Increasing access to diagnostics and treatments for Hepatitis C in resource limited settings: how should we move forwards?

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Médecins sans Frontières, Access Campaign

Background

HCV infects **150 to 180 million** people worldwide
- Most live in **resource limited settings**
- 2-5 million are **HIV** co-infected

New **oral treatments** will be:
- more **effective** than interferon (IFN)-based treatment
- **easier** to use
- **less toxic**
- necessary to allow for **simplified diagnostics** and treatment monitoring

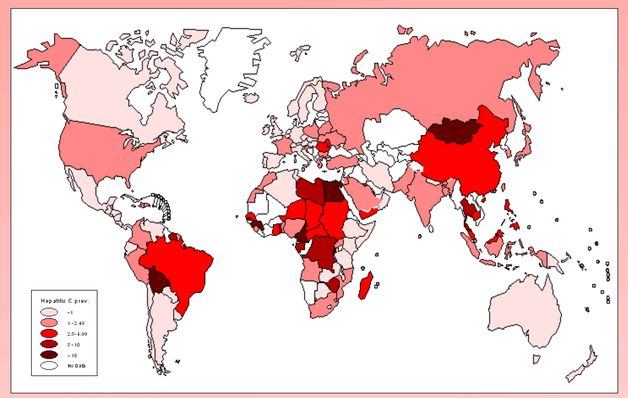
QUESTION:
How can we make both the drugs and the diagnostics **accessible and affordable** for people living in resource limited settings?

Methods

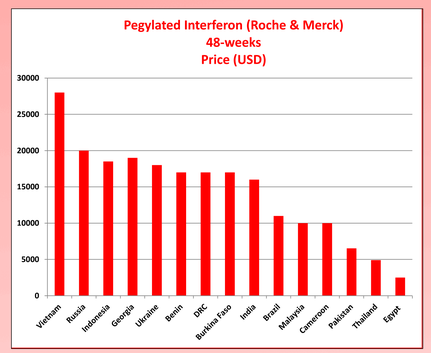
We conducted:
- formal and grey **literature reviews**
- key informant **interviews**
- expert **meetings**

We performed a peer reviewed technical HCV diagnostics and treatments **landscape report*** with the aim of identifying the:
- main **access barriers** to diagnosis, monitoring and treatments for people living with HCV
- potential **solutions and game-changers** for scaling-up access to HCV care in resource limited settings

***Report link: goo.gl/LqeSx**



The Global Prevalence of Hepatitis C (WHO)



Price of PEG-IFN-alfa
(A Momenghalibaf & P Cawthorne, MSF/OSF/TAG meeting, Paris, 2012)

Results

ACCESS BARRIER	SOLUTIONS / GAME CHANGERS
Lack of reliable **epidemiological** data	1. Country and WHO **surveillance** systems 2. Know your **epidemic**: highly vulnerable groups vs generalized epidemics
Lack of **political will** and civil society mobilization	**1. Right to care** for all **2. Political will** to confront burden of HCV epidemic & increase **awareness**
No prevention	**1. Safe** injections, medical & dental practices, & safe blood transfusions 2. Needle xchange programs, **decrease risk factors** for household transmission
No **rapid diagnostic tests (RDTs)** for HCV suitable for resource limited settings; no access to HCV **viral load (VL) and genotyping (GT)**	1. WHO **pre-qualification** of HCV screening tests 2. Affordable RDTs based on **ASSURED criteria** and accurate in HIV+ people **3. Simplified** HCV VL and GT tests, multi-analyte molecular tests, lab compatibility with dried blood spots 4. Simplified **algorithms**
No access to non- invasive markers of **liver fibrosis**	Affordable access to **Fibroscan®** and simple biological markers of fibrosis (APRI)
PEG-IFN-alfa not part of WHO EML; high price of originators; lack of internationally adopted evaluation scheme for biologics and biosimilars	1. PEG-IFN-alfa inserted in the **WHO EML** (MSF submitted a demand in 2012) **2. Price negotiations** with originators (Merck and Roche) 3. Price **monitoring and transparency** 4. WHO to set scheme for **evaluation of biologics & biosimilars**, to support identification of safe & effective alternatives to the originator products
Lack of an **oral HCV drugs** regimen	1. Identify **most effective short regimen adapted for resource limited settings**: pan-genotypic, IFN-free or -sparing, universally efficient, robust, safe, low side effects, & compatible with opioid treatment substitution, HIV ART, anti-TB treatments, & for people with advanced liver diseases, & treatment experienced people **2. Price negotiations** with originators; affordable prices through **generics**

CURRENT CARE	THE FUTURE
1. Complicated requirements for diagnosis, staging & treatment monitoring	**1. Simplified** laboratory requirements: diagnosis = serology & viral load; no staging; treatment monitoring = viral load, Hb, ALT
2. Toxic treatment with only approx **50% efficacy** & high cost	**2. Shorter & less toxic treatment with 90-100% efficacy**; cost??

Conclusion

1. Access to care depends on **political will and the mobilization of civil society**
2. HCV is a public health priority; new drugs and technologies will make **treatment possible for everyone**
3. It is critical to ensure that costs of diagnostics and therapies, including oral drugs, are **affordable to all**
4. As there is **NO FINANCING MECHANISM**, traditional funding & innovative financing should be stimulated (from **UNITAID, The Global Fund, domestic funding etc**) for enabling treatment in resource limited settings