# 3rd EU HCV Policy Summit

## Securing Wider EU Commitment to the Elimination of HCV


#HCVSummit

@HepBCPPA

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**#HCVSummit**

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# Welcome and introductory comments

**Chairs:**
**Prof Heiner Wedemeyer, Co-Chair HepBCPPA and Hannover Medical School, Germany**
**Prof George Papatheodoridis, Co-Chair HepBCPPA and University of Athens Medical School, Greece**

EUHCV
Policy Summit - 24.03.2021
Online event

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# Prof Heiner Wedemeyer

**Co-chair HepBCPPA and Hannover Medical School, Germany**

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# Prof George Papatheodoridis

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# Prof Maria Buti

## EU Policy Councillor, The European Association for the Study of the Liver


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# EASL HCV initiatives

Maria Buti MD

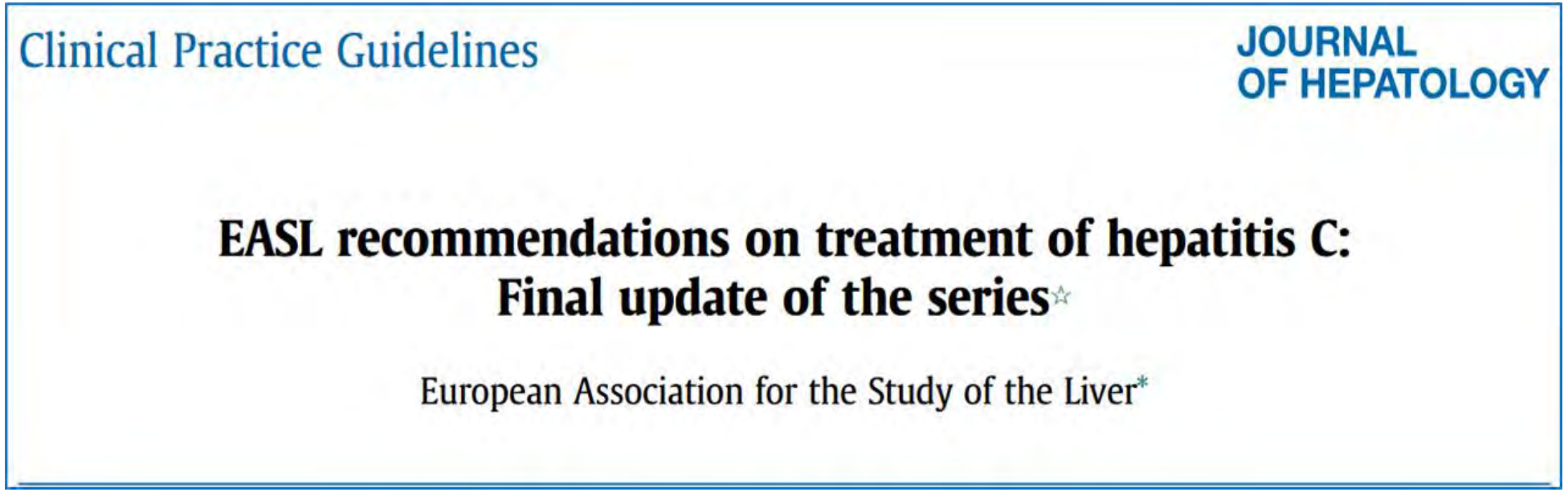
EASL Policy and Public Health Chairperson

# EASL HCV initiatives

- Healthcare professionals
- Policy makers
- Patients
- Healthcare systems
- National associations
- HCV partners

# Initiatives for healthcare professionals

- **ILC 2021: WHO - eCDC- CDC - EASL joint symposium on viral hepatitis elimination**
- **EASL Clinical practice guidelines**



# AT AN INTERNATIONAL LEVEL
# Call to Action for HCV Elimination

- **Simplification** of diagnosis and treatment in 1 single step
- **Integration** of HCV treatment with:
  - Primary care
  - Programs of other pathologies (TB, HIV, ...)
  - Hard-to-reach settings (damage reduction)
- **Decentralization** of HCV services
- **Share care chores** with other healthcare professionals


AASLD
AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES

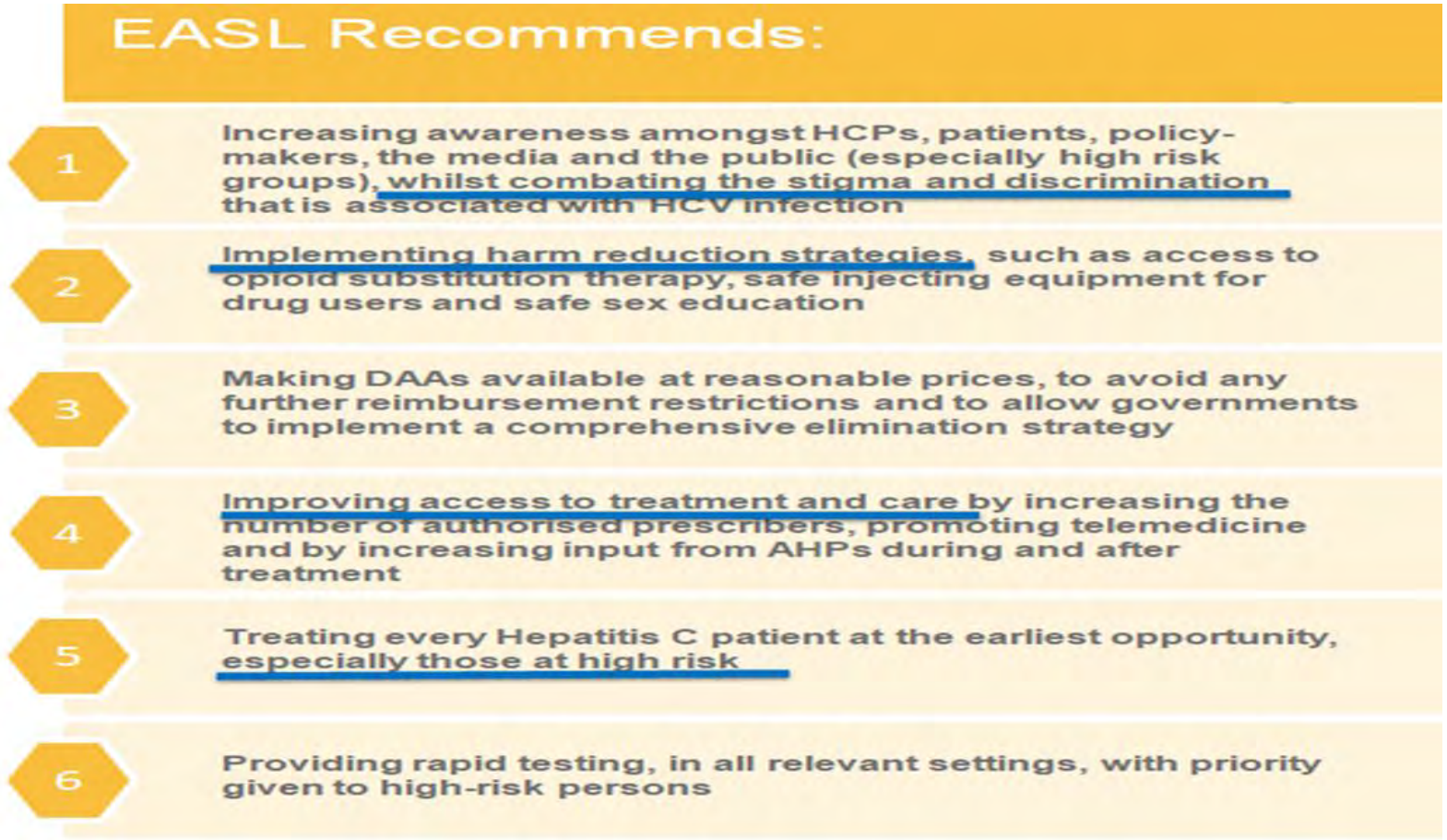
EASL
The Home of Hepatology

The Asian Pacific Association For The Study of Liver

ALEH
ASOCIACION LATINOAMERICANA PARA EL ESTUDIO DEL HIGADO | ASSOCIAÇÃO LATINO-AMERICANA PARA O ESTUDO DO FÍGADO

# Initiative for policy makers and patients

➢ **EASL Eliminating Hepatitis C – an action plan:**



# Initiative for policy makers and patients

- **EASL Policy statement on drug use and global hepatitis elimination goal**

# Initiatives with patient groups

- **EASL Patient Forum**
- **Declaration of support of EASL policy statement on drug use**


ELPA European Liver Patients' Association

Correlation European Harm Reduction Network

INPUD International Network *of* People *who* Use Drugs

GLI GLOBAL LIVER INSTITUTE

Faculty of Medicine Ain Shams University

Liver Patients International

World Hepatitis Alliance

# Initiatives with partners

- **EASL support to the EURO-TEST survey on Impact of the COVID-19 on linkage to and retention in care for HIV, hep B and C and sexually transmitted infections in the WHO European Region**
- **EASL support to the CGHE Global survey on the impact of COVID-19 response on hepatitis prevention care and treatment**

## Hepatitis Elimination countdown clock

# EASL Special Conference on Hepatitis Elimination in Brussels

➢ **Save the date : 23- 25 February 2022 -**

THANK YOU

Follow EASL: @EASLnews and @EASLedu

# Mr George Kalamitsis

## Co-Chair, ACHIEVE Coalition and Chair, Liver Patients International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# ACHIEVE COALITION

## George Kalamitsis, ACHIEVE Co-Chair

ACHIEVE

ASSOCIATIONS COLLABORATING ON HEPATITIS TO IMMUNIZE AND ELIMINATE THE VIRUSES IN EUROPE

The ACHIEVE coalition is enabled by the support of AbbVie, Abbott, Cepheid and Gilead Sciences

# Dr Antons Mozalevskis

## WHO Europe


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# Mr Petros Kokkalis

## Member of the European Parliament (MEP), Greece


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EUHCV

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**Third EU HCV Virtual Policy Summit**

**“Securing Wider EU Commitment to the Elimination of HCV”**

PETROS KOKKALIS
Member of the European Parliament

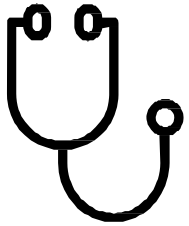
ΣΥΡΙΖΑ ΠΡΟΟΔΕΥΤΙΚΗ ΣΥΜΜΑΧΙΑ

GUE/NGL THE LEFT IN THE EUROPEAN PARLIAMENT

ΚΟΣΜΟΣ

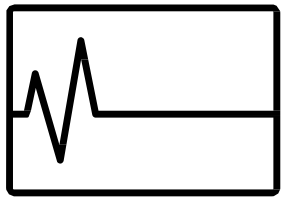
# HCV - GREECE

## HCV Infections (2016)
## 132,000 (1.1%)

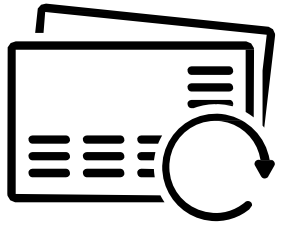


Diagnosed
34%

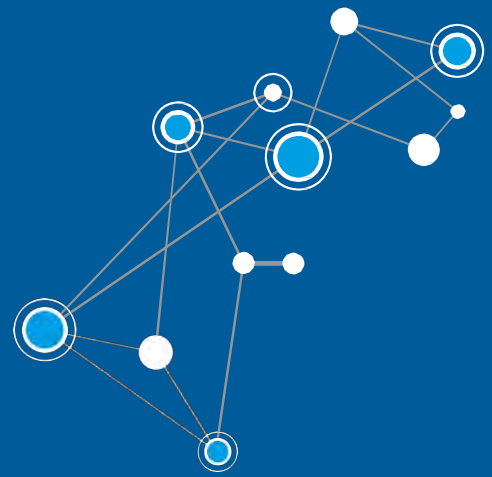
Annual
Treated
1%



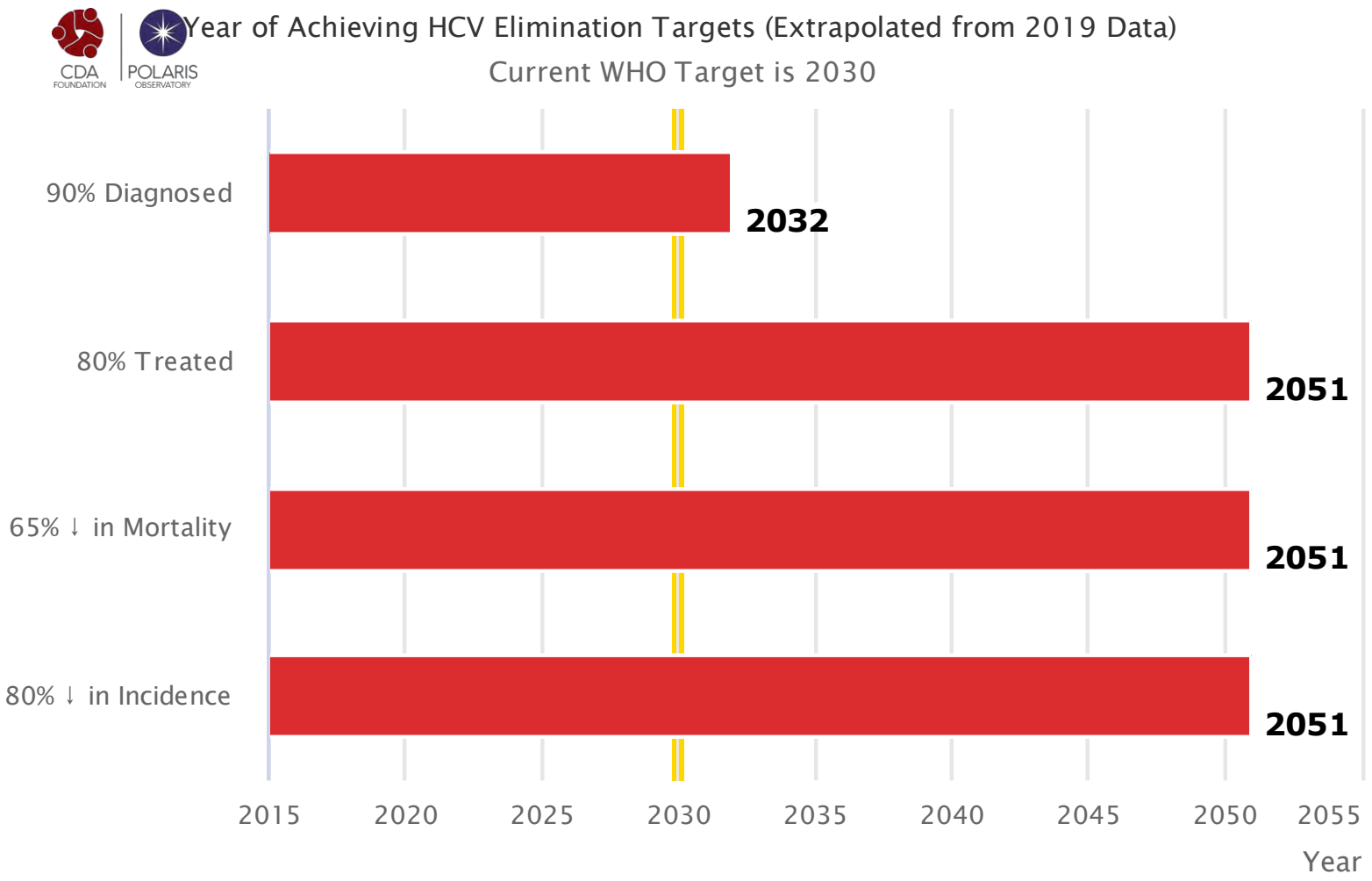
Annual
Deaths
790



Deaths
per
Day 2

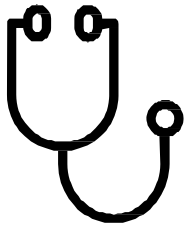


# HCV - GREECE


Year of Achieving HCV Elimination Targets (Extrapolated from 2019 Data)
Current WHO Target is 2030
90% Diagnosed
2032
80% Treated
2051
65% ↓ in Mortality
2051
80% ↓ in Incidence
2051
2015
2020
2025
2030
2035
2040
2045
2050
2055
Year

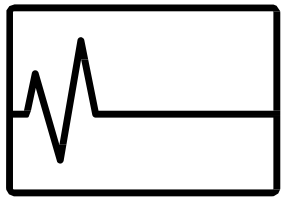
# HCV - EUROPE

## HCV Infections (2016)
## 9,283,000 (1.2%)

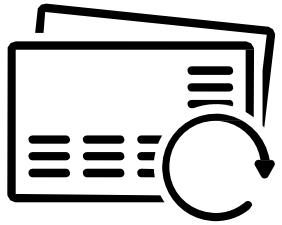


Diagnosed
34%

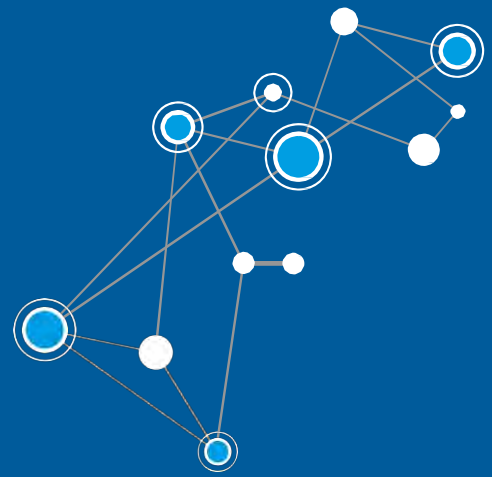
Annual
Treated
2%



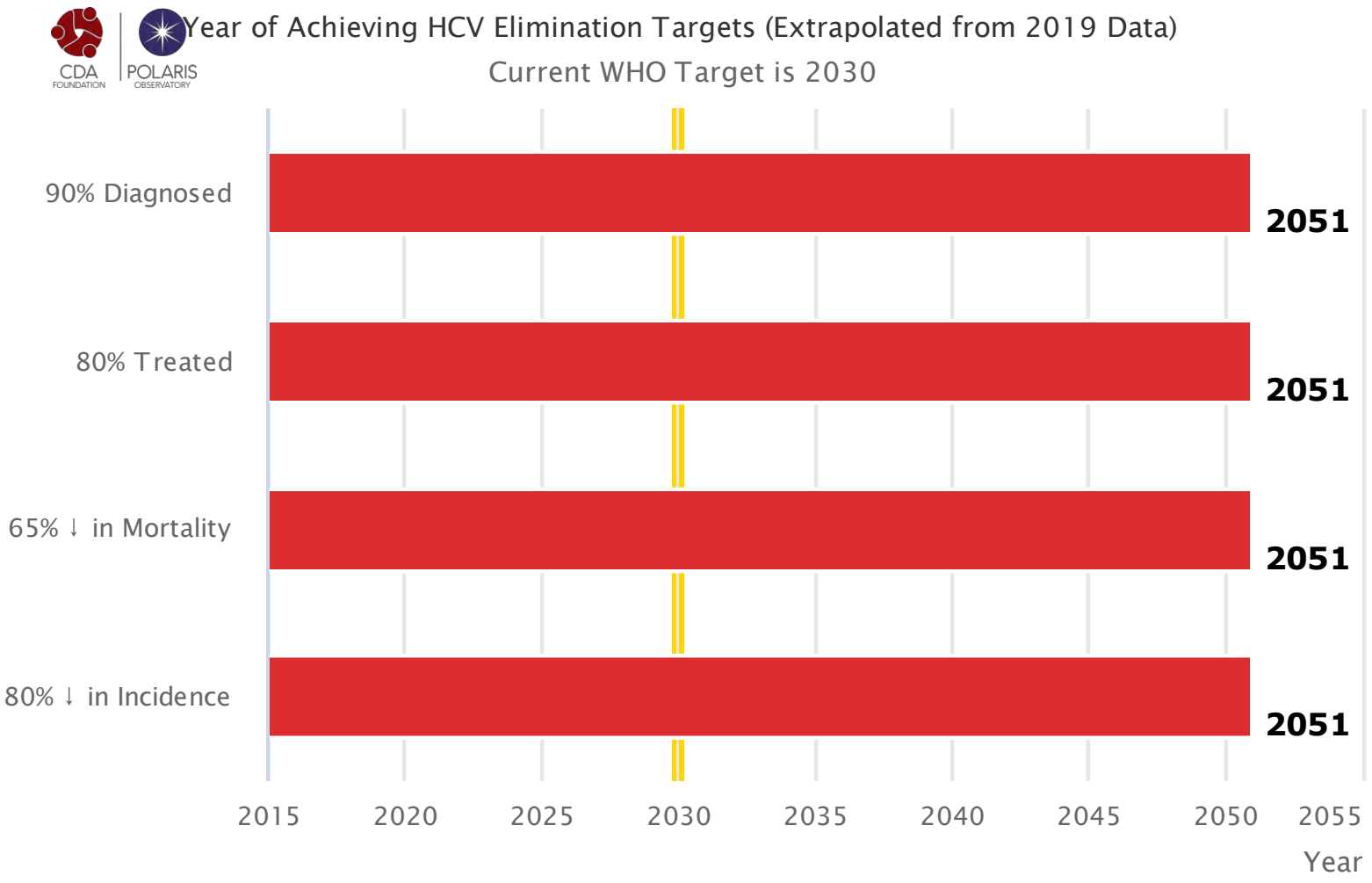
Annual
Deaths
40.000



Deaths
per
Hour 5



# HCV - EUROPE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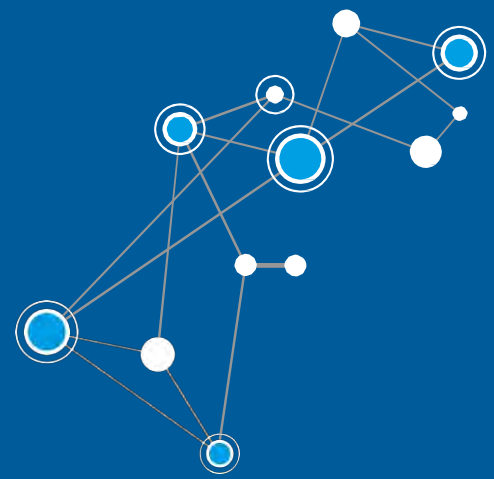
2030
2035
2040
2045
2050
2055
Year

# the EU's response to HIV/AIDS, Tuberculosis and Hepatitis C

European Parliament Resolution of 5 July 2017

1. Calls for a **comprehensive EU Policy Framework** addressing HIV/AIDS, tuberculosis and viral hepatitis
2. Calls for strengthen **work with communities and vulnerable people** … the provision of **services to the affected populations**
3. Calls for the launch a multidisciplinary plan, which will **standardise screening, testing and treatment protocols**
4. Calls on the Commission and the Member States to ensure **sustainable funding of national viral hepatitis elimination plans**
5. Calls for an EU-wide **harmonised infection surveillance programme** that can detect outbreaks of viral hepatitis

EUROPEAN PARLIAMENT



- The European Parliament insists on the implementation of the Sustainable Development Goals

- Ending the epidemics of AIDS, tuberculosis and the fight against hepatitis by 2030 is part of the objectives.

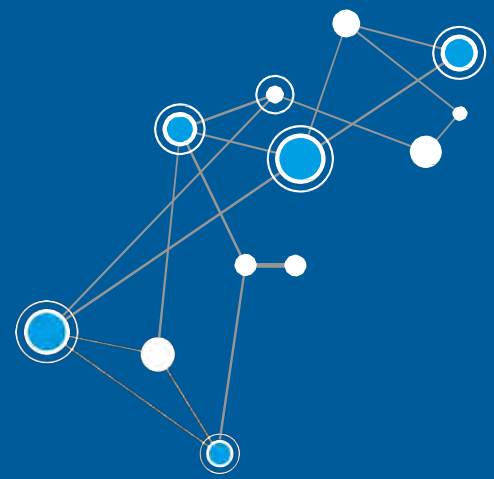
- In its resolution in 2017 it had called on the European Commission to create a new Action Plan to combat hepatitis, AIDS and tuberculosis.

- EP will insist that a new plan be submitted.

- EP insists on funding research through projects such as Horizon

- In the review of the medicines strategy, it will insist on the need to finance innovative medicines to treat these diseases and to access them.

