

Conference Review:

AFRICAN VIRAL HEPATITIS CONVENTION 2024



TABLE OF CONTENTS

1

Hope and determination key in Viral Hepatitis battle

5

When it comes to HCV, 'walk like an Egyptian'...

8

Vaccinate the children, for HBV sake!

12

Hep B Birth Dose vaccination – A lesson in saving lives

15

The victims and the heroes of Hep C

19

Lifesaving boost for viral hepatitis in Southern Africa

21

Palliative care as prevention – Krause

23

The complexities of HBV birth-dose vaccination

26

The 2024 African Viral Hepatitis Convention Declaration

Hope and determination key in Viral Hepatitis battle

Just over two decades ago, a young South African hepatologist, Dr Neliswa Gogela, sat holding the hand of a 21-year-old man dying from primary liver cancer in Groote Schuur Hospital.

Today, countless deaths later, this continues, representing a fraction of the 15000 Viral Hepatitis B and C-associated avoidable deaths annually in Africa.

It's easy to feel hopeless, which she often does, but she and fellow African colleagues across all disciplines dare not crumble – the silent and deadly epidemic is being overcome in five, (of 54), African countries.

The prevention, diagnosis, treatment, and cure figures for the continent are shocking and intimidating, putting AIDS, TB, and malaria, which have been addressed far more assertively, in the shade. Sub Saharan African, (SSA), countries alone have the highest known age-standardised incidence rates of Viral Hepatitis in the world with an estimated 30,83 cases per 100 000 inhabitants diagnosed annually.

Eighty five percent of hepatocellular carcinoma (HCC or liver cancer) patients globally are estimated to occur in SSA, (liver cancer being an inevitable result of mostly asymptomatic viral hepatitis.) Ninety five percent of the region's patients currently present with advanced incurable disease, with a median survival time after diagnosis of 2,5 months.

Less than one percent of SSA patients are undergoing curative intended treatment – compared to 55% in high income countries. There's a dire lack of appropriate palliative care with more than 85% of patients with HCC dying with untreated moderate or severe pain. Less than 0,1% of palliative patients in SSA will receive treatment with potentially life-prolonging interventional or systemic therapies.



Groote Schuur hepatologist, Dr Neliswa Gogela, consults a patient

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This grim picture led to a joint declaration after the African Viral Hepatitis Convention held at the Cape Town International Convention Centre from May 16–18, by the International Hepato-pancreato-biliary Association, (IHPBA), the Gastroenterology and Hepatology Association of South Africa, (GHASSA), and the African Palliative Care Association, (APCA).

They say multiple factors contribute to this ‘unfortunate reality,’ but the major ones are a **failure to:**

- Manage chronic viral hepatitis. The Africa region accounts for 66% of new Hepatitis B Virus, (HBV), infections, of whom 4,2% have been diagnosed, with just 0,2% of those living with diagnosed HBV.
- Recognise that HBV is the leading cause of Hepatocellular Carcinoma in Sub Saharan Africa, (SSA), and is an entirely vaccine-preventable disease with only 18 SSA countries having introduced timely HB birth-dose vaccination.
- Prevent out of pocket expenditure for diagnosis, such as viral diagnostic markers, especially molecular diagnostics, with greater domestic funding for treatment of VH and HCC, thereby contributing to poverty levels.
- Screen for risk factors and surveillance in high-risk populations.
- Provide HCC-directed treatment resources, including systemic therapies, surgical and other interventional procedures, and resources needed for end-of-life treatment, in particular pain management.

Collectively, the associations call for all AU member states, partners, and stakeholders to prioritise the actions required for the elimination of viral hepatitis as a public health threat by 2030. These include:

- introducing the monovalent Hep B birth dose vaccination to prevent mother-to-child transmission as part of the Expanded Programme of Immunisation in all countries.
- Strengthening and increasing coverage of universal HBV vaccination in national immunisation programmes to 90%, strengthening linkages to care and the provision of ART for people with chronic HBV and HCB infection.
- Establishing screening and surveillance programs for patient groups at risk for developing liver cancer to enable diagnosis at earlier stages where patients would be eligible for curative-intended treatment and,
- Expanding the capacity for curative treatment interventions through systemic therapies and palliative care.

The document was signed by the leaders of all three associations, who committed their members to continue engaging and working with State and non-State actors, policy makers and health ministries, patient advocacy groups and the biomedical industry, “to ensure sustainable access to affordable diagnostics and all therapeutic options for viral hepatitis and liver cancer, including appropriate palliative care.”



**Professor Wendy Spearman,
Convention Organiser and
Head of the UCT/Groote Schuur
Liver Clinic**



**Professor Chris Kassianides, Convention
Organiser, Founder and Chairperson of
Gastro Foundation of Sub Saharan Africa.**



**Professor Mark Sonderup Convention co-
convenor and senior hepatologist at Groote
Schoor's Liver Clinic.**

Speaking at the signing, Professor Mark Sonderup, co-convenor of the convention and a senior hepatology consultant at Groote Schuur Hospital, said the 'astounding' progress made by Egypt, Mauritius, Rwanda, Botswana, and Uganda was inspirational 'in moving the needle forward, but addressing the debilitating pandemic required a massive joint effort.

"There's no better time than now, especially after the WHO report showing inadequacy and a collective failure, both as advocates and not holding the right people accountable. It's a great shame that we're only at a 30% diagnosis in Africa. We all need to be advocates. The year 2030 (the elimination goal), is so close, yet we're so far from the target, he said.

Last year the African Viral Hepatitis Action Group was formed to unite policy makers, clinicians and patient advocacy groups and harmonize action. Dr Arafat Bwambale, a long-time Ugandan Hepatitis B activist and elimination champion, said 7 700 annual new Hep B infections in Africa was astonishing when 'all the tools are there.'

"Yet everybody is wondering - young people in Africa are crying out for help. To have nine out of ten women affected is unacceptable."

Professor Chris Kassianides, Founder and Chairperson of GHASSA, said it was crucial to "keep this networking and communication open, especially when the 'good intentions of leading stakeholders are not 'trickling down.'"

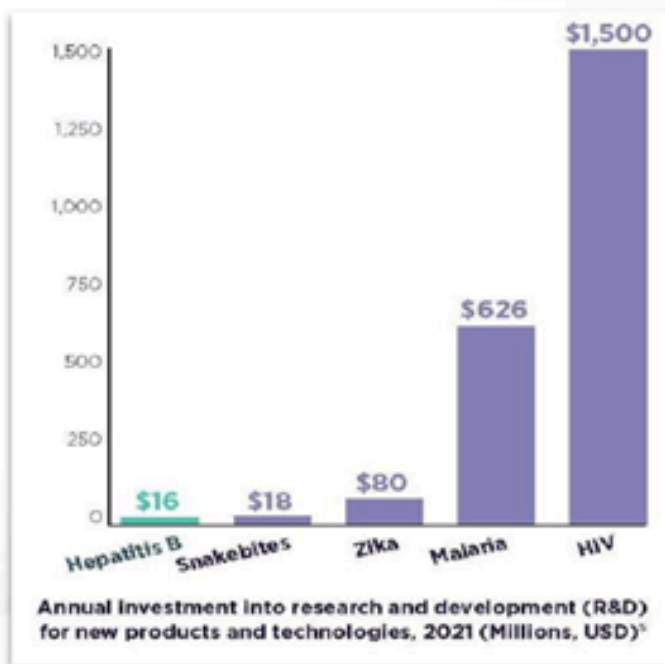
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“Perhaps we need a bottom-up approach to try and meet somewhere in the middle, inviting African businessmen to take leadership and push in US dollars or in communications and expertise of business to try and increase the pace,” he said.

