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Prevention, Screening and Treatment of HIV and Hepatitis C in Burkina Faso (2013-2024): Progress towards Eradication

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Abstract

Background: Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) represent a major public health challenge in Burkina Faso due to their high morbidity and mortality rates among the working-age population. To limit their impact, national strategies have been implemented, including awareness campaigns, screening, subsidized treatment, and prevention of mother-to-child transmission. **Objective:** To analyze the epidemiological trends of HIV and HCV from 2013 to 2024, with a view to strengthening control strategies and improving the medical care of patients. **Methods:** A retrospective cross-sectional study was conducted between 2013 and 2023 among adult male and female patients who presented at the CERBA (Center for Research and Evaluation in Health and Social Care) for HIV and/or HCV screening. In addition, a prospective study was conducted in 2024 during a community-based HIV and HCV screening campaign in Ouagadougou, using rapid tests. Data analysis was performed using SPSS version 20.0 and EpiInfo 7. Results were considered statistically significant for a p-value < 0.05. The sociodemographic and epidemiological data collected were analyzed to highlight the main epidemiological trends. **Results:** The study included 2,576 patients, of whom 1133 were women (44.0%) and 1443 were men (56.0%), with a mean age of 30.1 ± 10.8 years. Between 2013 and 2024, the overall observed seroprevalence was 2.1% (53/2576) for HIV and 3.4% (87/2576) for HCV. A statistically significant de-

crease was observed for both infections. The prevalence of HIV decreased from 2.2% (14/630) in 2013 to 1.5% (10/663) in 2024, as described by linear regression ($y = -0.154x + 2.55$). Similarly, HCV prevalence decreased from 4.3% (27/630) in 2013 to 1.4% (9/663) in 2024, according to a linear regression ($y = -0.899x + 5.63$). First-line antiretroviral therapy dominates HIV management (83.44%) in Burkina Faso, while second-line regimens remain essential in cases of resistance. Furthermore, pangenotypic direct-acting antivirals (DAAs) are effective against HCV regardless of genotype, rapidly suppressing viral load and confirming their therapeutic superiority. **Conclusion:** To achieve the goals set by the WHO, it is necessary to strengthen screening strategies, intensify prevention measures among at-risk populations and ensure optimal care, based on antiretrovirals for people living with HIV and on pangenotypic direct-acting antivirals for patients infected with HCV.

Keywords

HIV/AIDS, Hepatitis C, Antiretrovirals, Direct Acting Antivirals (DAAs), Burkina Faso

1. Introduction

Human immunodeficiency virus (HIV) and hepatitis C virus (HCV) represent two of the world's major infectious threats, responsible for severe health and socioeconomic consequences. Together, they cause more than 1.4 million new infections each year [1] [2]. Since its emergence in the early 1980s, HIV has spread exponentially, particularly in sub-Saharan Africa, the region that now accounts for the majority of cases. In 2022, UNAIDS estimated that 39 million people were living with HIV, 54% of whom were women, while 630,000 deaths were attributed to the infection [3]. Despite therapeutic advances, only 75% of patients had access to treatment in 2021, which contributes to continued transmission and mortality [4].

Hepatitis C, meanwhile, remains a major chronic viral infection, affecting approximately 70 million people worldwide and causing nearly 399,000 deaths annually [5]. The lack of vaccination and the high risk of progression to cirrhosis or hepatocellular carcinoma (HCC) make it a major public health problem [6]. Although direct-acting antivirals now allow for a cure in 95% of cases, access to testing and treatment remains limited in many resource-constrained countries.

