25 March 2015

Dr. Nafsiah Mboi
Chair of the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria

Ambassador Mireille Guigaz
Vice-Chair of the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria

All Board Members of the Global Fund to Fight AIDS, Tuberculosis and Malaria

Letter from Civil Society Organizations to the Global Fund Board in advance of its Thirty-Third Meeting regarding the role of the Global Fund in providing and scaling up access to hepatitis C treatment

Dear Global Fund Board members,

We, the undersigned organizations and advocates from different regions and countries of the world, would like to thank you for taking forward the discussions on diagnostic and treatment support for hepatitis C virus (HCV) during your 32nd Board meeting. We also understand that the Strategy, Investment and Impact Committee (SIIC) is seriously deliberating the list of co-infections and co-morbidities that could be funded through Global Fund grant mechanisms, and we would like to extend our appreciation for that as well.

We are writing to you regarding issues surrounding access to HCV-related services that have relevance for resource-limited countries in our regions.

As many as 150 million people worldwide are living with chronic HCV. Of those infected, 9 million are living in the European region[1] and 30 million in South East Asia.[2] Unlike HIV, this virus can be completely cured in the majority of cases, but despite this, it now kills an estimated 500,000 people each year.

HIV and HCV co-infection has a global prevalence of 16%, representing up to 4-5 million people living with both viruses.[3] The alarming levels of co-infection among people who inject drugs are also well documented. Up to 90% of people who inject drugs (PWID) in some parts of Eastern Europe and Central Asia (EECA) could be infected with HCV.[4] In countries like Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand, co-infection prevalence rates are as high as 50-100%.[5] In many cases, although being included in Global Fund-supported HIV prevention and treatment programs, these people die because of the absence of access to HCV treatment. In countries such as Russia and Ukraine, which are responsible for the majority of HIV cases in their region, the co-infection rates reach up to 70-80%,[6] and HCV is becoming one of the major causes of death among people living with HIV.

Studies have shown that HIV infection accelerates HCV-related disease progression and mortality.[7,8] However, a majority of the countries we work in do not provide HCV prevention, care and treatment

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[1] Berlin Declaration 2014. Hepatitis C: Access to Prevention, Testing, Treatment and Care for People who Use Drugs.
[2] World Health Organization, **Prevention and Control of Viral Hepatitis Infection: Framework for Global Action.**
[3] Alter MJ, (2006) **Epidemiology of viral hepatitis and HIV co-infection,** Journal of Hepatology, (Suppl. 1):S6–9.
[4] Andrey Rylkov Foundation. Report at The Commission on Narcotics and Drugs on the course of implementation by the Russian Federation of the Political Declaration and Plan of Action on International Cooperation **towards an Integrated and Balanced Strategy to Counter the World Drug Problem. 2011.**
[5] World Health Organization, Regional Office for South- East Asia (2011), **Viral Hepatitis in the WHO South-East Asia Region, Know it. Confront it. Hepatitis affects everyone, everywhere.**
[6] The 3rd Eastern Europe and Central Asia AIDS Conference. HCV at EECCAC: GFATM to provide funding for HCV and civil society discussion: "patents should not cost more than lives!"
[7] Mohsen AH, et al. (July 2003) **Impact of human immunodeficiency virus (HIV) infection on the progression of liver fibrosis in hepatitis C virus infected patients,** GUT, International Journal of Gastroenterology and Hepatology.

services as part of their national public health programs. Consequently, despite scale-up of antiretroviral therapy and improved control of HIV disease progression in our region, people living with HIV are increasingly dying of HCV-related complications.

We understand that co-infected people in our countries are already at advanced stages of liver disease. In recent data from four Southeast Asian countries, 63% of co-infected people meet international standards for initiating HCV treatment, of whom 39% have severe liver fibrosis or cirrhosis (i.e., FibroScan® scores of F3 or F4), which are associated with a higher risk of HCV-related mortality.[9]

We stand at a critical juncture in our choice of treatment strategies. Newer direct-acting antivirals have received regulatory approvals in many countries, including developing countries, and are available in commercial markets with the possibility of affordable generics on the horizon. These newer antivirals offer higher cure rates, fewer side effects, shorter treatment durations and the opportunity for treatment without pegylated interferon or ribavirin.

Studies have also demonstrated that people treated for HCV infection in resource-limited countries have treatment success rates comparable to those in developed countries,[10] further justifying increasing efforts to expand access to HCV treatment.

