR_COLLABORATIVE_INTERVENTIONS.pdf.
44. Schatz E, Schiffer K, Maher M, et al. The Berlin Hepatitis C Manifesto: access to prevention, testing, treatment and care for people who use drugs. *Hepatology, Medicine and Policy* 2016; **1**(14): 1-9.