In Burkina Faso, studies conducted between 2003 and 2024 have shown HIV seroprevalence rates varying from 1.8% [7] at 2.5% [8] among blood donors, and from 4.8% [9] to 10.6% [10] in pregnant women. Regarding the hepatitis C virus (HCV), seroprevalence ranged from 3.3% [10] to 6.1% (26/429) [11] [12] in pregnant women, while it was between 3.9% [13] and 4.4% [7], which can reach 6.9% [14], in blood donors. Thus, nearly 7% of people infected with HIV are also co-

infected with HCV [10]. A synergistic interaction of infections is observed between HIV and HCV. Thus, the hepatitis C virus tends to promote its co-infection with HIV and vice versa; this would explain the strong correlation observed between these two viruses. Furthermore, HIV and the hepatitis C virus share similar modes of transmission, particularly through blood: transfusion, sharing of injection equipment, tattooing, scarification, excision with contaminated instruments, or occupational exposure to blood [15]. The lack of a vaccine against these two infections makes early screening, awareness and access to treatments crucial to limit transmission and prevent serious complications, with a view to eradication by 2030 according to WHO recommendations.

Despite the efforts of health authorities and strategic plans aligned with the WHO's 2030 goals—aiming for the elimination of HIV and a 90% reduction in chronic HCV cases [12]—the persistence of these infections in sub-Saharan Africa, where 25.6 million people live with HIV and 11 million with HCV [16], underlines the urgency of continued surveillance.

In this context, the present study, entitled "*Prevention*, *Screening*, *and Treatment of HIV and Hepatitis C in Burkina Faso* (2013-2024): *Progress towards Eradication*," aims to analyze the evolution of the prevalence of these two infections in Burkina Faso over an eleven-year period. The objective was to analyze the epidemiological trends of HIV and HCV from 2013 to 2024, with a view to strengthening control strategies and improving the medical care of patients.

2. Methodology

2.1. Study Type and Population

This retrospective cross-sectional study analyzed data collected between 2013 and 2023 at the Pietro Annigoni Biomolecular Research Center (CERBA) in Ouagadougou. It included all individuals tested for HIV and HCV, regardless of gender, status, or diagnostic context. In addition, a prospective study was conducted in 2024 as part of a community-based HIV and HCV screening campaign in Ouagadougou. Participants in World Hepatitis Day underwent serological screening for HIV and HCV, performed as part of premarital, prenatal, or ongoing therapeutic monitoring.

2.2. Data Collection

The data were collected from information available in the CERBA databases, as well as during viral hepatitis and HIV prevention and screening campaigns. The variables studied included sex, age, and serological results related to HIV and hepatitis C virus (HCV).

2.3. Laboratory Analyses: Serological and Molecular Diagnosis of HIV and HCV

A venous blood sample was taken from each participant. Five milliliters were collected, one in a dry tube and the other in a tube containing EDTA. After centrif-

ugation of the samples at 3000 rpm for 10 minutes, the resulting plasma or serum was used for laboratory analyses. When these analyses were not performed on the same day, the samples were stored at −20˚C or −80˚C. Additionally, whole blood stains were recorded on dried-type paper. Blood spot (DBS) samples were prepared and stored at room temperature. Whole blood was also stored at −80˚C for subsequent molecular biology analyses. Between 2013 and 2024, immunology reagents and automated systems underwent significant developments, leading to the gradual replacement of many diagnostic reagents used at the beginning of the study period.

2.4. HIV Screening

HIV serological screening of patients was performed using two rapid tests: Determine® (Abbott Laboratories, Tokyo, Japan) and SD Bioline (Standard Diagnostics, Inc., Korea). In cases of discordant results between these two tests for the same individual, a third confirmatory test was immediately recommended, in accordance with the national algorithm. For this step, the ImmunoComb®II HIV-1&2 Bispot kit (Orgenics, Yavne, Israel) was used [17]. Currently, when uncertainties persist after the use of these three tests, the sample in question is sent either to the Cobas 6000 analyzer for the "Elecsys HIV combi PT" test (Roche Diagnostics GmbH, Mannheim, Germany), which allows for the simultaneous detection of HIV-1 p24 antigen, anti-HIV-1 and anti-HIV-2 antibodies, or to a qualitative analysis by polymerase chain reaction (PCR). DNA extraction from dried blood spots (DBS) were detected using the QIAamp DNA Blood Mini Kit (QIAGEN, Hilden, Germany), according to the manufacturer's instructions. HIV-1 proviral DNA detection was then performed using the Applied system. Biosystems GeneAmp® PCR System 9700 associated with the "Generic HIV DNA Cell" kit (Biocentric, Bandol, France), following the protocol recommended by the manufacturer.

