Accelerating action towards the elimination of viral hepatitis
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World Hepatitis Summit 2017
SÃO PAULO, BRAZIL  1-3 NOVEMBER

THE EVENT
IN NUMBERS

750+ DELEGATES FROM 106 COUNTRIES

118 GLOBAL EXPERT SPEAKERS

82 PROGRAMME MANAGERS FROM 65 COUNTRIES

8060 TWEETS TO #HEPSUMMIT2017

300 ABSTRACT POSTERS DISPLAYED

900+ PIECES OF MEDIA COVERAGE

91.3 MIL SOCIAL MEDIA IMPRESSIONS

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INTRODUCTION

In November 2017, over 750 delegates from the global hepatitis sector came together at the World Trade Center in São Paulo, Brazil in order to attend the second World Hepatitis Summit.

The event was a large-scale, global meeting to advance the viral hepatitis agenda and to provide a platform for a broad hepatitis community to share ideas, experiences and best practice in addressing the many challenges of viral hepatitis.

In production for nearly two years, this globally significant event was a joint initiative between the World Health Organization (WHO) and the World Hepatitis Alliance (WHA) in collaboration with the host Government of Brazil.
The World Hepatitis Summit focuses on a public health approach to viral hepatitis. It was initially convened to build on the World Health Assembly 67.6 resolution, which asked WHO Member States to develop and implement national viral hepatitis strategies and to call on WHO to examine the feasibility of eliminating hepatitis B and C with a view to setting global targets and developing a monitoring mechanism.

Such elimination efforts can only be realised when the world is united in action. Consequently, the Summit was developed to provide a much-needed platform for over 100 Member States to learn from others in implementing their viral hepatitis action plans and to create opportunities for multi-sector audiences to share key learnings from country scale-up activities and national efforts to eliminate hepatitis.

The Summit was also designed to forge relationships between civil society and governments and to strengthen the community voice in the viral hepatitis response.

This community voice is relatively new within viral hepatitis and still needs strengthening. The Summit was therefore designed to specifically fill a gap in an area that had traditionally been saturated by scientific and medical conferences but which has lacked a platform for civil society and government to come together for the benefit of hepatitis patients.
Worldwide, viral hepatitis kills approximately 1.34 million people a year and more than 325 million people are chronically infected with hepatitis B or C. Yet, until very recently, there had been a remarkable lack of global action to combat the disease.

In May 2016, a historic commitment to eliminate viral hepatitis by 2030 was made by 194 Member States. At the 69th World Health Assembly, governments unanimously voted to adopt the first ever Global Viral Hepatitis Strategy (GHSS), signalling the greatest global commitment to viral hepatitis to date.

The GHSS was the first of its kind and will contribute to the achievement of the 2030 Agenda for Sustainable Development. The Strategy set a goal of eliminating hepatitis B and C as a public health threat by 2030 and includes a number of priority actions for countries which, if reached, will strengthen health systems, reduce annual deaths by 65% and increase treatment to 80%, saving 10 million lives globally in the next 13 years.

The Strategy outlines a number of key targets that would eliminate hepatitis B and C as a public health threat by 2030:

- 90% of infants receive a hepatitis B birth dose vaccination
- 100% of blood donations screened
- 90% of injections are safe
- 90% of people aware of their illness
- 80% of people treated

Although the adoption of the Strategy demonstrated considerable political will, more work is still needed to make the elimination of viral hepatitis a reality. Implementation is the new focus for governments across the world. Many countries still do not have national hepatitis plans in place – meaning a dramatic scale up in resources and prioritisation is vital.

“We cannot lose sight of the fact that last year 194 governments committed to eliminating viral hepatitis by 2030. For sure, we are still a long way from this goal but that doesn’t mean it’s some unattainable dream. It’s eminently achievable. It just requires immediate action,” says Charles Gore, Past President and Founder of the World Hepatitis Alliance. "The World Hepatitis Summit 2017 is all about how to turn WHO’s global Strategy into concrete actions and inspire people to leave with a ‘can do’ attitude”.

The inaugural World Hepatitis Summit took place in September 2015 in Glasgow to provide an opportunity for Member States to develop national hepatitis strategies. The second Summit in Brazil picked up from this starting point and looked at the implementation of such strategies – as indicated by the event’s strapline: Implementing the Global Health Sector Strategy on Viral Hepatitis (GHSS): Towards the elimination of hepatitis as a public health threat). This focus on implementation built on the momentum of the inaugural event and provided the obvious next step in the fight towards elimination within the context of the GHSS.

This global strategy outlines a vision, goals, targets and five critical strategic directions to eliminate viral hepatitis:

- Strategic direction 1: Strategic information for focused action
- Strategic direction 2: Interventions for impact
- Strategic direction 3: Delivering for equity
- Strategic direction 4: Financing for sustainability
- Strategic direction 5: Innovation for acceleration

These five strategic directions provided the framework for the Summit, which methodically addressed each direction across its three days of plenary sessions, panels, workshops and side meetings.
OBJECTIVES

The World Hepatitis Summit 2017 was a public-policy three day event in São Paulo, Brazil. It brought together a global audience from 106 countries that included civil society groups, WHO and its Member States, patient organisations, policy-makers, Ministers of Health, public health scientists and funders.

The Summit’s key aims and objectives were:

- To increase the number of countries developing viral hepatitis action plans by making use of the latest public health research and technical support from WHO
- To improve the implementation of existing viral hepatitis action plans through the sharing of best practice
- To support clause 1.3 of WHO’s Resolution WHA67.6, which urges Member States to “promote the involvement of civil society in all aspects of preventing, diagnosing and treating viral hepatitis”
- To discuss funding mechanisms for medicines and/or diagnostics through engagement of key stakeholders
- To raise the profile of viral hepatitis by engagement of international top-tier media.
- To encourage and direct public health research to where it is needed by engaging key global funders.
Day One:
1 November 2017

Opening session and partner introductions
Making elimination a reality
Strategic direction 1: Strategic information for focused action
The critical role of strategic information: HCV elimination in Georgia
Developing a national plan on viral hepatitis
How to develop an investment case?
How to develop successful awareness raising campaigns? Harnessing the learning from civil society and other global initiatives
Unitaid’s role in the global hepatitis C response
Policy as a tool for hep C elimination

KEY
- Plenary
- Side meeting
- Workshop
- Submissions presentations
**OPENING CEREMONY**

The World Hepatitis Summit opened with a short address from Raquel Peck, WHA’s Chief Executive Officer, and other speakers before the stage was handed over to the Honourable Ricardo Barros, Minister of Health for Brazil.

Brazil had championed the cause of hepatitis on the world stage for many years and had pushed for an intensified and global hepatitis response.

In 2010, at the 63rd World Health Assembly, Brazil was instrumental in putting hepatitis in the spotlight by proposing the first ever viral hepatitis resolution (WHA63.18), which established World Hepatitis Day as one of only four WHO disease-specific days. Similarly, in 2014, at the 67th World Health Assembly, Brazil co-sponsored a new WHO resolution (WHA67.6), which urged governments to develop and implement coordinated, multisectoral national strategies for preventing, diagnosing and treating viral hepatitis.

Consequently, Brazil was chosen to partner and host the World Hepatitis Summit 2017, in recognition of the country’s ongoing national initiatives and consistent international leadership in the area of viral hepatitis.

Mr Barros took to the podium to tell delegates of the host nation’s ambitious plans to eliminate hepatitis by 2030.