Dr Gogela added; “If we don’t do something our continent will perish. It’s been said at this conference that we’re not beggars, but we will be if we don’t do things for ourselves. Not standing up and doing something will mean we’re still at this point in 2030”.

Deputy Director General of SA’s National Health Department, Dr Anban Pillay said his department had not given as much attention to Hepatitis B as they would like. He added, “this conference has helped highlight the gaps in our program that we need to fill so we can catch up, taking our lead from those champion countries.”

Investments in HBV Care Research is Limited



CGHE, Operational Research Roadmap to Simplify Hepatitis B Care in LMICs, 2023

- CGHE scoping review identified limited number of operational research for HBV care delivery in LMICs
- WHO global systematic review of models of care
- Research funding for HBV remains highly limited when compared to other global health threats



THE TASK FORCE FOR GLOBAL HEALTH

- WHO figures show that Viral Hepatitis research last year attracted 1,06% of the global funding that HIV/AIDS got (\$16m v \$1,5 b), and attracted two million dollars less than snakebite research (\$18m).

When it comes to HCV, 'walk like an Egyptian'...

Egypt has become the first country globally to eliminate Hepatitis C, and together with Mauritius, Rwanda, and Botswana, is setting an example for other African nations.



**Egyptian, Professor Imam Waked,
Dean Emeritus of Egypt's
National Liver Institute**

Until 2016, Egypt had the highest prevalence of Hepatitis C Virus, (HCV), in the world.

Interviewed at the African Viral Hepatitis Convention held at the Cape Town International Convention Centre from 15 to 18 May, Professor Imam Waked, Dean Emeritus of the National Liver Institute near Cairo, says Egypt's overall hepatitis prevalence dropped from seven percent (or 5,5 million people) in 2013, to 0,3% (or 330 000 people) last year (10 years).

In a public health campaign extraordinary for both its scale and its success, Egypt screened its entire population, brokered a deal for hugely discounted drugs and cured almost everyone with the virus.

It was described by Dr John W. Ward, Director of the Coalition for Global Hepatitis Elimination at the Task Force for Global Health as, "one of the greatest accomplishments ever in public health."

The local origin of the disease which at one stage affected 50% of all Egyptians under 15, was the use of poorly sterilized needles to treat schistosomiasis, a widespread Nile-River-acquired parasitic infection acquired by millions in the 1950's and early 1960's.

Asked how the campaign succeeded, Waked said not only did the then president suffer from viral hepatitis, but so too did most of his cabinet.

"We did cost-effectiveness studies convincing the politicians to align themselves behind the program and to negotiate really cheap diagnostics and medication – of course it helps if your politicians have suffered from the disease itself," he added wryly.

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When it was put to him that South Africa, although having a viral hepatitis prevalence of just 0,1% has failed to prioritize a disease that kills more people than HIV, TB, or Malaria, he described the local numbers as 'eminently manageable.' "You can get a cure in just three months through vaccination, especially with newborns (the disease is asymptomatic and kills most of its adult victims when it evolves into cancer), at a cost of about R450 per person."

He described the downstream health cost savings as 'huge.'

"We were lucky enough to have a Minister of Health in 2006 who was a businessman and able to adopt the national vaccination and treatment program because he knew how to source funding and negotiate prices down," he observed.

Waked said an estimated 330 000 VH infected Egyptians had either yet to be tracked down or were living abroad.

Egypt is leveraging its victory into a campaign of "health diplomacy," pledging to donate drugs and share expertise, with the goal of treating a million African patients.

Dr Zaid Heetun, Chairperson of the Mauritian National Committee of Viral Hepatitis, said his teams treated more patients last year than in the previous 14 years. Of some four hundred prisoners screened over 48 hours, nearly 90% turned out to be HCV-positive. HCV had since been eliminated in prisons.

He said that each morning some five thousand intravenous drug-using patients across the island received methadone as part of their drug substitution treatment in a new national rehabilitation program. The main catalyst for the transformation was a large donation by Gilead.

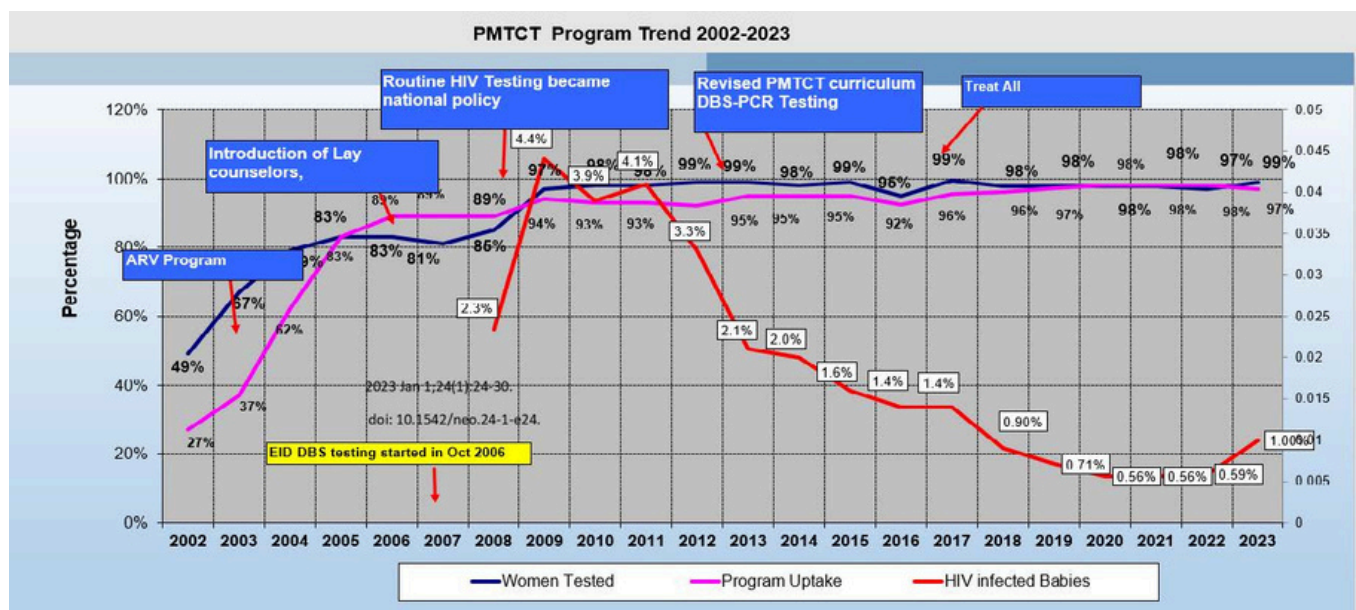
The current national scenario was dramatically different to between 2005 and 2018 when there was just one treatment centre (Victoria Hospital) and no HCV care anywhere else.

There were also no clear referral pathways, no in-house PCR testing, no fibro scans, a total absence of training and widespread stigmatization, he added. All had since been addressed via a massive advocacy and awareness campaign, with an HPV conference in 2018 the springboard for change. Since then, 12 treatment centres and an AIDS unit were set up with many more staff appointed.

“We’ve been through three phases; from getting all patients off dialysis, to eliminating Hepatitis C in prisons – and we’re now on the road to eliminating HCV in the entire population,” he said. Effective treatment regimens had been identified while there were now 5086 Hepatitis C positive patients identified and on treatment, mainly male intravenous drug users. Rapid-access HCV clinics, community outreach and decentralization care were behind the success, with a rapid upscaling of the national HPV data-base facilitating care.