EUROPEAN PARLIAMENT



# BECA Committee

- **Committee Mandate**
  - References Hepatitis B and C as preventable risk factors for cancer
  - identification of measures **to increase vaccination and treatment for infections**…" i
- **Contributed to the Eruopean Commission's** Europe's Beating Cancer Plan
  - ensuring access to Hep. B vaccination and treatment for cancers associated with Hep. C
- Development of **BECA Committee Europe's Beating Cancer Plan report**
  - Working document highlights focus on cancer prevention
  - Expected draft in May

# ECDC Mandate

- European Commission presented a porposal to expand the legal mandate of ECDC:
  - "To **reinforce surveillance: a strengthened, integrated surveillance system** will be created at EU level, using artificial intelligence and other advanced technology"
  - "To **improve data reporting**: Member States will be required to step up their reporting of health systems indicators (e.g. hospital beds availability, specialised treatment and intensive care capacity, number of medically trained staff etc.)"
- Opporuntities in tackling viral hepatitis
  - Improve the **monitoring and surveillance of communicable diseases**
  - Fill **information gaps**
  - **Monitor prgress** towards elimination
- EP ENVI Committee
  - Expected adoption in July 2021

# THANK YOU

PETROS KOKKALIS
Member of the European Parliament

# Keynote addresses

**Chair:**
**Prof Rafael Esteban Mur, Co-Chair HepBCPPA and University Hospital Vall d'Hebron, Barcelona, Spain**

EUHCV
Policy Summit - 24.03.2021
Online event

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# Mr John F Ryan

## Director of Public Health, Country Knowledge, Crisis Management, DG SANTE, European Commission

***Presentation by Mr Stefan Schreck***


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@HepBCPPA

European Commission

# Third EU HCV Virtual Policy Summit
# "Securing Wider EU Commitment to the Elimination of HCV

# The clock is ticking

# - how can the EU help deliver on the WHO elimination goal for viral Hepatitis B and C?

**Stefan Schreck, Adviser for Stakeholder relations, Directorate-General for Health and Food Safety, European Commission**

**24 March 2021**

Health

# WHO goal:
# Elimination of viral hepatitis as a major public health threat by 2030

**Global Health Sector Strategy on viral hepatitis 2016-2021**
**https://apps.who.int/iris/bitstream/handle/10665/246177/WHO-HIV-2016.06-eng.pdf;jsessionid=F25A4BAADD1A277849E342852F7DAC20?sequence=1**

**Action plan for the health sector response to viral hepatitis in the WHO European Region**
**https://www.euro.who.int/__data/assets/pdf_file/0008/357236/Hepatitis-9789289052870-eng.pdf**

# Hepatitis at global level:

## +/- 325 million people live with hepatitis B and/or C worldwide

## WHO 2021: better access to hepatitis C diagnostics and treatment in low- and middle-income countries

## Progress is fragile

**Accelerating access to hepatitis C diagnostics and treatment:**
**https://www.who.int/publications/i/item/9789240019003**

European Commission

# Hepatitis in the EU, the EEA an the UK:

## +/- 4.7 million cases of chronic hepatitis B.

## +/- 3.9 million cases of chronic hepatitis C.

**Prevention of hepatitis B and C in the EU, EEA and the UK:**
**https://www.ecdc.europa.eu/en/publications-data/prevention-hepatitis-b-and-c-eueea-and-uk**

Health

## ECDC monitoring framework for hepatitis B and C – some key findings:

- **Vaccination is a key element in hepatitis B prevention strategies**
- **All countries have blood screening/heamovigilance systems in place to prevent hepatitis B and C via blood transfusions**
- **Some countries work with people who inject drugs and men who have sex with men**
- **+/- 1/3 of EU/EEA countries have no plan/strategy for hepatitis prevention**
- **Significant data gaps**

**Monitoring the responses to hepatitis B and C epidemics in the EU/EEA Member States**
**https://www.ecdc.europa.eu/en/publications-data/monitoring-responses-hepatitis-b-and-c-epidemics-eueea-member-states-2019**

# European Commission action on (hepatitis B) vaccination

- **Council Recommendation on strengthened cooperation against vaccine-preventable diseases (https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32018H1228(01))**
- **Roadmap (https://ec.europa.eu/health/sites/health/files/vaccination/docs/2019-2022_roadmap_en.pdf**
- **ECDC technical guidance: https://www.ecdc.europa.eu/en/publications-data/prevention-hepatitis-b-and-c-eueea-and-uk**

European Commission

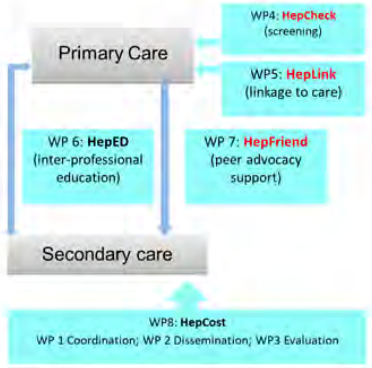
HA·REAC
JOINT ACTION ON HIV AND CO-INFEC
PREVENTION AND HARM REDUCTION

- **HA-REACT Joint Action** addressed gaps in prevention of HIV/AIDS, TB and hepatitis among people who inject drugs.
  - Tested over 1.000 PWID for HIV or for hepatitis B and C
  - Distributed 44.500 condoms and 213.700 syringes / needles
  - Counselling services to 725 patients
  - Trained 1.300 health care workers in prison and community settings.
  - Mobile unit offering harm reduction services for PWID
- Training on testing of HIV and HCV in Latvia and Hungary

https://www.hareact.eu//en

# HepCare Europe

- Support development of national hepatitis strategies, screening and treatment guidelines
- Introduce an integrated care model of hepatitis C care for at-risk populations, including PWID
- Tested more than 2.600 people in Romania, Spain, Ireland and the UK
  - over 1.000 (41.8%) were infected with viral hepatitis C
  - 650 (60.5%) were linked to care and 299 (43.5%) put on treatment
  - Educated over 500 health care professionals
- Trained 29 peers for peer support

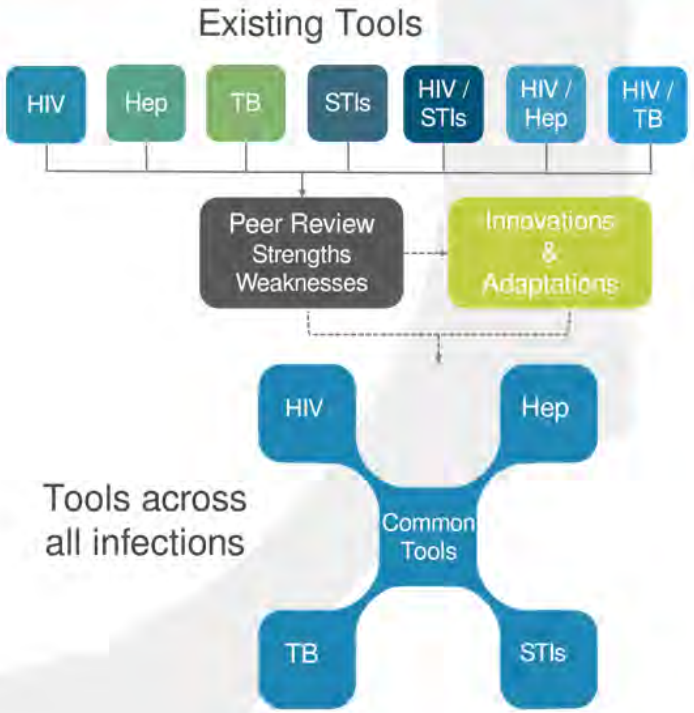



http://www.ucd.ie/medicine/hepcare/

# Integrate - integrating prevention, testing and linkage to care strategies across HIV, viral hepatitis, TB

Integrate

- INTEGRATE focuses on how effective tools for diagnosis and linkage to care in one disease area can be used in other
- Point of departure in HIV tools to increase earlier diagnosis and linkage to care and treatment
- Expanding on lessons learned from previous European projects (OptTEST, EuroHIVEdat, HIV in Europe, European Testing Week)



- **Patient centred**

- **Four pillars** Prevention - Early detection - Diagnosis and treatment - Quality of life with and after cancer

- **Cross-cutting** Quality – Research – Digital – Inequalities - Childhood and adolescents

- **UN Sustainable Development Goals** and **WHO** targets on non-communicable diseases

- Benefit on **major non-communicable diseases**

## Prevention

- Reduce harmful **alcohol consumption**
- **Healthy diets**
- Measures to reduce exposure to **hazardous substances**
- Preventing **cancers related infections (HBV vaccination and treatment, HCV treatment)**

## Early detection

- Identification of **asymptomatic infections**
- **Routine screening** for heapatocellular carcinoma in individuals with chronic liver disease


# Thank you!

Health

# Mr Alexis Goosdeel

## Director, European Monitoring Centre for Drugs and Drug Addiction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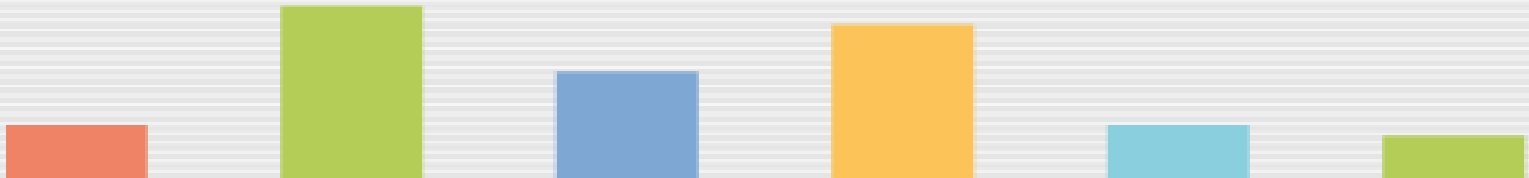
European Monitoring Centre
for Drugs and Drug Addiction

# The Elimination of Viral Hepatitis as a Public Health Threat in the EU: Keeping People Who Inject Drugs in Focus

Alexis GOOSDEEL, EMCDDA Director

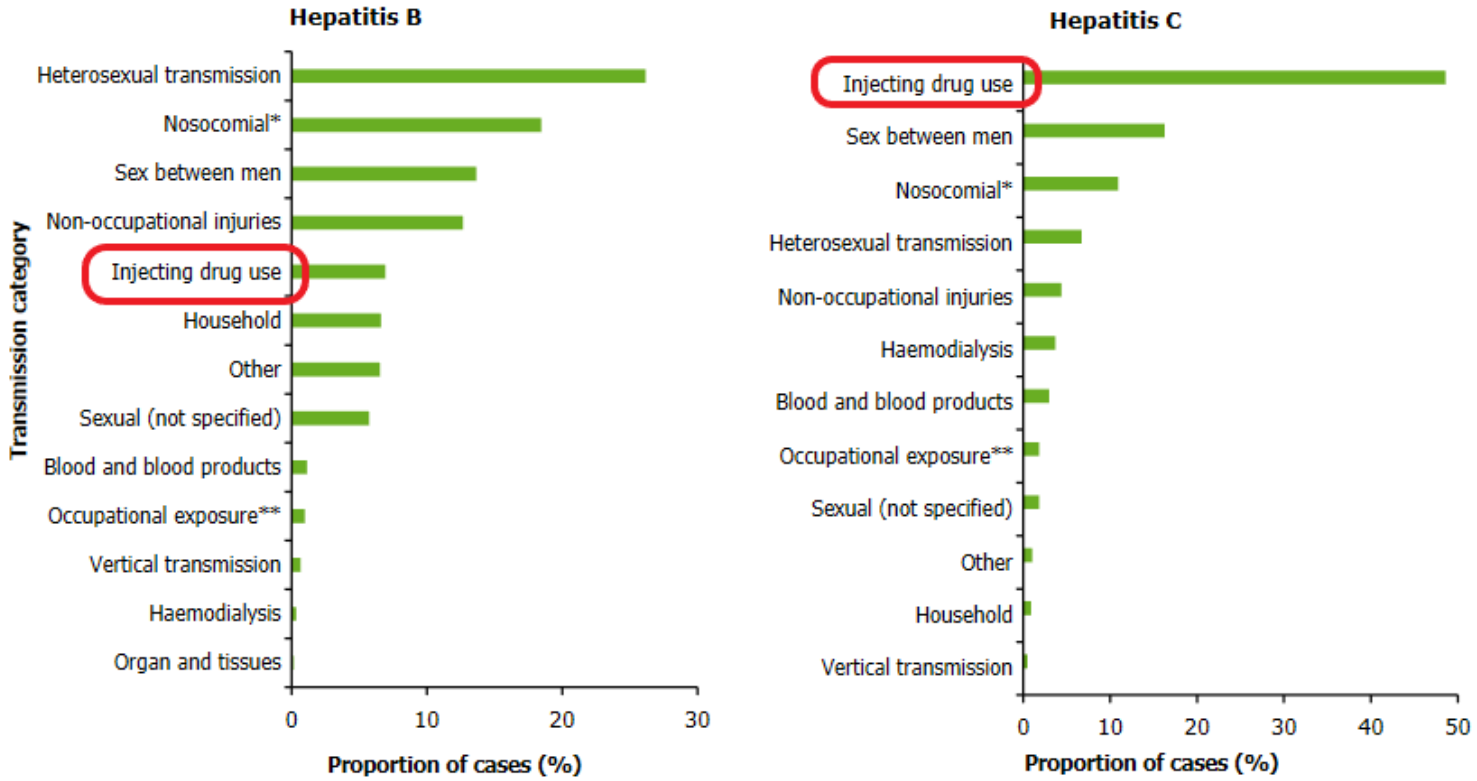
Third European policy summit dedicated to the elimination of the Hepatitis C Virus (HCV) in Europe "Securing Wider EU Commitment to Eliminate HCV"



# CONTEXT: TRANSMISSION

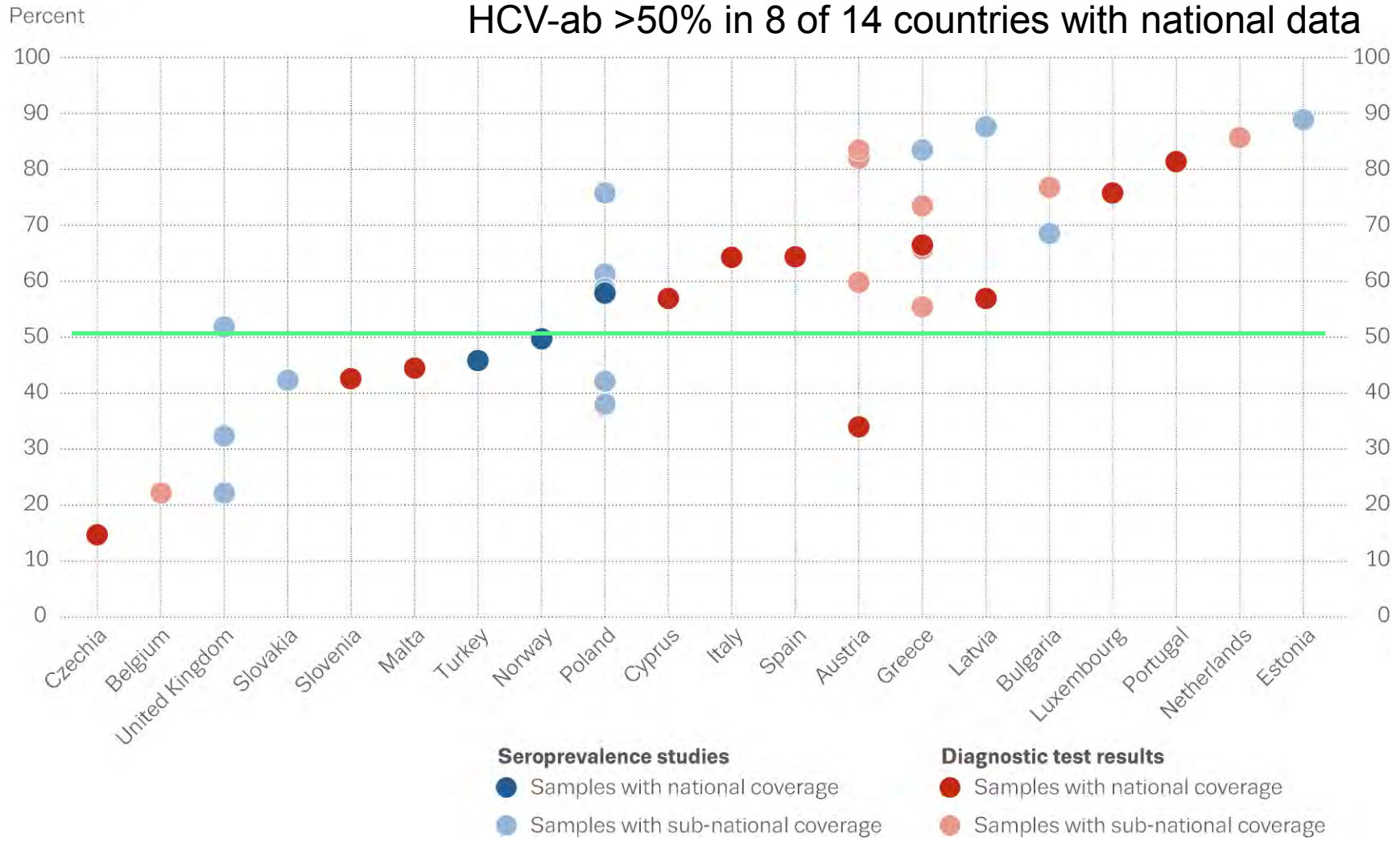
## A high proportion of new HCV and HBV cases (transmission) occur among PWID

**Figure 2. Transmission category of hepatitis B and C acute cases in the EU/EEA and the UK in 2018 [3, 4]**



# HCV-ab PREVALENCE IN PWID

HCV-ab >50% in 8 of 14 countries with national data




Source: EMCDDA Rapid Communication DRID, 2019

# INTERVENTIONS AMONG PWID

- **Prevention: NSP+OST+HBV vaccination + safe sex= cost-saving**

- **Treatment:**

  Short-course **effective DAA** to cure HCV + potentially indirect impact in reducing transmission* (“treatment as prevention”) - 21 000 euros (US) and 10 300 euros (UK)

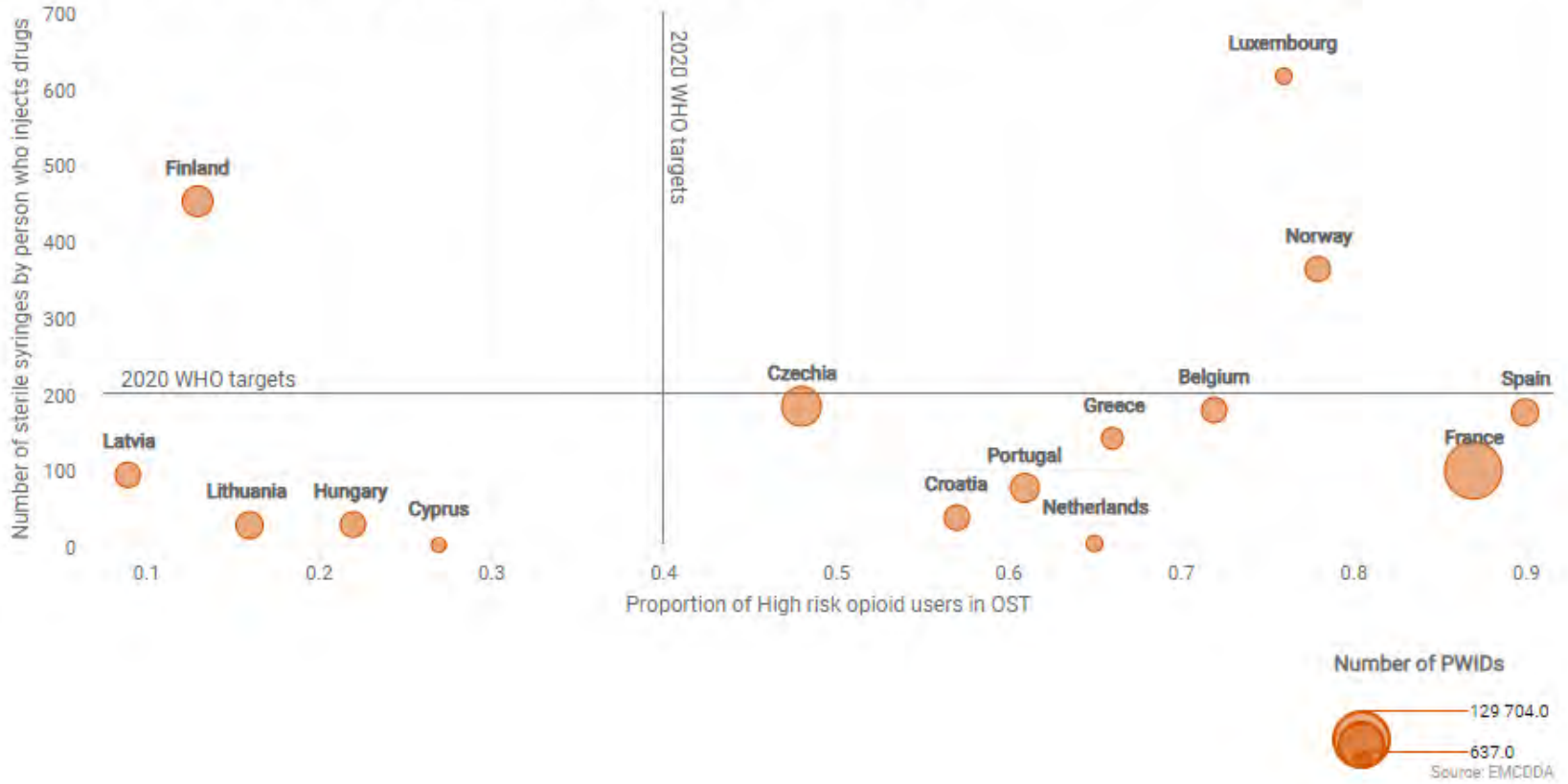
  Generic long-term oral antiviral agents for HBV to reach viral suppression and improve long term survival - <50 euros per year

- **Large scale implementation requires a well-funded inclusive policy**

* In modelling work, no real-life evidence yet

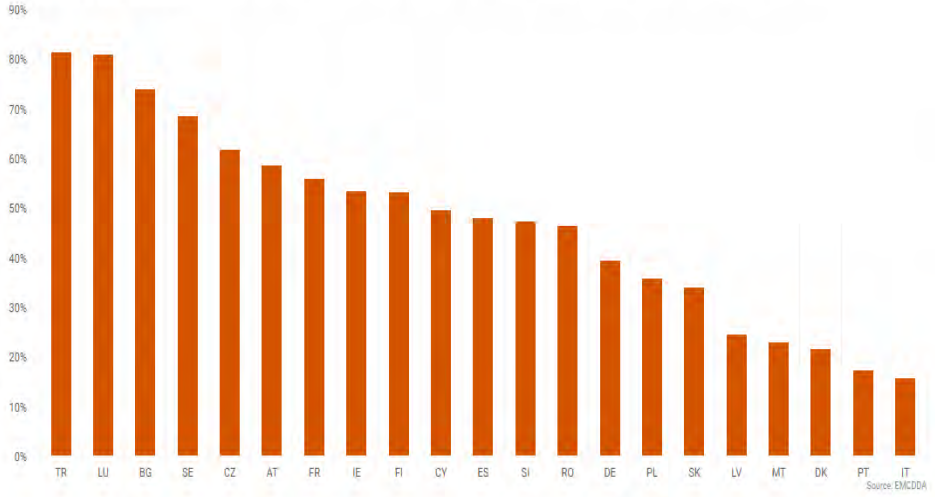
# WHO PREVENTION TARGETS AMONG PWID

**Figure 6. Number of clean syringes distributed per PWID and proportion of high-risk opioid users in opioid substitution treatment, EU countries, 2019 or latest available data**



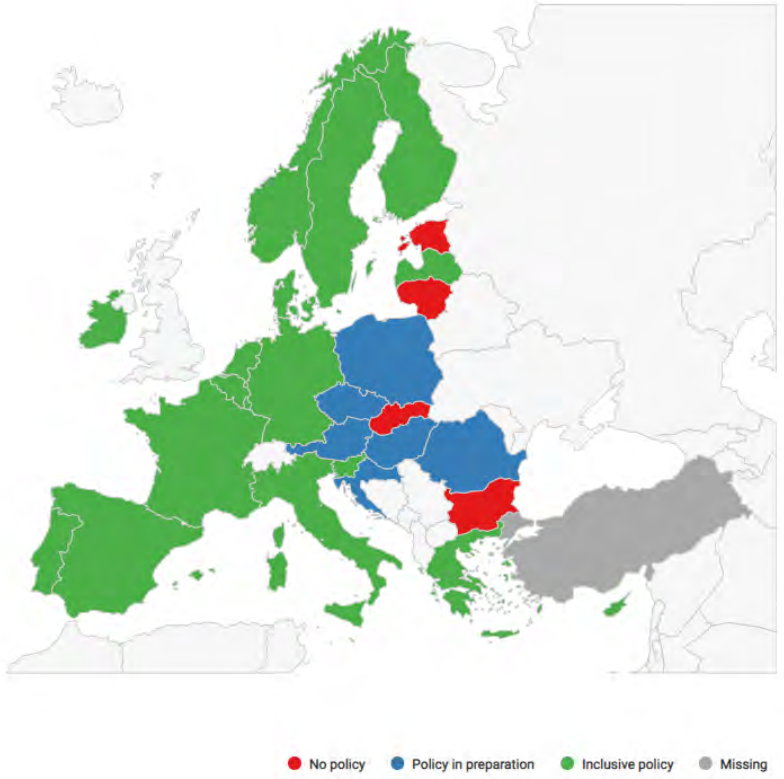
# WHO TESTING AND POLICY TARGETS PWID

Figure 8. Percentage of people entering drug treatment reporting injecting drugs who had an HCV test in the previous 12 months, 2019 or latest data available




Related 2020 target: 50% of people who are chronically infected with viral hepatitis are diagnosed

Figure 5. Countries with viral hepatitis policy inclusive of PWID, 2019




Source: EMCDDA, preliminary data

# RECOMMENDATION

## Policies should promote an integrated approach with HR services at the centre

**It is cheaper to prevent a case than to (re)treat a case (Prevention is cost-saving)**

- MoH with limited budget: DAA still much more expensive than NSP/HBV vaccines (Resp/Equip guidance)

**It is within harm reduction services that PWID are better diagnosed, linked to care and treated (Integration within HR is key)**

- Integrated treatment is more effective (RCT) with HR as essential link (Testing initiative, Models of care)

**The elimination strategy is an opportunity to strengthen HR services and to prevent and treat other infectious diseases like HIV (Integration across ID is key)**

- Clear economies of scale (Prevention and control of BBV in prison settings, Update of PWID guidance)

**EU should consider doing common procurement to get cheaper DAA medicines (like for COVD-19 vaccine) (Keep reducing opportunity cost of DAA)**

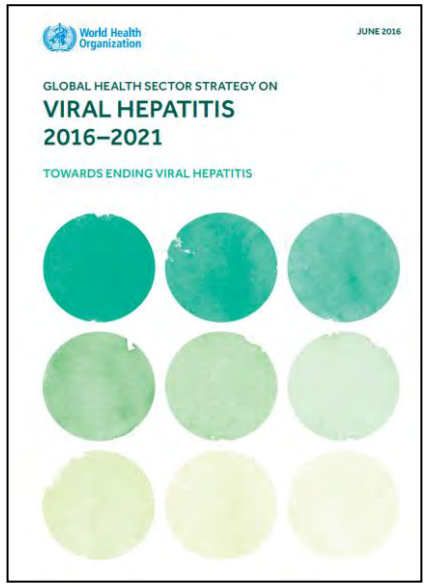
- Keep reducing financial barriers during the economic crisis to make DAA cost-saving

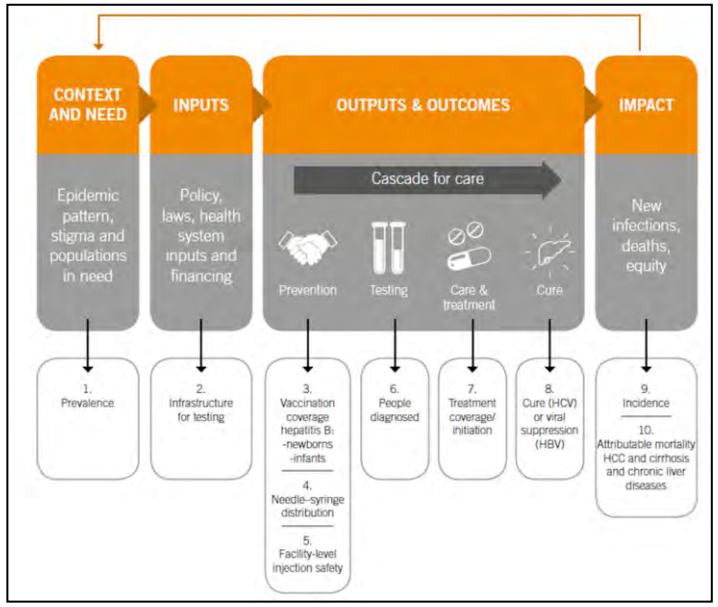
**The elimination strategy is an opportunity to prevent cases, cure patients and save resources if HR services are given the institutional support they need as essential services**

# Sustainable Development Goals 2030

## GOAL 3: Good Health and Well-being






WHO - GHSS: To eliminate viral hepatitis as a public health threat by 2030.

Prevention → Testing → Treatment and Care

# EMCDDA Hepatitis C initiative

**Our objective**

- To support EU Member States' efforts in improving national practices in areas of harm reduction (HCV, DRD, etc.)

