Hepatitis C is a silent time bomb for UK’s investment in HIV/AIDS

Our submission focuses on people who use drugs and their health needs, in particular access to HIV antiretroviral treatment (ARVs), hepatitis C (HCV) treatment, substitution therapy and naloxone, an overdose prevention medicine.

This submission is made by the International HIV/AIDS Alliance with contributions from our civil society partners - Rumah Cemara and the Indonesian Network of People who use Drugs (PKNI) in Indonesia, KHANA in Cambodia, SCDI in Vietnam and the International HIV/AIDS Alliance in Ukraine. Evidence collection from partners in Indonesia, Cambodia and Vietnam has been conducted by International HIV/AIDS Alliance as part of ‘Asia Action on Harm Reduction’ project funded by the European Union.

The International HIV/AIDS Alliance (the Alliance) is an alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS. The Alliance partnership is made up of national Linking Organisations in 40 countries, 2,132 local community based organisations, seven regional technical support hubs, and an international secretariat based in Brighton, with policy offices in Brussels, Geneva and Washington DC. Together we reach almost seven million people annually with HIV prevention, treatment and care services, along with advocacy and community mobilisation efforts to advance the human rights of people most affected by HIV and AIDS.

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Low access of people who use drugs to the medicines

1. HIV remains a health emergency for the majority of people who inject drugs globally and particularly in Eastern Europe and in Asia. Access to HIV antiretroviral treatment (ARVs), hepatitis C (HCV) treatment, substitution therapy and naloxone, an overdose prevention medicine, is critically low. People who use drugs are disproportionally affected by HIV and HCV because of poor access to clean needles and substitution therapy. That is why access to medicines among people who use drugs should be accelerated.

2. Current HCV medicine (Interferon plus) together with the emerging new class of drugs (Sofosbuvir and Simeprevir) have a strong potential to eradicate the HCV virus. However, because the price of these drugs is too high, there will be access problem among people living in low and middle-income countries, particularly those who inject drugs.

3. People who inject drugs have poor access to ARVs, HCV treatment, substitution therapy and naloxone due to weak health care systems and stigma relating to both HIV and drug use. To reach people who inject drugs with life saving medicines, it is important to invest in community health systems run by community based organisations. Fear of arrest, compulsory registration as a drug user and discriminatory treatment in formal health services drive people who inject drugs away from those services. Strong community systems are important to reach people who use drugs because they are more likely to be trusted by and accessible to people who inject drugs.

4. In order to improve and sustain access to medicines among people who use drugs, the majority of whom live in middle-income countries, donors and governments should fully fund health needs of people who use drugs; governments should include people who use drugs in medical insurance schemes.

5. We commend the European Union for funding projects, like Asia Action on Harm Reduction. This support allows civil society in Asia to address structural barriers which impede access to medicines among people who use drugs.

Ways of addressing this challenge

6. Through multilateral and bilateral assistance we ask DFID to show leadership in addressing low treatment access, most urgently for treating HIV and HCV/HIV co-infection, for people who use drugs in middle income countries.

7. To deliver Millennium Development Goal 6 to combat HIV/AIDS, malaria and other diseases by 2015, we call on DFID to work with bilateral and multilateral partners to scale up access to HCV treatment, substitution therapy, ARVs, clean needles and naloxone among people who inject drugs in middle income countries.
8. Through its membership of and contribution to UNITAID, we ask the UK government to ensure UNITAID implements its strategy\(^1\) and facilitates the market dynamics (price, quality and access) for diagnostics and treatment of HIV/HCV co-infection.

9. The UK’s contribution to the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (the Global Fund) should ensure the Global Fund implements its guidance note on Harm Reduction\(^2\) and provides resources through the new funding model to scale up access to ARVs, HCV treatment, substitution therapy and naloxone among people who use drugs living in middle-income countries. Investment in HCV treatment provides protection for the UK’s investment in addressing HIV and AIDS.