“What is crucial now is to maintain momentum. At our centre for hepatology and gastroenterology we’re conducting 6240 procedures per annum and seeing 15 000 patients annually in the outpatients’ department, with minimal waiting times,” he concluded.

Botswana’s, Dr Gaboratenelwe-Gabakgore, said his country was the first in the region, “to be open about the high burden of HIV – it spread very fast and before we knew it, we had the highest prevalence.”



The Journey of Elimination of Mother to Child Transmission of HIV (Botswana) 1990.

He said Botswana’s overall HPV prevalence was estimated at four percent. A recent national HCV prevalence study of 12 610 people (without HIV), in his country, revealed an HCV prevalence of between 1,7% and 10,6%. Of this number, in Gaberone and surrounding areas, blood donors accounted for one percent, pregnant women for 1,1%, and infants for 0,67% (all without HIV.)

He said the greatest hindrance to HCV elimination was the lack of nationally representative data. Targeted interventions were however accelerating the reduction of HCV prevalence, but surveillance of clinically relevant mutations was needed to improve prevention strategies.

Vaccinate the children!!

The majority of the world's 250 million people living with chronic Hepatitis B are infected perinatally or acquired it in early childhood – something entirely preventable through vaccination.



**Groote Schuur hepatologist,
Dr Gogela**

That's according to Dr Neliswa Gogela, of the Division of Hepatology and Liver at the University of Cape Town who was addressing the topic of "HIV-HBV co-infection," at the conference last month.

We have a bullet-proof HBV vaccine – we must just get it right. We need a birth dose vaccine plus the current routine 3 dose schedule in neonates. Until then, transmission will continue like Cape Town's wild mountain fires," she told delegates during a session entitled 'Co-factors in Viral Hepatitis – opportunities for elimination.'

Because of the shared routes of transmission, about ten percent of HIV infected people were infected with hepatitis, leading to an acceleration of the latter disease to cirrhosis, end stage liver disease and hepatocellular carcinoma. She said that with the majority of viral hepatitis infections being in Africa there was still a huge amount of missing global data, the highest risk cohorts being people who inject drugs, and men who have sex with HIV positive men. Patients who were HIV positive were 1,5 times more likely to have hepatitis B compared to patients who were HIV negative, with the majority of these having contracted hepatitis in early childhood.

"The reason is simple. As children we don't yet have robust immunity, so 90% of them progress to chronic infections before five years old with 30% of those likely to progress further. But if you are an adult and you're exposed to HIV, the chances of contracting viral hepatitis are very high," she added. Research showed that if a child was exposed to viral hepatitis before the age of one year old, they had a between two and ten percent chance of advancing fibrosis every year.

The chances of them reaching 20 years old with a viable liver were nil, while the risk of cancer vastly increased.

Gogela said there was ‘nothing more devastating,’ than a 30-year-old with viral hepatitis who has never abused alcohol or drugs, thus aggravating cirrhosis of the liver, and having to tell them that they had three months to live. “They look you in the eye and say, ‘but I’ve just secured a job,’ or, “I m building a house for my mother, and now you tell me I’m dying?!”

She said it was ‘tragic’ that a preventative vaccine had been available for nearly 40 years, ‘yet we still find ourselves chasing targets.” Two to three booster doses were needed after an initial vaccination to achieve 95% or more protection – but just as important was to vaccinate all pregnant women after first testing them for hepatitis during their first antenatal clinic visit.

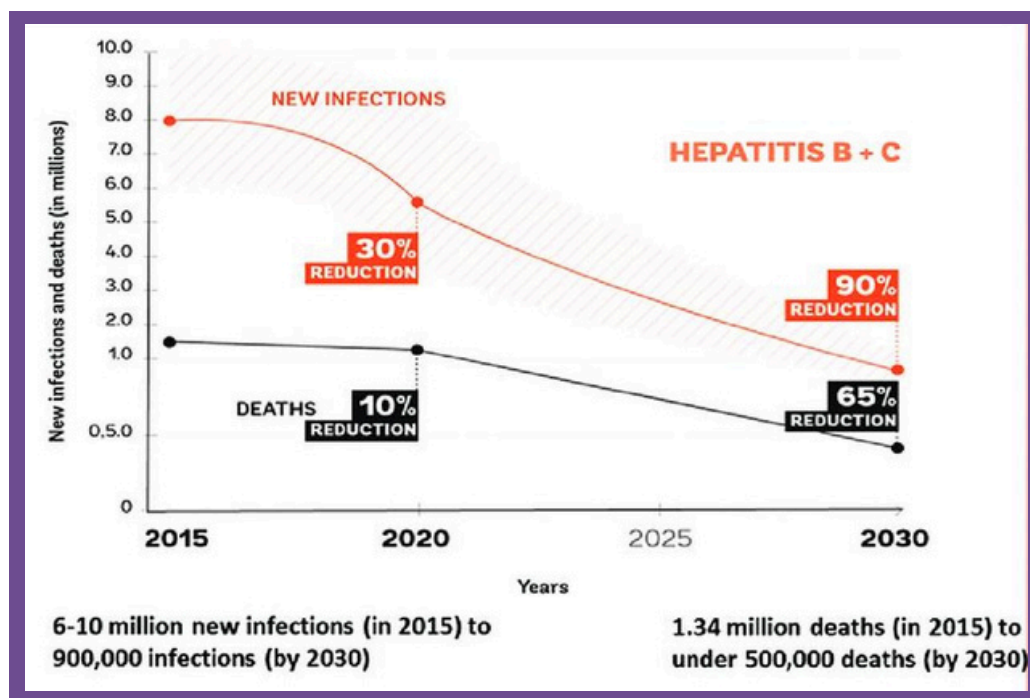
“Just as we test them for HIV or syphilis or other STD’s, we should test them for viral hepatitis surface antigen. If you don’t have the resources, give them the geography (i.e. refer to a clinic that does). Don’t wait until the second trimester because you might miss the opportunity. If you wait until the second trimester you might miss that opportunity. They might deliver at home, and you might never see them again.” She said that unlike HIV, few patients knew or understood anything about viral hepatitis, yet millions had been started on ART, unlike VH vaccination. She cited an online survey conducted in the USA last year asking chronically infected hepatitis patients whether they’d ever been told about the possibility of being treated or having the disease progression delayed.

Half of them said no, while 85% said they would very much like to know.

She said the hepatitis antigen was first discovered in Australia in 1963, with tests for the vaccine beginning in 1975 and a successful HBV vaccine emerging in 1982, with licensing four years later.

“And this is 2024!”

Gogela exclaimed, alluding to how poorly the world has responded to the disease.



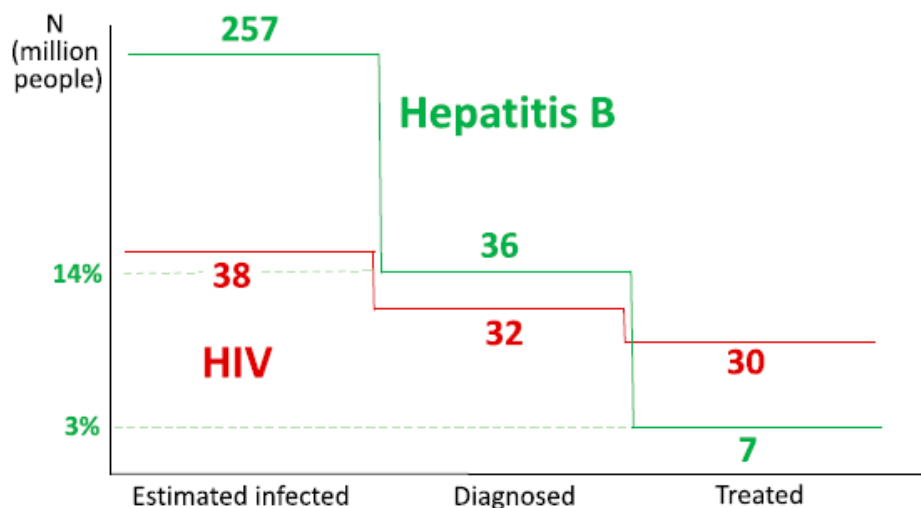
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She stressed that a single VH finding could ‘unlock a series of doors,’ while providing an opportunity to prevent and educate.