**How?**

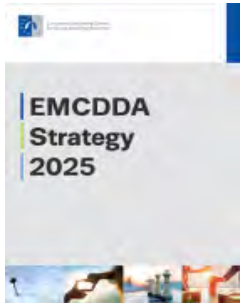
- By producing a **comprehensive toolbox** with high-quality materials to support implementation

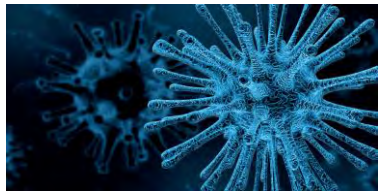
**These structured tools provide a methodology to**

- identify current barriers and facilitators to evidence-based action
- plan and implement effective responses

**For whom?**

- National and local decision makers & professionals working in the field



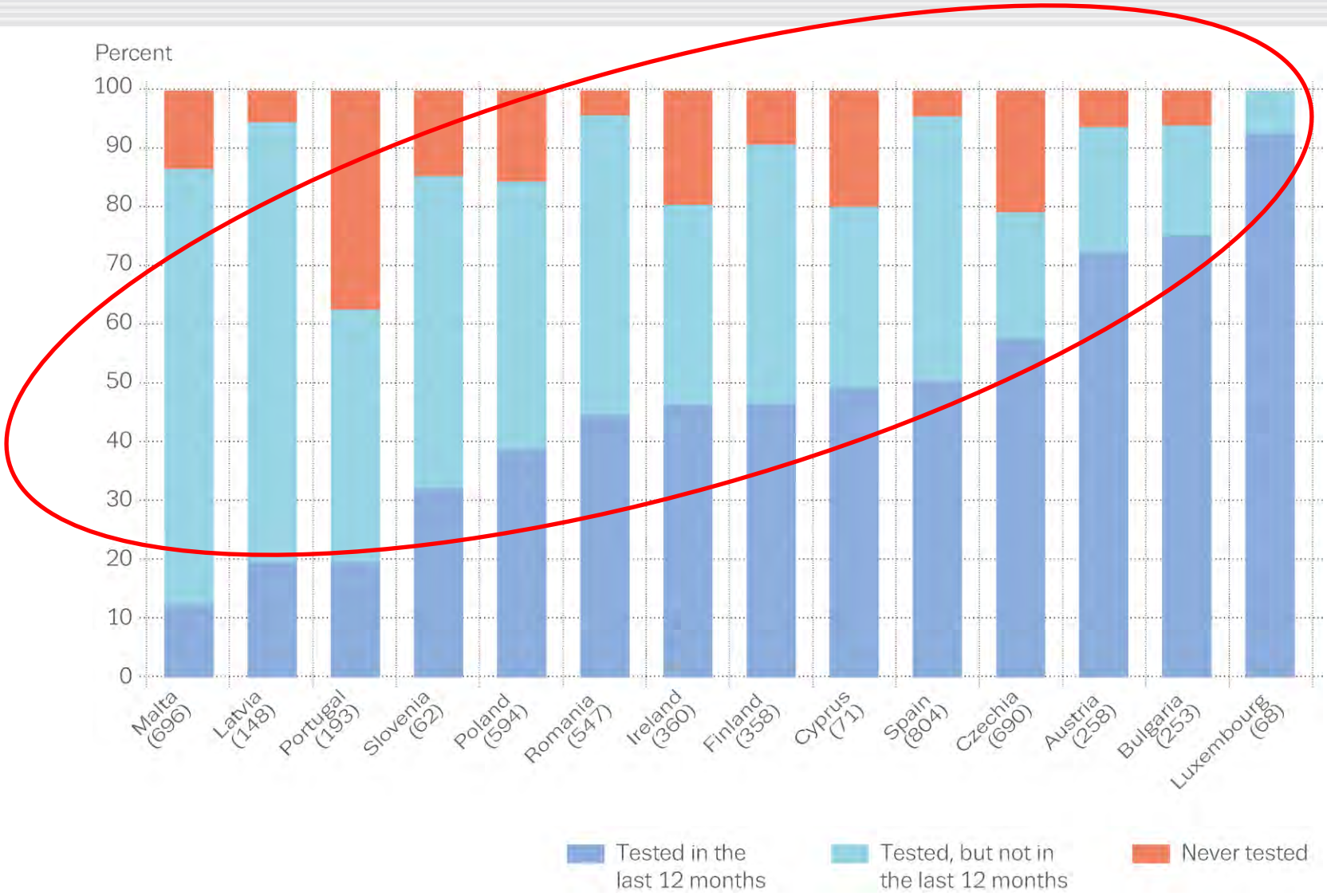
# DRUGS SERVICES: ADVANTAGES

Definition: harm reduction and drug treatment facilities

- ✓ Opportunity to timely *identify* chronic carriers through active screening
- ✓ Ideal place make diagnostics and adequate treatment widely available (including treatment as prevention)
- ✓ Qualified and interested staff to organise efficient chain of care, including through peer workers
- ✓ Europe-wide treatment monitoring network

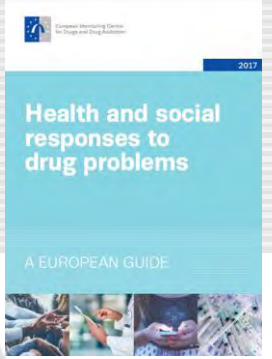
  e.g. in 2016: covering 4000 outpatient units treating 100.000 people who inject heroin

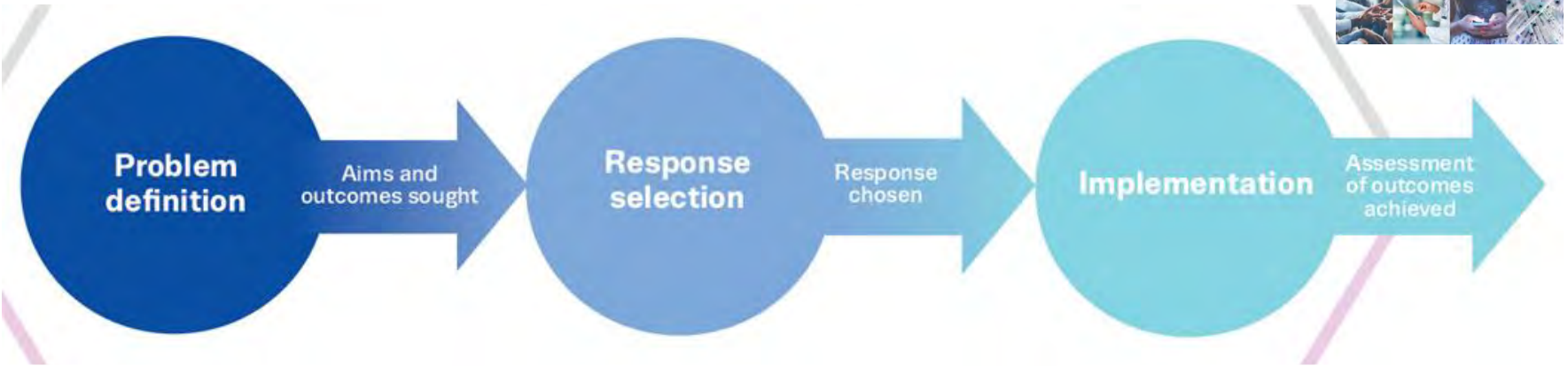
# A high proportion of PWID entering treatment report not having been tested for HCV (LYP/ever)

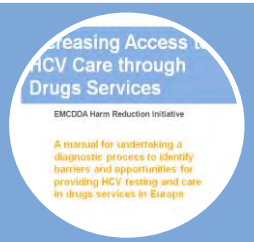



Source: TDI network. Self-report, data year: 2017. EMCDDA Rapid Communication DRID, 2019

# Toolbox: HCV testing & referral to care



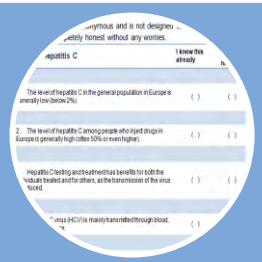




## Diagnostic process

- Mapping the current situation – barometer
- Roundtable discussion
- Action planning


## Models of care

- Selection of testing programmes
- Identification of other responses
- Implementation experience focus



## Materials for action

- Information material for drug services to raise awareness among staff
- Knowledge Questionnaire

# Module 1: The diagnostic process

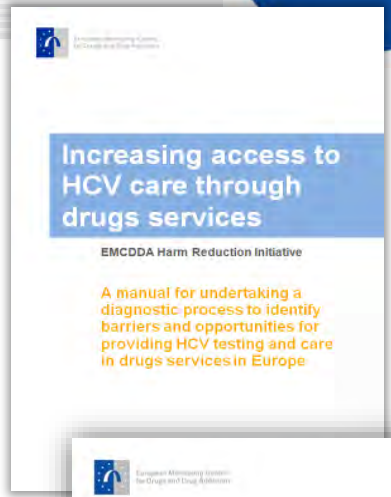
Problem definition

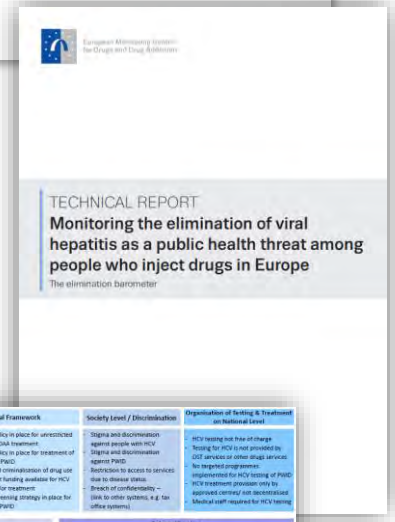
**What**: Diagnostic process to identify barriers and opportunities for HCV testing and care for PWID at system-, provider- and client level

**Who:** Multi-disciplinary: policy makers, service providers, service users. Close collaboration between national Focal Points Infectious Diseases and Drugs

**How:** Needs-assessment (barometer) + roundtable + action plan

**Where:** Country or regional/city level



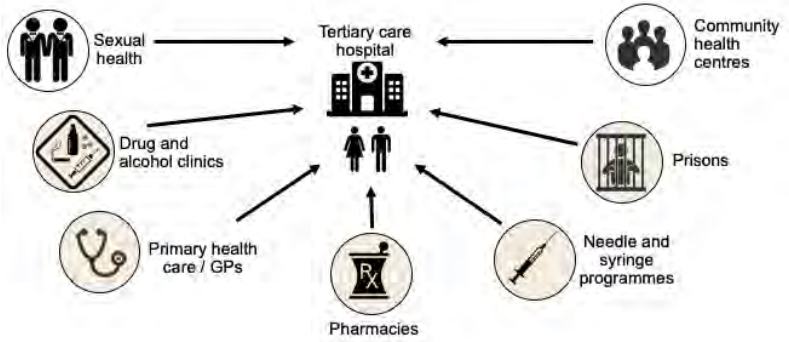

Piloted in Luxembourg (Jan) and Poland (June);
Launch of the manual: beginning of 2020

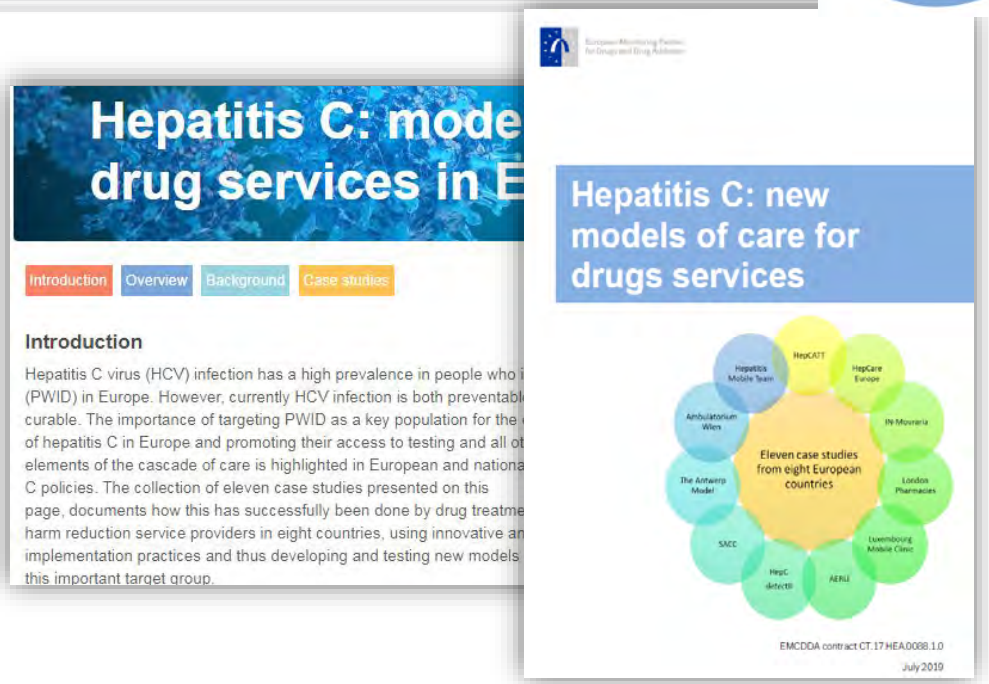
# Module 2: How to successfully reach PWID

## 11 case studies illustrating new Models of care

Response selection

Traditional **models of care** determined by interferon-based treatment regimens and based on referral of client to hospitals (tertiary care).
**High loss to follow-up among PWID**




Need to **bring HCV care to the community** where PWID access services

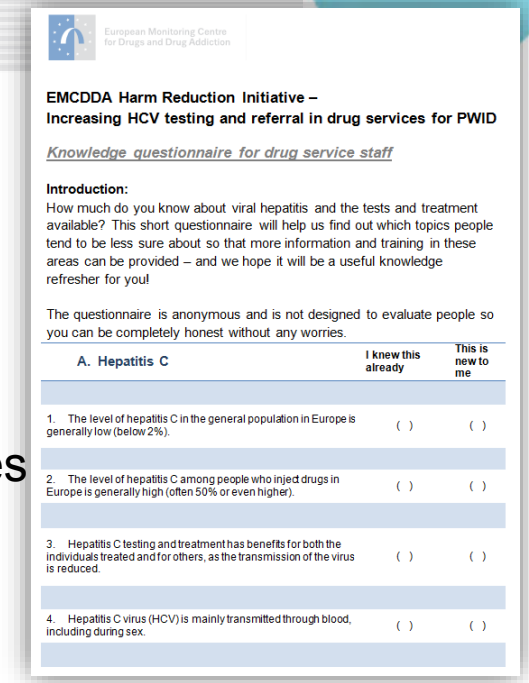
Compilation of 11 case studies from Europe illustrating **new models of HCV testing and treatment** that complement and replace traditional referral models

Reference: **Effective strategies to enhance testing, linkage to and retention in care and treatment for PWID.** Treloar, C. & Grebely, J. 2019

# Module 3: Materials to support action

Implementation

- Information material for drug services to raise awareness among staff & promote testing among clients
- Knowledge Questionnaire
- Inventory of promotional materials in different languages
- Training provision



European Monitoring Centre for Drugs and Drug Addiction

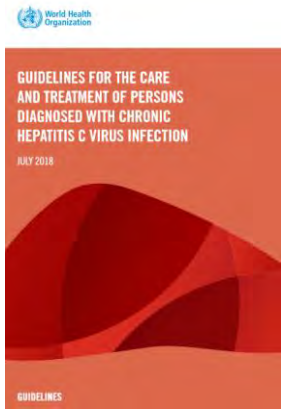
**EMCDDA Harm Reduction Initiative –**
**Increasing HCV testing and referral in drug services for PWID**

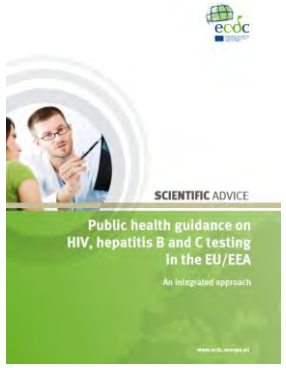
*Knowledge questionnaire for drug service staff*

**Introduction:**
How much do you know about viral hepatitis and the tests and treatment available? This short questionnaire will help us find out which topics people tend to be less sure about so that more information and training in these areas can be provided – and we hope it will be a useful knowledge refresher for you!

The questionnaire is anonymous and is not designed to evaluate people so you can be completely honest without any worries.

| A. Hepatitis C | I knew this already | This is new to me |
|---|---|---|
| 1. The level of hepatitis C in the general population in Europe is generally low (below 2%). | ( ) | ( ) |
| 2. The level of hepatitis C among people who inject drugs in Europe is generally high (often 50% or even higher). | ( ) | ( ) |
| 3. Hepatitis C testing and treatment has benefits for both the individuals treated and for others, as the transmission of the virus is reduced. | ( ) | ( ) |
| 4. Hepatitis C virus (HCV) is mainly transmitted through blood, including during sex. | ( ) | ( ) |





http://www.emcdda.europa.eu/activities/promoting-hcv-hepatitis-c-virus-testing-and-linkage-ca

# COMING BACK TO ESSENTIALS

**…WITH THE EU FACING**

- THE HIGHEST EVER AVAILABILITY, PURITY AND POTENCY OF ALL DRUGS
- A PERMANENT CHANGE OF RISK BEHAVIOURS AND INJECTION USE

**…WE NEED MORE THAN EVER**

- TO PUSH FORWARD A PUBLIC HEALTH APPROACH OF DRUGS
- TO PUT PEOPLE WHO ARE USING DRUGS AT THE CENTRE OF OUR STRATEGIES AND
- TO BRING SERVICES WHERE USERS ARE

European Monitoring Centre
for Drugs and Drug Addiction

# www.emcdda.europa.eu

http://www.emcdda.europa.eu/activities/promoting-hcv-hepatitis-c-virus-testing-and-linkage-care-drugs-services_en

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# Session 1: Progress in HCV elimination in Europe

**Chairs:**
**Prof Massimo Colombo, San Raffaele Hospital, Milan, Italy**
**Prof Markus Peck-Radosavljevic, Klinikum Klagenfurt, Klagenfurt, Austria**

EUHCV
Policy Summit - 24.03.2021
Online event

#HCVSummit
@HepBCPPA

# Dr Homie Razavi

## Centre for Disease Analysis, USA

# Progress in HCV elimination in the European Union

H. Razavi

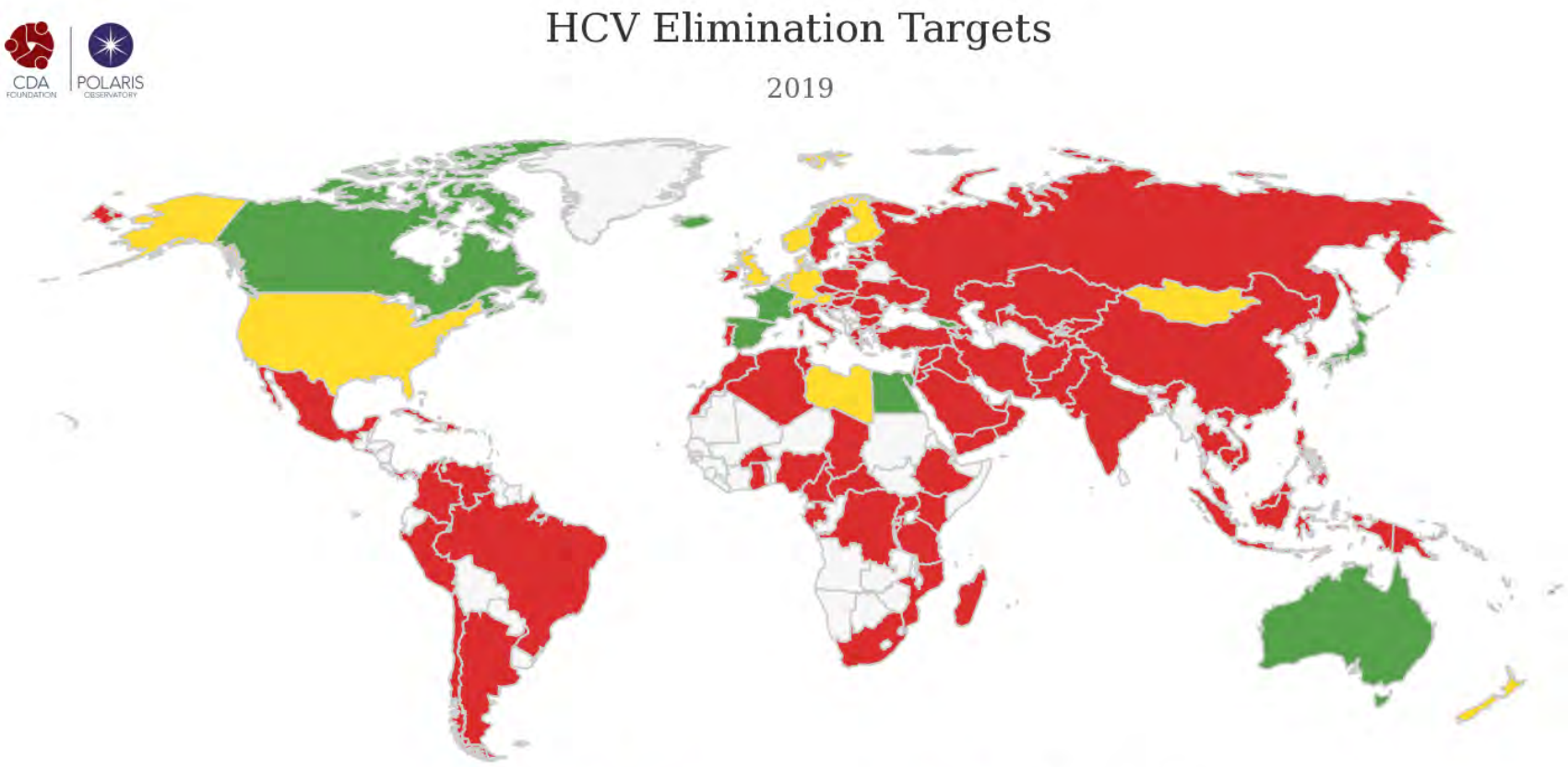
24 March 2021

@CDAFound

hrazavi@cdafound.org

CDA FOUNDATION

# By 2019, eight countries were on track to eliminate HCV by 2030 and another 14 countries before 2050 – COVID-19 has caused delays in all programs



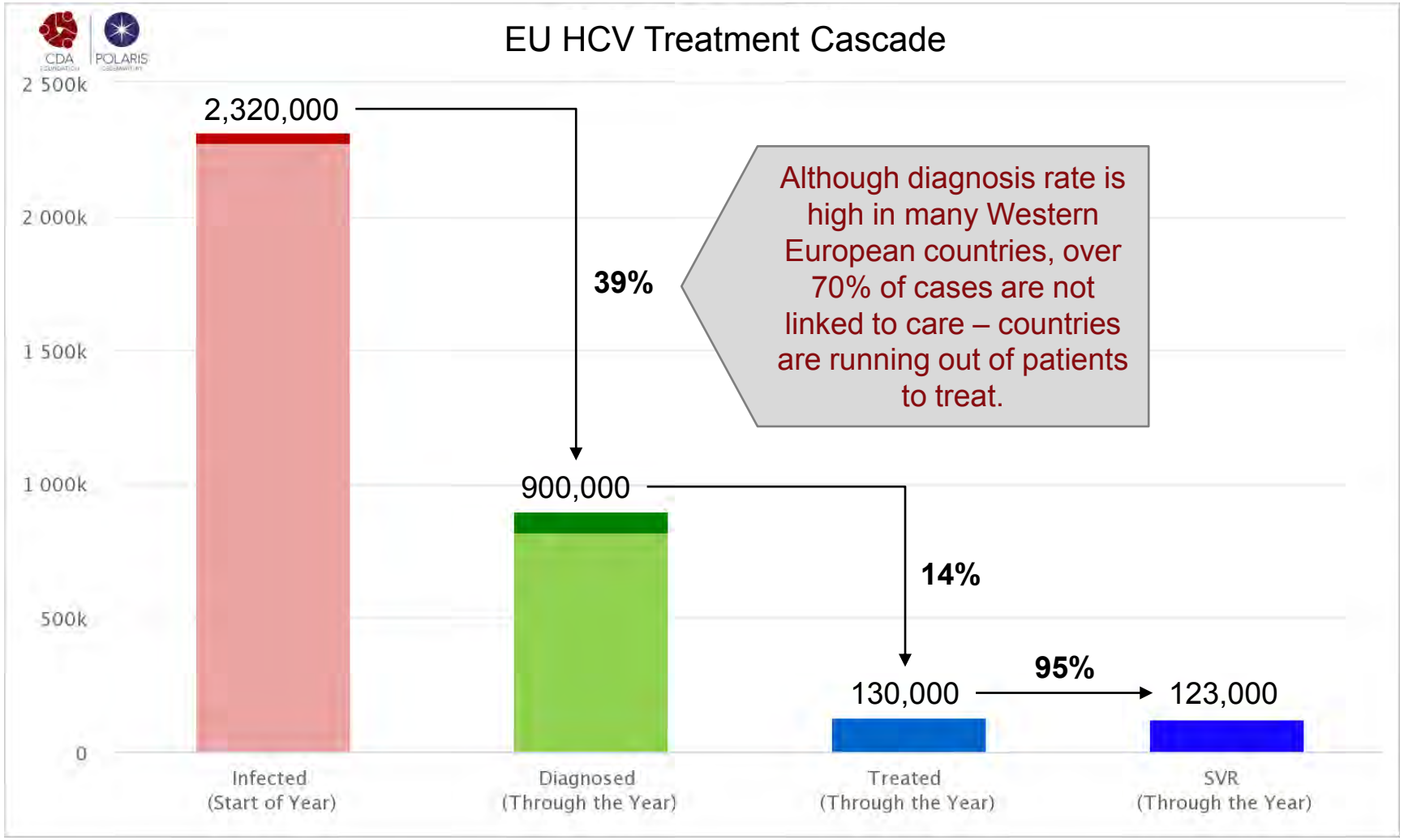

On Track for WHO Elimination Targets

| | | | | |
|---|---|---|---|---|
| Australia | Canada | Egypt | France | Georgia |
| Iceland | Japan | Spain | | |

Working Towards Elimination

| | | | | |
|---|---|---|---|---|
| Austria | Belgium | Denmark | Finland | Germany |
| Libya | Malta | Mongolia | Netherlands | New Zealand |
| Norway | Switzerland | United Kingdom | United States | |

# In 2019, 14% of all diagnosed patients were being treated, accounting for 5.6% of all HCV infections – not enough to reach the WHO 2030 elimination targets

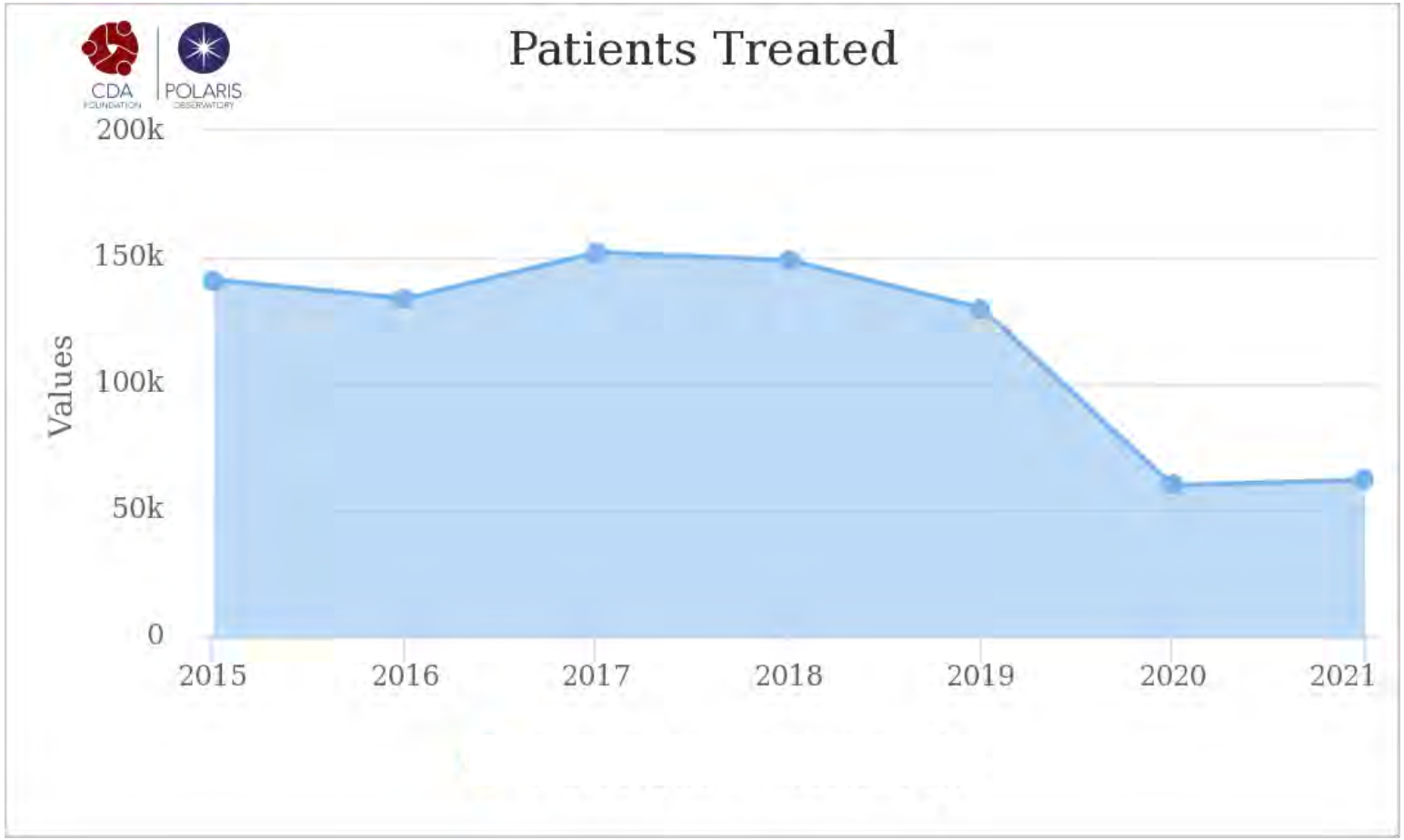



*Polaris Observatory (https://cdafound.org/polaris-observ-access/) Accessed 17 March 2021*

# In the EU, newly diagnosed cases peaked in 2016 and the number of treated patients peaked in 2017. Overall, total HCV infections and mortality have decreased


*Polaris Observatory (https://cdafound.org/polaris-observ-access/) Accessed 17 March 2021*

# Unfortunately, the COVID-19 pandemic has resulted in a 55% reduction in treatment in 2020 across the EU (as compared to 2019)