10. FCO and DFID country staff should implement DFID’s HIV/AIDS strategy\(^3\) and ensure marginalised groups, including people who use drugs, are supported to define priorities within the Global Fund country dialogues.

11. Through membership of and contribution to WHO, we call on the UK government to ensure WHO includes new treatments for HCV in WHO Essential List of Medicines and provides Ministries of Health with guidance on diagnosing and treating patients with HIV/HCV co-infection.

12. We call on the UK government to work with partner governments to ensure the health needs of people who inject drugs are fully funded and are addressed through national insurance schemes.

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\(^1\) Objective 3 of UNITAID 2013-2016 strategy\(^1\) is about increasing access to emerging medicines and/or regimens as well as new formulations, dosage forms, or strengths of existing medicines that will improve the treatment of HIV/AIDS and co-infections, such as viral hepatitis. [http://www.unitaid.eu/images/strategy/UNITAID-Strategy_2013-2016-Full-English.pdf](http://www.unitaid.eu/images/strategy/UNITAID-Strategy_2013-2016-Full-English.pdf)


\(^3\) "DFID will increasingly work through global and regional mechanisms and partners. In particular, DFID will support civil society such as through the Robert Carr Civil Society Networks Fund and to continue its strong financial and policy support to the Global Fund to ensure that the needs of particularly vulnerable populations are met and human rights protected. DFID continues to support evidence-based prevention, including comprehensive harm reduction for injecting drug user’. Towards Zero Infections – Two Years On. DFID Strategy on HIV/AIDS, 2013. [http://reliefweb.int/sites/reliefweb.int/files/resources/Towards%20zero%20infections%20two%20years%20on_0.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/Towards%20zero%20infections%20two%20years%20on_0.pdf)
Question 1: ii, iv. Main factors impeding access to medicines among people who inject drugs

1. Globally, around 16 million people inject drugs and 3 million of them are living with HIV. On average, one out of every ten new HIV infections is caused by injecting drug use and in parts of Eastern Europe and Central Asia over 80 per cent of all HIV infections are related to drug use. In Vietnam and Indonesia, there is no data about access of people who inject drugs to ARVs, HCV treatment and naloxone. High infection rates occur where there is lack of provision of clean needles.

2. Access to HCV treatment is one of the main challenges for the health of people who inject drugs in low and middle-income countries. HCV primarily attacks the liver. It is transmitted in a variety of ways, including through contaminated needles used for injecting drugs. If left untreated, the majority develop a long-term (chronic) infection that affects the liver and finally causes cirrhosis. It can cause liver cancer.

3. Access to access to ARVs, clean needles, HCV treatment, substitution therapy and naloxone remains very limited for people who use drugs in pre-trial and prison settings.

Scale of HCV problem

4. According to a recent report on access to new HCV treatment, 185 million people across the world are infected with HCV; 150 million are chronically infected. The HCV pandemic is concentrated in middle-income countries (MICs); while 15% of the 150 million people with chronic HCV live in high-income countries (HICs), 72% live in MICs and 13% in low-income countries (LICs). It is estimated that HCV-related liver complications kill 350,000 people annually.

5. The most recent national estimates suggest that around 215,000 individuals are chronically infected with HCV in the UK. Levels of infection are highest among people who inject drugs. In 2012 49% of people who inject drugs in England, 34% - in Northern Ireland and 33% - in Wales tested positive for antibodies to HCV.

6. Of the 16 million people who inject drugs worldwide, an estimated 10 million are infected with HCV (67%). Globally, around 90% of new HCV infections are attributed to injection drug use, but there is a continuing reluctance from a majority of governments and health institutions to provide treatment to people who inject drugs: only 2-4 percent of them are currently receiving treatment.

7. A growing number of people are co-infected with both HIV and HCV. Current estimates suggest that chronic HCV infection affects 20% of people living with HIV worldwide, with the majority living in low- and middle-income countries. This proportion is especially high among

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4 http://www.who.int/hiv/topics/idu/en/
5 Source - Pham Hoai Thanh from SCDI in Vietnam, RC and PKNI in Indonesia.
8 Ibid.
9 Ibid.
HIV-positive people who inject drugs – approximately 75% are co-infected with HCV. HCV can accelerate the progression of HIV disease.