Nurturing hope involved decentralisation of care, point of care testing, vaccination, and treatment, she stressed.

WHO AND HIV: 40-YEAR TIMELINE

1983/88 In 1983, the HIV virus was first isolated by Dr Françoise Barré-Sinoussi and Dr Luc Montagnier at the Institut Pasteur in Paris. WHO celebrates the first World AIDS Day in 1988 acknowledging the key role of civil society in mobilizing a global response.	1990 WHO publishes the first guidelines on the clinical management of HIV infection with disease staging. World AIDS Day 1990 calls for a global focus on women and HIV, for their role and contributions in the global response, as patients and carers, and in prevention of mother-to-child transmission.	1991 The number of countries with national AIDS programmes rises from 7 to 130 within a year.
2002 Of the 28.5 million people living with HIV in Africa, only 35 000 are accessing HIV treatment. WHO issues its first full guidelines on HIV treatment.	1996 Highly active antiretroviral therapy is first introduced changing the mood of the HIV response from despair to great hope. WHO, together with 5 UN agencies, establishes the Joint United Nations Programme on AIDS (UNAIDS).	1994 WHO estimates 13–14 million people are living with HIV, with this figure projected to reach 30–40 million by 2000.
2003 WHO launches the global ‘3 by 5’ initiative, to provide HIV treatment to 3 million people in developing countries by 2005.	2007 Only 10% of people with HIV knew of their diagnosis in 2005. WHO recommends a revolutionary step to offer provider-initiated HIV testing and counselling.	2014 The world is on track to achieve the Millennium Development Goal target to treat 15 million people with HIV by 2015.
2021 WHO worked with partners to track the impact of the COVID-19 pandemic including understanding implications for people living with HIV and through tracking disruptions including in the provision of antiretroviral therapy services.	2018 HIV testing reaches 75% of people with HIV and nearly 60% of people with HIV are receiving treatment. Despite successes, huge disparities still exist – many populations are being left behind, particularly key populations. Half of the people living with HIV are not virally suppressed, and 1.8 million people are newly infected every year.	2016 WHO launches historic guidelines recommending treatment for all people living with HIV, for both prevention and treatment outcomes. Further innovations, including pre-exposure prophylaxis and self-testing are recommended.
2022 Approximately 86% of people living with HIV knew their HIV status, 76% were receiving HIV treatment, and 71% were virally suppressed. HIV services in some communities and context diverted in support of the multi-country mpox outbreak. Strategies and approaches increasingly focus on integration, universal health coverage and primary health care.	2023 People living with HIV who achieve an undetectable level of virus by consistent use of antiretroviral therapy do not transmit HIV to their sexual partner(s). At the end of 2022, 29.8 million of the 39 million people living with HIV were taking antiretroviral treatment (which means 76% of all people living with HIV) with almost three-quarters of them (71%) living with suppressed HIV.	ENDING AIDS BY 2030 IS ACHIEVABLE IF WE KEEP OUR EFFORTS STRONG.

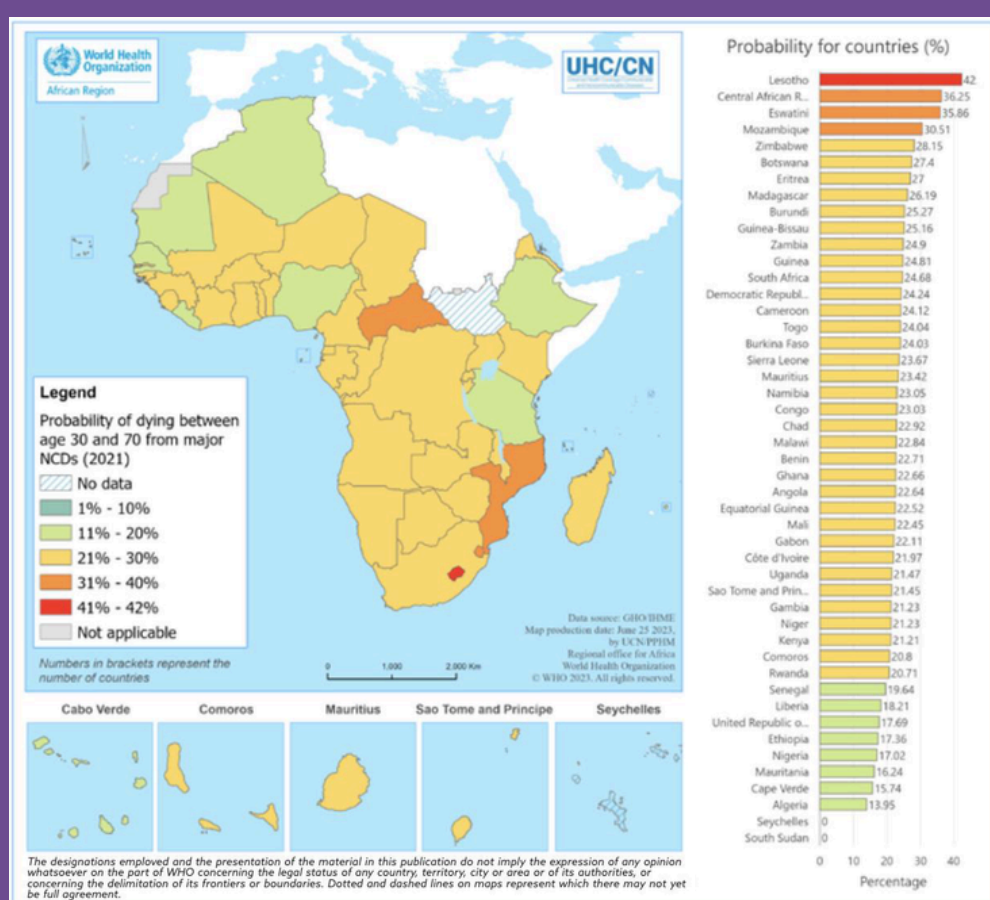


Earlier, Dr Bilal Bobat of the Wits Donald Gordon Medical Centre in Gauteng, spoke on the debilitating convergence between communicable and non-communicable diseases, (NCD's), focusing on Metabolic Dysfunction-Associated Steatotic Liver Disease, (MASLD) and viral hepatitis. MASLD often occurs along with other metabolic disorders such as high cholesterol, obesity, and diabetes.

He said that globally, 436 million adults had Type Two Diabetes, 65% of whom had MASLD, a percentage which had risen from 55% between 1990 and 2004. Africa accounted for some 30 million of these, with Asia leading that pack at about 75 million. She said the burden of non-alcoholic fatty liver disease, (NAFLD), had risen rapidly across the globe from 1990 to 2019 with 1,23 million patients suffering from NAFLD and 168 236 dying by liver death in 2019 alone. The adult death rate of NAFLD had increased by 1,18% per annum between 2010 and 2019.

Bobat said there was 'considerable overlap' with viral hepatitis while the epidemiology showed that NCD's aggravated one another, with malnutrition and ultra-processed foods playing a major role. When a patient was co-infected there was a worsening of fibrosis and an elevated risk of Hepatitis C. Therapeutic considerations included being aware of drug-drug considerations while there was still a need to manage MASLD separately.