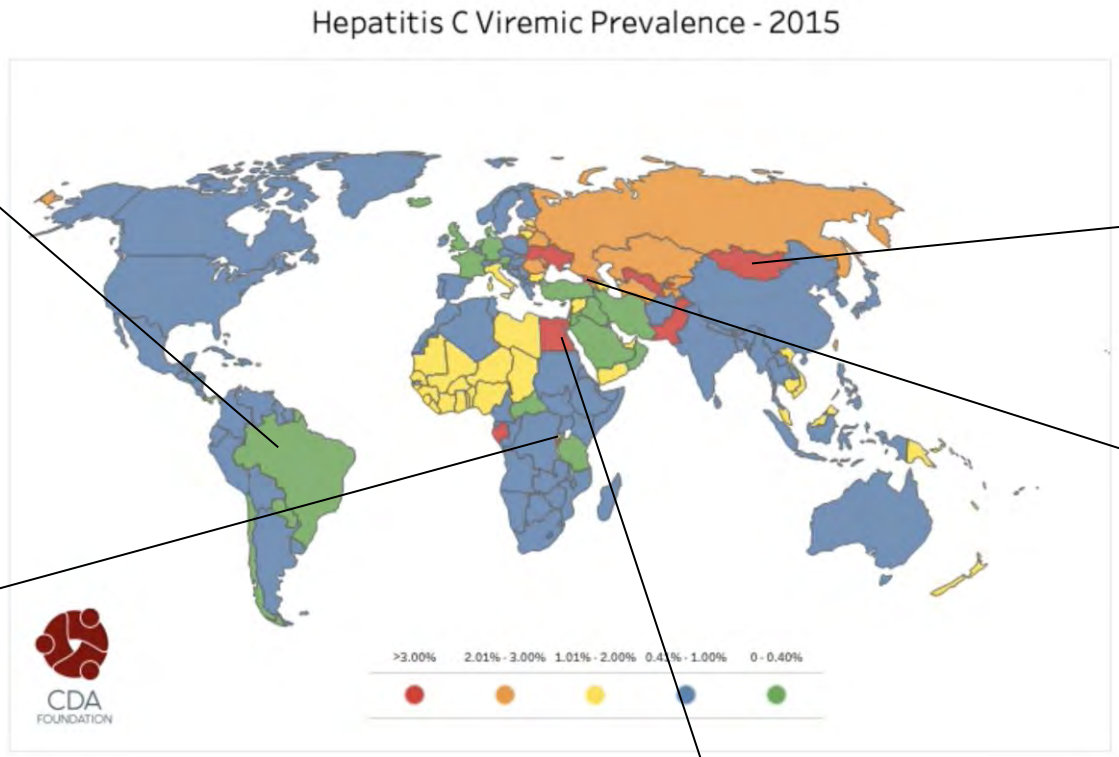



*Polaris Observatory (https://cdafound.org/polaris-observ-access/) Accessed 17 March 2021*

# Low and middle-income countries have already demonstrated that large scale HCV testing and treatment programs are feasible

**Brazil:**
Screened 9 million people for HCV in 2017 alone & treated 18% of chronic cases.

**Rwanda:**
Screened 4 million people (60% of adult population) for HCV & treated 16% of all chronic cases




**Egypt:**
48 million adults were screened in 2018-2019 & 3.5 million were treated in 2015-2019

**Mongolia:**
As of 2020, screened 52% of the total adult population & treated 22% of chronic cases.

**Georgia:**
As of 2020, screened 71% of the total adult population & treated 48% of chronic cases.

# Changing the viral hepatitis elimination targets to absolute numbers allows countries that have a low burden to achieve the new targets

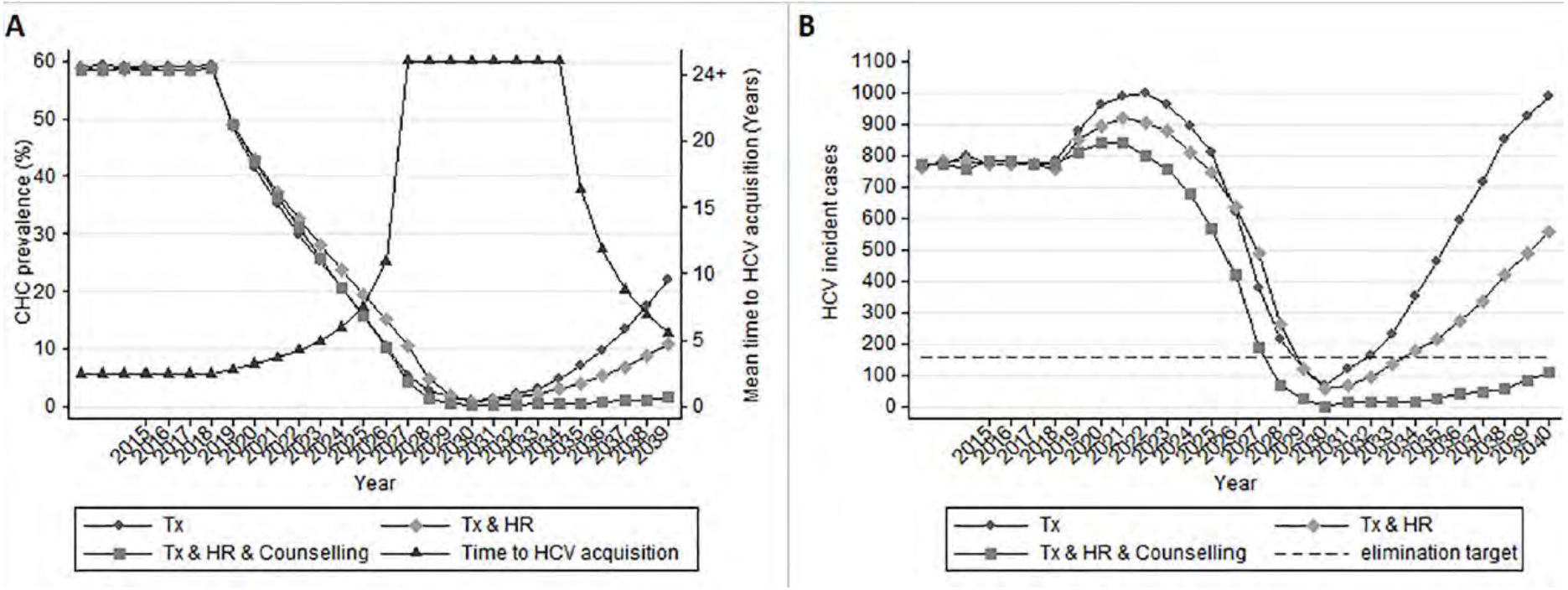
- Request that WHO also includes absolute elimination targets
  - » Currently all WHO elimination targets (90% diagnosed, 80% treated, 65% reduction in mortality, 80% reduction in incidence) are relative to 2015 estimates
  - » Absolute targets say that if disease burden is below a set of agreed numbers, countries have already met the elimination targets
    - Incidence - reduce new chronic infections to 5 per 100,000
    - Mortality – reduce mortality to 5 per 100,000 & decrease in new HCC cases

| The EU countries meeting the current WHO Viral Hepatitis Elimination Targets | The EU countries meeting the absolute Viral Hepatitis Elimination Targets |
|---|---|
| France | France |
| Spain | Spain |
| | **Austria** |
| | **Germany** |
| | **Italy** |
| | **Netherlands** |

The idea of absolute targets is not to stop the hepatitis programs. It is to recognize the low endemicity of HCV in the country.

Polaris Observatory Collaborators. The case for simplifying and using absolute targets for viral hepatitis elimination goals. J Viral Hepat. 2021 Jan;28(1):12-19. doi: 10.1111/jvh.13412. Epub 2020 Nov 4. PMID: 32979881.

# Absolute targets may also be more appropriate in EU where injection drug use continues to be a main risk factor for new HCV infections




HCV elimination programs in high-risk populations cannot slow down as HCV prevalence will increase as soon as treatment and/or harm reduction programs stop.

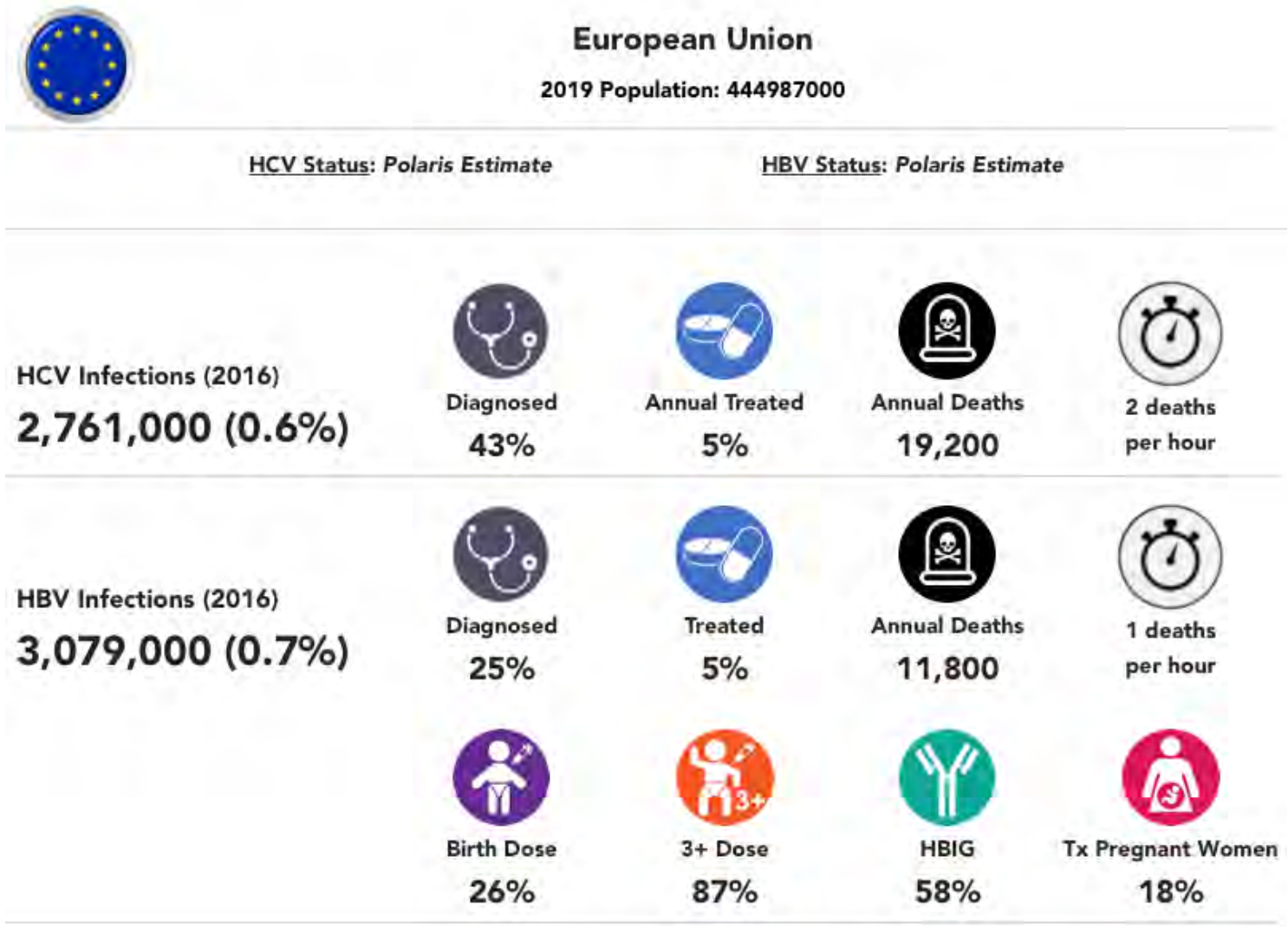
*Gountas I, Sypsa V, Blach S, Razavi H, Hatzakis A. HCV elimination among people who inject drugs. Modelling pre- and post-WHO elimination era. PLoS One. 2018 Aug 16;13(8):e0202109. doi: 10.1371/journal.pone.0202109. PMID: 30114207; PMCID: PMC6095544.*

## Conclusions

- Prior to 2020, a number of countries in the EU were making progress toward HCV elimination – France, Spain, Austria, Belgium, Denmark, Finland, Germany, Netherlands, Norway and UK.
- HCV prevalence and mortality has been decreasing as the result of the national programs despite removing treatment restrictions.
- HCV treatment has been declining in the EU since 2017 since most national HCV elimination programs lack a wide scale screening strategy – running out of patients.
- Simplified national screening programs have been demonstrated in numerous LMIC. National screening is not impossible but may not be justifiable given the low prevalence.
- The EU countries should consider supporting absolute HCV elimination targets since overall burden and incidence are low.
- Reducing incidence in the EU will be a challenge for the foreseeable future until HCV vaccines or HCV PrEP are available.

# Appendix

# As of 2016, one person died of hepatitis C or B every 17 minutes in the EU




*Polaris Observatory (https://cdafound.org/dashboard/polaris/dashboard_regions.html) Accessed 17 March 2021*

# Prof Jeffrey Lazarus

## ISGlobal, Barcelona, Spain


#HCVSummit
@HepBCPPA

EUHCV
Policy Summit - 24.03.2021
Online event

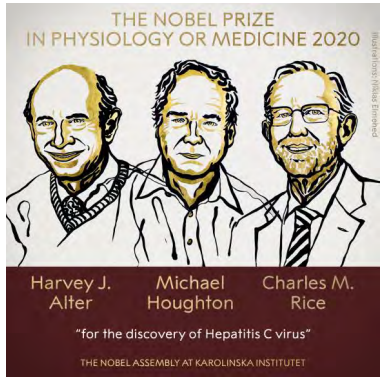
3rd EU HCV Virtual Policy Summit DRAFT Programme
"Securing Wider EU Commitment to the elimination of HCV"
*Wednesday, 24 March 2021*
*14:00 – 18:30 CET*

# HCV Care Continuum and Barriers

**Prof. Jeffrey V. Lazarus [Jeffrey.Lazarus@ISGlobal.org]**

Associate Research Professor, ISGlobal, Hospital Clínic
Associate Professor, Faculty of Medicine, Univ of Barcelona
Vice-chair, EASL International Liver Foundation

ISGlobal Barcelona Institute for Global Health
CLÍNIC BARCELONA Hospital Universitari
UNIVERSITAT DE BARCELONA

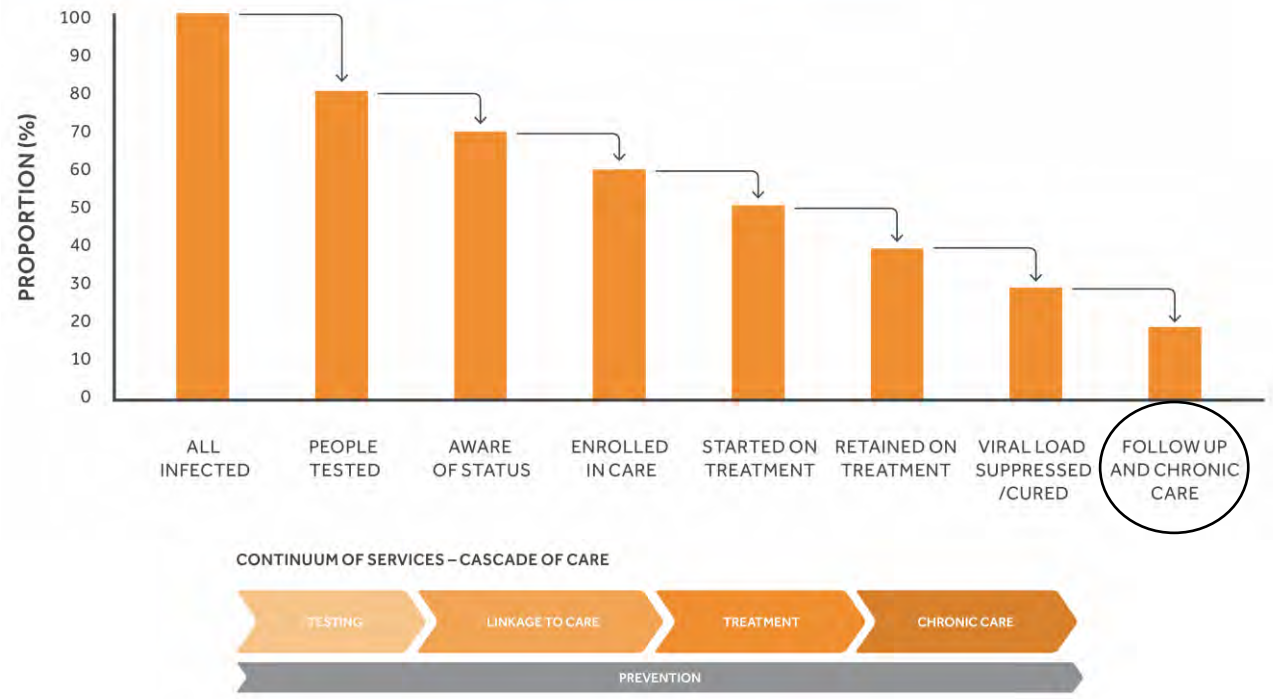



24 March 2021



@JVLazarus


# The continuum of viral hepatitis services and the retention cascade




***Source:*** WHO Global Hepatitis Report, 2017. Available at www.who.int/hepatitis/publications/global-hepatitis-report2017/en/ (accessed May 2017).

# Outcome: the Consensus HCV CoC

**Box 1. Definitions for the Consensus Hepatitis C Cascade of Care for a given year**

*The 2017 calendar year is used to illustrate these definitions, which can be applied to any 12-month period.*

Infected = Number of people estimated to have viremic HCV infection on 1 January 2017.

Diagnosed = Number of people who received a diagnosis of viremic HCV infection before or during 2017, were still infected at the beginning of 2017 and were still alive at the end of 2017. This number excludes people whose HCV infection was cured (spontaneously or through treatment) before 2017, but includes those whose HCV infection was cured over the course of 2017. (People who have only had an antibody-based diagnosis are excluded.)

Treated = Number of diagnosed people (as defined above) who initiated HCV treatment at any time during 2017 (all types of treatment, including interferon-based regimens).

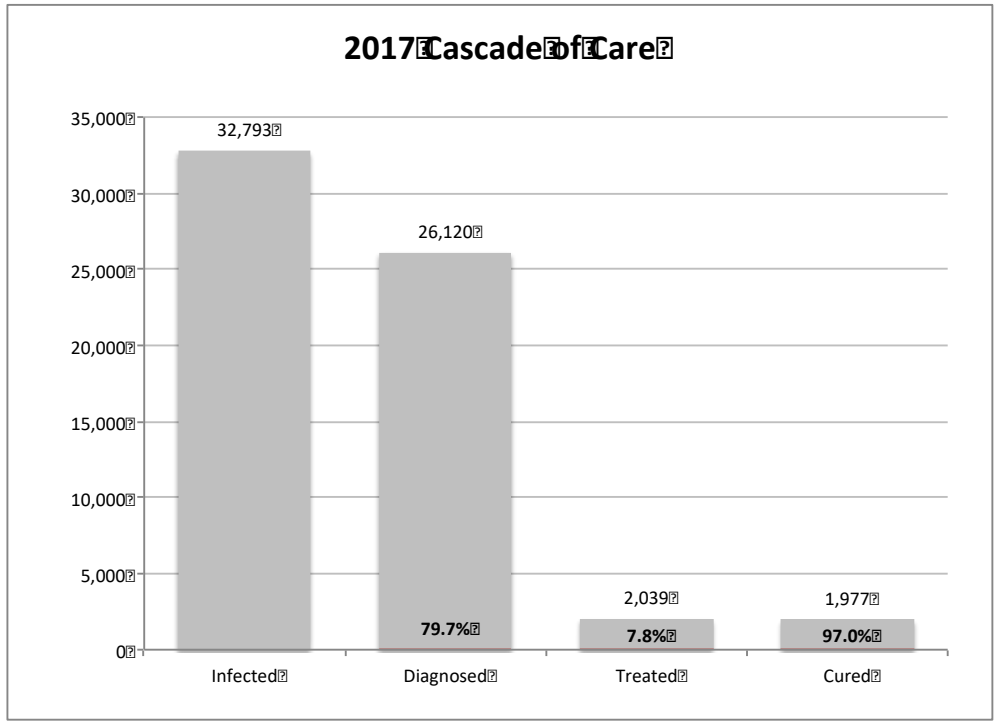
Cured = Number of treated people (as defined above) who attained a sustained virologic response (SVR)*, including people who initiated treatment in 2017 and underwent SVR testing within the first six months of 2018.

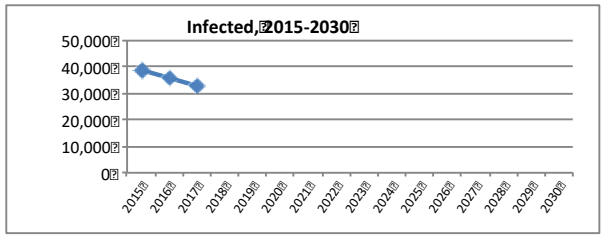
*SVR is defined according to the latest clinical practice guidelines that are relevant for the country of interest, e.g., guidelines from a national clinical society or from the World Health Organization, the European Association for the Study of the Liver or the American Association for the Study of Liver Diseases.

***Source:*** Safreed-Harmon *et al. Clin Infect Dis*. 2019 Nov 27;69(12):2218-2227.

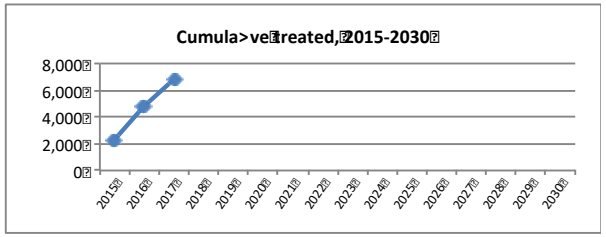
# CoC – Sweden

A useful tool for comparison among countries and over time.



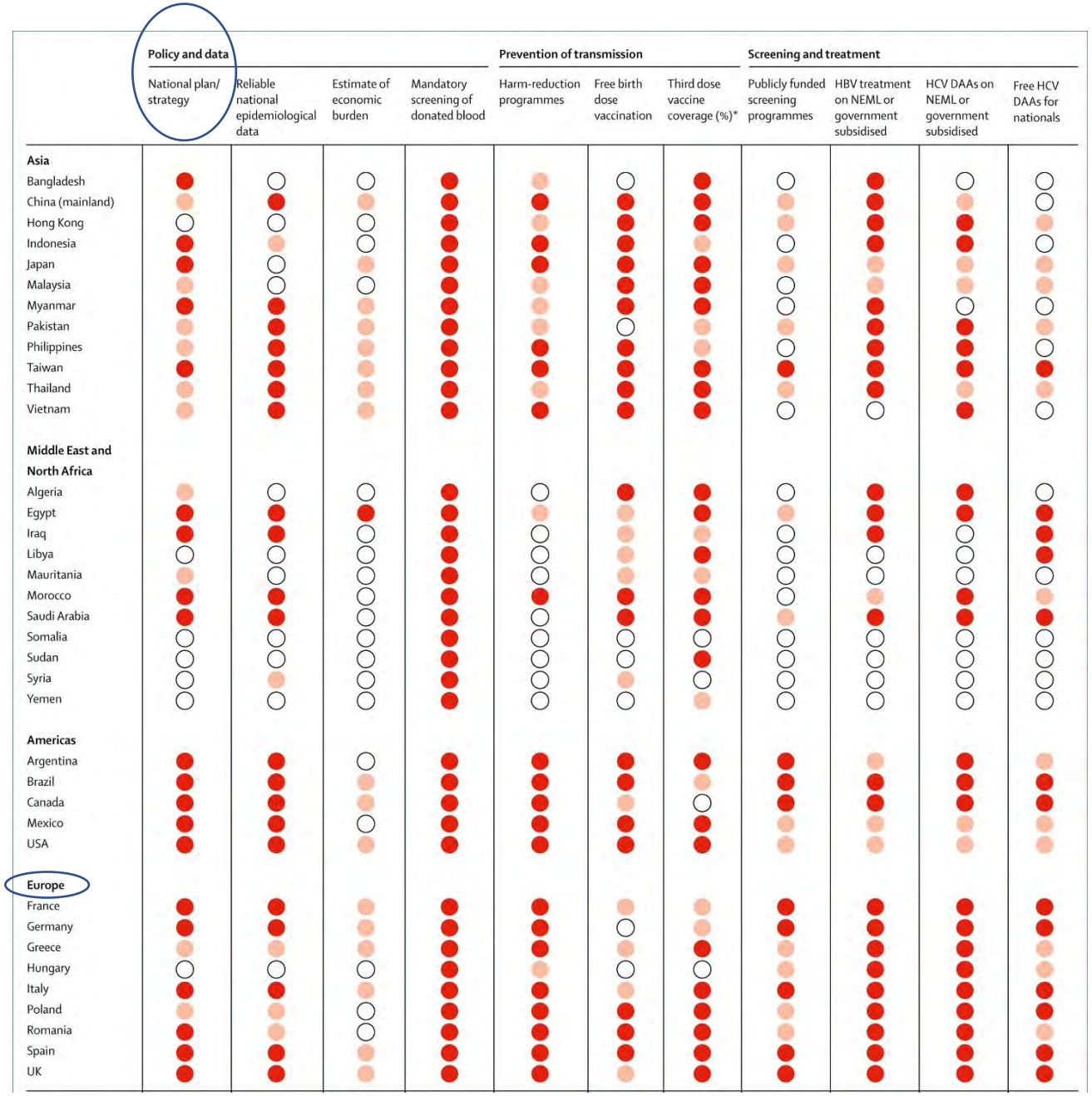








***Source:*** Safreed-Harmon *et al.* Clin Infect Dis. 2019 Nov 27;69(12):2218-2227.

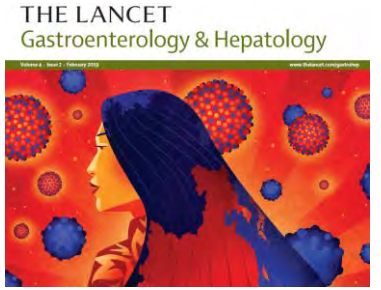
# HCV policies




Red circles denote the existence of a policy.

Pink circles denote that a policy is in development, is not well applied, or is in place for specific subpopulations;

White denotes the absence of a policy.




***Source:*** Cooke G et al. Lancet Commission: Accelerating the Elimination of Viral Hepatitis, *The Lancet Gastroenterology & Hepatology,* 2019; 4: 135–84.