Having already increased the number of those eligible for free hepatitis B vaccinations from those up to the age of 49 in 2013 to universal free access in 2016, Mr Barros used the Summit to formally announce that Brazil would now be treating and curing all of the estimated 660,000 Brazilians thought to be infected with hepatitis C.

He ended his speech by declaring that Brazil was one of the first nations to begin the fight against viral hepatitis, being a key player in various WHO resolutions on the disease and the creation of World Hepatitis Day. He concluded: “I hope that this event will be a big step forward in the treatment of viral hepatitis around the world.”

Director for STI, HIV/AIDS and Viral Hepatitis Department of the Ministry of Health of Brazil, Dr Adele Benzaken echoed the Minister’s comments on their treatment for all announcement:

“Brazil is honoured to host the World Hepatitis Summit 2017 – and welcomes this extraordinary team of experts, researchers, managers and civil society representatives to discuss the global health problem posed by viral hepatitis…Brazil is committed to taking recent advances in its response to hepatitis forward – on the road to elimination.”

**MAKING ELIMINATION A REALITY**

The start of the meeting offered a series of high-profile government case studies that demonstrated strong political commitment to the elimination of viral hepatitis.

Chaired by Dr Gottfried Hirnschall, Director of the HIV/AIDS Department and the Global Hepatitis Programme (GHp) at WHO and Raquel Peck, the making elimination a reality session brought together senior leaders from the centre of government – those responsible for leading on health reforms.

Showing truly global representation, 12 Ministers and Ministerial Representatives took to the stage to share their national successes and challenges in implementing viral hepatitis initiatives to help reach elimination by 2030:

- Firdous Yousif, Minister, Sudan
- Ricardo Barros, Minister, Brazil
- Manthabiseng Phohleli, Minister, Lesotho
- Christopher Fearne, Minister, Malta
- Nizar Yazji, Minister, Syria
- Saira Afzal Tarar, Minister, Pakistan
- Dr Aceng, Minister, Uganda
- Kadi Ad Said, Minister (Chairman of the National Committee), Egypt
- Amiran Gamkrelidze, Programme Manager, Georgia
- Wang Guoqiang, Vice Minister, China
- Byambasuren Lamjav, Vice Minister, Mongolia
- Greg Hunt, Minister (by video), Australia

Bollywood veteran and WHO Goodwill Ambassador for Hepatitis in South-East Asia Region, Amitabh Bachchan, also welcomed delegates to the event. The actor, who lost 75% of his liver to hepatitis B, having contracted the infection in 1982 when he received contaminated blood transfusions, reiterated his support and commitment to lead the fight to eliminate viral hepatitis.

To reinforce the demonstration of international government commitment to viral hepatitis still further, Raquel Peck launched the NOhep Visionary Programme, which is designed to bring together key change makers in governments, medical professions and civil society organisations to accelerate action towards elimination.

The programme was spearheaded by six countries (Brazil, Egypt, Mongolia, Bangladesh, The Gambia and Georgia) who are taking bold steps in the elimination of viral hepatitis within their regions and whose stories and case studies were presented in more detail throughout the Summit.

“I am extremely pleased that the world has a new vision to eliminate hepatitis by 2030. The question now really is how to make hepatitis elimination a reality for all.

Amitabh Bachchan WHO Goodwill Ambassador for Hepatitis in South-East Asia Region
The Summit’s sessions dealing with the global Strategy’s first strategic direction looked at the extent of the hepatitis epidemic and response in order to recognise what tailored investments may be implemented. In order to baseline this, WHO initiated a project in 2016 to establish Country Profiles on Viral Hepatitis with the aim of determining the status of WHO Member States in relation to the GHSS and their preparedness to respond to hepatitis.

Sharon Hutchinson, Professor of Epidemiology and Population Health at Glasgow Caledonian University, gave delegates an overview on global progress on viral hepatitis. This used the latest data and preliminary intelligence from these WHO Country Profiles, from which there had been responses from 132 countries – equal to 87% of the 325 million infected with viral hepatitis.

The session underlined the fact that progress is being made by countries across WHO regions in responding to viral hepatitis – with a near five-fold rise in countries developing national plans over the last five years.

Professor Hutchinson announced that in total, 82 countries now have viral hepatitis plans in place but obstacles to elimination still exist.

Most fundamentally, financing remains an issue for most countries – an issue that would be addressed in financing sessions on the closing day, which were designed to offer Member States sustainable and innovative models for financing their hepatitis responses.

Moreover, Professor Hutchinson explained that whilst the majority of countries now have policies on testing, these are not all comprehensive. Similarly, she stressed that access to optimal therapies also remains an issue for diagnosed patients in many countries.

Finally, whilst many countries are setting targets - the data to measure progress in reaching these targets is lacking: countries therefore need to invest more in strategic information systems to monitor progress towards elimination. Such systems will generate the necessary data to create awareness, advocate for action and work to improve quality and outcomes.

The session also demonstrated that a robust strategic information system that analyses and translates up-to-date data on viral hepatitis into usable information can leverage much needed political commitment. To reiterate this important point, a number of country level case studies were presented by Ministerial Representatives from Zimbabwe, Vietnam and Indonesia - who detailed how they used such strategic information to inform their own national hepatitis responses.

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**Strategic direction 1: Strategic information for focused action**

The first strategic direction from the Global Health Sector Strategy focuses on the need to understand the viral hepatitis epidemic and response as a basis for advocacy, political commitment and national planning.

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**Advocacy**

The World Hepatitis Summit is the only meeting that brings together both decision makers and people with lived experience, which makes it a unique advocacy event. Summit presenters throughout the meeting repeatedly stressed that concerted advocacy efforts, particularly by political and community leaders, are required to increase public and political awareness of the public health importance of viral hepatitis to generate resources and to mobilise action.

Underscoring the opening sessions was the importance of the patient voice and the critical role people living with viral hepatitis can play in breaking down barriers, finding the undiagnosed and achieving the elimination of viral hepatitis. Professor Hutchinson evidenced this using WHO Country Profiles, which demonstrated that countries engaged with civil society are more advanced both in developing both their national plans and in securing funding.
Attendees spent the afternoon listening and exchanging best practices at various parallel sessions around strategic direction and national planning initiatives:

**The Critical Role of Strategic Information: HCV Elimination in Georgia**

In the HCV elimination in Georgia session Professor Gamkrelidze, from National Centre for Disease Control and Public Health, presented on elimination work within Georgia. Georgia is a small country with a population of just 3.7 million but with a high prevalence of hepatitis C attributable to injecting drug use. The country’s government is committed to elimination and now has an ambitious elimination plan using baselined national prevalence data that it created based on strategic information.

**How to Develop an Investment Case?**

In the ‘How to develop an investment case’ workshop delegates heard how the treatment landscape for hepatitis C has been disrupted by the development of multiple direct-acting antivirals (DAAs), which are medications targeted at specific steps within the hepatitis C life cycle. These interferon-free interventions are well tolerated and effective, however the price of DAAs remains a significant impediment to treatment. Cost-effectiveness analysis here can therefore play a vital role in making a case for how investment in resources impacts long-term outcomes.

Offering actionable, national insights into this process, Rakash Aggarwal, Professor of Gastroenterology, Institute of Medical Sciences, presented an economic analysis for hepatitis C treatment in India as the “first building block of an investment case” concluding that “HCV treatment should be a priority from both public health and economic perspectives.”