Opportunities for NCD programs abounded, she said, but pivoted on cost considerations and screening.



Hep B Birth Dose vaccination – A lesson in saving lives

A modelling study across 110 low and middle income countries shows that scale up of Hepatitis B birth dose vaccination with >90% coverage would avert an estimated six million new neonatal infections between 2024 and 2030. The greatest impact would be in the WHO Africa region.

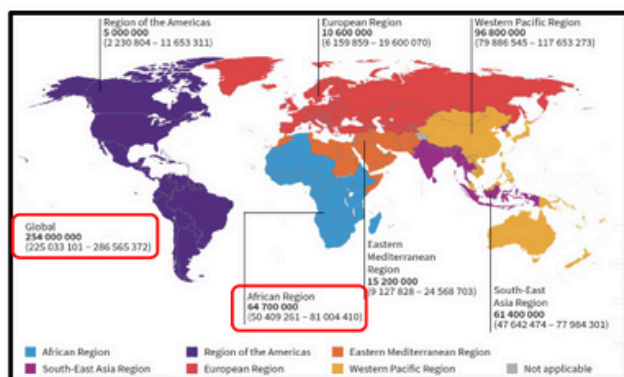


Viral hepatitis, (HBV), is a silent and deadly killer carried mostly asymptotically into early adulthood, with a 90% risk of chronic infection with mother-to-child transmission. Africa accounts for 63% of all new HBV infections.

In a presentation to the conference, Professor Wendy Spearman, Head of the Division of Hepatology, Department of Medicine, Faculty of Health Sciences at UCT, told delegates that although HBV was vaccine-preventable, only fifteen of forty-seven WHO African countries had introduced HB Birth dose vaccination – and only 18% had timely HB Birth dose vaccination. She said that according to WHO 2022 estimates, Africa had 64,7 million HBV-infected people with just 2,7 million (4,2%), diagnosed and 150 000 (0,2% treated), with an annual death toll of 272 000.

Hepatitis B in Africa

- **Hepatitis B is endemic**
- **HBsAg modelled prevalence in 2022: 5.8% in WHO AFRO region**
- **WHO Africa: Accounts for 63% of all new HBV infections**



<https://immunizationdata.who.int/pages/coverage/hepb.html>
WHO 2024 Global Hepatitis Report

WHO Africa 2022: 64.7 M (50.4-81.0 M) estimated to be HBV-infected

- New infections: 771 000
- **Diagnosed: 2.7 M (4.2%)**
- **Treated: 150 000 (0.2%)**
- Deaths: 272 000

HBV is vaccine preventable BUT

- Only 15 (32%) African countries have implemented HB Birth dose vaccine
- Full HBV-3 vaccine coverage: 72%

The Western sub-Saharan region had the highest HBsAg prevalence at 9% with the Southern sub-Saharan region the lowest at 4,5%. Two out of three new HBV infections globally occurred in Africa. The HBV prevalence in children under five years old in Africa was 2,4-fold higher than the global prevalence with 64% of all children living with chronic HBV residing in Africa. The WHO global and WHO African HBV prevalence reduction targets for children under 5 years (by 2020), were set at below one percent (actual 0,7%), and below two percent (actual 1,7%), respectively.

Spearman said the failure of maternal and child services in Africa to identify HBV-infected pregnant women and implement appropriate Tenofovir prophylaxis and timely Hep B Birth dose vaccination to prevent mother-to-child transmission was one of the biggest obstacles to mitigation and elimination of the disease. Another was HBV/HIV coinfection resulting in an increased HBV viral load and HBeAg positivity (HBeAg is the viral protein made by the hepatitis B virus and is released from the infected liver cells into the blood) with an increased risk of transmission.

Spearman said that in sub-Saharan Africa an estimated 360 000 of newborns (or one percent), were perinatally infected with HBV annually, resulting in a 15% to 25% risk of premature death from cirrhosis and hepatocellular carcinoma, (liver cancer), later in life. She said the risk of chronic infection and complications depended on the age of acquisition with mother-to-child transmission carrying a 90% risk of chronic infection, while infection of children under five years of age carried a 30–50% risk. One in four children were at risk for HBV-related liver disease and premature death.

The WHO Hepatitis B vaccination goals for countries with universal Hep B Birth dose vaccination was ninety percent or above coverage for both the hepatitis B infant vaccination (3 doses) and timely Hep B BD vaccine. The same goal was set for countries with targeted Hep B BD vaccination, including ninety percent or more coverage of maternal antenatal HBsAg screening, 90 percent, or greater coverage with antivirals for eligible HBsAg positive pregnant women and at least a two percent prevention of mother-to-child transmission rate.

All these targets had to be achieved and maintained for at least two years for an optimal chance of mitigation or elimination. The WHO's goal is to eliminate hepatitis B as a public health problem and eliminate MTCT of HBV by 2030. Scaling up the HepB-BD vaccine coverage to ≥90% and maintaining the present coverage for the hepatitis B infant vaccination would prevent an estimated forty-one million chronic HBV infections globally and prevent 710 000 deaths, including 554 000 deaths (78%) in WHO African region countries among people born between 2020 and 2030. In South Africa, this would avert 9 383 deaths.

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WHO 2022 data showed The Gambia to have the worst birth dose vaccination coverage, despite vaccination having been introduced there earlier than any other African country (1997) at 26%. This was followed by Botswana at 40% coverage (2000), and Nigeria at 52% (2004). The best performing African country was Algeria at 99% (vaccine introduced in 2001), followed by Cabo Verde at 97% (2002) and Namibia at 79% (2014). There was no data available for South Africa and Angola.

“Timely Hep B Birth dose vaccination followed by the 3 dose hepatitis B infant vaccination remains the foundation for the addition of maternal HBsAg screening and other interventions to eliminate HBV MTCT,” she said.

The average global Hep B Birth dose vaccination coverage for WHO member countries stood at forty five percent while the average coverage among WHO African countries was eighteen percent. HB Birth dose vaccination is highly effective in reducing the Hepatitis B sAg prevalence as demonstrated in a number of countries ranging from 78% decrease in HBsAg prevalence in Oman to 100% decrease in United States.

Besides a rapid global scale up of Hepatitis B birth dose vaccination averting an estimated six million new neonatal infections, the addition of TDF (tenofovir disoproxil fumarate) prophylaxis in HBsAg-positive pregnant women would avert an extra 1,1 million new neonatal infections by 2030, modelling studies showed. The highest impact of this would be on Africa.

The Economic and financial costs of introducing HepB-BD vaccination was assessed in Senegal. The costs of a full program implementation (all costs included) would come to the equivalent of R43 per newborn vaccinated while taking into account savings from use of existing staff and equipment would bring this cost down to just R3,60 per newborn.

A survey of public and private facilities in Botswana, the Gambia, Namibia, Nigeria, Sao Tome and Principe showed that parents and caregivers readily accepted Hep B Birth dose vaccination.

Among the chief reasons or dismal uptake were a lack of policies for routine and timely Hep B-BD vaccination, the high proportion of home births, a lack of access to skilled health attendants and poor awareness among health workers, parents, and general public about the transmission risks and the safety, efficacy and benefits of HB-BD vaccination. She said that until these barriers were resolutely tackled, the chances of reducing Africa’s Hepatitis B prevalence of 5,8% would be difficult. GAVI’s resumption of its commitment to support HB-BD vaccination in LICs would have a major positive impact.