# Eliminate late presentation

Mauss *et al. BMC Medicine* (2017) 15:92
DOI 10.1186/s12916-017-0856-y

BMC Medicine

CORRESPONDENCE Open Access

## Late presentation of chronic viral hepatitis for medical care: a consensus definition

Stefan Mauss[1,2], Stanislas Pol[2,9], Maria Buti[2,3], Erika Duffell[4], Charles Gore[5], Jeffrey V. Lazarus[6], Hilje Logtenberg-van der Grient[7], Jens Lundgren[6], Antons Mozalevskis[6,8], Dorthe Raben[6,10*], Eberhard Schatz[11], Stefan Wiktor[12], Jürgen K. Rockstroh[10,13] and on behalf of the European consensus working group on late presentation for Viral Hepatitis Care

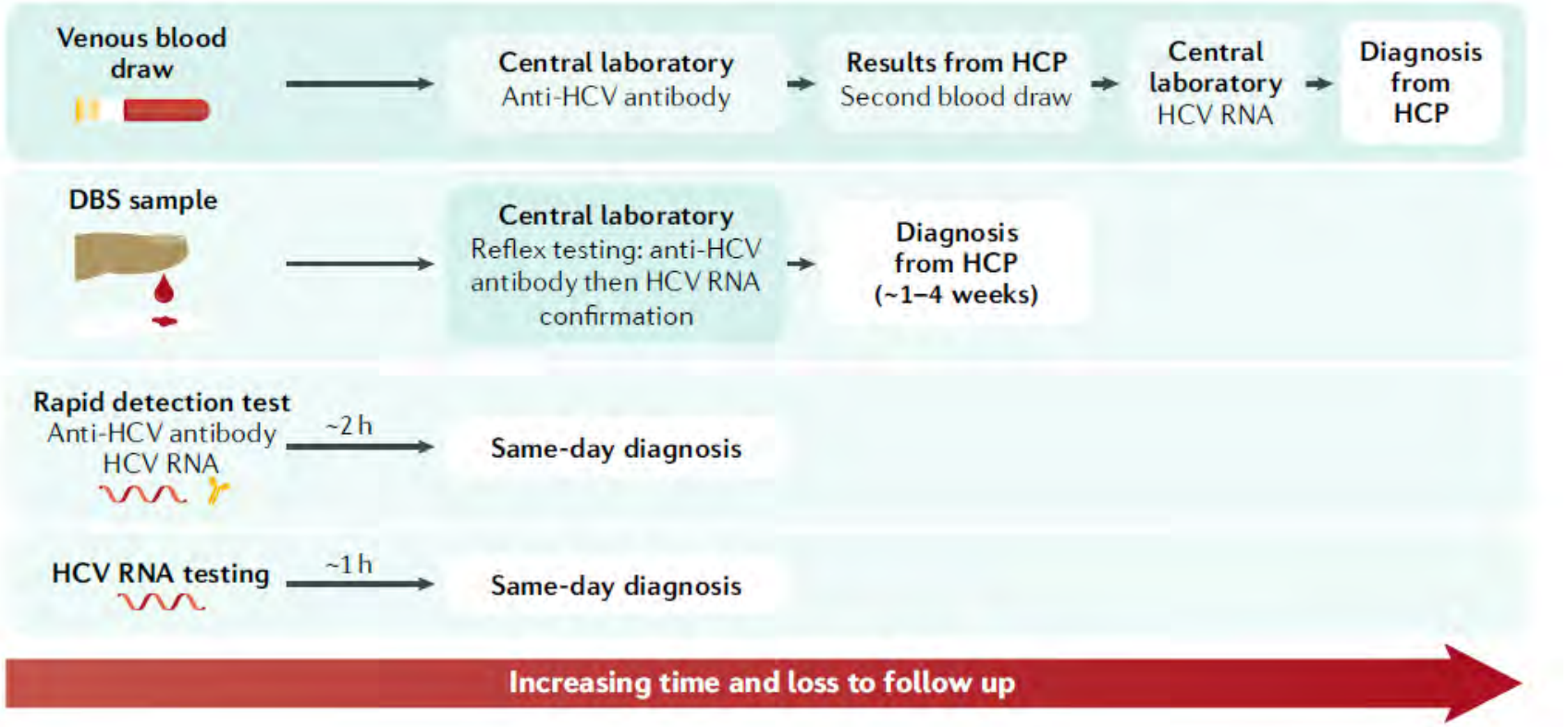
**Abstract**

**Introduction:** We present two consensus definitions of advanced and late stage liver disease being used as epidemiological tools. These definitions can be applied to assess the morbidity caused by liver diseases in different health care systems. We focus is on hepatitis B and C virus infections, because effective and well tolerated treatments for both of these infections have greatly improved our ability to successfully treat and prevent advanced and late stage disease, especially if diagnosed early. A consensus definition of late presentation with viral hepatitis is important to create a homogenous, easy-to-use reference for public health authorities in Europe and elsewhere to better assess the clinical situation on a population basis.

**Methods:** A working group including viral hepatitis experts from the European Association for the Study of the

***Source:*** Mauss et al. *BMC Med*, 2017.

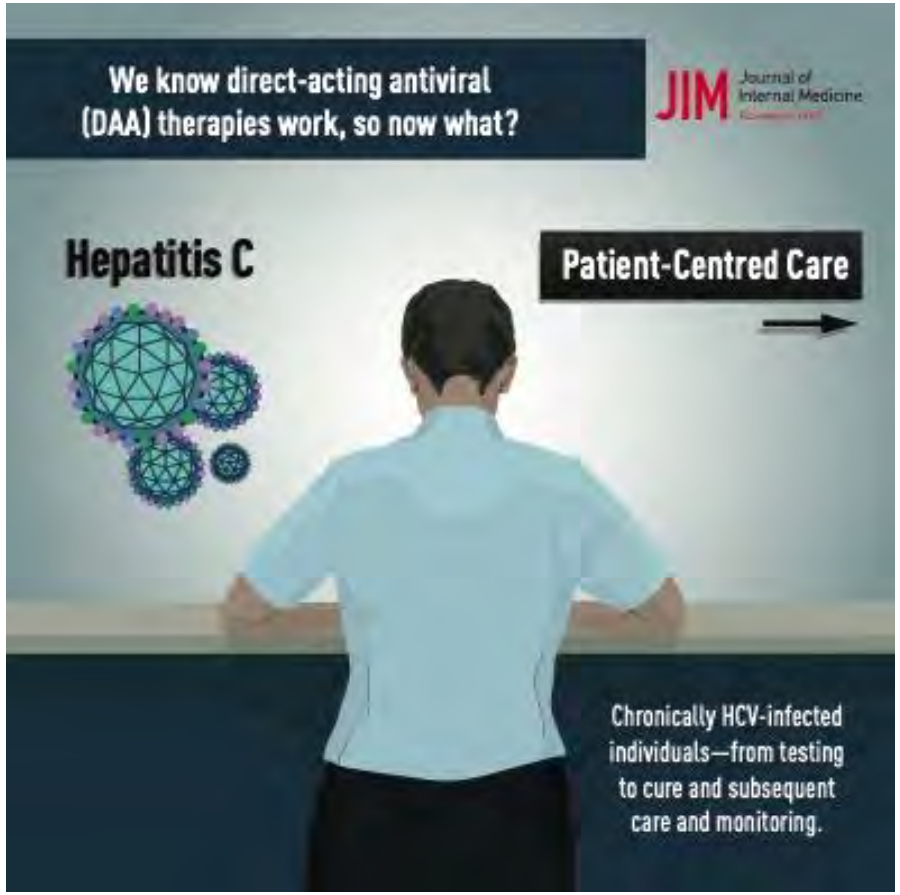
# Fewer visits please…




*Sources*: Lazarus et al. Too many people with viral hepatitis are diagnosed late – with dire consequences. *Nature Rev*, Aug 2019.
Grebely et al. Hepatitis C point-of-care diagnostics: in search of a single visit diagnosis. *Expert Review of Molecular Diagnostics.* 2017;1473-7159.

# What is an ideal MoC for HCV?

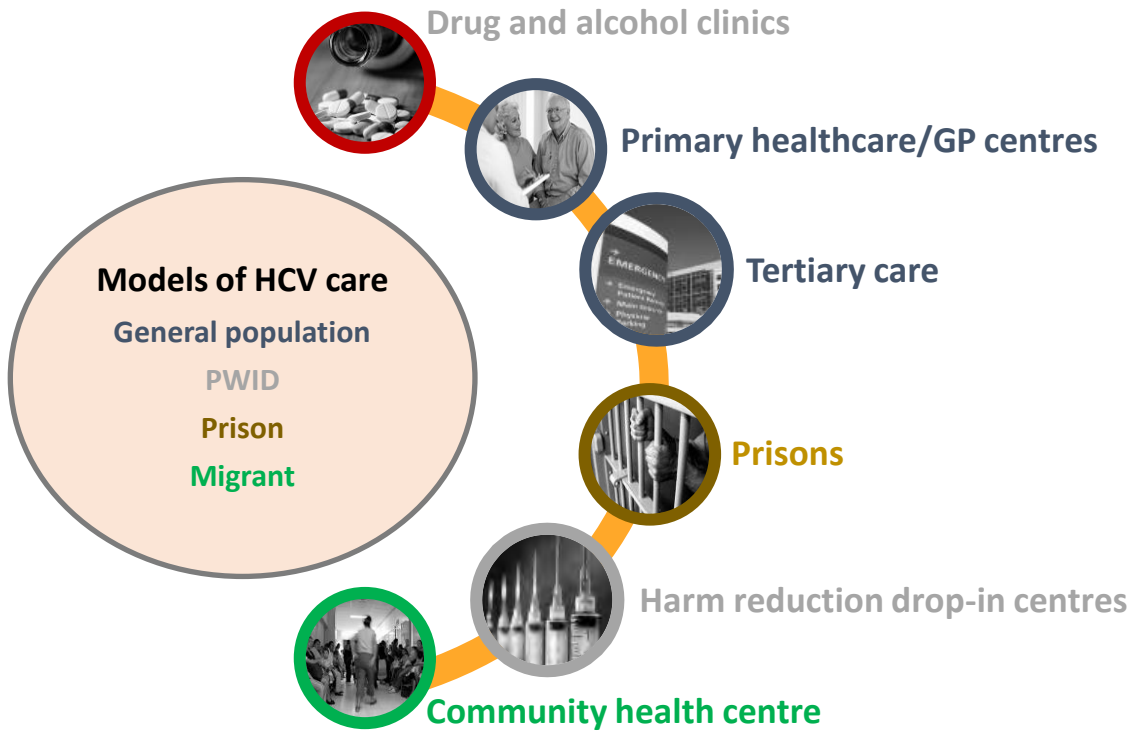
- Much can be learned from examining innovative MoCs, which suggest that an effective MoC for HCV infection should be:
  - Simple
  - Targeted
  - Multidisciplinary
  - Scalable
  - Integrated
  - Patient-centred and affordable.




***Source:*** Lazarus JV et al. We know DAAs work, so now what? Simplifying models of care to enhance the hepatitis C cascade. *J Int Med* 2019.

# Different models of HCV care are needed for different HCV subpopulations for testing and treatment

**Multiple models essential**




GP: general practitioner

***Source:*** Bruggmann P, Litwin AH. *Clin Infect Dis* 2013;57(Suppl 2):S56–61.
Lazarus JV et al. We know DAAs work, so now what? Simplifying models of care to enhance the hepatitis C cascade. *J Int Med* 2019.

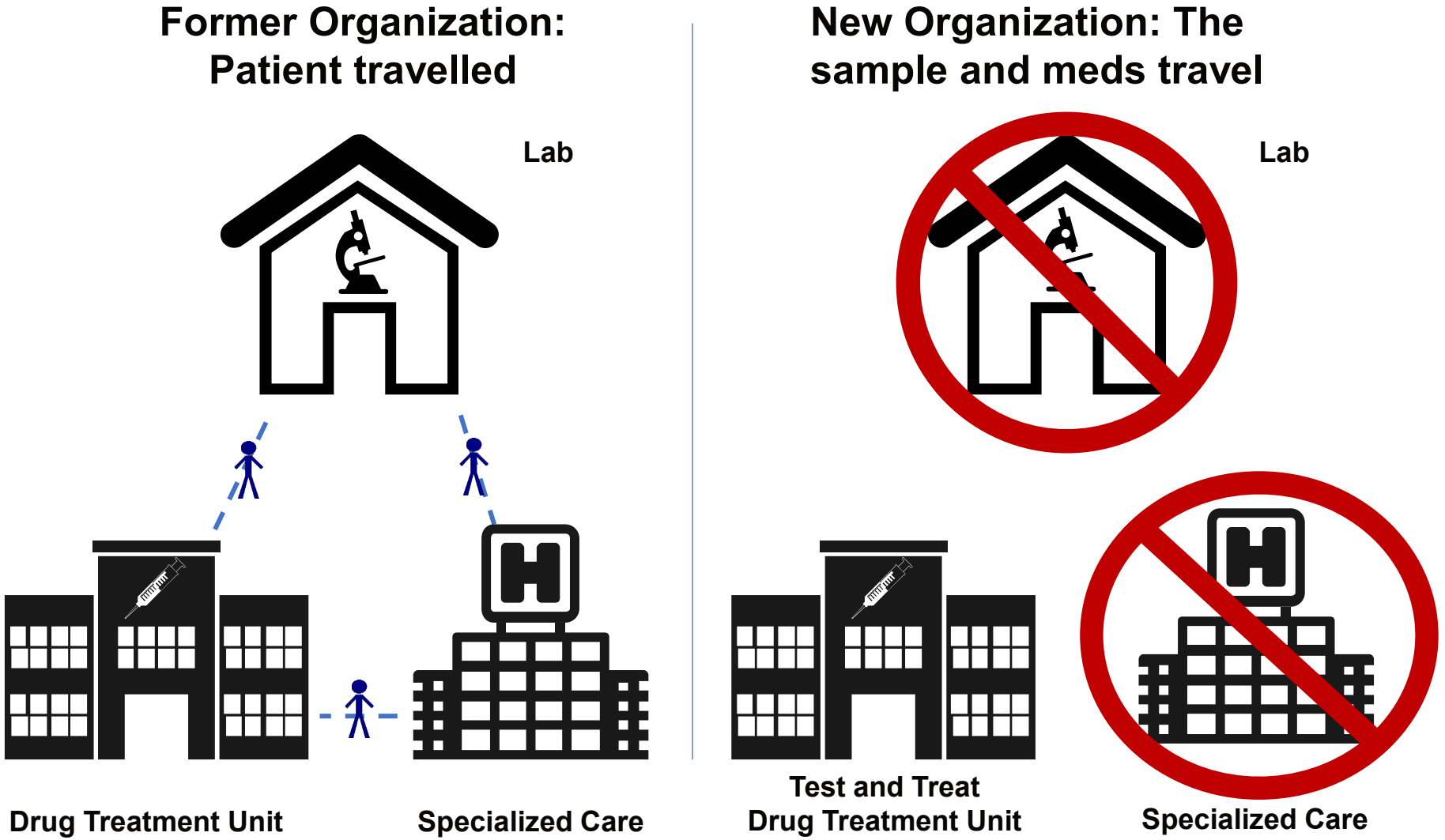
# Hepatitis C standards of care: A review of good practices

- In addition to DAAs, we need evidence-based good practices to help countries eliminate viral hepatitis C.
- The tools required for elimination have largely been established, and the issue at hand is more how they should best be implemented.
- Good practices that have become standard of care in some settings include:
  - Reflex testing
  - Point of Care testing (including RDT and DBS)
  - HCV care in prison settings
- Good practices that should become the standard of care:

Dried blood spot testing, Decentralised and community-based testing services, Treatment provision in non-clinical settings, Peer support, Retrieving those lost to follow-up, **Integrated testing**, Clinician reminders, Telemedicine, and Task-shifting

***Source:*** Lazarus et al. Hepatitis C standards of care: A review of good practices since the advent of direct-acting antiviral therapy. *Clinics and Research in Hepatology and Gastroenterology* (2021) 45, 101564.

# Case 1. Where Would You Want To Be Tested and Treated?




***Source:*** Shared Addiction Care Copenhagen (SACC) Report 2017. Available at: http://www.chip.dk/Collaborations/SACC (accessed July 2018).

# Case 2. T'n'T, Copenhagen Denmark

- Running from April 2019.
- Parked behind the main train station in Copenhagen, Denmark's largest open drug scene
- Peer-led by Brugernes Akademi, Denmark, with on-site nurses.
- GeneXpert® machine in the van.
- Linkage to care at hospital – medicine can be delivered to the van.


***Source:*** Lazarus 2019


# HCV (micro-) elimination in certain populations is also feasible in the short-to-medium term

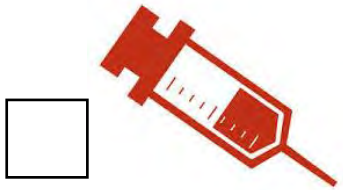
**Decompensated cirrhotics**

**Veterans**

**Patients with haemophilia**

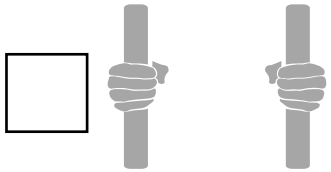
**Patients with chronic kidney disease**

**Transplant patients**



**PWID**

**HIV/HCV co-infected**

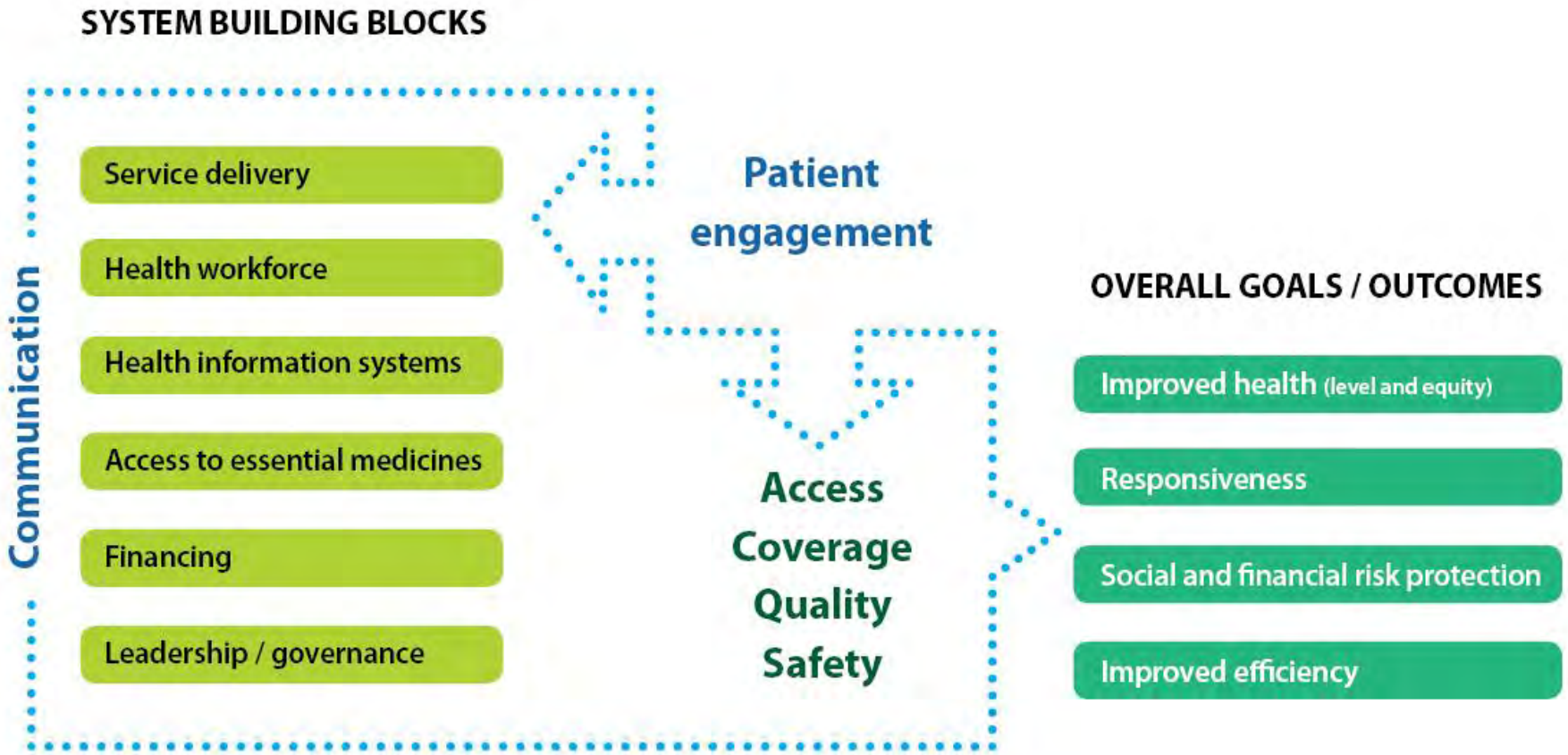


**Incarcerated individuals**

***Sources:*** Lazarus JV *et al.* The micro-elimination approach to eliminating hepatitis C: strategic and operational considerations. *Seminars in Liver Disease*, In press July 2018.

Lazarus JV, Wiktor SZ, Colombo M, Thursz M. Micro-elimination – a path to global elimination of hepatitis C. *Journal of Hepatology*, July 2017.

# A paradigm change:
# The central role of people and communication




***Source:*** Lazarus and France. A new era for the WHO health system building blocks? 2014

# *Putting it all together …*

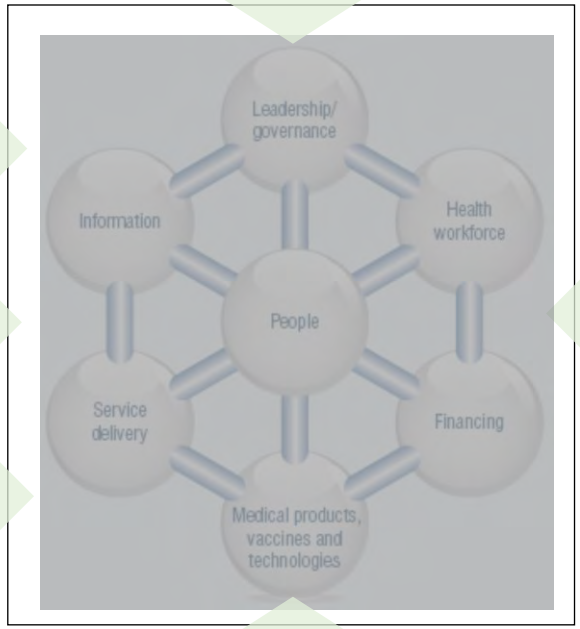
## A people-centred health systems approach to HCV elimination in central and eastern Europe

Policy leaders

Academia

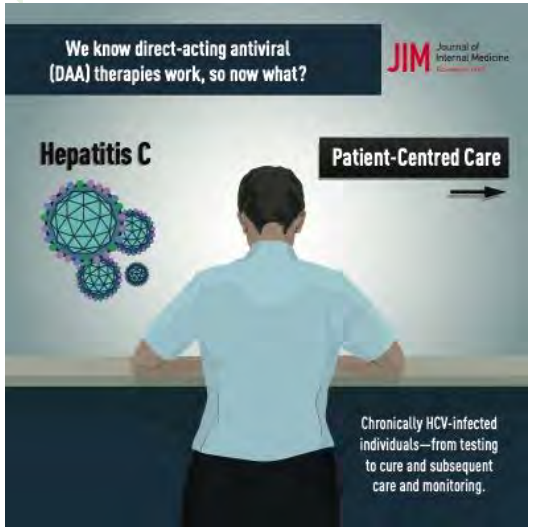
Industry

Other stakeholders




Health care providers

Civil society



# Acknowledgements

**All authors of all cited studies,** especially Camila Picchio, Elisa Martró Català, Graham Cooke, Tim France, Lars Peters and authors of the "We know DAAs work, so now what? Simplifying models of care to enhance the hepatitis C cascade" review: Camila Picchio, Juan M Pèricas, Jasna Cernosa, Mishka Hoekstra, Niklas Luhmann, Mojca Maticic, Phillip Read, Emma Robinson, and John Dillon.

*And the EASL International Liver Foundation for the work on micro-elimination.*

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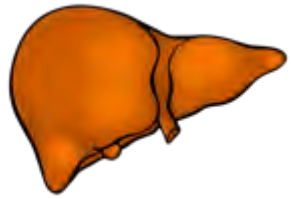
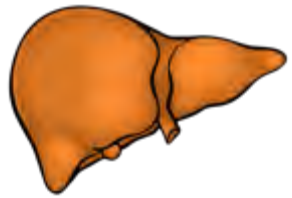
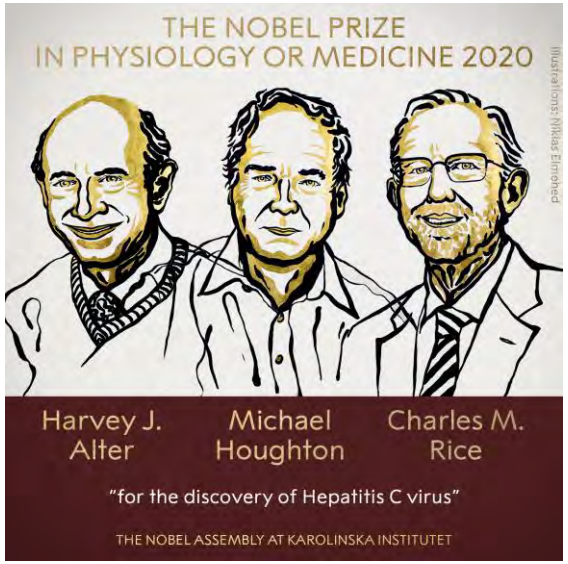




EASL
INTERNATIONAL
LIVER
FOUNDATION




***Contact:*** Jeffrey.Lazarus@ISGlobal.org

http://pathtozero.eiu.com/

# Prof Sharon Hutchinson

## Glasgow Caledonian University, Glasgow, UK


#HCVSummit
@HepBCPPA

# Synergies of harm reduction and HCV elimination

**Sharon Hutchinson**

3rd EU HCV Virtual Policy Summit , *24th March 2021*

GCU Glasgow Caledonian University

University for the Common Good

Public Health Scotland

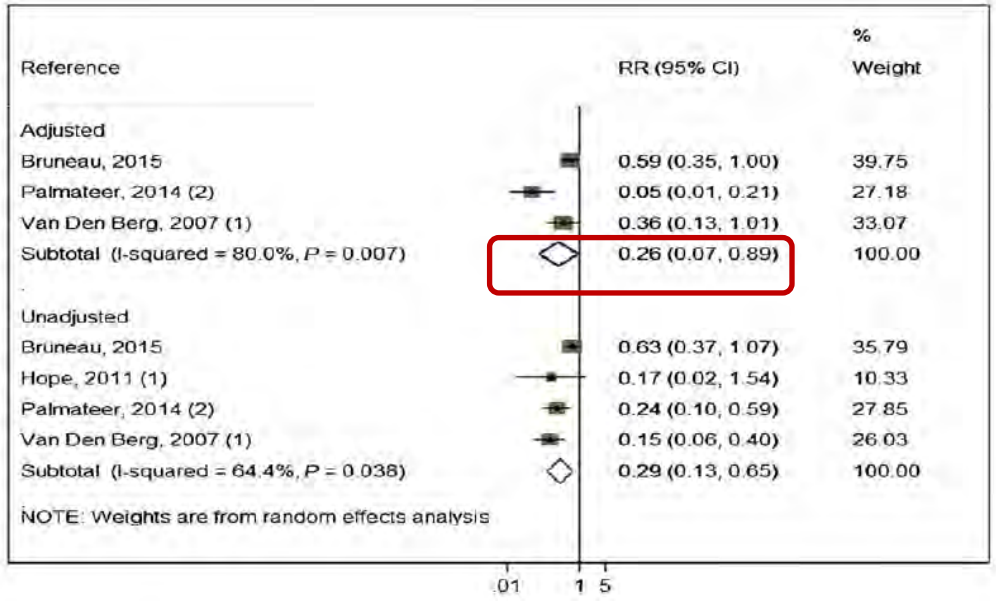
# Impact of harm reduction on acquisition of HCV infection among people who inject drugs (PWID)

- Cochrane review and meta-analysis of 28 studies involving ~6300 subjects examining effect of Needle and Syringe Programme (NSP) and Opioid Substitution Therapy (OST) on HCV acquisition among PWID

- **Current OST associated with 50% reduction in HCV risk** (RR=0.5, 04-0.6)

- **High NSP coverage in European studies associated with 56% reduction in HCV risk** (RR=0.44, 0.2-0.8)

- **<u>Combined</u> OST/high NSP coverage associated with 74% reduction in HCV acquisition risk** (RR=0.26, 0.1-0.9)




**Association between combined OST and high NSP coverage on HCV incidence**

**Platt L et al.** Needle and syringe programmes and opioid substitution therapy for preventing HCV transmission among people who inject drugs: findings from a Cochrane Review and meta-analysis. **Addiction 2018**

# Country-level data shows poor coverage of harm reduction interventions (OST and NSP)

**<1% of PWID globally live in countries with high coverage of both NSP and OST**
(4 countries including Austria, Netherlands and Norway)

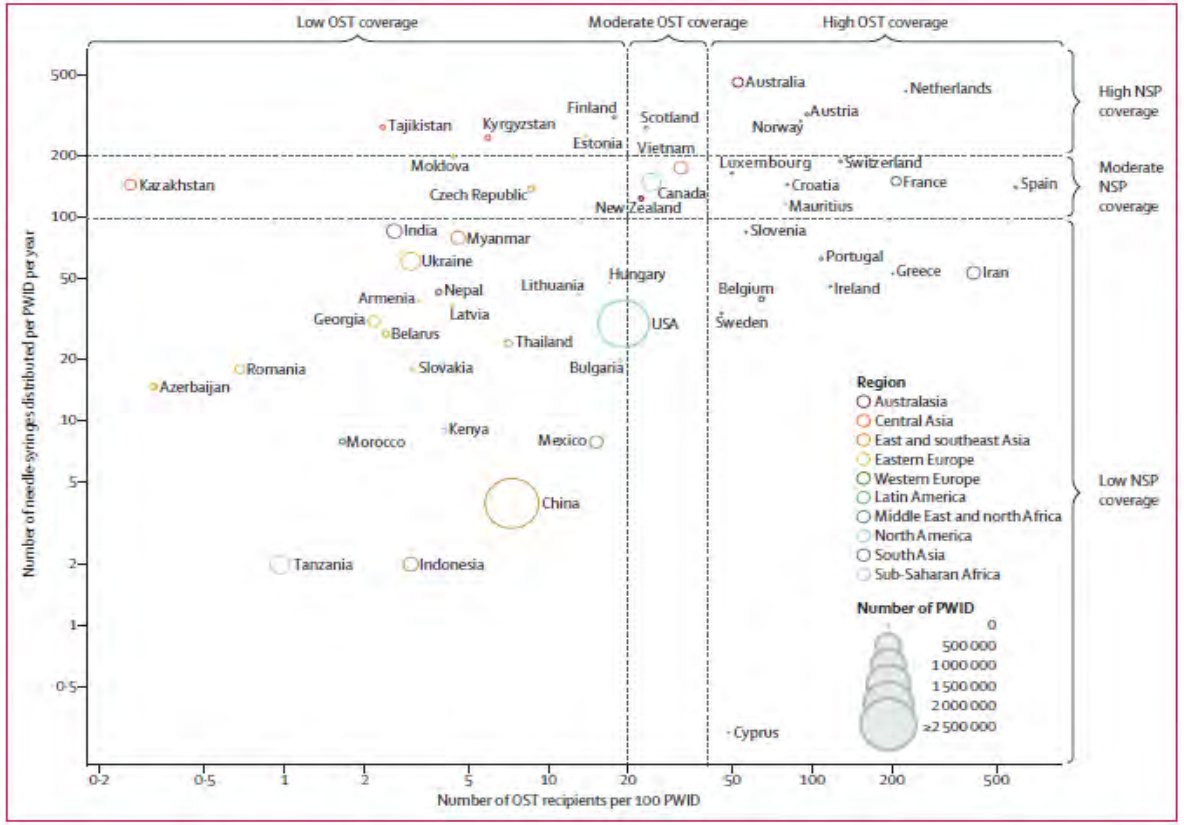



*Figure 4*: **Combination coverage of needle and syringe programmes and opioid substitution therapy for people who inject drugs**
Includes only countries with a non-zero estimate of both NSP and OST coverage. Circle area indicates national estimate of population size of PWID. PWID=people who inject drugs. NSP=needle and syringe programmes. OST=opioid substitution therapy.