Jagpreet Chhatwal, Senior Scientist at the Institute for Technology Assessment at Massachusetts General Hospital, and Assistant Professor, Harvard Medical School, closed the workshop with a presentation about an online financing resource: an interactive Hep C calculator that is designed to evaluate the cost-effectiveness of DAAs for the treatment of hepatitis C globally. The tool utilises a mathematical model to simulate the life course of hepatitis C-infected populations in 28 countries that are considered as priority countries by the WHO.

**How to Develop Successful Awareness Raising Campaigns? Harnessing the Learning from Civil Society and Other Global Initiatives**

The ‘how to develop successful awareness campaigns’ session looked at global health campaigns - using case studies from Bangladesh and the United States - and the learning that can be taken from this for viral hepatitis. The session urged delegates to engage communities in all phases of intervention and research design and to be inclusive of vulnerable and underserved populations.
**Day Two: 2 November 2017**

- End of viral hepatitis? Not without tackling hepatitis E!
- Liver societies’ role towards viral hepatitis elimination
- Strategic direction 2 and 3: Interventions for impact and delivering for equity
- Access to hepatitis medicines
- Options for countries without access to generic hepatitis medicines
- Options for countries with access to generic hepatitis medicines
- Advocacy for access to hepatitis treatment
- Measuring access to medicines and reporting mechanisms
- Service delivery - models for testing and treatment
- Service delivery for hepatitis: priority populations
- Modelling and cost effectiveness for global scale up
- Testing interventions
- Treatment interventions
- Prevention interventions
- Delivering equitable services
- Delivering high quality hepatitis services
- Epidemiology and risk factors for viral hepatitis - a global perspective
- National and population-specific experience with national scale-up
- Hepatitis in children
- Addressing the neglected burden of hepatitis D
- **KEY**
  - Plenary
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  - Workshop
  - Submissions presentations
STRATEGIC DIRECTIONS 2 AND 3: INTERVENTIONS FOR IMPACT AND DELIVERING FOR EQUITY

The second strategic direction from the GHSS describes the essential package of high-impact interventions that need to be delivered along the continuum of hepatitis services to reach country and global targets, and which should be considered for inclusion in national health benefit packages.

The third strategic direction from the GHSS identifies the best methods and approaches to ensure hepatitis services reach different populations and locations, so as to achieve equity, maximise impact and ensure quality.

Hande Harmanci from WHO’s Global Hepatitis Program opened the second day by explaining that each country needs to select the essential viral hepatitis interventions, services, medicines and commodities that should be included in the national health benefit package, stressing the importance of a public health approach in delivering such interventions.

The session also featured presentations on scaling-up treatment services in Brazil by Director for STI, HIV/AIDS and Viral Hepatitis Department of the Ministry of Health of Brazil, Dr Adele Benzaken, challenges and opportunities for hepatitis B services in Nigeria from the Ministry of Health, and interventions to prevent hepatitis B infection at birth from Dr John Ward, Director of the Division of Viral Hepatitis, U.S. Center for Disease Control.

Professor Greg Dore, Head, Viral Hepatitis Clinical Research Program, Kirby Institute, looked at the issue of hepatitis C prevention and treatment for People Who Inject Drugs (PWID). His presentation highlighted that reductions in DAA pricing are essential for the removal of drug use restrictions, that drug law reform is essential, and that without harm reduction access hepatitis C elimination is unachievable in countries with PWID transmission.

Professor Dore concluded with a Declaration, co-signed by WHA, on behalf of the hepatitis community endorsing the decriminalization of drug use. The Declaration called on world political leaders “to remove all barriers to the uptake of the full range of prevention services by people who use drugs by reforming laws, law enforcement procedures and discrimination that hinder access.”

We call on world political leaders to remove all barriers to the uptake of the full range of prevention services by people who use drugs by reforming laws, law enforcement procedures and discrimination that hinder access.

No Elimination without Decriminalization! Community Declaration
**Access to Hepatitis Medicines**

The access to hepatitis medicines session addressed topics of access, cost, and efficacy of generics. The session was opened by Portuguese MP Ricardo Baptista Leite, who reaffirmed that governments must make access a priority. His speech ended with a poignant note: “political commitment from governments is a moral and ethical obligation.”

Giten Khwairakpam, Community and Policy Project Manager, amfAR, Thailand provided an overview on how to secure generics with a focus within WHO’s Western Pacific and South-East Asia regions. His presentation determined that there is a clear need to make medications more affordable in order to improve access and offered Egypt and India as country examples where there had been such major price reductions. He also made the strategic recommendation of expanding the pool of treating providers and improving the skills of non-specialist healthcare professionals in order to manage liver disease and implement treatment.

This was followed by Dr Andrew Hill, Senior Visiting Research Fellow, Liverpool University, who spoke about the cost and efficacy of generics and whose studies have shown that hepatitis C medicine can be purchased for $70 - and, within a year, could be as low as $50.

Both Giten Khwairakpam and Dr Andrew Hill agreed that without greater diagnosis and better linkages to care, dropping prices simply won’t make a difference – an assertion supported by Dr Yvan Hutin, Technical Officer, WHO, who concluded the session by stressing that price is only one aspect of generics: “access will only be successful when it’s the right product, in the right place, at the right time and for all the people who need it.”

The global strategy carries ambitious targets, including the increasing of treatment rates to 80%. Session presenters repeatedly stated that access to treatment must be significantly increased globally if this 2030 elimination target is to be achievable.

**Options for Countries Without Access to Generic Hepatitis Medicines**

In the options for countries without access to generic hepatitis medicines workshop, Olivier Maguet, Responsible for the Drug Pricing Campaign, Médicines du Monde’s Drug Pricing Campaign, explained that the free market has failed to achieve sustainable prices for DAAs and proposed a new frontier for European advocacy that exists around challenging patents on drugs.

**Options for Countries with Access to Generic Hepatitis Medicines**

The options for countries with access to generic hepatitis medicines workshop was presented by Dr Jean Damascene Makuza, Ag. Director of Sexual Transmitted Infections and Viral Hepatitis in HIV/AIDS, STIs and OBI Division, Rwanda Biomedical Center, who gave a case study of the viral hepatitis work within Rwanda – a country that has been treating patients with originators’ products in 2016 and 2017 after the Ministry of Health negotiated donations from Gilead and Bristol-Myers Squibb. Dr Damascene stated that some companies producing generics have received WHO prequalification for SoF. Nevertheless, he concluded that to date, no combination drug has WHO-PQ or US-FDA approval and stressed the need to speed up the process of pre-qualification for these important generic combinations.

**Advocacy for Access to Hepatitis Treatment**

In the advocacy for access to hepatitis treatment session, Luis Mendão from GAT – Treatment Activist Group stressed that advocacy work should be based on human rights and evidenced-based policies. He stated that elimination will not be possible without full and targeted access for undocumented people, people using drugs and people in prison. He concluded that this will require communities to work together with scientists and health professionals in dealing with the government and pharmaceutical industry.