The victims and the heroes of Hep C

A clarion call for action

The harrowing stories of two viral hepatitis survivors plus vaccination advocacy advice from the co-founder of South Africa's celebrated HIV/AIDS treatment action campaign, Mark Heywood, had conference delegates riveted on the final conference day.

The session was entitled, "The community and patient voice in amplifying viral hepatitis elimination – people living with hepatitis B and C." It began with "Living with Hep-T t-shirt wearing Nigerian, Danjuma Adda, the immediate past president of the World Hepatitis Alliance, saying those responsible for treatment inaction should be 'shamed.'"

He said this was because the disease was entirely preventable via birth-dose vaccination and had been all but eliminated in five of fifty-two several African countries. "We need to shame those accountable and make decision makers passionate about viral hepatitis," Adda, a Hep C survivor who lost his mother to the disease, said.

He asked how politicians and health bureaucrats could believe that the lives of people with viral hepatitis were not worth a mere \$29 per year (the price of HPV vaccination and/or treatment).

However, the recent formation of the African Parliamentary Network Against Viral Hepatitis and Liver Disease, was a positive start.

"We have the richest man in Africa in Nigeria and there are billionaires in South Africa, so we want to network contributions towards the reduction of viral hepatitis," he added.

Heywood said the parallels between a hepatitis vaccination and treatment access campaign and the HIV/AIDS Treatment Action Campaign were striking, as was the potential.



Mark Heywood, a co-founder of the Treatment Action Campaign, (TAC), whose activism and legal challenges led to the SA government's reluctant roll out of ARV's and drugs for HIV positive mothers

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“We don’t have to reinvent the wheel here. I consider myself a veteran table shaker. We can take this movement down that path. Yes, there are differences, but also many similarities.”

When the TAC began its campaign, spurred on by the tragic murder of HIV positive Gugu Dlamini in KwaMashu twenty-five years ago, SA was experiencing 1000 new HIV infections and six to seven hundred AIDS-related deaths daily. By the end of the 1990’s an ARV drug design breakthrough happened in the United States. Africa struggled on without access – a similar situation to viral hepatitis vaccination and treatment medications today.

“There was that famous saying that you can’t provide ARV’s in Africa because most people don’t have watches, he said wryly, adding that there was also a false perception that African health systems were insufficiently robust. As with viral hepatitis, stigma around HIV was rife, leading to political disinterest and later, outright AIDS denialism.

“On 10 December 1998, we decided enough was enough and launched on the steps of St George’s Cathedral in Cape Town, initially targeting the pharma companies because the access problem was primarily price-driven. We didn’t expect that we’d be fighting our own government, which ended up as the biggest struggle.”

He cited five “quick things,” that helped the TAC succeed.

Launching on International Human Rights Day, the protest message was that access to treatment was a legal and human constitutional right. The second building block was destigmatizing people living with HIV and placing them front and center of the agenda.

“It was difficult wearing those ‘I am HIV positive’ T shirts, but it was the basis for building solidarity.”

A critical factor was treatment literacy. TAC members contacted ACTUP, (the AIDS Coalition to Unleash Power, an international, grassroots political group working to end the AIDS pandemic), asking to be taught the science of HIV so they could educate people.

“Also, we weren’t afraid of confrontation. We weren’t naturally confrontational, but it was a matter of life and death, so we were prepared to organize confrontation – within the law. It was often difficult,” he admitted.

The TAC allied themselves with local scientists and physicians which helped them develop sound policy guidelines – while everybody with AIDS was dying and 70 000 children were being born with HIV each year, most of them perishing within the first two years of life.

“Today close to six million people are on ARV’s while at most one in every 2000 infants is born with HIV, thanks to the prevention of mother to child transmission, PMTCT, drug program.”

The large-scale rollout of HIV/AIDS drugs was directly due to activism pressure, legal action and growing external political pressure.

“This wasn’t flash-in-the pan activism,” Heywood observed.

Session facilitator, Professor Mark Sonderup, a senior hepatology consultant at Groote Schuur Hospital and former doctors’ rights and treatment activist, said a strong theme at the conference was the lack of action on viral hepatitis.

“Inaction now results in a much bigger problem later. We’re still having infections, yet we’re still kicking the can down the road,” he said. Pretoria doctor and viral hepatitis activist, Elaine Saayman, outlined how she formed a public private NGO, diagnosing almost seven hundred people with VH over the last five years and presenting talks to “all sorts of groups.”

“Over the years we’ve treated almost two hundred patients, with a cure rate of 90% and above. We’re often intimidated by the complexity of those who take drugs, but the impact on individual lives is huge and it has a positive snowball effect. People are ignorant, whether they’re urban, peri-urban, or rural, let alone know their own status,” she said. Her crew had refined ways of securing advice from specialists without referral or sending patients to hospital.

“You actually have a better chance in the community than sending them away and making it somebody else’s problem,” she said appealing to delegates to “shine a bit of light in the corner wherever you are. Don’t go away and do nothing. Do just one thing when you get back.”

Yolaan Andrews, Program Manager for Key Populations at NACOSA, (Networking HIV & AIDS Community of Southern Africa, runs a community led, nurse driven harm reduction program for people who inject drugs in Cape Town. Her outfit in Cape Town serves some 7000 people who injected drugs, supported by nurses and physicians – and learns daily from clients.

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Between 14 and 21% of the estimated 75,000 people who inject drugs in South Africa are living with HIV, many of them co-infected with viral hepatitis.

Capetonian, Marius Pedro poignantly shared how he and his brother, lost their brother, to liver cancer in an all-too-common late diagnosis and first presentation.

"He was only 30 and very healthy but was more tired than normal. The local clinic gave him some laxatives and sent him home. However, the pain in his tummy persisted, and his wife insisted he go for a scan. That led to him being told he had liver cancer. It was due to his having chronic hepatitis B infection. He never knew he had hepatitis B. He went downhill rapidly after that. We tried everything - calling overseas as well. He died within a month. We found the Liver Clinic at Groote Schuur who insisted we all be tested. My remaining brother and I tested positive for hepatitis B, and we were treated back to full health. Just a simple blood test saved our lives," he said. We now attend every 6 months for our blood tests and liver scan. "A pill a day keeps the hepatitis B at bay"

Pedro, a former health equipment salesman, said he felt 'very angry' that there was insufficient community awareness of viral hepatitis to enable more lives to be saved.

A former homeless 44-year-old drug injecting addict from Bellville who identified himself only as Werner, told delegates how a mobile needle exchange clinic saved his life. By using methadone as an opioid substitution drug after being convinced to attend the clinic regularly, he was able to get clean.

"On the clinic day you want to go, but you have to have your fix, so you don't. I'd been on OST (opioid substitution therapy) for two years when they checked me for Hep C and I tested positive," he said.

He said he remembered sharing a needle in 2017 "with a guy who told me afterwards that he forgot to tell me he was Hep C positive."

"The next day I started on medication, but the clinics before that discriminated against me. It was like I was being pushed aside because I was a drug addict. I wish I had a camera to record how we were treated."

He said he'd been Hep C negative since 2023. Prof Sonderup said a key thing about marginalised populations was that "for the first time, you're being told you actually matter when somebody says, 'I'm going to treat you.'"

Lifesaving boost for viral hepatitis in Southern Africa

A highlight of the conference was the announcement by an award-winning Zimbabwean industrialist and philanthropist of an unprecedented \$25 million, (R451 m) annual drive to eliminate viral hepatitis, (VH), in sub-Saharan Africa. This will be done by vaccinating all infants in Africa at the time of birth and through the detection of carriers of the hepatitis B and C viruses.