**Scaling up of harm reduction interventions remains a crucial priority for HCV and HIV transmission elimination strategies**

**Larney S**, et al. **Lancet Glob Health 2017.**

# Scale-up of harm reduction increases the benefit of HCV IFN-free DAA therapy among PWID

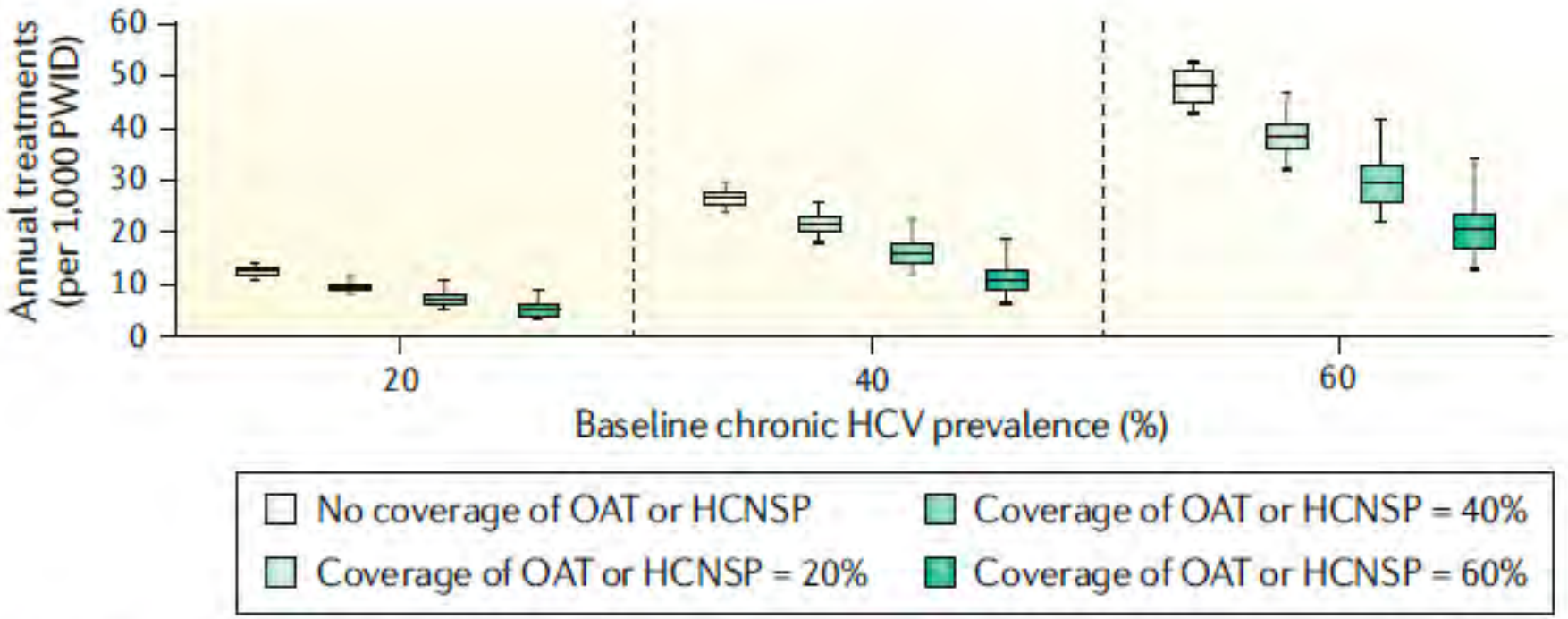
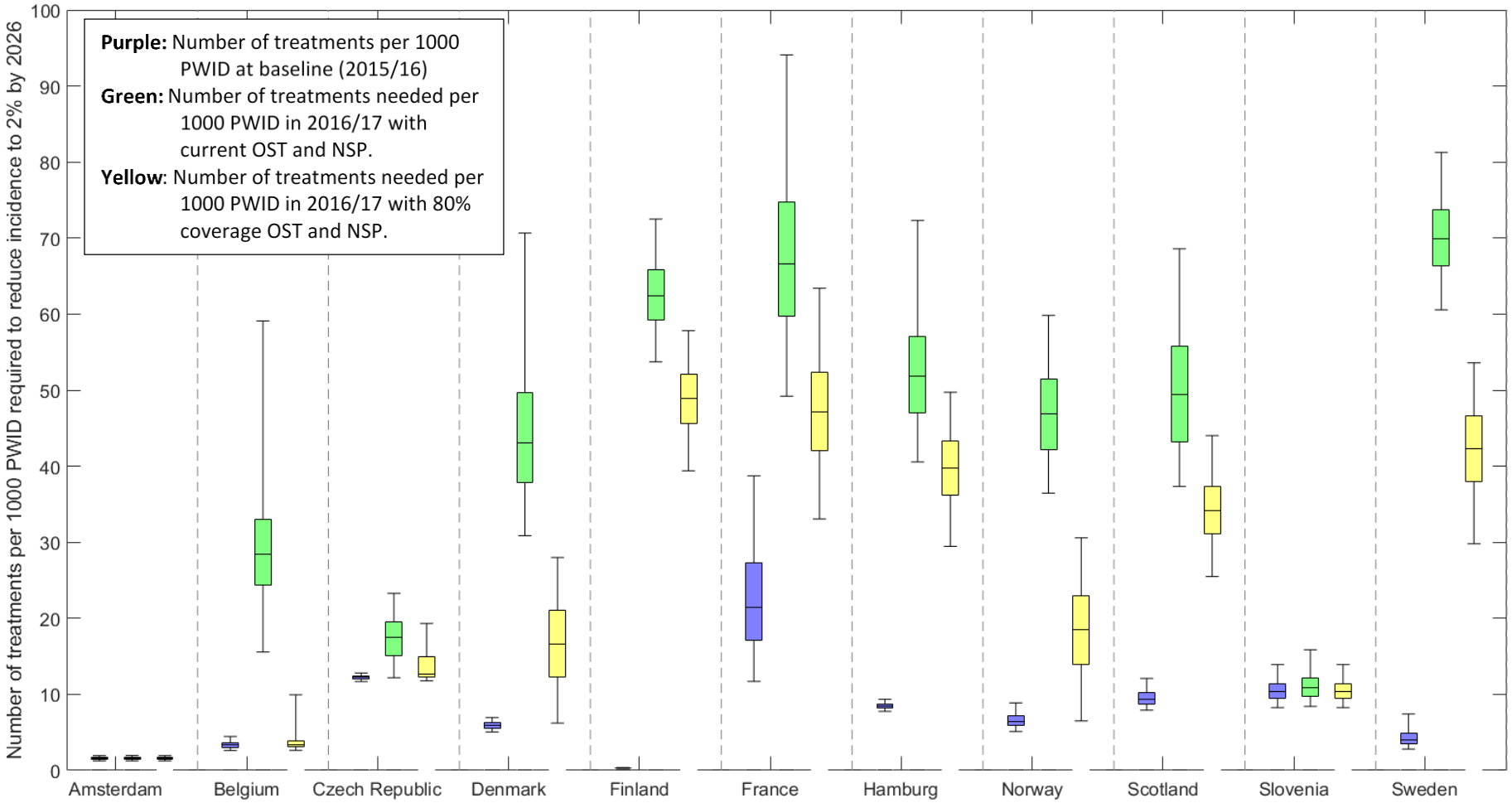



Fig. 8 | **Model projections of the effect of various treatments on transmission of HCV in people with OUD.** Hepatitis C virus (HCV) treatment rates required to halve HCV prevalence. HCNSP, high-coverage needle and syringe programmes; OAT, opioid agonist therapy; OUD, opioid use disorder; PWID, people who inject drugs. Adapted from REF.[385], CC-BY-3.0 (https://creativecommons.org/licenses/by/3.0/).

**Strang J**, et al. Opioid use disorder. **Nat Rev Dis Primers 2020**. Adapted from **Martin NK,** et al**. Clin Infect Dis. 2013.**

# Scale-up of DAA treatment and harm reduction needed in most settings in Europe to minimise HCV transmission among PWID




**Fraser H**, et al. **J Hepatol. 2018.**

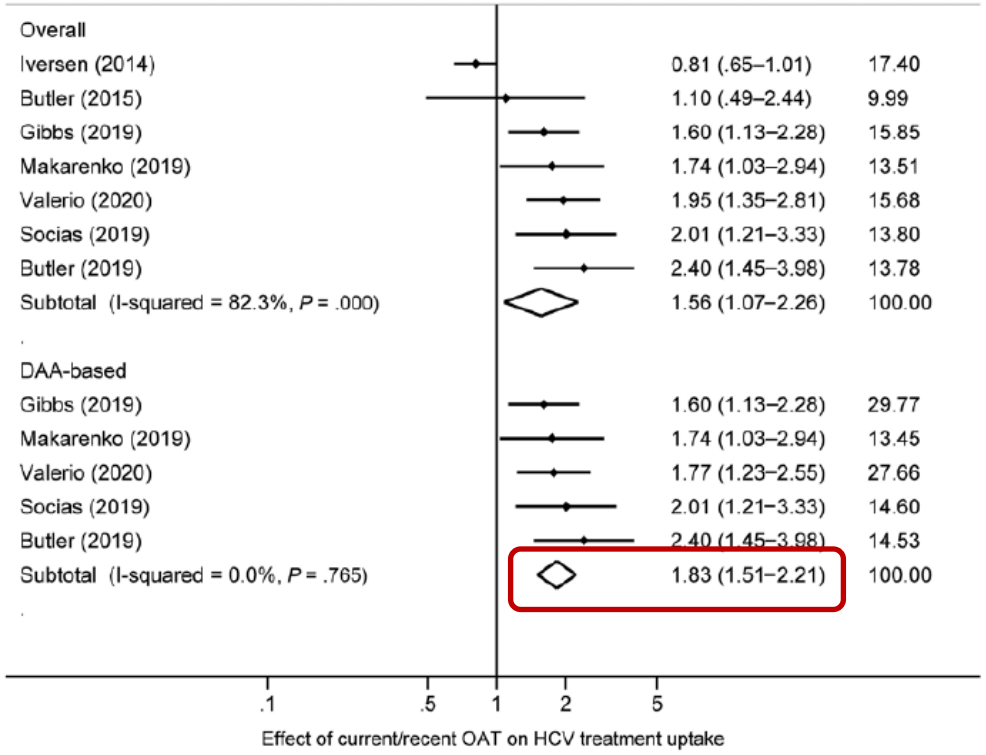
# Harm reduction services can increase HCV testing and treatment among PWID

- PWID experience barriers to accessing HCV testing and treatment. A recent systematic review assessed the role of Opioid Agonist Therapy (OAT) in HCV testing and treatment outcomes among PWID.

- **Current/recent OAT associated with 80% increased odds of recent HCV Ab testing** (4 studies; OR 1.8, 1.4-2.3)

- **Current/recent OAT associated with 80% increased odds of DAA treatment uptake** (5 studies; OR 1.8, 1.5-2.2)

- **Evidence supports integration of HCV services in drug treatment settings**

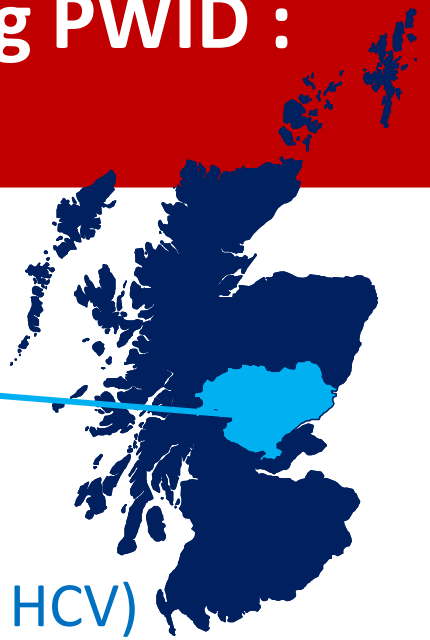



**Grebely J,** et al. **Clin Infect Dis. 2020.**

# Rapid major scale-up of DAAs among PWID : a feasibility study

## NHS Tayside 'elimination' plan*

- Rapid & major scale-up of DAAs among PWID (500 over 2 years)
- Aim to reduce chronic HCV prevalence among PWID from 30% to <10%
- Testing (by services) & treatment (by nurses & pharmacists) in multiple community settings

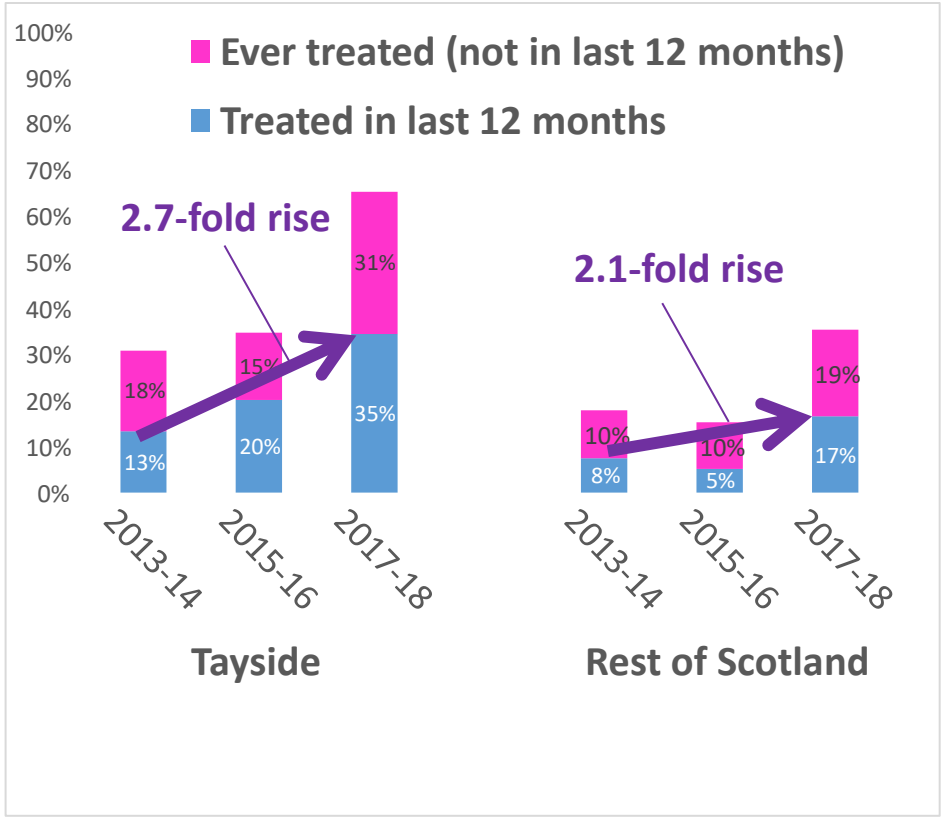


**NHS Tayside**
Popln: 400,000
PWID: 2,700
(800 with chronic HCV)

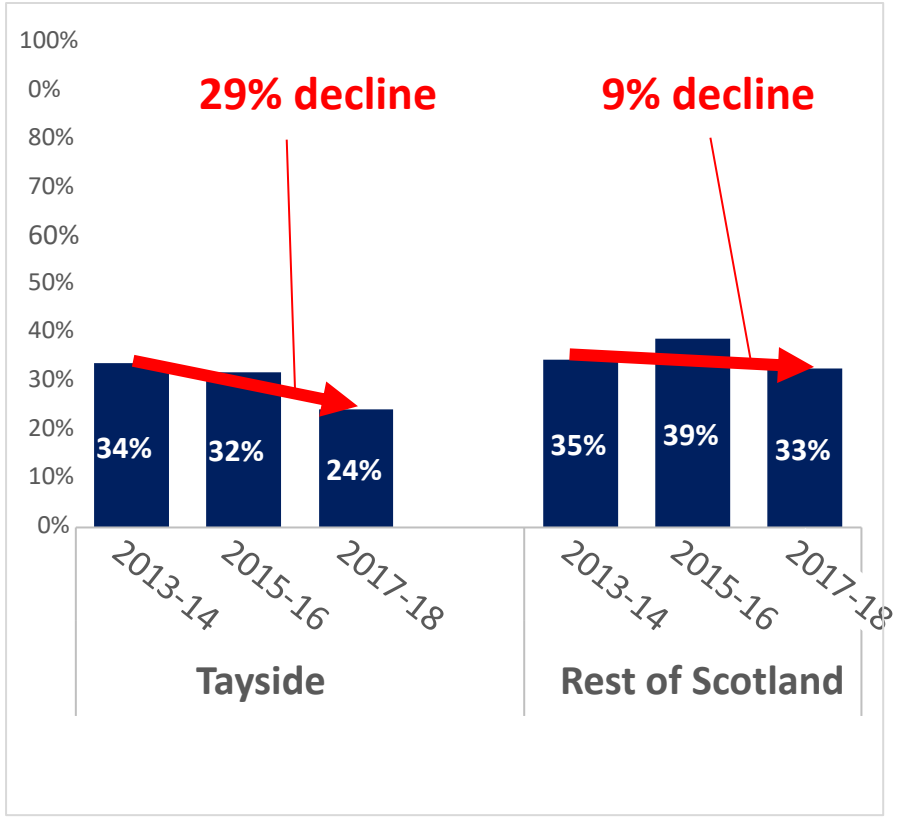

Hickman M, et al. *BMJ Open* 2019.

# Reduction in the population prevalence of HCV among PWID associated with scale-up of DAAs in community drug services : real-world data from Scotland

## (a) Scale-up of HCV therapy among PWID in Scotland

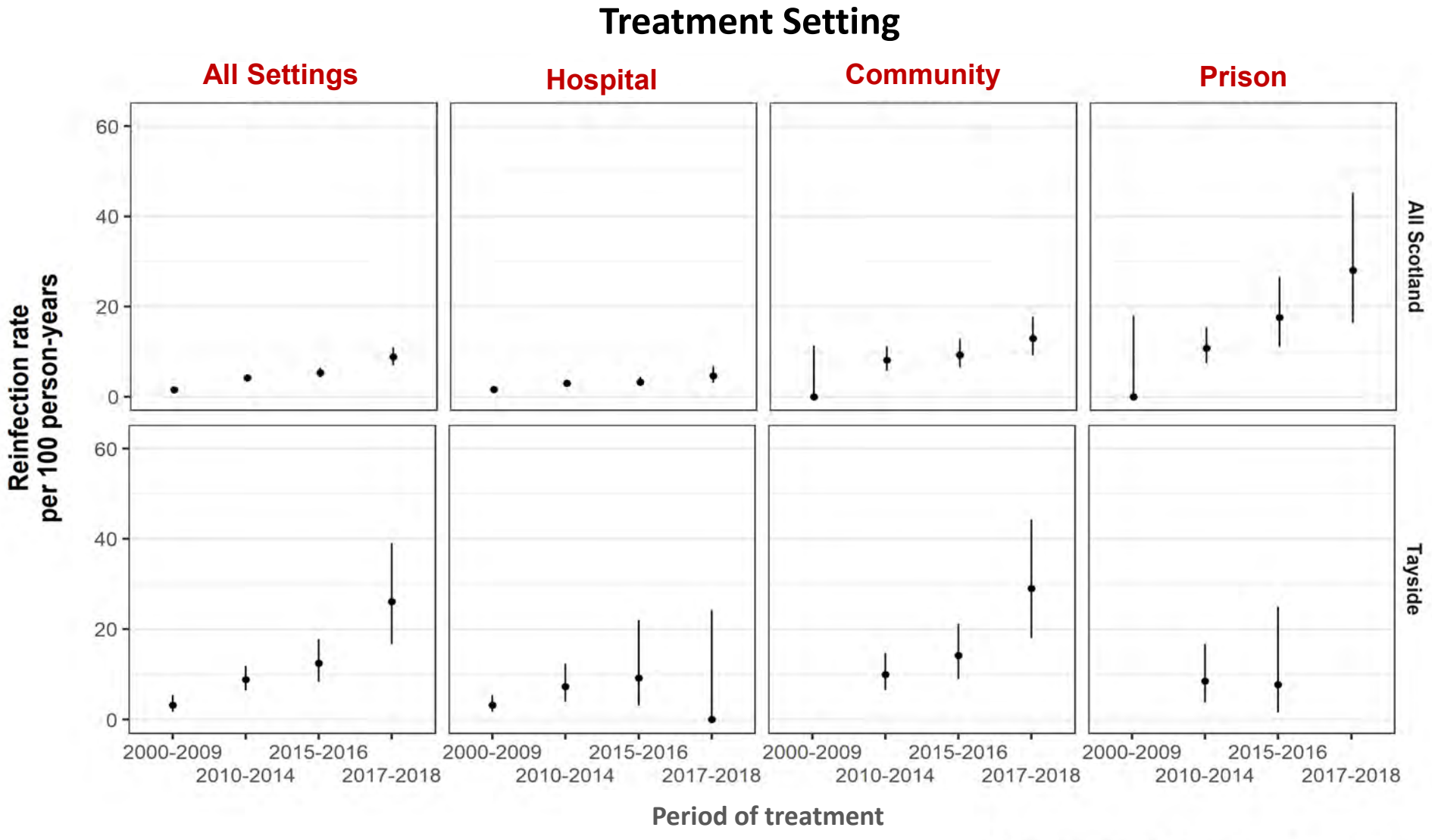



## (b) Impact on HCV prevalence among PWID in Scotland




**Palmateer N,** et al. **Addiction (in press)**

# Rise in HCV re-infection rates associated with scale-up of DAAs in community drug services : real-world data




*Categories with less than 10 person-years of follow-up are not shown.*
*Hospital includes data where treatment setting was other/not known.*

**Yeung A,** et al. Unpublished 2021

# Conclusions

1. Strong evidence that harm reduction services (OST in combination with NSP) should be expanded to prevent HCV transmission
2. Despite this strong evidence, coverage of these interventions is low even in high income settings
3. Projections indicate that scaling up DAAs in combination with harm reduction will have greatest impact in reducing HCV to elimination levels
4. This scale up of both DAAs and harm reduction is required in most EU settings
5. Strong evidence that OST services can enhance HCV diagnosis and treatment
6. Evidence that rapid scale-up of DAAs among PWID is feasible through testing and treatment in the community alongside services providing harm reduction
7. Evidence that rapid scale-up of DAAs leads to reduction of HCV among PWID
8. Harm reduction services have crucial role in the testing for and diagnosis of re-infection post SVR among PWID

# Panel discussion and Q&A


#HCVSummit
@HepBCPPA

# Session 2:
# HCV diagnosis in the era of HCV elimination

**Chairs:**
**Prof Angelos Hatzakis, Co-Chair HepBC PPA & University of Athens Medical School**
**Prof Nurdan Tözün, Acıbadem University School of Medicine, Turkey**

EUHCV
Policy Summit - 24.03.2021
Online event

#HCVSummit
@HepBCPPA

# Prof Stanislas Pol

## Hôpital Cochin, Paris, France

# Screening of the general population for HCV

**EU HCV**
24.03.2021
HCV diagnosis in the era
of HCV elimination

Stanislas Pol, MD, PhD

Université de Paris
Département d'Hépatologie/Addictologie,
Hôpital Cochin

stanislas.pol@aphp.fr

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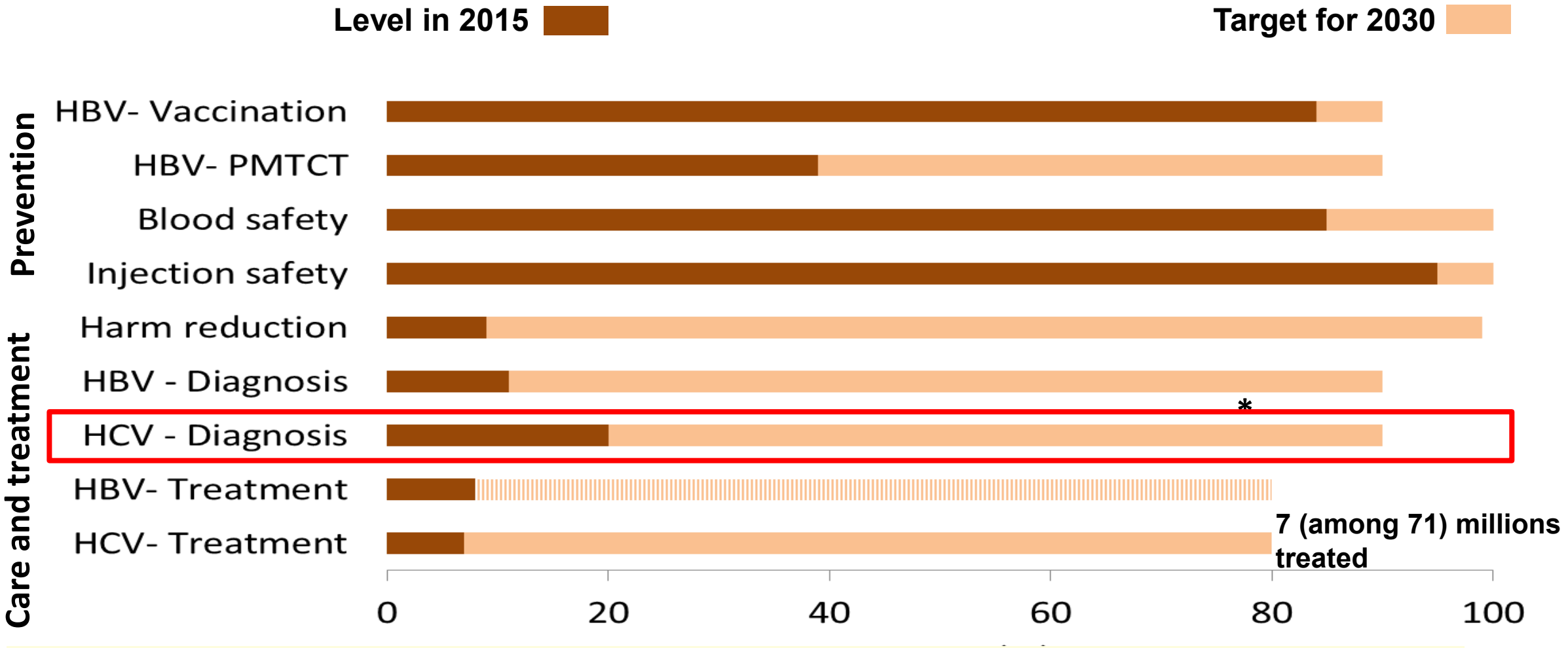
# Disclosures