Over the past few years, the Global Fund has supported limited HCV treatment in a number of countries.[11] We acknowledge the essential role the Global Fund has played in scaling up HIV treatment. However, HCV treatment will not be scaled up without the commitment of international donors. We hope that the Global Fund will go beyond the status quo of your earlier Round 10 guidance note on HCV, and take a clear position on allowing applicants to include testing, diagnostics and treatment of HCV in their proposals. We also ask the Global Fund to develop and provide clear and specific guidance on the inclusion of HCV components - especially those targeting PLHIV, PWID, MSM and other vulnerable groups - into the concept notes within the New Funding Model and allow re-programming of the approved grants to include HCV treatment components within approved funding amount.

The HCV programs supported by the Global Fund should catalyze national responses to the HCV epidemic, including price reduction dialogues, options for generic medications, development of comprehensive national care programs, healthcare infrastructure development, and community mobilization around HCV. We ask that the Global Fund take into consideration the rapidly evolving landscape of new commercial and generic HCV medications, and expand its support to improve HCV prevention, care, and treatment access for people living with HIV and HCV co-infection.

Sincerely,

(1) AIDS ACCESS Foundation, Bangkok, Thailand

(2) All-Ukrainian Network of People Living with HIV, Kyiv, Ukraine

(3) Andrey Rylkov Foundation for Health and Social Justice, Moscow, Russia

(4) Asia Pacific Network of People Living with HIV and AIDS (APN+), Bangkok

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[8] Smit C, et al. (February 2008) **Risk of hepatitis-related mortality increased among hepatitis C virus/HIVcoinfected drug users compared with drug users infected only with hepatitis C virus: A 20-year prospective study**, Journal of Acquired Immune Deficiency Syndromes.

[9] Durier N, et al, **Hepatitis C virus RNA and genotype, IL28B genotype, and liver fibrosis scores in a regional cohort of HIV-HCV co-infected patients under routine HIV care in Asia,** AASLD, 2014, Poster number 1544.

10 Ford N, et.al. (March 2012) **Chronic hepatitis C treatment outcomes in low- and middle-income countries: a systematic review and meta-analysis,** Bulletin of the World Health Organization.

[11] Ford N, et.al. (March 2012) **Expanding Access to Treatment for Hepatitis C in Resource-Limited Settings: Lessons from HIV/AIDS,** Clinical Infectious Diseases.

(5) Asian Network of People who Use Drugs (ANPUD), Bangkok

(6) Association of substitution treatment advocates of Ukraine (ASTAU), Dnepropetrovs, Ukraine.

(7) Association of harm reduction programs "Partner network", Bishkek, Kyrgyz Republic

(8) Center for Supporting Community Development Initiatives (SCDI), Hanoi, Vietnam

(9) Community Network for Empowerment (CoNE), Manipur, India

(10) Delhi Network of Positive People (DNP+), New Delhi, India

(11) East Europe & Central Asia Union of People Living with HIV, Kyiv, Ukraine

(12) Eurasian Coalition on Male Health (EHRN), Tallinn, Estonia

(13) Eurasian Harm Reduction Network (EHRN), Vilnius, Lithuania

(14) Hepatitis Coalition of Nagaland (HepCoN), Nagaland , India

(15) Indian Drug Users Forum (IDUF), India

(16) Indonesian AIDS Coalition (IAC), Jakarta, Indonesia

(17) International HIV/AIDS Alliance in Ukraine, Kyiv, Ukraine

(18) International Network of People who Use Drugs (INPUD), London

(19) International Treatment Preparedness Coalition (ITPC), South Asia

(20) Jaringan Methadone Indonesia, Jakarta , Indonesia

(21) NGO Mothers for Life, Chisinau, Moldova

(22) NGO New Life, Chisinau, Moldova

(23) Perssaudaraan Korban Napza Indonesia (PKNI), Jakarta, Indonesia

(24) Positive Initiative, Chisinau, Moldova

(25) Regional Center for Community Policies, Chisinau, Moldova

(26) Rumah Cemera, Bandung, Indonesia

(27) Sankalp Rehabilitation Trust, Mumbai, India

(28) Spiritia Foundation, Jakarta, Indonesia

(29) TREAT Asia, Bangkok, Thailand

(30) Union C, Kathmandu, Nepal

(31) Vietnam Network of People Living with HIV (VNP+), Hanoi, Vietnam

(32) Western India Harm Reduction Network, Mumbai, India

(33) Mr. Paul Cawthorne, Treatment Advocate, Bangkok

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