Adam Molai, founder of TRT Investments (manufacturing, bottling, property development and financial services), announced the drive, to be called “Hepbridge,” during the landmark convention on May 18th.

His foundation seeds self-sustaining agricultural projects in Zimbabwe and has helped with several disaster relief efforts.

Africa carries 78% of the annual global viral hepatitis mortality burden – for a disease that’s entirely preventable. Only Egypt has come close to eliminating VH through political will and funding vaccination and awareness campaigns. The continent carries some 602 000 of the 771 000 global VH mortalities– in spite of a single vaccination costing just fifty cents. The disease is transmissible and asymptomatic in its initial stages, making it a silent and deadly killer. It is often passed from mother to unborn child. The lack of detection as children grow-up drives mortality. However, its prevalence can be dramatically reduced by inoculating newborn infants.

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Professor Chris Kassianides, Chairperson of the GFSSA and GHASSA with Emmanuel Luyirika, Chairman of the African Palliative Care Association, and Prof William Jarnagin, of the International Hepato-Pancreato-Biliary Association

Undetected in youths and adults, viral hepatitis progresses to various forms of cancer with an almost 100% fatality rate. Early detection is essential. Lack of individual and population awareness are the biggest challenges, making advocacy, awareness campaigns and detection via screening and testing vital.

Molai told conference delegates that by next year, Africa would have the largest and youngest workforce in the world, with 70% of its population consisting of this youthful demographic.

Viral hepatitis posed a major threat to economic stability and growth, both in Africa and globally, with the continent a major supplier of raw materials needed for products, from cell phones to electric vehicles.

“Who mines our resources or grows our food if not for a healthy young African workforce? There is no business that can survive without customers and employees. If seventy percent of its customers are affected by this scourge and an unhealthy workforce curtails productivity and escalates health costs, it will impact global markets. From what I’ve learnt here, hepatitis kills more than HIV, TB, or Malaria – and yet it lacks comparable funding.”

Molai said he was ‘shattered,’ to learn from epidemiologists and clinicians at the gathering how much of the global hepatitis burden Africa carried – and that only 20% of newborns in the region received the birth vaccination dose for hepatitis B. “I was even more astounded to learn that twice as many children are born with hepatitis than with HIV, yet the focus remains on HIV. These figures are stark, demanding immediate action,” he said.

He said the drive had already engaged with the Global Alliance for Vaccination and Immunisation, (GAAVI), “to see how we can collaborate on the post vaccination journey in the countries we’re covering – as well as covering the 40% of births that happen out of hospitals.”

The countries being considered for the Hepbridge drive are Namibia, Botswana, Zimbabwe, and Mozambique, Malawi, and Zambia.

Founder and chairperson of the GFSSA, Professor Chris Kassianides, said of the Hepbridge drive, “This is a huge breakthrough and will address the apathy that exists with regard to the screening treatment and vaccination of all Africans on the continent.”

The drive has been welcomed and is being strongly supported by the African Union and the New Partnership for Africa's Development (NEPAD).

Palliative care as prevention – Krause

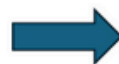
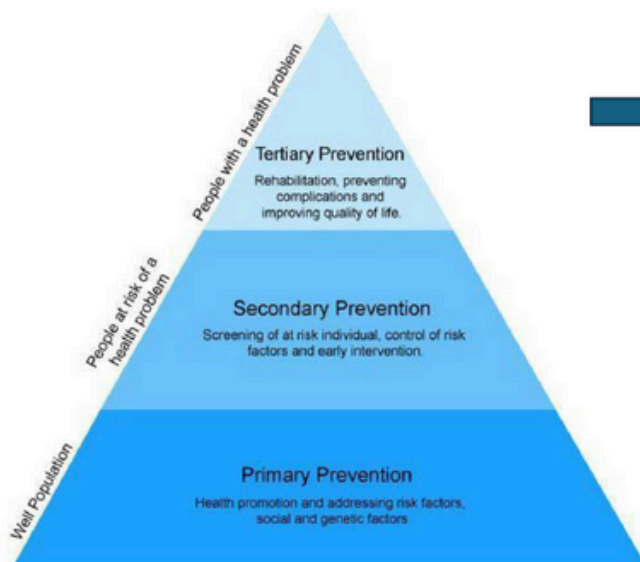
With so many patients progressing from viral hepatitis to end-stage cancers, it is vital to educate their families and partners about infection, especially when HIV/AIDS is involved.

This was said by Professor Rene Krause, a senior lecturer in Palliative Medicine and co-ordinator of Groote Schuur Hospital's Palliative Care Unit. She was chairing a session with Dr Emmanuel Luyirika of Uganda, the Executive Director of the African Palliative Care Association, on, 'the role of palliative care as prevention.'

Krause said patients were often in a tremendous amount of pain after progressing to liver cancer and it required skill to apply preventative measures, "while you are in the eye of the (family) storm." Navigating family dynamics and educating to prevent infection was complex, especially when alcoholism or drug dependence were involved.

"You want to educate the family and the patient, so they don't get it, and work with the family who are also collaborating with the patient. Perhaps there's a partner who's been sexually exposed, especially with HIV. Then there are also often children involved.

Linking palliation to prevention



- Pain and symptom control to improve QOL
- Bereavement care

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**Dr Rene Krause, Head of
Groote Schuur Hospital's
Palliative Care Unit**

"We must ensure we get the guidelines right and work beyond the silo, collaborating with other members of the clinical care team. Often you have limited resources. You have this one chance to educate and prevent," she added. Krause said she constantly worked with pancreatic cancer patients, many of whom had presented late with viral hepatitis, meaning little outside of palliative care could be done for them. Patients were often despondent because they felt the healthcare system had let them down, with nobody having picked up the asymptomatic hepatitis early enough to prevent the ensuing fatal cancer. "That's why at Groote Schuur we start the palliative care for these patients as soon as they're diagnosed. It's a routine part of care. As soon as they are diagnosed with irresectable (non-operable), liver cancer the palliative care starts," she added.

She said the biggest impact on the hepatitis pandemic in Africa would come from integrated preventative and palliative care, the former often exceedingly early in the process, (highly effective new-born vaccination), and the latter during adult end stage disease. "We have to ask how much money we can spend curatively in Africa. The majority of our populations don't have access to complex chemotherapy drugs, nor to expert surgeons, so prevention has to be the way to go," she said.

"We also have to ask ourselves how we deal with that foreign refugee with liver cancer living on the street. How are we supporting them?" she asked. Quoting the WHO 2020 definition of palliative care, she said it was an approach that improved the quality of life of patients and their families, facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Comprehensive family care involved applying the skills required to address risk factors at a highly emotive time.

She shared a standard referral letter to physicians or nursing sisters from a palliative care professional requesting family member care.

It reads, "this patient's relative has been diagnosed with chronic hepatitis B and hepatocellular carcinoma. Please provide screening and linkage to appropriate care. Screening tests for hepatitis B include Hep B surface antigen and Hep B surface antibody. If Hepatitis B surface antigen is positive, please provide linkage to long term care and treatment. If Hepatitis B surface antigen is positive, please provide linkage to long term care and treatment. If both are negative, please provide a three-dose course of Hepatitis B vaccination."

Luyirika spoke on integrating grief and bereavement services in palliative care to improve outcomes for bereaved caregivers. He said inferior quality of death and dying led to poor bereavement outcomes.

The recorded impact on caregivers in his home country, Uganda, included depression, hopelessness, anxiety, blindness, early dementia, a predisposal to non-communicable diseases, loss of income and broken families.