**Speaker** or **Board member** : Janssen, Gilead, Roche, MSD, Abbvie, Biotest, Shinogui, Vivv, NovoNordisk, LFB

**Grants** : Gilead, Roche, MSD

# Interventions and targets



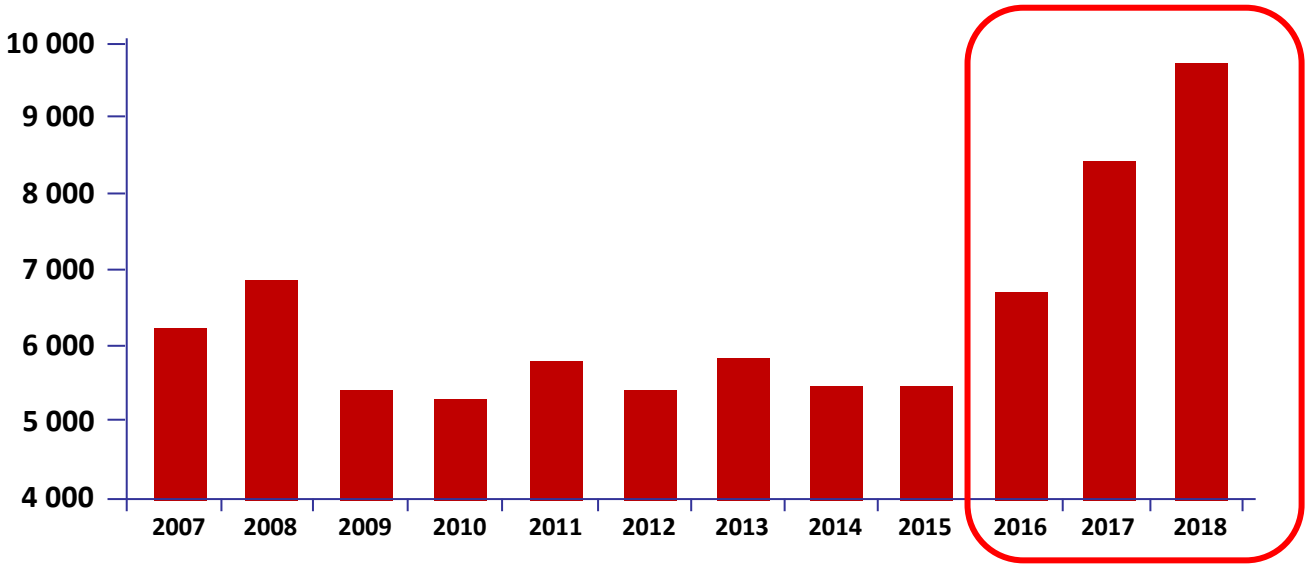

**HCV Screening is a key of elimination: 20% only have been diagnosed!**

Global Report on Hepatitis, WHO, 2017

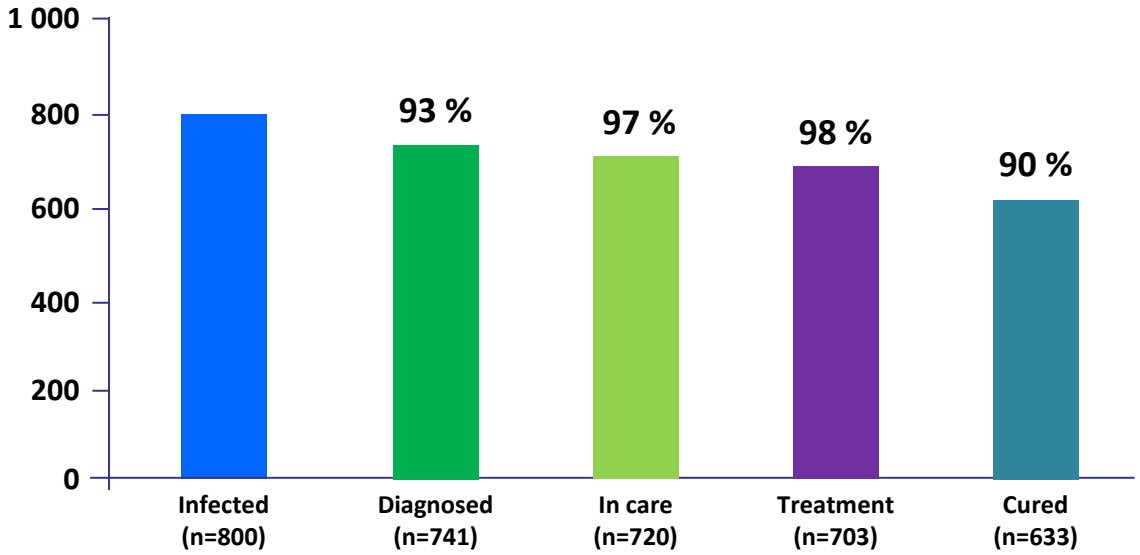
# Elimination of hepatitis C in Iceland

- In 2015, about 800 to 1000 people (drug users in more than 90% of cases) were infected in Iceland
- Thanks to a policy of screening, treatment and prevention, WHO's goal of reducing the incidence of HCV infection by 80% has been achieved

**Number of serologies performed per year**




**Cascade of care**

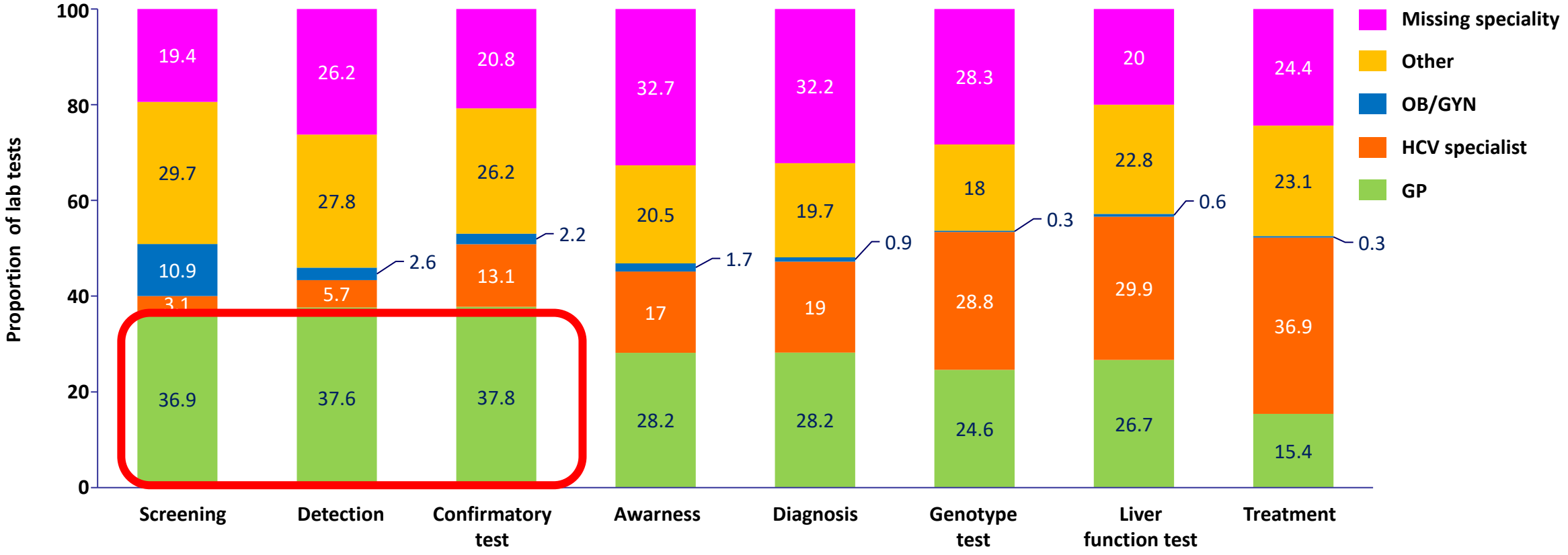



➔ In the history of hepatitis C, Iceland will remain the first country to have eliminated this infection from its territory

Olafsson S et al.,EASL 2019, Abs. THU-412

# HCV screening: a multidisciplinary task

## HCV care cascade by physician speciality

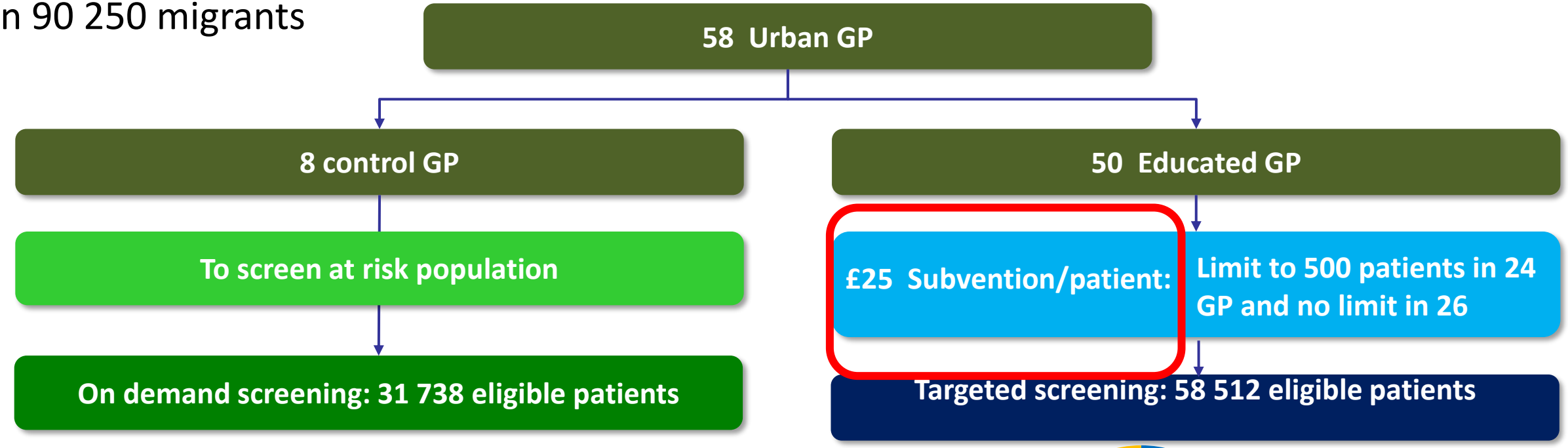


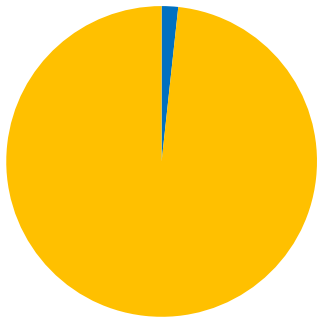

➔ Important role of GP for screening and the leading role of the specialist in the care

Rege S et al., EASL 2019, Abs. PS-066

# HCV screening: incitation

**HepFree**: 18-month controlled study of hepatitis screening (HBsAg, AntiHCV, HCVRNA) in 90 250 migrants



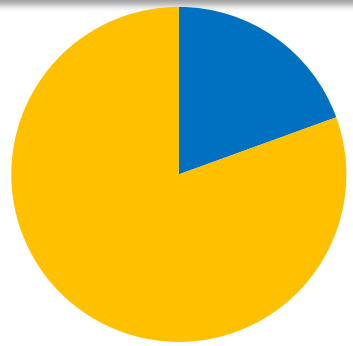



Tested : 543 (1.7 %) vs. 11 386 (19.5 %)

Non tested: 31 195 vs. 47 126

Incidence ratio 3.7

p = 0.014



Flanagan S, et al., EASL 2018, Abs. PS-093

# Universal screening

## AFEF calls for universal screening to overcome final barrier to hepatitis C eradication in France

Paris, 26 September 2017

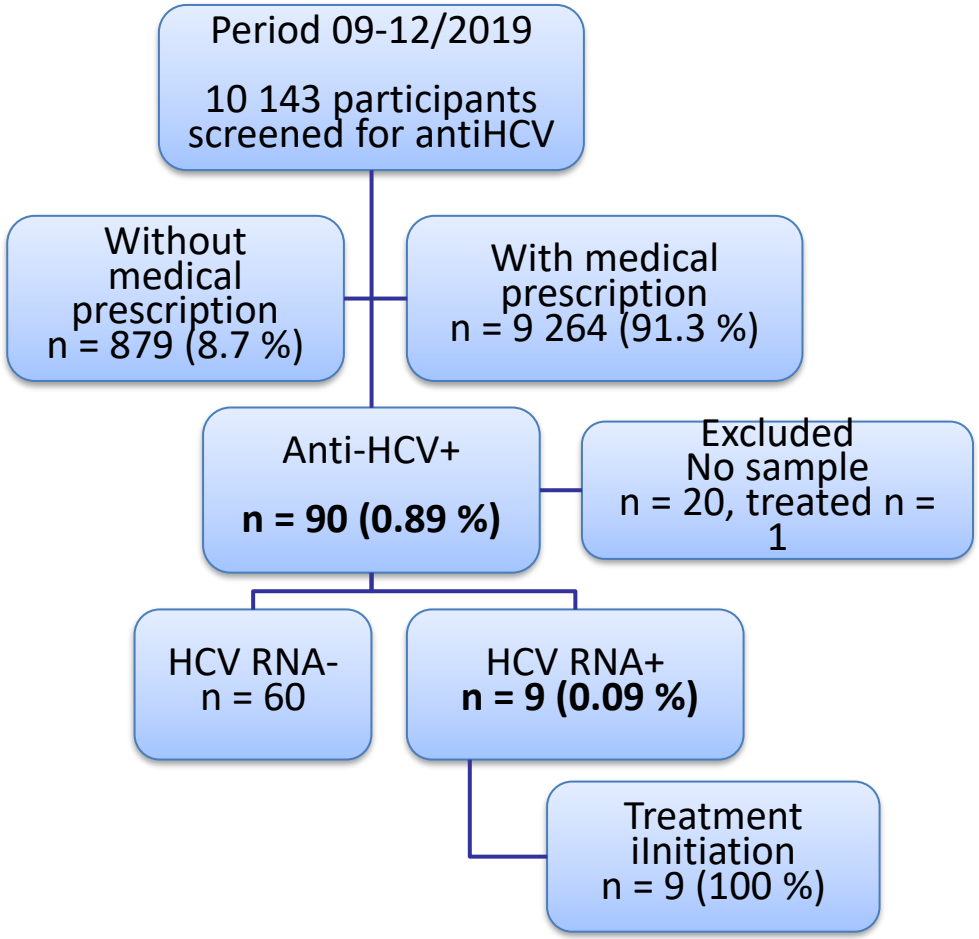
Chronic hepatitis C is now the only chronic viral disease that can be cured. Recent advances in the treatment of this chronic infection lead to rapid recovery in over 95% of patients, with almost no side effects. There should be no reason why the disease cannot be eradicated, yet due to the inconsistency of hepatitis C screening in France, 75,000 patients remain unaware that they are infected. During its annual conference, to be held in Nice from 4 to 7 October, the French Association for the Study of the Liver (AFEF) will call for the introduction of universal hepatitis C screening in France.

**Universal (one-time in life) screening has been refused by the french High Authority of Health (HAS)**

Paris, 26 septembre 2017

# Universal screening

## AntiHCV screening in the general population in last trimester 2019




- **+22 % more tests than in the same period in 2018**
- **Decreased anti-HCV prevalence VHC vs. 2018 (1,12 %)**
- **70 % aged 20-49 years**
- **83 % of anti-HCV+ > 40 years**

| | |
|---|---|
| **HBV** | **0.57 %** |
| **HIV** | **0.34 %** |
| **Syphilis** | **1.42 %** |

**5 220 questionnaires**

**Main risk factors**
**33 % nosocomial <1992**
**33 % various : tatoos, piercing, scarifications**
**37 % declared no risk factor**

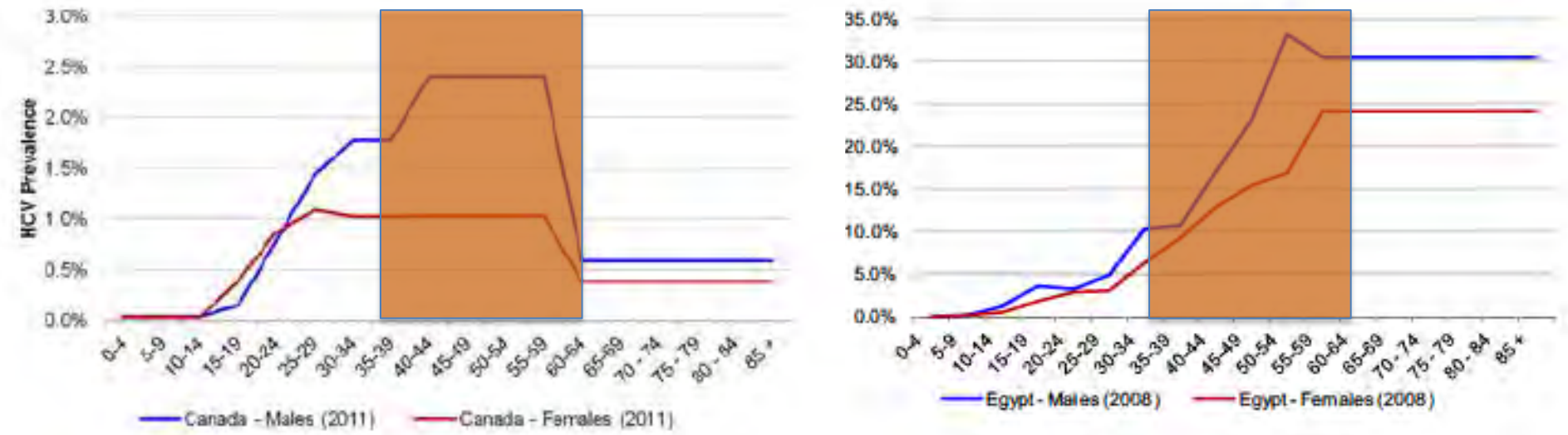
➔ **HCV Screening in general population is not an accurate option**

Pageaux GP, et al.AASLD 2020, Abs. 966

# « Universal » screening in USA

- Age-based screening: persons born in 1945-1965 (baby-boomers)

**Canada** | **Viremic prevalence by age and gender** | **Egypt**




- **1945 to 1970 birth cohort**
- **Similar to the US where if combine birth cohort + risk factor-based screening → 74% of cases identified**

**Birth cohort screening makes sense**

- **1945 to 1970 birth cohort would miss the highest prevalence groups**

**Screen all adults likely more effective**


1. Beckett GA et al. MMRW Recomm Rec 2012; 2. Bruggmann P, *et al. J Viral Hep* 2014; 21:5–33; 3. Mahajan R, *et al. Am J Pub Health* 2013; 103:1445–1449.

# « Universal » screening in Egypt

**Table 1. Participation in Screening and HCV Seroprevalence According to Sex.***

| Variable | Men | Women | Total |
|---|---|---|---|
| Screening target population — no.† | 32,207,165 | 30,298,399 | 62,505,564 |
| Participated in screening — no. (%)‡ | 24,018,428 (74.57) | 25,611,891 (84.53) | 49,630,319 (79.40) |
| Previously treated for HCV infection with direct-acting antivirals since 2014 — no. (%)§ | 692,632 (2.88) | 591,739 (2.31) | 1,284,371 (2.59) |
| Screened for HCV antibodies — no. (%)§ | 23,325,796 (97.12) | 25,020,152 (97.69) | 48,345,948 (97.41) |
| HCV seropositive | | | |
| No. of adults | 1,252,443 | 976,885 | 2,229,328 |
| Percent (95% CI)¶ | 5.37 (5.36–5.38) | 3.90 (3.90–3.91) | 4.61 (4.61–4.62) |

**1,501,307 participants → 76.5% HCV RNA+ → 91.8% started DAA → 65.1% completed**

**98.8% SVR**

Waked I et al. NEJM 2020

# « Universal » screening in USA

- * Age-based screening
- **At least once in adults > 18 years and in all pregnant women except in settings where HCV prevalence is <0.1%
- **Any person who request HCV testing
- All persons with risk factors and periodic testing while the risk persist
- One-time HCV testing among persons with recognized risk factors or exposure  Persons with underlying medical conditions

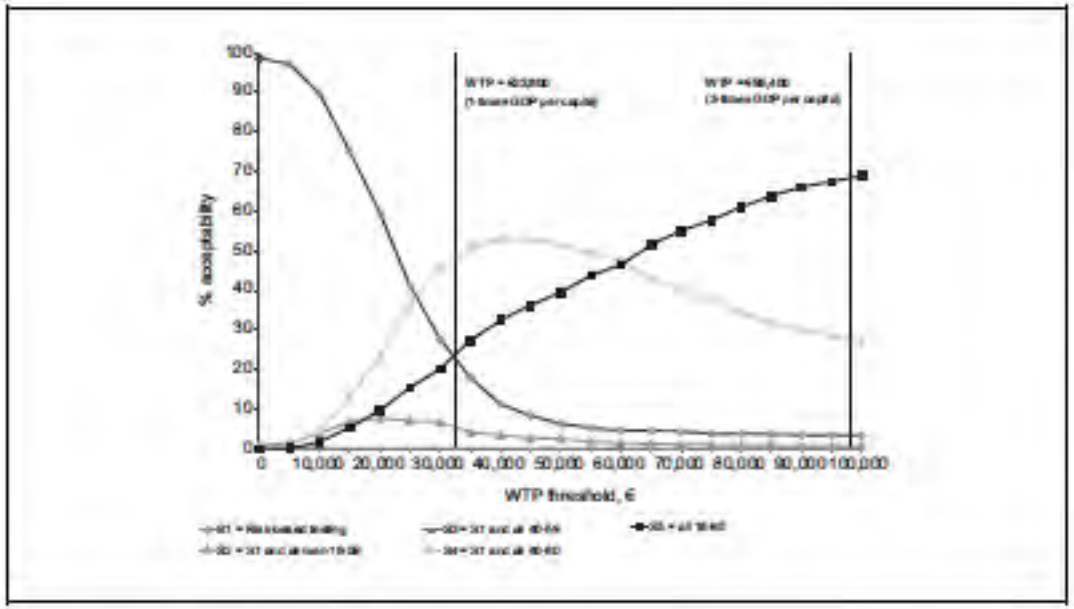

- Beckett GA et al. MMRW Recomm Rec 2012
- ** Schillie S et al. MMRW 2020

# « Universal » screening is cost-effective

Cost-effectiveness of screening adults >18 years: incremental ICER $11,378 per QALY vs. baby-boomers policy

Universal screening reduced HCV-attributable mortality by 16% and more than doubled the proportion of infants born to HCV-infected mothers

Schillie S et al. MMRW 2020

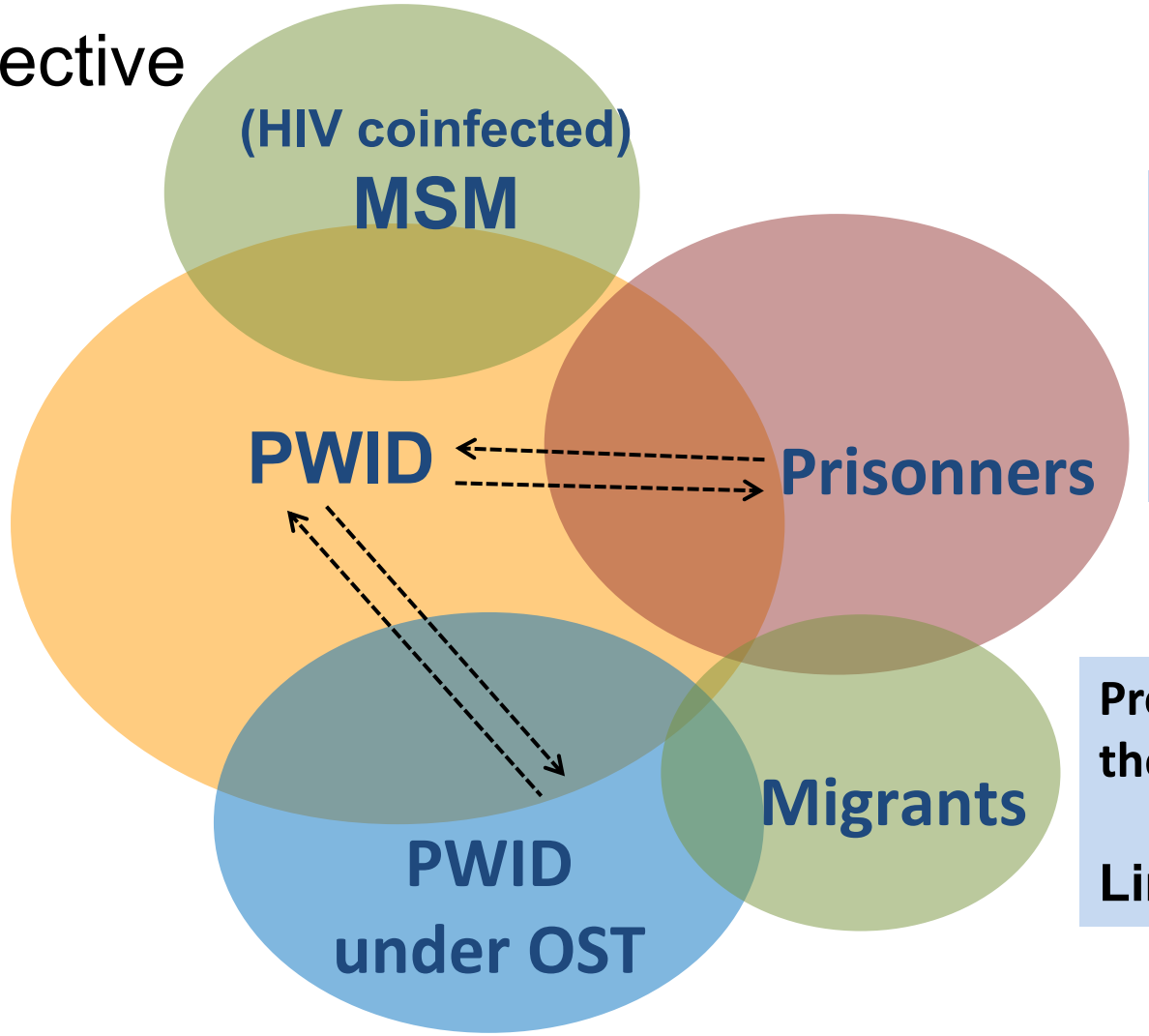



Universal screening (once in 18-80 years is the most effective screening strategy and is cost-effective (€31,000/QALY)

