The International Network of People who Use Drugs' (INPUD) response to the Global Fund's Board decision on financing hepatitis C treatment for coinfected people

A lack of harm reduction

Appropriate harm reduction interventions at a sufficient scale, with the full involvement of the drug using community in the realisation of these interventions, are imperative if incidence of blood-borne viruses is to decrease. But **the vast majority of people who inject drugs do not have access to harm reduction services**; only 10% of people worldwide who require harm reduction services have access to them. It has been estimated that globally each injecting drug user receives only two needles and syringes per month. Only around 8% receive opiate substitution, which can further act to reduce the spread of blood-borne infections. Drug consumption rooms have not been established in the vast majority of countries, with only 61 cities having established such facilities by 2009.

HIV and hepatitis C amongst people who inject drugs

Amongst people who inject drugs, transmission of blood borne viruses, primarily HIV and hepatitis C, is predominantly driven by a lack of access to harm reduction services – principally by a lack of access to sterile injecting equipment, resulting in equipment being shared. It is estimated that almost 18% of people who inject drugs are living with HIV; that is 2.8 million people. Hepatitis C is far more virulent and readily transmissible than HIV, and hepatitis C is therefore the most important and prevalent blood-borne virus affecting people who inject drugs: between 45.2% and 55.3% are estimated to be living with hepatitis C. Due to the fact that HIV and hepatitis C are transmitted by the same route amongst people who inject drugs, coinfection with both viruses is frequent.

HIV and hepatitis C coinfection

In some communities of people who inject drugs, rates of HIV and hepatitis C coinfection are as high as 90%. Coinfection increases complications associated with both HIV and hepatitis C. Mental impairment, developing liver cirrhosis, and cardiovascular diseases are more likely, and HIV can accelerate the progression of hepatitis C, with hepatitis C additionally increasing the risks of AIDS-related illnesses. In short, coinfection substantially increases the risk of morbidity and mortality.

Global fund financing of hepatitis C treatment

Yet huge numbers of people who inject drugs and are living with HIV and hepatitis C do not have access to the medical treatments that they need. Antiretroviral therapy coverage of people who inject drugs living with HIV is around 4% globally, and in some countries is less than 1%. New direct acting antiviral (DAA) treatments for hepatitis C, such as sofosbuvir, provide a considerable opportunity in terms of treating hepatitis C, but DAA costs are hugely prohibitive. Gilead, for example, has set the price for its patented sofosbuvir ('Sovaldi') at USD $84,000 for a twelve week curative course. The course is comprised of one pill per day, so the cost works out at USD $1,000 per day, i.e. $1,000 per pill. According to modeling by Andrew Hill et al., generically produced sofosbuvir (and similar drugs) – which are neither complex nor expensive to manufacture – should cost around $68-$136 for a 12 week course, astronomically less than current prices.[1]

The Global Fund Board's meeting in March 2015 on the Global Fund's role in funding treatment of co-infections and of HIV/AIDS is important. Though INPUD welcomes the fact that the Global Fund will continue to fund hepatitis C treatments as an interim measure where previously allowed for in existing Global Fund grants,[2] **funding for hepatitis C treatment needs to go substantially further**, and states need to be permitted to spend their Global Fund allocations on hepatitis C treatment. Though the cost of new DAA regimens may currently be prohibitive, costs are coming down and will, in all likelihood, continue to do so. Hepatitis C is curable; scaling up antiretroviral therapies whilst failing to scale up hepatitis C funding will mean that people continue to unnecessarily suffer and die from a treatable infection, even when maintained on antiretrovirals for their HIV. In short, there is little point in treating people living with HIV with antiretrovirals if they are to die from liver cirrhosis.

INPUD's *Drug User Peace Initiative*

INPUD will continue to fight to promote the health and defend the human rights of people who use drugs. In the coming weeks, we will release four papers of INPUD's *Drug User Peace Initiative*, which highlights some of the most considerable and systemic harms that are done to people who use drugs in the name of the war on drugs; harms that notably include a disproportionate burden of blood-borne viruses like HIV and hepatitis C that are spread due to a lack of harm reduction and healthcare provision.

[1] Hill, A., Khoo, S., Simmons, B., and Ford, N., What is the minimum cost per person to cure HCV? *7th IAS Conference on HIV Pathogenesis, Treatment and Prevention, 30 June – 3 July 2013*, available at http://pag.ias2013.org/abstracts.aspx?aid=3142 (last accessed 8th December 2014)

[2] Available at http://www.theglobalfund.org/Knowledge/Decisions/GF/B32/DP07/ (last accessed 8th December 2014)