**Measuring Access to Medicines and Reporting Mechanisms**

Dr Yvan Hutin, WHO, underlined the importance of measuring treatment access (since “what gets measured gets done!”) in the measuring access to medicines and reporting mechanisms workshop. Dr Hutin proposed that countries use the hepatitis B and C cascades defined by WHO, generate baseline estimates of the cascade using available data and document diagnosis and treatment from the clinic level to national and global reporting.
An effective hepatitis response requires robust and flexible health systems that can sustainably deliver people-centred care across the full continuum of services to those populations, locations and settings in greatest need. Attendees listened and exchanged best practice in realising these ambitions at various afternoon parallel sessions around strategic directions 2 and 3:

**Testing Interventions**

In the testing interventions workshop a panel of four expert speakers reviewed the scientific, logistical, ethical and political processes leading to the implementation of state-of-the-art testing for viral hepatitis. Professor Philippa Easterbrook, Senior Scientist, WHO, stated that, while there had been much progress in treatment in the past year, there had not been the same progress in testing and a large burden of hepatitis B and C infection exists. Professor Easterbrook argued that success in increasing testing was still possible by following the HIV testing model.

**Prevention Interventions**

The prevention interventions session kicked off with Dr Amr Kandeel, Ministry of Health, Egypt, discussing how the country’s adoption of a comprehensive prevention control plan in 2003 has led to 95% hepatitis B coverage and screening of more than 4 million people for hepatitis C. Dr Arshad Altaf, Consultant for Infection Prevention and Control, WHO, added to this update by focusing on injection safety pilot studies in Uganda and India. Dr Altaf stated that unsafe injections have been repeatedly reported from seven out of 11 countries that carry a 50% global burden of hepatitis and that eliminating unnecessary injections has to be one of the highest priorities towards preventing injection associated infections.

**Delivering Equitable Services**

The delivering equitable services interactive workshop had delegates working together and thinking differently by applying an equity framework to imagined country scenarios. The session identified the factors behind health inequalities and looked at opportunities to ensure that resources are directed at tackling inequalities in an explicit and measurable way.

**Delivering High Quality Hepatitis Services**

In the delivering high quality hepatitis services session, Margaret Hellard, Deputy Director (Programs), the Burnet Institute, gave a presentation regarding the importance of delivering high quality health services to people who inject drugs. She insisted that such services are essential if hepatitis C elimination is to be achieved and stated “if you build it, they will come”. Abigail Lukhwaro, Advocacy Officer, Médecins du Monde, reiterated the idea in presenting on a pilot access to hepatitis C services for people who inject drugs programme within Kenya – a country with an HCV prevalence amongst the PWID community of between 20-40% but with limited access to DAAs in the public health system. She concluded by stressing the importance of registering the new generation DAAs nationally and the need for national guidelines to standardise the quality of service-delivery and advocacy tools.
DAY THREE:
3 NOVEMBER 2017

Service delivery for viral hepatitis: good practice principles in health delivery

Strategic direction 4: financing for sustainability

Different financing mechanisms for viral hepatitis programmes

Public private partnership to eliminate hepatitis and the role of civil society

Strategic direction 5: innovation for acceleration

Close of the World Hepatitis Summit 2017

KEY

Plenary
Side meeting
Workshop
Submissions presentations
The fourth strategic direction from the GHSS addresses the issue of universal health coverage by identifying sustainable and innovative models for financing hepatitis responses.

Chaired by Dr Amanda Kgomotso Vilakazi Nhlapo, National Department of Health, South Africa and Dr John Ward, Director of the Division of Viral Hepatitis, US Centers for Disease Control and Prevention (CDC), panellists took to the stage to discuss how a sustainable response will require using available funds as efficiently as possible and looking at innovative ways for countries to finance their hepatitis work. All agreed that adequate investment in the full continuum of hepatitis services will be necessary to achieve the targets for 2020 and 2030.

Charles Gore, Founder and Past President, World Hepatitis Alliance, opened the session — highlighting that financing remains a significant issue for most countries. He detailed that a total of USD $3.5 billion per year on average in new investments will be required by 135 low- and middle-income countries in order to reach elimination. While this figure is significant, he offered up the comparisons of South Africa — who spent more than USD $3 billion on the 2010 World Cup and India — who spent USD $4.1 billion on the 2010 Commonwealth Games in order to give some perspective to the final level of investment needed.

The presentation repeatedly demonstrated that financing hepatitis is achievable and offered a four-stage approach for countries to take in developing a strategic approach to financing a viral hepatitis strategy:

1. **Cost the programme.** The national hepatitis programme should be fully costed with the objective to reach the 2020 and 2030 WHO targets. The outcome of which will give countries an overall cost for elimination.

2. **Create the investment case.** There are two types of analysis, a cost-effectiveness analysis and a cost-benefit analysis. These analyses can be used to help you make adjustments for programme efficiency or to justify investment in a programme.

3. **Budget.** Determine what can be implemented within the next budget cycle and budget for this accordingly. Mr Gore cautioned that countries may wish to undertake scenario planning using conservative, moderate and aggressive budget scenarios so that any three could be implemented depending on the resources available.

4. **Financing strategies.** Financing can come from three key sources: domestic, patient payments and external. To fully fund a hepatitis programme, it is likely that financing will need to come from a combination of these options. Countries may want to consider financing for a hepatitis programme within the context of Universal Health Coverage (UHC) and ideally as part of an overall increase in spending on the health budget.

The key refrain throughout the presentation was that “financing does not need to be a barrier to elimination.”

Mr Gore finished by reiterating the importance of advocating for financing and stressed the important role civil society can play here in creating the necessary external pressure on governments to push for comprehensive funding of hepatitis programmes.

Dr Jeremy Lauer, an economist from WHO, addressed the issue of efficiency. His presentation highlighted how funders are increasingly prioritising to cope with fewer resources and more goals and that hepatitis programmes understandably identify this as a concern.

Given this trend, Dr Lauer advocated for a big-picture, joined-up approach to financing and cautioned countries not to focus on sustaining “a programme” since programmes are a means, not an end. Instead, he proposed that the focus should be on increasing effective coverage and using a person-centred approach when designing hepatitis programmes and financing. He stated that silo working is ineffective and that fragmented funding simply leads to fragmented services — insisting that it is therefore vital to integrate hepatitis within health systems and to “reach clients” rather than “fund programmes”. Dr Lauer closed by suggesting countries streamline financing with common pooling and purchasing arrangements — arguing that is better to have HIV and hepatitis together than to have hepatitis alone.

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The discussion reiterated that domestic funding will be key to financing hepatitis programmes and that the most effective way to achieve this is through integration. Highlighting the differences between the HIV/AIDS response, panellists underlined that the world has moved on from focusing on a single disease area and now countries must work to develop sustainable and universal health coverage systems.

Panellists also agreed that sustainable financing is intrinsically linked to political will — giving Colombia as an example of a country that has effective commitment to elimination. Over the last few years Colombia has procured hepatitis C treatment for lower costs through PAHO and have now committed to increasing treatment by 500 people each year until 2020.

Dr David Wilson, Global Lead for Decision and Delivery Science and Global HIV/AIDS Program Director, World Bank, emphasised that many countries still don’t give enough of their national budget to health — offering the example of Pakistan where only 1% of GDP is allocated to health.

Homie Razavi, Managing Director, Center for Disease Analysis Foundation, explained the economics underwriting elimination efforts and concluded the session with his assertion that ultimately, “countries will spend less eliminating hepatitis C than doing nothing at all”.