Grief and bereavement were part of palliative care but received less attention. Families, communities, health workers were commonly less equipped. Grief was best expressed within and supported by family and community, he said. Death, dying and bereavement had become medicalised and there needed to be a shift back into the community to support. In the interim, institutions and family centred care fostered family's dependence on the system, so there was a moral imperative to continue care into bereavement.

The complexities of HBV birth-dose vaccination

While securing supplies of birth-dose hepatitis vaccine and garnering financial and political support are major issues, ensuring uptake is complex and challenging, a study of twelve African countries shows.

Tasneem Solomon-Rakiep, a University of Cape Town, (UCT), based health systems and policy researcher says a myriad of inter-connected and complex factors affect uptake, often varying between regions.

She systematically reviewed twenty-eight literature sources in research across Nigeria, Senegal, Uganda, the Gambia, Mozambique, Sao Tome' and Principe, Burkina Faso, Ethiopia, Cote d'Ivoire, Benin, Bolivia, and Botswana, to provide delegates with invaluable insights.

These boiled down to eight "sources of complexity," which she listed as availability and interpretation of Hep B birth-dose vaccination policy, the capacity of Hep B birth dose supply and cold chain systems, the availability of equitable and sustainable financing for Hep B birth dose vaccination programs,

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**Tasneem Solomon-Rakiep,
UCT-based health systems
and policy researcher**

and the capacity of healthcare workers delivering the birth dose vaccination programs. Others were the role of immunization monitoring systems and impaired feedback loops, the influence of context versus system design on the timeliness of Hep B birth dose vaccination, the influence of maternal knowledge and socio-economic factors on timely vaccination dosage and the influence of wider contextual factors, such as home births, on timely Heb B birth dose vaccination.

With over 40% of births in Africa happening at home, this emerged as the top challenge, resulting in the optimal administration of the vaccine within 24 hours of birth seldom being achieved.

Faulty guidelines in both Nigeria and Namibia spoke of “timely” vaccination as being within two weeks of birth, while the observed average age of Hep B birth dose in Nigeria ranged between six days to five weeks across several studies. Unfortunately, and perhaps predictably, once the guideline was amended to emphasize the importance of administering the vaccine within 24 hours, coverage declined.

Further misinterpretation resulted in limited administration of the vaccine beyond 24 hours (two subsequent doses being WHO recommended). Solomon Rakiep said guidelines and policies should be clear and coupled with appropriate training to enhance understanding.

She said her review showed that healthcare workers had a good awareness of viral hepatitis, but HBV-specific knowledge was ‘largely lacking.’ In Senegal, a study among healthcare workers in antenatal clinics revealed that only 47%, had received HBV-specific training.

Only fifty one percent of medical practitioners in that country thought it safe to administer vaccines to newborns and labored under misconceptions around infertility (48%) and neurological disorders (37,8%).

In Nigeria, although 92% of women attended antenatal care, (ANC), clinics, only 57% received any information about HBV, despite nurses and ANC visits being their main sources of information. Similarly, in Uganda mothers preferred getting Hep B information at their ANC consults rather than over electronic media. A Nigerian study found that mothers who attended ANC clinics were ten times more likely to present for timely Hep B birth dose vaccination.

Solomon Rakiep said accessibility of services had a significant influence on uptake with allocation of only certain days in the week to vaccination a problem. In Senegal and Nigeria timely institutional delivery of vaccines meant newborns were 1,6 times and six times more likely to get a timely, and thus more effective, dose.

Nigeria saw half of all births overseen by traditional birth attendants at home where just 30% of infants received the Hep B dose compared to seventy five percent with hospital deliveries.

However, the Gambia boasted comparatively greater success in traditional home birth dosing versus hospital delivery vaccination, (29,8% to 40,3%).

The cultural practices of post birth isolation of mother and child for seven days in Nigeria and The Gambia and of waiting seven days before circumcising male infants were also barriers to effective implementation. Religion and ethnicity also influenced birth practices; Solomon Rakiep told the conference.

Rationale and Research Focus



- The WHO 2024 Global Hepatitis Report states viral hepatitis is now the second leading cause of infectious disease deaths globally.
- The WHO African Region (WHO AFRO) bears **63% of new hepatitis B** infections, despite this, **only 18% of newborns** in the region receive the hepatitis B birth-dose vaccination.
- The current prevalence among under 5-year-olds in **WHO AFRO of 2,5% surpasses the global average more than 2-fold (0,9%)**.
- Without urgent intervention, the region is on course to have one of the **highest prevalence of chronic HBV** compared to all other regions of the world.
- Exploring the complexities leading to poor uptake and performance of hepatitis B birth-dose vaccination programs in WHO AFRO is pertinent to curbing the epidemic in the region.

The 2024 African Viral Hepatitis Convention Declaration of Cape Town

We, those present and today assembled on the 18th May 2024, affirm the following:

In April 2024, the WHO updated its Global Viral Hepatitis Report and for Africa noted:

1. Almost 2/3rds or 63% of the global burden of hepatitis virus infection now occurs in Africa
2. 771 000 new hepatitis B and 172 000 new hepatitis C virus infections will occur this year in Africa
3. 272 000 will die from hepatitis B, and 35 000 from hepatitis C in 2024 alone
4. Children below the age of 5 will still not reach the <0.1% hepatitis B seroprevalence target
5. Liver cancer rates continue to rise – now the 3rd leading cancer in men
6. Only 18% of babies received a hepatitis B birth dose vaccination and PMTCT programs are minimal.

This is happening:

1. 45 years after the availability of the hepatitis B vaccine
2. With the youngest population worldwide, only 13 African countries having introduced a universal hepatitis B birth dose vaccination policy and 2 countries targeted hepatitis B birth dose vaccination
3. Globally available and affordable hepatitis B treatment
4. 10 years after the availability of highly effective cure for hepatitis C
5. 28 countries have developed a national hepatitis strategic plan for viral hepatitis; but most are still in draft form with only 13 officially published and disseminated.
6. 5 years after the African Union endorsed the **Cairo Declaration on Viral Hepatitis in Africa**

PEOPLE ARE STILL DYING! As a community of people living with viral hepatitis, advocates for those living with viral hepatitis, healthcare workers, academics and those who simply care, we say **NO MORE!**

All the tools to eliminate viral hepatitis are available and are uncomplicated interventions. In 2016, our global leaders signed up to eliminate viral hepatitis as a public health threat by 2030. Africa is among the regions lagging and will miss out in achieving the target of testing 90% people with viral hepatitis and treating 80% of diagnosed individuals. We know it can be done. When there is political will there is a way! Egypt, Rwanda, Namibia, and Mauritius, amongst others, have shown us the way and are beacons of hope, leading the way forward.

Our leaders lack the political will. Our leaders have failed us by not demonstrating that they truly care

We say No more silence!

We say No more marginalization!

We say No more barriers to implementation!

We say No more excuses!

We say No more to a lack of domestic funding!

We say No more to any care without a patient centered approach!

Viral hepatitis is a silent disease that kills – we will be silent no more!! Silence = Complicity. Silence = Death

We demand:

1. To be heard and to be seen
2. The immediate prioritization of national elimination plans (National Strategic Plans) – vaccinate – prevent – screen – treat!
3. The immediate allocation of the needed resources and domestic funding
4. No more talking – we need African action
5. The political will and commitment to institute policy and remove discrimination.

2 great African leaders once said, “It always seems impossible until it's done” (Nelson Mandela) and “It can be done, play your part”! (Mwalimu Julius Nyerere Kambarage).

Eliminating viral hepatitis is not impossible – and it can and will be done in Africa. We reaffirm ourselves to the struggle today!



Faculty of Health Sciences
Department of Family Medicine



GREAT LAKES PEACE CENTER