2.5. Screening for Hepatitis C

Screening for hepatitis C virus (HCV) was performed using the Elecsys kit Anti-HCV II (Roche Diagnostics GmbH, Mannheim, Germany). If necessary, a further analysis by qualitative polymerase chain reaction (PCR) was performed.

2.6. Data Analysis

The data were compiled using Microsoft Excel 2016 software. Statistical analyses were performed with SPSS version 20.0 and EpiInfo7. A p-value less than 0.05 was considered statistically significant.

2.7. Ethical Considerations

The HOSCO/CERBA Institutional Ethics Committee approved this study by Resolution No. 2024-07-CE dated May 15, 2024. The confidentiality and anonymity of information from patient registers and files were rigorously respected.

3. Results

3.1. Sociodemographic Characteristics

The study population comprised 2576 participants, including 1133 women (43.98%) and 1443 men (56.02%). The subjects' ages ranged from 2 to 72 years, with a mean of 30.05 ± 10.78 years. The 15 - 29 age group represented the largest proportion, at 56.17% (1447/2576) of the sample (Table 1).

3.2. Burden of HIV and Hepatitis C

In the population studied from 2013 to 2024, the HIV prevalence was 2.06% (53/2576), with a mean age of 35.43 ± 4.19 years (Table 2). For hepatitis C virus (HCV), a prevalence of 3.38% (87/2576) was observed, associated with a mean age of 29.08 ± 9.91 years. Statistical analysis revealed no significant difference between HIV-infected and uninfected individuals (p = 0.392), nor between subjects with hepatitis C and those without (p = 0.395); Table 2.

Table 1. Sociodemographic characteristics of the population from 2013 to 2024.

Age groups (years)	N	%	Men	%	Women	%	Average ages	P
<15	30	1.16	14	46.67	16	53.33	7.27 ± 4.73	0.732
15 - 29	1447	56.17	799	55.21	648	44.78	23.07± 3.38	<0.0001
30 - 44	812	31.52	461	56.77	351	43.23	35.43± 4.19	<0.0001
45 - 59	244	9.47	143	58.60	101	41.40	49.97 ± 4.12	0.008
>59	43	1.67	26	60.47	17	39.53	66.14 ± 5.21	0.191
Total	**2576**	**100**	**1443**	**56.00**	**1133**	**44.00**	**30.05±10.78**	**0.427**

Table 2. HIV and HCV test results according to patients' average ages.

	N	%	Middle ages	P
HIV				
Negative	2523	97.94	30.02 ± 10.75	0.392
Positif	53	2.06	31.30 ± 11.74	
Total	2576	100.00	30.05 ± 10.78	
HCV				
Negative	2489	96.62	30.08 ± 10.80	0.395
Positif	87	3.38	29.08 ± 9.91	
Total	2576	100.00	30.05 ± 10.78	

The prevalence of HIV was estimated at 3.19% (11/345) in individuals aged 45 - 59 years, while no cases were identified in children under 15 years of age (0%). Regarding hepatitis C virus (HCV), a significant prevalence of 4.10% (10/344) was observed in the 15 - 29 and 45 - 59 age groups. Furthermore, the prevalence of

HIV was slightly higher in women (2.21%, 25/1133) than in men (1.94%, 28/1443). Conversely, hepatitis C showed a male predominance of 3.60% (52/1443) compared to a female prevalence of 3.09% (35/1133) (Table 3).

The 2024 HIV and hepatitis C virus (HCV) screening campaign included a total of 663 participants, comprising 289 women and 374 men. The mean age of the study population was 37.24 ± 13.54 years. The results revealed a seroprevalence of 1.51% for HIV and 1.36% for HCV (Table 4).