**Strategic direction 4: financing for sustainability**

**Financing does not need to be a barrier to elimination**

Charles Gore  
Past President and Founder  
World Hepatitis Alliance

**Countries will spend less eliminating hepatitis C than doing nothing at all**

Homie Razavi  
Managing Director  
Center for Disease Analysis Foundation
DIFFERENT FINANCING MECHANISMS FOR VIRAL HEPATITIS PROGRAMMES

The different financing mechanisms for viral hepatitis programmes session was chaired by Dr Adele Benzaken from the Ministry of Health of Brazil and Dr Philippe Duneton, Deputy Executive Director, Unitaid. The session recapitulated a number of themes already addressed by presenters, including the need to encourage Ministers of Finance to make investments and the importance of integration within health services.

The session stressed that Ministries of Health will need to look at a combination of financing strategies and sources in funding hepatitis programmes and the need to ensure buy-in from different groups, including the Ministry of Finance.

Eduardo Gonzalez Pier looked at practical ways of engaging Ministries of Finance by speaking to them within their own terms - urging Member States to build dialogue around hepatitis by demonstrating a clear investment case in the first instance.

Presenters explained that for Ministers of Finance, elimination is not always seen as cost effective despite empirical research demonstrating that regardless of upfront costs, significant healthcare savings will always be generated over time as fewer people are hospitalised from complications associated to viral hepatitis.

Homie Razavi likened these upfront prevention and treatment costs to that of buying a house – arguing that buying, rather than renting, will mean larger savings in the longer-term despite upfront down payments and monthly mortgage costs. His presentation concluded with the assertion that national financing for elimination can be supported either through self-funding; co-pay that diminishes with price reduction and bonds/loans. Regardless, prices will go down with volume due to economies of scale but a global procurement mechanism is still needed to support countries with smaller orders.

The session ended with a discussion between Dr Jeremy Lauer of WHO and Dr Chinburen Jigjidsuren from the Ministry of Health in Mongolia. They discussed the importance of civil society groups in lobbying the government for funding. Dr Chinburen Jigjidsuren stressed the importance of evidence-based research in making such approaches. All panellists agreed that whilst no one-size-fits all solution exists, a number of high quality financial tools are now available to support counties in making a sustainable plan.
STRATEGIC DIRECTION 5: INNOVATION FOR ACCELERATION

The fifth strategic direction from the GHSS identifies where innovation is required to shift the trajectory of the viral hepatitis response in order for the 2020 and 2030 targets to be achieved.

We cannot meet the ambitious hepatitis elimination targets without innovation in prevention interventions and approaches, and implementing them to scale,” said Dr Ren Minghui, Assistant Director-General for Communicable Diseases, WHO. “The great successes of hepatitis B vaccination programmes in many countries need to be replicated and sustained globally in the context of moving forward to universal health coverage.”

Dr Henry Cohen, ECHO Project, Uruguay, explained how the project aims to innovatively scale up access to hepatitis care by linking expert specialist teams at an academic centre of excellence with primary care clinicians in local communities. Dr Cohen concluded “Project ECHO is a cost-effective way to treat patients with HCV infection at scale, using existing primary care providers. This approach could substantially reduce the burden of chronic hepatitis C infection in the United States.”

Prof. Christian Trepo of Institut national de la santé et de la recherche médicale (Inserm), France, then discussed the outcome of an integrated HIV/hepatitis B research agenda in France, explaining that a lot of the work that created the new DAAs for hepatitis C was based on HIV research. “This common biology between hepatitis B and HIV commands for a combined eradication strategy,” he said, concluding that there are around 50 new drugs in the research pipeline for hepatitis B and several of them are likely to be approved.

Innovation Abstracts

The Summit launched a Call for Abstracts inviting individuals and organisations to identify and promote original contributions in the field of hepatitis with a broad public health focus that aligned with the strategic directions in the GHSS.

In total, over 300 abstracts were accepted for posters and oral presentations, of which the top six innovation submissions were invited to give oral presentations at the close of the Summit. These global finalists were chosen for their work in promoting and embracing innovation to drive rapid progress where there are major gaps in knowledge and technologies and to recognise the need for innovation to shift the trajectory of viral hepatitis responses in order for the 2020 and 2030 targets to be achieved.

The innovation finalists were:

• Emalie Huriaux from Project Inform and CalHep, who discussed an elimination strategy being devised within San Francisco to reach out to “difficult to engage” populations. Emalie demonstrated that focusing resources where marginalized populations access services creates opportunities to cure those at highest risk of acquiring and/or transmitting hepatitis C.

• Anila Goswami, Institute of Liver & Biliary Sciences (ILBS), New Delhi, who discussed an innovative hepatitis nurse coordinator treatment model, which improves treatment outcomes at low cost in India. This task-shifting initiative from doctors to nurses has allowed these nurse coordinators to monitor the care for more than 1,500 patients with hepatitis C so far and could allow huge treatment expansion in India if scaled up still further.

• Lien Tran of Hepatitis Victoria, Australia, who presented on the “Little HepB Hero” – a project that aims to help families have important conversations about hepatitis B and build understanding to help protect children and their families’ health and well-being. The initiative is completely conceptualised and implemented by the community, for the community.

• Ammal Metwally of Egypt, who discussed the screening and elimination of hepatitis C from Al-Othmanya in northern Egypt – a village of around 7,000 people. This innovative project employed an automated SMS system for delivering messages and Arabic song with recommended actions for every diagnosed patient. This community-based strategy was highly effective in achieving a large uptake of testing and has now been extended to 36 other villages across Egypt.

• Freke Zurre of the Public Health Service of Amsterdam, who presented on home-based HCV-RNA testing for men who have sex with men (MSM) - part of an integrated approach to eliminate HCV infection among this population.

• Momoko Iwamoto of the Epicenter, Médecins Sans Frontières, Cambodia, who discussed the optimal care model for hepatitis C in Cambodia where health systems do not have the capacity to support large-scale treatment programs. Momoko concluded that simplification is essential in delivering HCV treatment for patients in such resource-limited contexts.
Countries around the world are committed to the elimination of viral hepatitis

Progress is being made in treatment and cure

Diagnosis remains a challenge

Financing doesn’t have to be a barrier

Efforts must reach the furthest behind and those at greatest risk

Harm reduction is crucial

Putting people living with viral hepatitis at the heart of the response pays off
Many countries are demonstrating strong political leadership within the viral hepatitis space. The Summit offered a platform for dozens of national case studies and presentations about the valuable work being undertaken by Programme Managers and Policy Makers within their own countries and regions. 12 Ministers of Health and their Ministerial representatives took to the stage from Brazil, China, Egypt, Georgia, Lesotho, Malta, Mongolia, Pakistan, Sudan, Syria, Uganda and Australia to commit to elimination.

In 2016, 1.76 million people were newly treated for hepatitis C, a significant increase on the 1.1 million people who were treated in 2015. The 2.8 million additional people starting lifelong treatment for hepatitis B in 2016 was a marked increase from the 1.7 million people starting it in 2015. But these milestones represent only initial steps – access to treatment must be increased globally if the 80% treatment target is to be reached by 2030.

Delegates repeatedly heard that financing should not be a barrier to developing and implementing a national viral hepatitis programme. There is no global fund for hepatitis and countries will therefore need to think creatively when financing their programmes. Countries were urged to take a strategic approach to this work in order to ensure their hepatitis programmes will be fully costed in order to reach the 2020 and 2030 WHO targets. WHA announced its National Viral Hepatitis Programme Financing Strategy Template to support this ambition and elsewhere, an evening event launched Endhep2030 - a dedicated fund for the elimination of viral hepatitis. Across the sessions, presenters reiterated that integration into wider health systems will be key to achieving elimination and as Homie Razavi, CDA Foundation, reminded attendees, “countries will spend less eliminating hepatitis C than doing nothing at all”.