8. Currently, the standard of care is injectable peg-interferon (PEG-IFN) used in combination with ribavirin (RBV). The cure rate is 50-75%, and the treatment is associated with strong side effects. Worldwide, only a tiny percentage of people with HCV have access to treatment.

9. New treatments recently approved or soon to be authorized will offer a range of advantages compared with their predecessors: it is an oral drug with fewer side effects, cures HCV within 12 weeks and is 95% effective. The potential to cure HCV, and bring an end to the global HCV epidemic is now in our sights.

High price of HCV drugs, poor awareness and lack of political will - a deadly combination

10. Although new HCV drugs could improve the quality of life of people with HCV and increase the number of people cured, their price will be out of reach of most of the people who need them. The high price of HCV treatment and diagnostics, the lack of political will amongst many governments as well as lack of awareness about new treatment options among people who inject drugs and health workers are the main barriers to HCV treatment. "HCV treatment is currently not available and is not on the public radar in Vietnam. The awareness about the problem is low among decision makers and the government. Moreover, HCV treatment fee is now significantly higher than basic income. Vietnam Ministry of Health has not yet finalised the treatment formula". Main challenges of access to HCV treatment in Ukraine include high price for drugs and functional examinations, lack of government funding and difficult donor funding environment.

11. The scale of HCV problem is gigantic in many countries. ‘In Ukraine over 3% of population is infected with viral hepatitis, almost two million individuals’. There is low awareness about the scale of HIV/HCV co-infection. ‘In Ukraine HCV prevalence rates among people living with HIV who are injecting drug users is 94.8%. There is no official data about the prevalence of HCV amongst among people who inject drugs in Cambodia, but the anecdotal data of KHANA shows that the prevalence is not less than 80%’.

12. New treatments for HCV should become registered and approved in countries. They should be available at the affordable price and should be funded through national programmes.

13. International agencies should actively encourage countries to use the full range of flexibilities available under the TRIPS agreement and oppose strategies, such as voluntary

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11 Source - Pham Hoai Thanh from SCDI in Vietnam, RC and PKNI in Indonesia, KHANA in Cambodia, International HIV/AIDS Alliance in Ukraine

12 Source - Pham Hoai Thanh from SCDI in Vietnam.

13 Source - International HIV/AIDS Alliance in Ukraine.

14 Source - International HIV/AIDS Alliance in Ukraine.

15 Ibid.

16 Source - KHANA in Cambodia.
licensing, that will lead to substantial access barriers for the majority of people who need these drugs. Using generics should be encouraged in low-income and middle-income as well as in high-income countries, since, as was shown with HIV and AIDS, only competition among several manufacturers can guarantee a significant reduction in the cost of treatment. In the richest countries, the price of health products should be challenged and subject to public debate and the current model of research and development questioned.  

System failures in provision of ARVs for people who inject drugs

14. Only four in every 100 people who inject drugs that are living with HIV are receiving ARVs.  
Access to ARVs by people who inject drugs and live with HIV remains disproportionately low compared with other key populations at higher risk of HIV, particularly in low- and middle-income countries. For example, people who inject drugs comprise 67% of cumulative HIV cases in China, Vietnam, Russia, Ukraine, Malaysia, but only 25% of recipients have access to ARVs.  

15. Health care weaknesses, particularly weak integration between harm reduction, HIV and AIDS services, and discriminatory practices and attitudes in health care services constitute the main obstacle for access to ARVs for people who inject drugs. In South India, healthcare system barriers include actual or perceived unfriendly hospital environment and procedures such as requiring proof of address and identity from people who inject drugs; provider perception that people who inject drugs will not adhere to antiretroviral therapy, resulting in the therapy not being initiated; actual or perceived inadequate counselling services and lack of confidentiality; and lack of effective linkages between antiretroviral therapy centres, needle/syringe programs, and drug dependence treatment centres. ‘Low quality of ARVs side effects management, adherence support and laboratory tests create problems for people who inject drugs in Indonesia. There is lack of combination ARV drugs (one pill a day)’.  