Table 3. Prevalence of HIV and HCV by age group and sex from 2013 to 2024.

Age groups (years)	Sex	HIV				HCV			
		Total	Nég	Pos	%	Total	Nég	Pos	%
<15	F	16	16	0	0	16	16	0	0
	M	14	14	0	0	14	14	0	0
	Total	**30**	**30**	**0**	**0**	**30**	**30**	**0**	**0**
15 - 29	F	648	637	11	1.70	648	623	25	3.86
	M	799	781	18	2.25	799	765	34	4.25
	Total	**1447**	**1418**	**29**	**2.00**	**1447**	**1388**	**59**	**4.08**
30 - 44	F	351	342	9	2.56	351	344	7	1.99
	M	461	453	8	1.73	812	794	18	2.22
	Total	**812**	**795**	**17**	**2.09**	**1163**	**1138**	**25**	**2.15**
45 - 59	F	101	96	5	4.95	101	98	3	2.97
	M	244	238	6	2.46	143	136	7	4.89
	Total	**345**	**334**	**11**	**3.19**	**244**	**234**	**10**	**4.10**
59	F	17	17	0	0	17	17	0	0
	M	43	42	1	2.32	43	43	0	0
	Total	**60**	**59**	**1**	**1,66**	**60**	**60**	**0**	**0**
Total	F	1133	1108	25	2,21	1133	1098	35	3,09
	M	1443	1415	28	1,94	1443	1391	52	3,60
	Total	**2576**	**2523**	**53**	**2,06**	**2576**	**2489**	**87**	**3.38**

Table 4. Sociodemographic characteristics of participants in the 2024 HIV and HCV screening campaign.

	Negative	Positive	Total	P
HIV	653 (98.49%)	10 (1.51%)	663 (100.00%)	
HCV	654 (98.64%)	9 (1.36%)	663 (100.00%)	
	Female	Male	Total	P
Sex	289 (43.6%)	374 (56.4%)	663 (100.00%)	
Age (years)	36.44 ± 13.98	37.85 ± 13.18	663 (37.24 ± 13.54)	

Regarding co-infection, the analysis included a total of 2576 individuals who simultaneously underwent HIV and HCV screening tests. The proportion of HIV+/HCV+ co-infection observed in this population was 0.39% (10/2576) (Table 5).

Among 2576 samples analyzed between 2013 and 2014 in this study, 53 positive cases were identified. The majority involved HIV-1 (50 cases, 94.34%), followed by two cases of HIV-2 (3.77%) and one case of HIV-1/HIV-2 co-infection (1.89%). These findings highlight the predominance of HIV-1 in the studied population (Table 5).

Table 5. Co-infection rates among 2576 HIV-positive and HIV-negative individuals from 2013 to 2024.

	Test	HCV		Total
		-	+	
HIV	–	2446 (94.95%)	77 (2.99%)	2523
	+	43 (1.67%)	10 (0.39%)	53 (2.06%)
Total		2489	87 (3.38%)	2576

In this study, the evolution of HIV and HCV prevalence was modeled using two linear equations (Figure 1). Between 2013 and 2020, HCV prevalence showed a moderate decrease, from 4.29% to 3.84%, before experiencing a more pronounced decline to 1.51% in 2024. Regarding HIV, a slight increase was observed during the period 2013-2020 (from 2.22% to 2.76%), followed by a significant reduction to 1.36% in 2024 (Figure 1). Although year-to-year fluctuations were observed, the overall trend in HIV prevalence from 2013 to 2024 shows a progressive decrease.