Nine side meetings were developed with external partner organisations to present content around hard-to-reach groups and sub-populations, including children; those living with hepatitis E; indigenous populations and prisoners.

To achieve rapid scale-up of treatment, countries urgently need to increase uptake of testing and diagnosis for hepatitis B and C. As of 2015, an estimated 1 in 10 people living with hepatitis B, and 1 in 5 people living with hepatitis C, were aware of their infection. Countries need to improve policies and programmes to increase awareness and subsequent diagnosis.

People who inject drugs are particularly exposed to the hepatitis C virus, with one-quarter of new infections attributed to the sharing of unsterile injecting equipment. Yet their access to prevention, testing, treatment, and harm reduction services remains far behind the WHO targets. Despite the proven benefits, many countries lack such harm reduction services. Fifteen civil society organisations including WHA, Médecins du Monde, International Drug Policy Consortium, Treatment Action Group and Coalition Plus launched a declaration calling on world leaders to urgently increase access to harm reduction interventions and to reform criminalizing drug policies that hinder people’s access to health services.

Initial findings from WHO’s Country Profiles demonstrate a strong correlation between countries who involve civil society in their hepatitis response and those with a national plan and dedicated funding. Despite this, WHA’s Holding Government Accountable Civil Society Global report was launched at the Summit, which demonstrated that most civil society have had little involvement in their government’s response to stigma and discrimination and are only marginally more involved in the national response to viral hepatitis. This must change if elimination is going to be reached.

Put people living with viral hepatitis at the heart of the response and make it happen!
Based on the objectives set for the event, our assessment of the immediate impact of the event was framed around five key categories reflecting what we were trying to achieve:

- Were any significant call to actions and/or commitments made?
- How did it contribute to convening and networking?
- Did it increase knowledge and stimulate debate or new thinking?
- Did it raise awareness and profile of viral hepatitis?
- Was participation inclusive?
### Calls to Action and Commitments Made

- **The Brazilian Ministry of Health committed to lift treatment restrictions for hepatitis C** (previously, only the patients with the most advanced liver damage (fibrosis/cirrhosis) were eligible for treatment).

- **The Government of Malta** committed to meet the WHO targets and have since announced they **plan to eliminate hepatitis C by 2025**. They have also launched an open consultation on their proposed strategy.

- **São Paulo Government Declaration on Viral Hepatitis**: In this declaration, governments committed to taking a broad and coordinated approach to support implementation of the core interventions outlined in WHO’s Global Hepatitis Strategy with a special focus on viral hepatitis B and C (see annex A).

- **São Paulo Community Declaration on Viral Hepatitis**: In response to the government Declaration, the World Hepatitis Alliance and its 296 member organisations demanded that governments give viral hepatitis the same priority as HIV/AIDS, malaria and TB (see annex A).

- **Declaration of the wider Hepatitis Community: no elimination without decriminalization!** In order to achieve the goal of elimination by 2030, the community called on world political leaders to remove all barriers to the uptake of the full range of prevention services by people who use drugs and to adopt an approach based overwhelmingly on public health promotion, respect for human rights and evidence (see annex A).

- **Médecins Sans Frontières (MSF)**: MSF announced that it has secured **deals for generic hepatitis C medicines for as low as US$1.40 per day**, or $120 per 12-week treatment course for the key medicines sofosbuvir and daclatasvir.

- **Germany is convening a high level policy meeting including civil society to implement a targeted campaign on World Hepatitis Day to directly reach the global targets.**

### Convening and Networking

- **WHS17 brought together a global audience of 750 delegates** from civil society groups, WHO and its Member States, patient organisations, policy-makers, public health scientists and funders.

- **97 public health delegates.**

- **82 Programme Managers and governments across 65 countries** (see annex C) participated, including 12 Ministers of Health who formally spoke.

- **Representatives from 106 countries** attended the meeting (see annex B).

- **Five multi-national agencies and five funding bodies** attended.

- **A wonderful and unique opportunity to know the problems and the actions taken by the various countries of the world. It is a richness to coexist with diverse cultures and thoughts.**

- **The best outcome being connections created and inspirations from new friends.**

- **Inspiring event bringing together a perfect mix of stakeholders. The networking opportunities were great.**
INCREASING KNOWLEDGE AND STIMULATING DEBATE OR NEW THINKING

118 senior-level, global expert speakers presented to delegates across three days of meetings, including 17 workshops and 9 side meetings on relevant topics.

“The balance between high-level overview of each pillar of the strategy and practical presentations of country learnings and the tools developed to date was very helpful to have at this stage.”

Side meetings were often on specialist topics and so gave these sometimes overlooked areas a global audience (e.g. hepatitis in children).

12 Ministers and Ministerial Representatives presented case studies on their national successes and challenges in implementing viral hepatitis initiatives to help reach elimination by 2030.

“The summit was very inspiring, action-oriented and fostering the implementation the learnings.”

300 abstracts on innovative responses to viral hepatitis were accepted for posters and oral presentations, of which the top six innovation submissions were invited to give formal oral presentations at the close of the Summit. This category enjoyed a high number of delegates attending as a proportion of total invites (68%).

“The NOhep Visionaries Programme, designed to bring together key change makers in governments, medical professions and civil society organisations to accelerate action towards elimination, was launched. It was spearheaded by six countries (Brazil, Egypt, Mongolia, Bangladesh, The Gambia and Georgia) who are taking bold steps in the elimination of viral hepatitis.”

RAISING AWARENESS AND PROFILE OF VIRAL HEPATITIS

Innovative new platforms were launched:

- The National Viral Hepatitis Programme Financing Strategy Template, a tool for countries facing challenges in fully funding their hepatitis response was launched.

- WHO launched the hepatitis C economic analysis calculator – an interactive tool to help countries finance their national plans.

- The National Viral Hepatitis Programme Financing Strategy Template, a tool for countries facing challenges in fully funding their hepatitis response was launched.

- Let’s End Hep C – a cross country policy dashboard comparing different EU member states policies which was launched by Dr. Ricardo Baptista Leite a member of the Portuguese parliament.

Over 900 pieces of media coverage including BBC, El Mundo, The Times, AFP and Al Jazeera were secured across 53 countries - reaching 400 million people worldwide and with a total advertising value of over $3.2m.

10 media attended, including Al Jazeera and AFP, who filmed a number of interviews with stakeholders live at the event.

8,060 tweets were made to the event’s dedicated hashtag (#HepSummit2017) with 91.3 million impressions. The platform had a total reach of 25.5 million across 53 countries during and immediately after the event.