16. Comprehensive HIV and harm reduction services are the foundation for improving access to ARVs, substitution therapy, HCV treatment and naloxone for people who inject drugs. In order to end HIV and AIDS, HCV, amongst people who inject drugs, national governments and donors should fund community-based harm reduction programming. ‘In Cambodia, most of drug users are poor and cannot afford to access to health centre. Most of them experience discrimination from health staff. There are no ARVs or health services for people

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http://hepcollection.org/spip.php?article89&lang=en  
22 Source - Rumah Cemara and PKNI in Indonesia.  
http://www.who.int/hiv/pub/idu/targets_universal_access/en/
who inject drugs in police custody. The only friendly and accessible to basic medicines are community based drop in centre, like Mondul Meancheay Center of KHANA.24

17. Considering the high rates of injecting drug use and the complex interaction of HIV, viral hepatitis and tuberculosis in prison settings worldwide, there is an urgent need to implement and expand access to ARVs, clean needles, HCV treatment, substitution therapy and naloxone in pre-trial and prison settings. 25

Comorbidities

18. People who inject drugs and can access ARVs often die due to other comorbidities, such as overdose from drugs and HCV related liver failure. People who inject drugs have a 74% greater risk of overdose if they are HIV-positive compared to their HIV-negative counterparts.26 Naloxone is a cheap drug which prevents death from drug overdose. It is usually administered through injection and is very effective at treating overdose. It is in WHO Essential List of Medicines. There are many examples of successful community-based delivery systems whereby community outreach workers, people who inject drugs themselves and family members are trained to administer naloxone in emergency situations. Many lives have been saved by putting naloxone in the hands of people who are close to people who inject drugs, and training them to administer it. In Cambodia, Vietnam and Indonesia naloxone administration is restricted to medical facilities only and, as a result, access to naloxone is low and overdose death rates are high. Restricting naloxone access is a significant access barrier because most overdoses occur in the community and people who inject drugs never make it to the hospital due to fear of being reported to the police. Our experience shows that it is important to rapidly expand access to naloxone in the community.

Question 2: ii, iii, v. Countries graduating from low to middle-income status

19. The majority of people living with HIV are in middle-income countries. Some 58% of people living with HIV currently reside in middle-income countries, projected to reach 70% by 2020. 27 Middle-income countries also have far lower rates of ARV coverage for people living with HIV than low-income countries and much higher rates of multi-drug resistant tuberculosis. Although low-income countries need support to finance their HIV and health responses, middle-income countries undoubtedly have higher burdens of HIV. Marginalized people, such as people who inject drugs, are likely to be left behind by governments in middle-income countries.

24 Source - KHANA in Cambodia.
26 Ibid.
27 International HIV/AIDS Alliance based on data sourced from UNAIDS and the World Bank.
20. DFID is a leader in funding evidence-based harm reduction services. As the UK government is withdrawing its aid from middle-countries, we call on DFID to ensure that pharmaceutical companies provide drugs at the price affordable for the public health system. DFID should promote use of TRIPS flexibilities and encourage production of generic drugs. ‘Demand for antiretroviral drugs in Indonesia is high. Our government wants to produce generic ARVs at cheaper prices. Regulation 76/2012 on drug patents, technically “liberate” Indonesia from patent restrictions for HIV medications. However, in practice it has not been implemented because the cost required for Indonesia to produce its own generic medicines remains three times more expensive than the cost of imports’.  

21. The health needs of people who inject drugs should be covered by national insurance schemes and health equity funds. ‘In Indonesia HCV treatment is publicly funded under a national insurance scheme (BPJS), however people who inject drugs are excluded from BPJS based on Presidential decree no 12/2013 about BPJS’. 

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28 Source - Rumah Cemara and PKNI in Indonesia.  
29 Ibid.