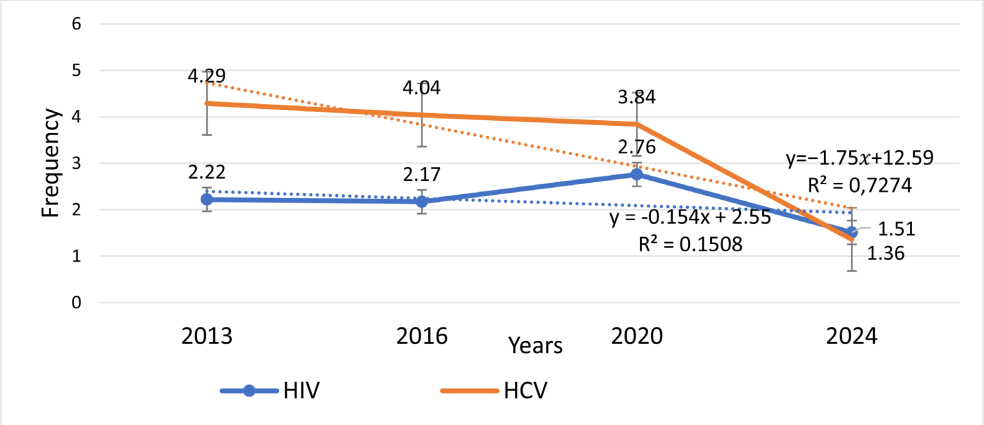

Figure 1. Graph showing the evolution of HIV and HCV prevalence rates from 2013 to 2024.

3.3. Pharmacotherapy of HIV Infection

The results of this research highlight the predominance of first-line treatments in the management of HIV-positive patients (83.44%), compared to 16.56% for sec-

ond-line regimens. This distribution is consistent with Burkina Faso national data, which confirms the efficacy and accessibility of initial therapies, while emphasizing the essential role of second-line regimens in cases of resistance or treatment failure (Ministry of Health, 2023; CNLS, 2021-2025; WHO, 2025). This distribution reflects the satisfactory efficacy and accessibility of initial therapies, while underscoring that second-line treatments remain essential for patients experiencing treatment failure or drug resistance (Table 6).

Table 6. Current status of therapeutic treatment for HIV-positive patients

Triple therapy	Men		Women		TOTAL	Percentage
	1st line	2nd line	1st line	2nd line		
TDF/3TC/DTG	224	24	738	91	1077	91.43
AZT/3TC + DTG	04	04	17	15	40	3.40
TDF/3TC + DTG	-	01	-	02	03	0.25
ABC/3TC + DTG	-	13	-	17	30	2.54
ABC/3TC/DTG	-	06	-	11	17	1.44
ABC/3TC + ABC + DTG	-	02	-	03	05	0.43
TDF/3TC/DTG + DTG	-	02	-	04	06	5.10
Total	**228**	**52**	**755**	**143**	**1178**	**100.00**
Pourcentage	19.34	4.41	64.1	12.14	100	**100.00**

3.4. Medical Treatment According to HCV Genotype and Viral Load

Like HIV infection, now controlled by antiretroviral therapy, hepatitis C virus (HCV) infection can be effectively managed with direct-acting antivirals (DAAs). The results of this study highlight the remarkable efficacy of these molecules in treating HCV, regardless of viral genotype and initial viral load in Burkina Faso [18]. Analysis of viral kinetics at 12 and 24 weeks shows that the combinations of sofosbuvir/daclatavir and sofosbuvir/velpatasvir induce complete viral suppression by week 12. This rapid virological response confirms the superiority of DAAs over previous treatment regimens and underscores their central role in the HCV eradication strategy (Table 7).

4. Discussion

The World Health Organization (WHO) has established a global health strategy for the period 2022-2030, aimed at intensifying the international response to the human immunodeficiency virus (HIV) and the hepatitis C virus (HCV). This roadmap commits Member States to developing and implementing specific strategic interventions with the goal of achieving eradication or, failing that, a significant reduction in the prevalence of these infections by 2030 [3]. Within this framework, the present study focuses on analyzing the epidemiological trends of

Table 7. Median viral load results of patients presented according to the regimen and at weeks 0, 12 and 24 on treatment [18].