**Inclusiveness of Participation**

- **Good proportion of civil society groups, WHO and its Member States, patient organisations from WHA’s organisational members, policy-makers, public health scientists and funders in attendance (see figure D).**

- **Testimonials from people living with viral hepatitis were shown at the start of each plenary session.**

- **5 programme sub-committees were established in order to reach a wide network of global experts and broaden responsibility for the intellectual content. Committee members were selected to promote inclusiveness (e.g. a civil society member on each committee).**

- **The Summit provided a unique stimulus for many of us who work with limited resources amidst low community awareness, giving us the opportunity to engage with our counterparts across the globe.**

- **An opportunity for all to become part of a global network sharing successful strategies and approaches to elimination.**

- **The attendance of 97.5% of resource limited patient organisations was fully funded.**

- **All plenaries were translated in English, French, Spanish and Portuguese.**

- **Great geographic spread making it a truly global event (see figure B).**

- **Bringing together governments, experts and civil societies together made the Summit a great and impacting event. The elimination of viral hepatitis is possible.**
ANNEX A: DECLARATIONS

SÃO PAULO DECLARATION ON VIRAL HEPATITIS

We, the high level representatives of governments who assembled at the World Hepatitis Summit in São Paulo, Brazil, from 1 to 3 November 2017;

1. Note, with deep concern, that 325 million people were living with chronic hepatitis infections worldwide and 1.34 million people died of viral hepatitis in 2015; 2. Consider that viral hepatitis is a serious global public health problem and express concern at the lack of progress in its prevention and control in developing countries, notably due to the lack of an integrated approach to prevention and control measures as well as the inadequate access to affordable, appropriate treatment and care;
3. Note that Hepatitis A and B can be prevented by vaccination and that there is a cure for Hepatitis C and treatment for Hepatitis B, while recognizing that Hepatitis C is still not preventable through vaccination;
4. Recognize the need for a global approach to eliminating viral hepatitis as a public health problem through preventing, diagnosing, treating and surveillance of all forms of viral hepatitis – with a special focus on viral hepatitis B and C, which have the higher rates of morbidity and mortality;
5. Express profound concern about the public health, economic and social impact of viral hepatitis and inadequate response globally to date;
6. Reaffirm the Global Health Sector Strategy on Viral Hepatitis adopted by Resolution WHA69.22 as well as World Health Assembly Resolutions WHA45.17, WHA63.18, WHA67.6 and WHA69.11 and recalling the 2015 Glasgow Declaration on Hepatitis;
7. Emphasize the importance of a comprehensive, integrated and multisectoral approach that includes implementation of high-impact viral hepatitis prevention and control measures as outlined in the global health sector strategy on viral hepatitis 2016-2021;
8. Acknowledge countries’ goals toward achieving universal health coverage and recognize the importance of health systems strengthening in this respect, including in the provision of and access to comprehensive community-based services and for the prevention and control of viral hepatitis, with particular attention to populations most affected and at risk, and that each country should define the specific populations within their country that are most affected by viral hepatitis epidemics and the response should be based on the epidemiological and social context;
9. Further recognize the need to strengthen health systems and integrated collaborative approaches and synergies between prevention and control measures for viral hepatitis, and those for infectious diseases such as HIV and other related sexually transmitted and bloodborne infections, those for mother to child transmitted diseases and those for cancer and other non-communicable diseases;
10. Recognize the importance of having strong, integrated strategic health information systems, that can provide publicly accessible information while ensuring protection of personal data, including epidemiological surveillance systems to better inform decision makers, focus and improve national planning, target-setting and monitoring the national and global response;
11. Highlight the need to mobilize adequate and predictable resources for the viral hepatitis response, especially in low and middle income countries, and to improve equitable access to and availability of quality, effective, safe diagnostics, vaccines, services and treatment and making them affordable at the country level to combat hepatitis and eliminate viral hepatitis as a public health threat by 2030;
12. Recognize with appreciation the introduction of new pharmaceutical products based on investment in innovation for Hepatitis B and C in recent years, and note with great concern the increasing cost to health systems and patients and also recognize the need to address this situation, including through promoting synergies in this context;
13. Recall that national ownership and a comprehensive approach are key elements for the success of the viral hepatitis response as well as the availability of adequate, sustained financial resources and trained human resources, complemented by international resources and technical assistance where needed;
14. Call on governments to include hepatitis B vaccines in national immunisation programmes, including for health workers as needed, feasible and appropriate, with regard to the national epidemiological situation, and expressing concern that currently the global hepatitis B vaccine coverage for infants is estimated at 84% and is therefore below the 90% global target, and concerned that current global coverage for birth dose of hepatitis B vaccine, to prevent mother-to-child transmission, is only 39%2, lower than the 50% global target by 2020 and the 90% target by 2030;
15. Reaffirming also the rights of governments to the full use of the flexibilities in the WTO Agreement on Trade-related Aspects of the Intellectual Property Rights (TRIPS) to increase access to affordable, safe, effective and quality medicines, noting that, inter alia, intellectual property rights are an important incentive in the development of new health products;
16. Acknowledge the need for new models of people-centered service delivery, including for early diagnosis, if we are to achieve global viral hepatitis targets in accordance with nationally set goals and priorities towards achieving Universal Health Coverage;
17. We reaffirm the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and resolve to fulfill our international obligations and commitments in this regard, and, in the context of viral hepatitis, with particular attention to populations most affected and most at risk and that each country should define the specific populations within their country that are most affected by viral hepatitis epidemics and the response should be based on the epidemiological and social context;
18. We will fully implement the global health sector strategy on viral Hepatitis, 2016-2021, adapted to national priorities, legislation and specific contexts, and reaffirm its five strategic directions: information for focused action; interventions for impact; delivering for equity; financing for sustainability; and innovation for acceleration, towards achieving the goal of eliminating viral hepatitis as a public health threat by 2030;
19. We will accelerate the implementation of the core interventions outlined in the global health sector strategy on viral hepatitis 2016-2021, adapted to national priorities, legislation and specific contexts: Hepatitis B vaccination; prevention of mother-to-child transmission of Hepatitis B; blood safety; injection safety; harm reduction; testing services and treatment;
20. We will accelerate implementation of the priority actions as outlined under each of the five strategic directions of the global health sector strategy on viral hepatitis 2016-2021, adapted to national legislation, priorities and contexts;
21. We will continue to strengthen international cooperation to achieve the goals of the global health sector
We, the viral hepatitis community, consisting of people living with and/or affected by viral hepatitis, who assembled at the World Hepatitis Summit in São Paulo, Brazil, from 1 to 3 November 2017
1. Wish to whole-heartedly support the São Paulo Declaration made by high-level representatives.
2. Wish to thank the Government of Brazil for hosting the Summit and to applaud their leadership in viral hepatitis.
3. Request that you fulfil, in relation to viral hepatitis, your governments’ pledge in the Sustainable Development Goals not just ‘that no-one will be left behind’ but that you ‘will endeavour to reach the furthest behind first’.
4. Request that you go beyond Sustainable Development Goal 3.3 of ‘combatting’ viral hepatitis and commit to ending this epidemic, as you have with HIV/AIDS, TB and malaria.
5. Request that you give viral hepatitis exactly the same priority that has been given to HIV/AIDS, TB and malaria which has been so effective in reducing mortality from those diseases.
6. Request that you put particular emphasis on finding the almost 300 million men, women and children who are living with hepatitis B or C but remain undiagnosed. Finding these ‘missing millions’ will be essential to preventing new infections and essential to providing access to the treatments that will stop 1.3 million of them dying every year.
7. Request that you make addressing stigma and discrimination a priority since they are a major impediment to finding these ‘missing millions’ and to giving those that need it appropriate care and treatment and hence to the goal of elimination set out in the Global Health Sector Strategy on viral hepatitis.
8. Request that you use whatever means are necessary and that you stop at nothing to ensure that all of those living with viral hepatitis have access to the tests and drugs they need either for free or at a price they can readily afford.
9. Request that you involve us, the people living with the disease, fully in the design and implementation of national viral hepatitis plans.
10. Pledge, in return, that we will work tirelessly to assist you in these endeavours, that we will be as free with our praise of fine work as we are with our criticism of an inadequate response and that we will provide the advocacy necessary to help you find the resources you need, achieve the commodity prices you want and reach the goal we all share which is the elimination of viral hepatitis by 2030.
DECLARATION OF THE HEPATITIS COMMUNITY: NO ELIMINATION WITHOUT DECRIMINALIZATION!