Treatment regimen	Viral load results (UI/mL)					
	Genotype 1			Genotype 2		
	W0	W12	W24	W0	W12	W24
Daclatasvir + Ribavirine (*n*)	61,945 (8)	Undetectable	Undetectable	*Molecule not used for this genotype*		
Interferon (*n*)	*Molecule not used for this genotype*			1,387,331 (10)	Undetectable	Undetectable
Ledispavir + Sofosbuvir (*n*)	1,444,201 (10)	Undetectable	Undetectable	1,141,602 (15)	512,340 (10)	Undetectable
Sofosbuvir + Daclatasvir (*n*)	*Molecule not used for this genotype*			719,436 (5)	Undetectable	Undetectable
Sofosbuvir + Ribavirine (*n*)	*Molecule not used for this genotype*			1,124,987 (46)	12 (5)	Undetectable
Sofosbuvir + Velpatasvir(*n*)	8011 (5)	Undetectable	Undetectable	2,163,767 (66)	Undetectable	Undetectable

Legend: W0: median viral load before the start of treatment; W12: median viral load 12 weeks after treatment; W24: median viral load 24 weeks after treatment, n: number of individuals.

HIV and HCV in order to contribute to the suppression or substantial reduction of their incidence within the affected populations.

4.1. The HIV Prevalence Rate and Its Evolution from 2013 to 2024

The analysis revealed a fluctuating trend in HIV prevalence over the past twelve years. This has ranged between 1.8% and 10.6% over the period 2003-2022 [12] and is consistent with the prevalence rates reported by Simpore *et al.* (2005) and Yooda *et al.* (2015), who found 7.79% respectively in pregnant women [11] and 1.8% among blood donors [7]. The observed decrease could be attributed to the effects of awareness and screening campaigns, as well as increased initiation of and adherence to antiretroviral therapy. The 2024 value is consistent with regional estimates, which indicate an average prevalence of 1.4% in West Africa [19]. UNAIDS data for 2021 report prevalences of 1.1% in Liberia and 1.3% in Nigeria [20]. Comparatively, these rates remain lower than those observed in Kenya (4.9%) [21] and the Congo (5.5%) [22], but higher than those reported in Mali (0.33%) [23] and Morocco (0.015%) [24]. Among the 53 HIV-positive samples analyzed, 50 (94.34%) were identified as HIV-1, two (3.77%) as HIV-2, and one (1.89%) as a case of HIV-1/HIV-2 co-infection. These results corroborate data from the literature, which highlight the predominance of HIV-1 and the rarity of HIV-1/HIV-2 coinfections. Studies conducted in Senegal (90% HIV-1) [25], Benin (97.6% HIV-1) [26], and Mali (94.64% HIV-1) [27] confirm this trend. The observed prevalence was 1.9% in men and 2.2% in women. This overrepresentation of women is also reported in other studies, notably in Togo [28] and Mozambique [29], and could be explained by factors related to gender norms and sexual violence. Finally, a peak in seroprevalence was observed in the 45-59 age group (3.2%). For comparison, the Demographic and Health Survey of Burkina Faso (2010) [30] as well as the work of Zoungrana *et al.* in Mali (2017) [31] and of Téclessou *et al.* in Togo (2017) [28] highlighted a notable increase in cases in the 30-34 age group. Data

analysis reveals a progressive decrease in HIV prevalence over the study period. This was estimated at 2.22% in 2013; 2.17% in 2016; 2.76% in 2020 and 1.36% in 2024. Statistical modeling established a linear relationship represented by the equation $y = -1.75x + 12.59$. The divergence in studies could be related to the retrospective nature of the present study, the study population, the sample size, the test kits and laboratory techniques used, which may indeed partially explain these differences in results.

4.2. HCV Prevalence Rate and Its Evolution from 2013 to 2024

Similar to HIV, the prevalence of HCV did not show a statistically significant decrease between 2013 and 2024. It was estimated at 4.29% in 2013, 4.04% [32] in 2016, 3.84% in 2020, and 1.51% in 2024. These results are consistent with those reported by other authors, who found prevalences of 3.3% [10], 3.6% [33], and 4.4% [32] [7]. Conversely, some studies reported higher rates, namely 6.07% [11], 8.5% [15], and 8.69% [34], while Simpore A. *et al.* 2022 observed a lower prevalence of 2.8% [35]. Similarly, as with HIV, the studied population, sample size, testing kits, and laboratory techniques used may partly explain these differences in results. Furthermore, the study is based on the combination of retrospective clinical data (2013-2023) and community-based screening data collected in 2024. While this complementary approach enhances the analysis, it may also introduce differences in demographic profiles and risk levels between the populations considered, which could affect the representativeness of the findings. In addition, the diagnostic reagents used for HIV and HCV screening evolved over the study period. All tests performed complied with national performance standards, and any discordant HIV or HCV results were systematically confirmed by PCR. Nevertheless, variations in the sensitivity or specificity of the reagents employed may have contributed to the fluctuations observed in positivity rates. These aspects should be acknowledged as a methodological limitation of the study.

4.3. Perspective for Strengthening Control Strategies and Improving the Medical Management of Patients

To date, no resistance-associated substitutions (RAS) have been identified in Burkina Faso. In this perspective, promoting access to innovative treatments—particularly pan-genotypic direct-acting antivirals (DAAs) such as the Sofosbuvir/Daclatasvir and Sofosbuvir/Velpatasvir combinations against the hepatitis C virus—represents a strategic orientation of high therapeutic value. Furthermore, first- and second-line antiretroviral regimens [TDF (Tenofovir disoproxil fumarate)/3TC (Lamivudine)/DTG (Dolutegravir)] [AZT (Zidovudine)/3TC (Lamivudine) + DTG (Dolutegravir)], and [ABC (Abacavir)/3TC (Lamivudine) + DTG (Dolutegravir)] represent essential pillars in the fight against HIV and in improving the medical management of patients in Burkina Faso. Antiretroviral therapy (ART) remains the most effective strategy for controlling HIV-1 infection by suppressing viral replication in infected individuals, provided that resistance

mutations are absent [36]. However, despite this effectiveness, ART does not eliminate infected cells for life. The persistence of HIV in cellular reservoirs, veritable viral sanctuaries, constitutes a major obstacle to its complete eradication in infected individuals [36] [37]. Indeed, this retrovirus persists within CD4+ T lymphocytes, macrophages, and dendritic cells located in hard-to-reach anatomical sites such as lymph nodes, intestinal lymphoid tissue (GALT), the central nervous system (microglia), and the genital organs. However, the emergence of nanoparticles as vectors for innovative pharmaceutical products opens up promising therapeutic perspectives, likely to target these viral sanctuaries more effectively and overcome the limitations of conventional approaches [38].

5. Conclusion

The progress made in Ouagadougou between 2013 and 2024 highlights the major impact of strengthening screening and expanding access to innovative treatments—particularly pangenotypic direct-acting antivirals (DAAs). such as the sofosbuvir/daclatasvir and sofosbuvir/velpatasvir combinations for HCV, as well as first- and second-line antiretrovirals (TDF/3TC/DTG, AZT/3TC + DTG, and ABC/3TC + DTG)—and the implementation of prevention strategies adapted to local realities. These advances demonstrate that global public health goals—such as the 95-95-95 target for HIV and the Global Health Sector Strategy aiming for a 90% reduction in chronic viral hepatitis and HIV cases by 2030—are now within reach, provided that efforts are maintained and intensified. Consolidating these gains requires continued investment in epidemiological surveillance, monitoring of viral resistance, and scientific research, coupled with universal health coverage and enhanced psychosocial support. The integration of community-based interventions and the promotion of safe practices are also essential levers for ensuring the sustainability of the results achieved. In this context, Ouagadougou appears as a promising model in sub-Saharan Africa, demonstrating that the eradication of HIV and Hepatitis C is no longer just a scientific ambition, but a realistic public health objective.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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