We, members and representatives of the viral hepatitis community - a community that includes people living with viral hepatitis, doctors, nurses, social workers, researchers, public health experts, and people who use drugs - are concerned over the growing gap between the enormous impact of hepatitis B and hepatitis C over people who use drugs and their almost non-existent access to prevention, diagnosis and treatment services around the world.

Sharing unsterile drug injecting equipment puts people at high risk of hepatitis B and hepatitis C infections. Globally it is estimated that among the 15.6 million people who currently inject drugs 52% are hepatitis C antibody positive, and 9% are living with chronic hepatitis B infection [1]. From a public health and human rights perspective, improving access to prevention and treatment for people who use drugs is crucial to reducing hepatitis C incidence and eliminating the epidemic, as sharing of needles, syringes and other injecting equipment is estimated to account for 23% of new infections [2].

Ensuring access to interventions such as low-threshold needle and syringe programmes, opioid substitution therapy, hepatitis C treatment and other harm reduction interventions are essential to reduce hepatitis C incidence and prevalence among people who inject drugs [3][4], and these interventions are cost-effective [5][6]. In 2016, the Member States of the World Health Organization (WHO) adopted the first ever Global Health Sector Strategy (GHSS) on viral hepatitis [7]. It identified harm reduction as one of five core interventions needed to reach the goal of viral hepatitis elimination by 2030.

Despite the evidence and WHO recommendations, comprehensive harm reduction services are inaccessible for most people who use drugs worldwide. In 2017, among the 179 countries and territories where injecting drug use has been reported, just 86 (48%) have implemented opioid substitution therapy and 93 (52%) have needle and syringe programmes [8]. Furthermore, the regional and national coverage varies substantially and is most often below WHO indicators, with less than 1% of people who inject drugs living in countries with high coverage of both services [8]. Even where services do exist, people who use drugs face more difficulties in accessing hepatitis C prevention and treatment due to poor access to health services, their exclusion through treatment criteria, threats of violence and abuse when disclosing status as drug users, and universal stigmatization. As a result, the hepatitis C epidemic continues to grow among people who use drugs [9].

This lack of access to hepatitis care for people who use drugs is deeply rooted in and driven by our laws and policies which criminalize drug use, drug possession and, ultimately, people who use drugs themselves [10][11]. Punitive drug law enforcement is a direct barrier to harm reduction services in many ways:

- the prohibition of drug paraphernalia possession impedes harm reduction service delivery and uptake;
- many national laws impose severe and disproportionate custodial sentences for minor, non-violent drug offenses (such as drug use, possession and low-level supply);
- people who use drugs are frequently incarcerated or extra-judicially detained, often leading to interruption of medical treatments, without access to prevention and other harm reduction services, and at heightened risk of hepatitis infection;
- policies criminalizing drug use fuel stereotypes and negative assumptions of people who use drugs, ultimately reinforcing stigmatization and discrimination.

Even in countries that have integrated harm reduction into domestic public health policies, criminalization remains a glass ceiling – as the fear of arrest continues to drive people away from prevention and care services.

A number of countries, such as Portugal and the Czech Republic, decriminalized minor drug offenses years ago with significant public health benefits [12][13]. These policy changes have proven very successful and have led to an increase of access to harm reduction and health services by people who use drugs – contributing to decreased new HIV infections, and reduced harms associated with drug use and drug dependence [14]. While our laws and policies that prohibit drugs are portrayed and defended as necessary to preserve public health and safety, the evidence overwhelmingly demonstrates that they have driven unnecessary and disproportionate human rights violations including violence, disease, discrimination, and the undermining of people’s right to health [10][11][12].

Growing recognition of the need for evidence-based drug policy reform has led several world leaders, public health experts, the WHO and other United Nations Agencies to recommend the decriminalization of minor, non-violent drug offenses, and a strengthening of health-oriented alternatives to criminal sanctions [9][15][16][17][18][19][20][21][22].

We, the viral hepatitis community, whole-heartedly support Member States’ commitment to the goal of eliminating viral hepatitis by 2030. In order to achieve that goal, we call on world political leaders to remove all barriers to the uptake of the full range of prevention services by people who use drugs by reforming laws, law enforcement procedures and discrimination that hinder access, including the criminalization of minor, non-violent drug offenses and to adopt an approach based overwhelmingly on public health promotion, respect for human rights and evidence.

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Annex B: Countries represented
(n=106)

Afghanistan, Algeria, Angola, Argentina, Armenia, Australia, Bangladesh, Belarus, Belgium, Benin, Bhutan, Bosnia, Brazil, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Canada, Chile, China, Colombia, Congo, Côte d’Ivoire, Croatia, Cuba, England, Estonia, Ethiopia, France, Gambia, Georgia, Ghana, Greece, Guatemala, Guinea, Haiti, India, Indonesia, Iran, Ireland, Israel, Italy, Japan, Jordan, Kenya, Kuwait, Kyrgyzstan, Lebanon, Lesotho, Libya, Macedonia, Madagascar, Malawi, Malaysia, Mali, Malta, Mauritania, Mauritius, Mexico, Moldova, Mongolia, Morocco, Mozambique, Myanmar, Nepal, Netherlands, New Zealand, Nigeria, Norway, Pakistan, Paraguay, Peru, Philippines, Portugal, Qatar, Romania, Russian Federation, Rwanda, Senegal, Serbia, Somalia, South Africa, Spain, Sudan, Suriname, Switzerland, Syria, Tajikistan, Tanzania, Thailand, Timor-Leste, Togo, Tonga, Tunisia, Turkey, Ukraine, United States, Uruguay, Uzbekistan, Vatican City, Vietnam, Zambia, Zimbabwe.

Annex C: Governments represented
(n=65)

Angola, Belarus, Brazil, Bulgaria, Burkina Faso, Cambodia, Cameroon, Canada, Chile, China, Colombia, Croatia, Cuba, Egypt, Ethiopia, France, Germany, Ghana, Greece, Guatemala, Guinea, Haiti, India, Indonesia, Jamaica, Japan, Jordan, Kazakhstan, Kyrgyzstan, Lesotho, Libya, Macedonia - The Former Yugoslav Republic Of, Madagascar, Malawi, Malta, Mauritius, Mexico, Moldova - Republic of, Mongolia, Mozambique, Nepal, Nigeria, Pakistan, Paraguay, Philippines, Portugal, Qatar, Romania, Russian Federation, Rwanda, Senegal, Serbia, South Africa, Sudan, Suriname, Switzerland, Syria, Tanzania - United Republic of, Thailand, Timor-Leste, Tunisia, Uganda, Ukraine, Uzbekistan, Vietnam, Zambia, Zimbabwe.
**Annex D: Delegate Types**

- Patient organisations (23%)
- Governments (13%)
- Brazilian delegates (23%)
- Media (1%)
- Civil society (9%)
- Funding bodies (1%)
- Public health (16%)
- Multi-national agencies (1%)
- Industry (7%)
- Abstract authors (6%)

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