Deuffic-Burban S et al. J Hepatol 2018

# Risk-based screening in high-risk population

The most cost-effective




**Prevalence: 4.3-6.7%**
**Screening in 36-70%:**
- 46% HCV RNA+
- 3.9-46% treated

Remy A-J. BEH 2017

**Prevalence: >3-fold higher than the general population**

**Limited screening**

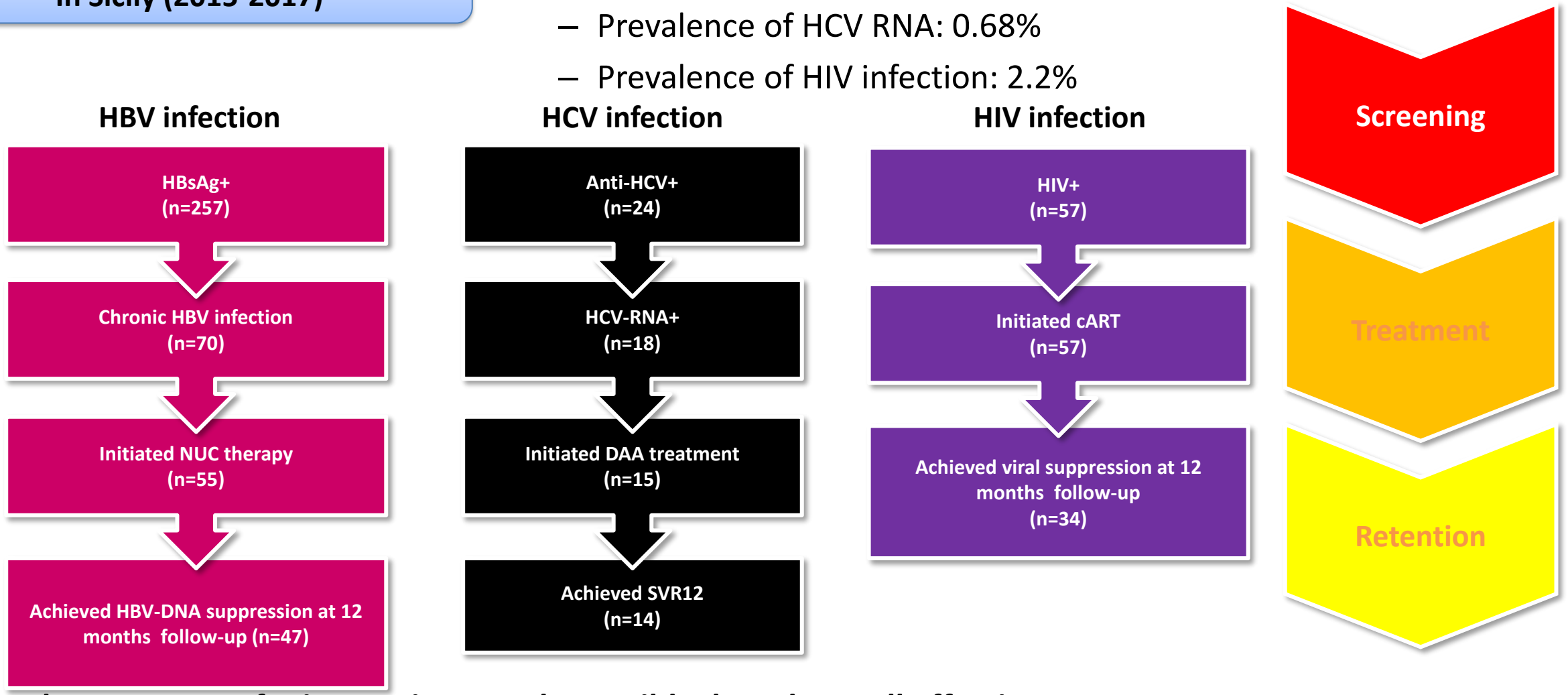
**«Diagnosis Burn-out »:**
**5-fold more new infections than diagnosed**
**5-fold less cure than new infections**

Hill A et al. J Viral Erad 2017

# Early screening in migrants

**2,639 of 2750 migrants screened In Sicily (2015-2017)**

- Acceptance of screening: 96%
- Prevalence of HBs antigen: 9.7%
- Prevalence of HCV RNA: 0.68%
- Prevalence of HIV infection: 2.2%




➔ **Early treatment of migrants is not only possible, but above all effective**

Prestileo T, EASL 2019, Abs. LBP-011

# Screening in hidden or forgotten population

## « Profile »-based screening: mental illness

Hughes E et al. Lancet Psychiatry 2016; 3:40-8

| | HIV | | Hepatitis B virus | | Hepatitis C virus | |
|---|---|---|---|---|---|---|
| | Studies (n) | Prevalence (95% CI) | Studies (n) | Prevalence (95% CI) | Studies (n) | Prevalence (95% CI) |
| North America | 21 | 6·0% (4·3–8·3) | 2 | 2·2% (0·5–9·9) | 13 | 17·4% (13·2–22·6) |
| Europe | 5 | 1·9% (0·8–4·8) | 4 | 2·7% (1·8–3·9) | 6 | 4·9% (3·0–7·9) |
| Oceania | 0 | .. | 0 | .. | 1 | 3·1% (1·0–9·3) |
| Africa | 8 | 19·2% (14·4–25·2) | 0 | .. | 0 | .. |
| Asia | 5 | 1·5% (1·0–2·4) | 10 | 9·7% (0·6–15·3) | 7 | 4·4% (2·8–6·9) |
| Central and South America | 5 | 2·7% (0·8–8·2) | 3 | 2·6% (1·0–6·1) | 2 | 3·0% (1·8–5·0) |

*Table 2:* **Pooled prevalence in people with serious mental illness**

- HCV Screening from 1/04/2018 to 31/07/2019,
- 1 158 psychiatric patients
  and 2 877 patients in Internal Medicine in Virginia

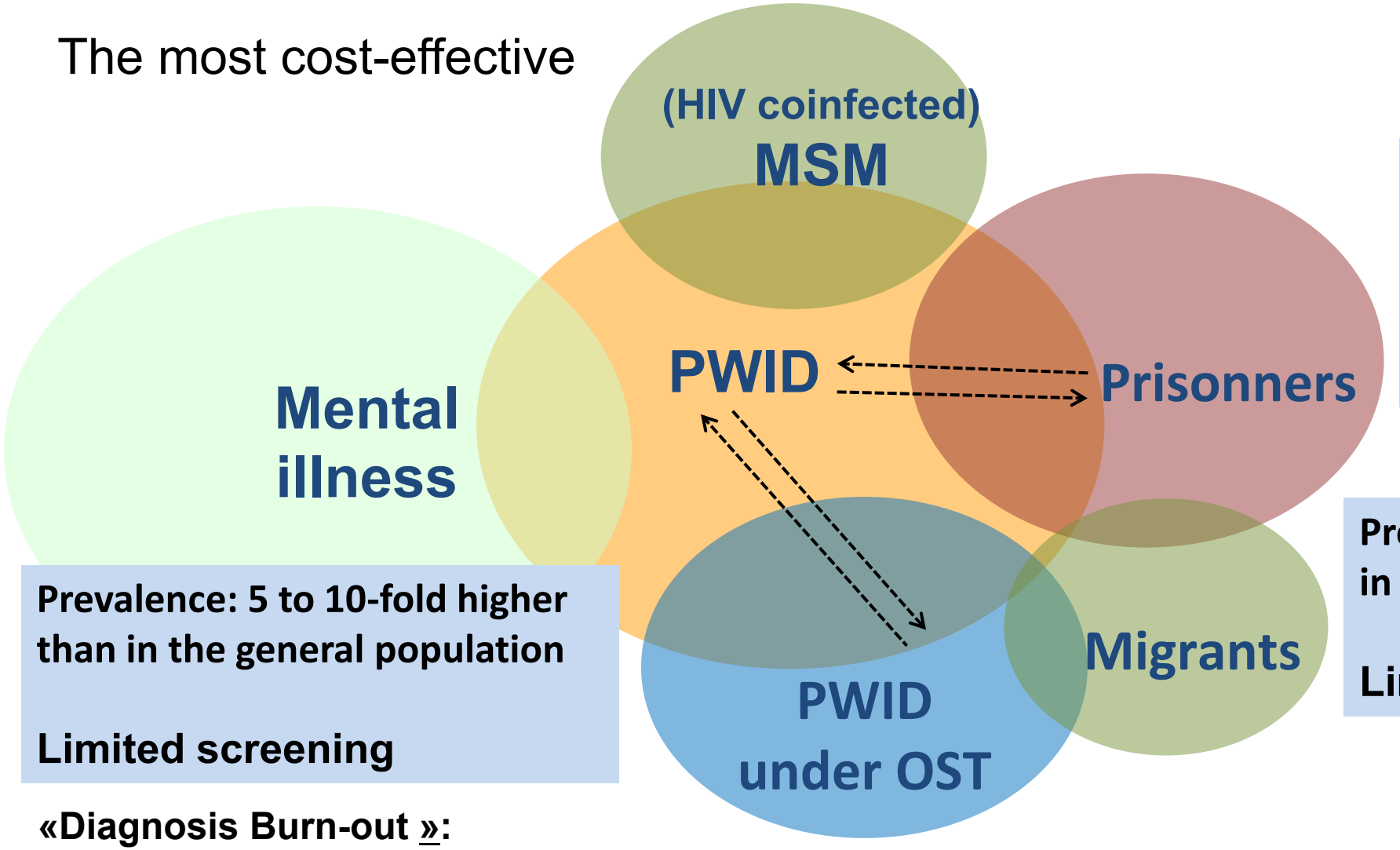
| | Internal Medicine | Psychiatry |
|---|---|---|
| **HCV RNA+** | **1.11 %** | **7.08 %** |

50 % of psychiatric patients were < 35 years (hospitalization for addiction, psychosis, suicide attempt; 30 % from 35-60 years (alcohol, depression) ; 20 % > 60 years (dementia, cognitive trouble or depression)
63 % of psychiatric patients were in charge for HCV and 84 % for IM patients

Kesat V, Etats-Unis, AASLD 2019, Abs. 539

# Risk-based screening in high-risk population

The most cost-effective




**Prevalence: 4.3-6.7%**
**Screening in 36-70%:**
- 46% HCV RNA+
- 3.9-46% treated

Remy A-J. BEH 2017

**Prevalence: 5 to 10-fold higher than in the general population**

**Limited screening**

**Prevalence: >3-fold higher than in the general population**

**Limited screening**

**«Diagnosis Burn-out »:**
**5-fold more new infections than diagnosed**
**5-fold less cure than new infections**

Hill A et al. J Viral Erad 2017

# Screening in “low-risk” population

- One-time HCV testing among persons with recognized risk factors or exposure (delivery < 1990; any surgery < 1990…)

- Persons with underlying medical conditions (oncology, anesthesiology…)

Systematic screening (HBsAg and HCV antibodies) in 3000 patients in anesthesia consultation for a single outpatient surgery

| % |
|---|
| HBsAg+ = 0.26 |
| Anti-HBc+ = 4.32 |
| HBV DNA+ = 0.13 |
| Anti-HCV+ = 0.44 |
| HCV RNA+ = 0.07 |

Patients underlined in:
Yellow: patients had HCV RNA+
Green: patients with SVR

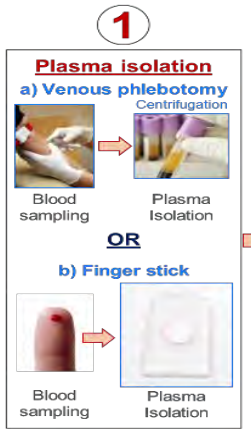
**Characteristics of the 12 HCV patients screened**

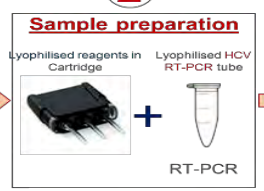

**Consider combining anti-Covid19 screening with HBsAg & anti-HCV testing ?**

Trabelsi A, Switzerland, EASL 2019, Abs. FRI-261

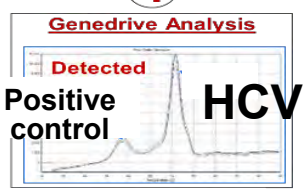
# To adjust the screening tools to delocalized situations

**Saliva or blood rapid antibody test**




1.Prevent coagulation and make viral RNA available
2. HCV RT-PCR reagents

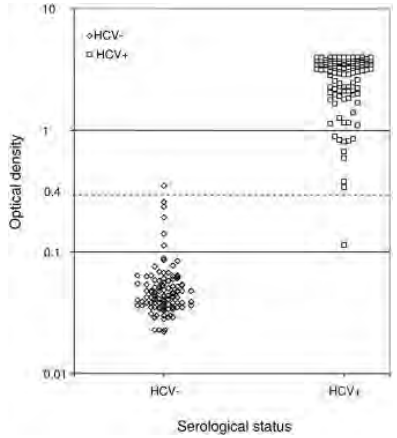



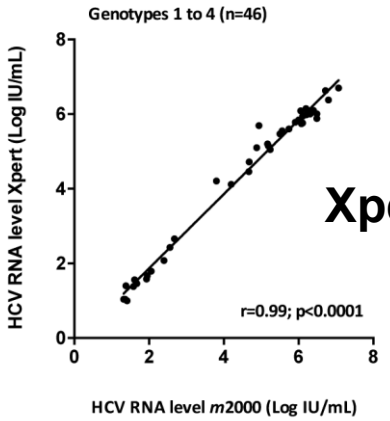

**Point-of-care PCR test**

**Automated orders: antiHCV+= HCVRNA**

**Test and treat**

**Dried Blood Spot**




**Xpert HCV (Cepheid)**

Tuaillon et al., Hepatology 2010, 51(3): 752-758; Chevalliez S et al. J Clin Virol 2017; Lancet Gastroenterol Hepatol 2017; Llibre A et al. Gut 2018

# Screening of the general population for HCV

- Screening of the general population is the best policy,

is cost-effective but is not usually recommended by health authorities at least in low-endemicity regions

- Screening should be mainly based on risk factors and has to be

delocalized with a reflex testing which allows a « test and treat » policy

- HCV elimination is feasible if screening and access to care are facilitated

by the health care system without fibrosis restriction and with harm reduction policies

# Dr Lina Nerlander

## European Centre for Disease Prevention and Control


#HCVSummit
@HepBCPPA

European Centre for Disease Prevention and Control

# From evidence to impact: reaching the elimination targets in the EU/EEA

Dr. Lina Nerlander

HCV policy summit, March 24 2021

# Sustainable development goals (SDGs)


**Goal 3. Ensure healthy lives and promote well-being for all at all ages**

*3.3* ***By 2030****, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and* ***combat hepatitis****, water-borne diseases and other communicable diseases.*

ECDC works to monitor progress towards the SDGs

WHO European Action Plan sets specific targets for hepatitis

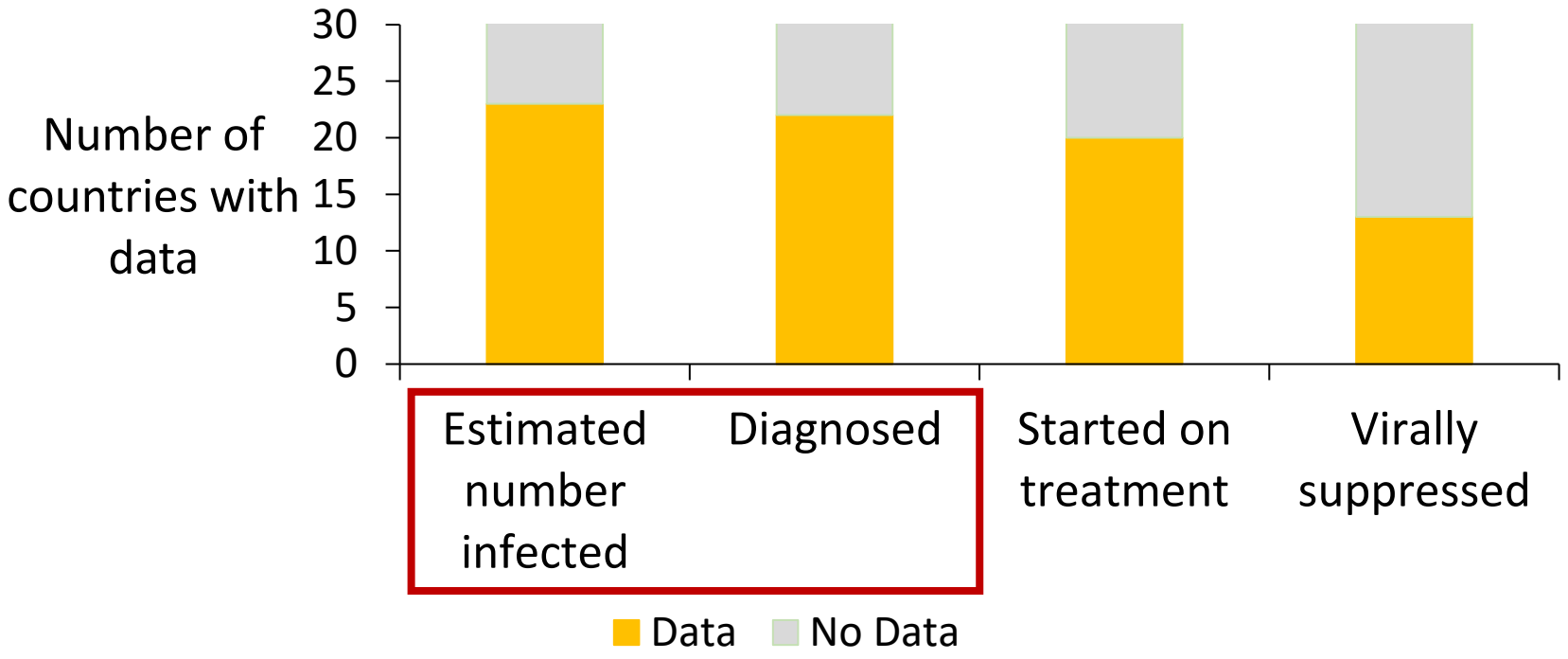
Action plan for the health sector response to viral hepatitis in the WHO European Region (2017)
https://www.euro.who.int/en/health-topics/communicable-diseases/hepatitis/publications/2017/action-plan-for-the-health-sector-response-to-viral-hepatitis-in-the-who-european-region-2017

# Hepatitis monitoring system for the EU/EEA

- System developed together with WHO and EU advisory group to support countries in monitoring
- Data on progress relating to prevention and along the continuum of care: prevalence, testing, treatment etc
- Data reported directly to ECDC by National Focal Points or collated from existing sources (e.g. EMCDDA)
- First data collection 2019


**Source**: Monitoring of the responses to the hepatitis B and C epidemics in EU/EEA Member States, 2019, ECDC
https://www.ecdc.europa.eu/en/publications-data/monitoring-responses-hepatitis-b-and-c-epidemics-eueea-member-states-2019

# Data availability for hepatitis continuum of care, EU/EEA 2019




WHO target for proportion diagnosed: 50%

$$\text{Proportion diagnosed} = \frac{\text{Numbers diagnosed}}{\text{Numbers chronically infected}}$$

Only 16 countries had sufficient data on both

# Proportion of people living with HCV who have been diagnosed in the EU/EEA, 2017 (n=16 countries)


**Data represent England and Scotland only*

**Source**: Monitoring of the responses to the hepatitis B and C epidemics in EU/EEA Member States, 2019, ECDC
https://www.ecdc.europa.eu/en/publications-data/monitoring-responses-hepatitis-b-and-c-epidemics-eueea-member-states-2019

# Data limitations and the way forward

**Quality concerns with data:**
- Some Member States only provided 1-2 years of data
- Many estimates derived from low quality sources

$$\text{Proportion diagnosed} = \frac{\text{Numbers diagnosed}}{\text{Numbers with chronic infection}}$$

**Quality concerns with data:**
- Many estimates >10 years old
- Many estimates derived from low quality sources
- Some estimates based on numbers anti-HCV

ECDC work on improving data:

- EU Hepatitis Network
- Technical support to countries
- Facilitate collaborations with clinicians
- Support countries to do surveys of prevalence
- Mathematical modelling

# Developing additional indicators

Current indicator (proportion diagnosed) challenging to interpret across countries

Developed additional indicators with advisory group

- Numbers undiagnosed per 100,000 population
- Diagnosed in reporting year per 100,000 population

# Are people diagnosed in time?

ECDC monitors:

Proportion of newly diagnosed people with end stage liver disease

- Only 10 countries were able to report data

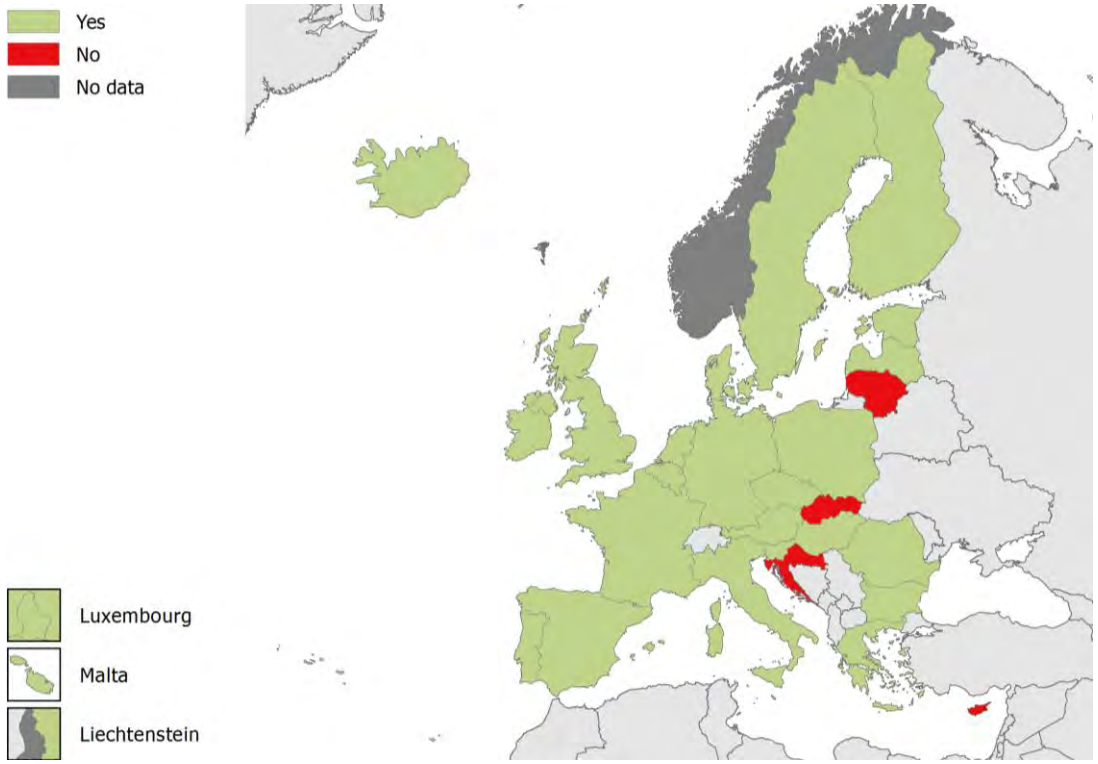
- Estimates of proportion of newly diagnosed people with end stage liver disease range from 0.2% to 45%

- Validity concerns – work ongoing

**Source**: Monitoring of the responses to the hepatitis B and C epidemics in EU/EEA Member States, 2019, ECDC
https://www.ecdc.europa.eu/en/publications-data/monitoring-responses-hepatitis-b-and-c-epidemics-eueea-member-states-2019

# Testing is sub-optimal among people who inject drugs (PWID)

Countries offering HCV testing in at least some harm reduction services, 2017

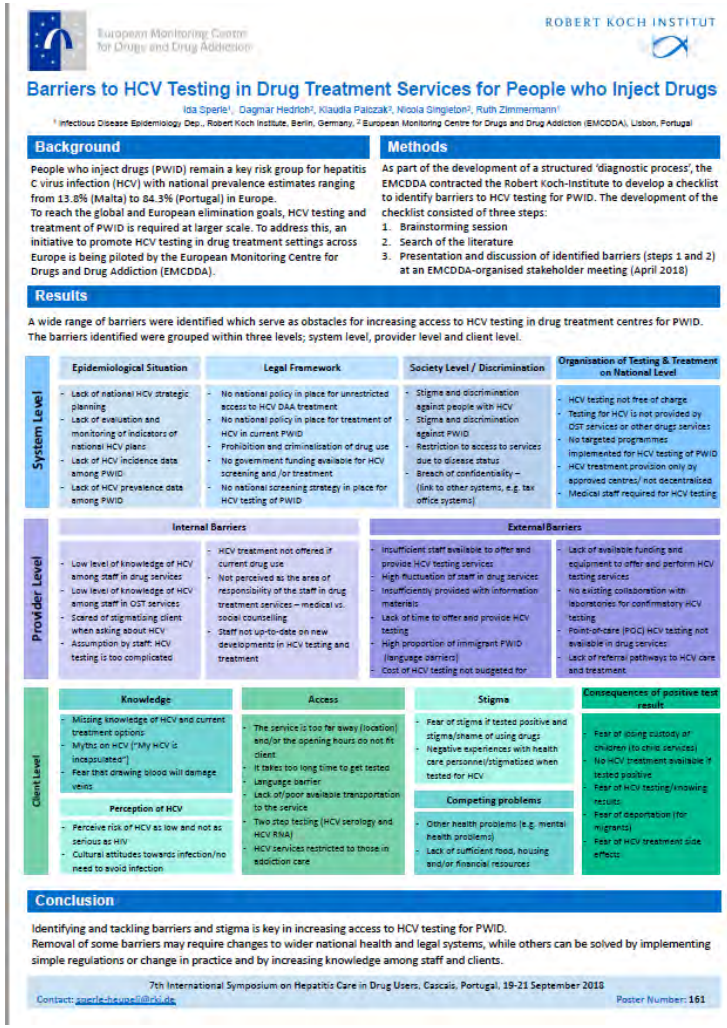



Only 5 countries report that >50% of PWID entering drug treatment had been tested in the past year.

ECDC testing guidance recommends that PWID are tested up to every 6 months for those at ongoing risk or more frequently depending on local HCV prevalence/ incidence.

Source: EMCDDA, The elimination barometer for viral hepatitis among PWID in Europe and ECDC Monitoring of the responses to the hepatitis B and C epidemics in EU/EEA Member States, 2019. Stockholm: ECDC; 2019.
Public health guidance on HIV, hepatitis B and C testing in the EU/EEA, ECDC
https://www.ecdc.europa.eu/sites/default/files/documents/hiv-hep-testing-guidance_0.pdf

# Improving testing among PWID



European Monitoring Centre for Drugs and Drug Addiction

ROBERT KOCH INSTITUT

## Barriers to HCV Testing in Drug Treatment Services for People who Inject Drugs

Ida Sperle[1], Dagmar Hedrich[2], Klaudia Palczak[2], Nicola Singleton[2], Ruth Zimmermann[1]
[1] Infectious Disease Epidemiology Dep., Robert Koch Institute, Berlin, Germany, [2] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Lisbon, Portugal

### Background

People who inject drugs (PWID) remain a key risk group for hepatitis C virus infection (HCV) with national prevalence estimates ranging from 13.8% (Malta) to 84.3% (Portugal) in Europe.
To reach the global and European elimination goals, HCV testing and treatment of PWID is required at larger scale. To address this, an initiative to promote HCV testing in drug treatment settings across Europe is being piloted by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

### Methods

As part of the development of a structured 'diagnostic process', the EMCDDA contracted the Robert Koch-Institute to develop a checklist to identify barriers to HCV testing for PWID. The development of the checklist consisted of three steps:
1. Brainstorming session
2. Search of the literature
3. Presentation and discussion of identified barriers (steps 1 and 2) at an EMCDDA-organised stakeholder meeting (April 2018)

### Results

A wide range of barriers were identified which serve as obstacles for increasing access to HCV testing in drug treatment centres for PWID. The barriers identified were grouped within three levels; system level, provider level and client level.

**System Level**

| Epidemiological Situation | Legal Framework | Society Level / Discrimination | Organisation of Testing & Treatment on National Level |
|---|---|---|---|
| - Lack of national HCV strategic planning<br>- Lack of evaluation and monitoring of indicators of national HCV plans<br>- Lack of HCV incidence data among PWID<br>- Lack of HCV prevalence data among PWID | - No national policy in place for unrestricted access to HCV DAA treatment<br>- No national policy in place for treatment of HCV in current PWID<br>- Prohibition and criminalisation of drug use<br>- No government funding available for HCV screening and /or treatment<br>- No national screening strategy in place for HCV testing of PWID | - Stigma and discrimination against people with HCV<br>- Stigma and discrimination against PWID<br>- Restriction to access to services due to disease status<br>- Breach of confidentiality – (link to other systems, e.g. tax office systems) | - HCV testing not free of charge<br>- Testing for HCV is not provided by OST services or other drugs services<br>- No targeted programmes implemented for HCV testing of PWID<br>- HCV treatment provision only by approved centres/ not decentralised<br>- Medical staff required for HCV testing |

**Provider Level**

| Internal Barriers | | External Barriers | |
|---|---|---|---|
| - Low level of knowledge of HCV among staff in drug services<br>- Low level of knowledge of HCV among staff in OST services<br>- Scared of stigmatising client when asking about HCV<br>- Assumption by staff: HCV testing is too complicated | - HCV treatment not offered if current drug use<br>- Not perceived as the area of responsibility of the staff in drug treatment services – medical vs. social counselling<br>- Staff not up-to-date on new developments in HCV testing and treatment | - Insufficient staff available to offer and provide HCV testing services<br>- High fluctuation of staff in drug services<br>- Insufficiently provided with information materials<br>- Lack of time to offer and provide HCV testing<br>- High proportion of immigrant PWID (language barriers)<br>- Cost of HCV testing not budgeted for | - Lack of available funding and equipment to offer and perform HCV testing services<br>- No existing collaboration with laboratories for confirmatory HCV testing<br>- Point-of-care (POC) HCV testing not available in drug services<br>- Lack of referral pathways to HCV care and treatment |

**Client Level**

| Knowledge | Access | Stigma | Consequences of positive test result |
|---|---|---|---|
| - Missing knowledge of HCV and current treatment options<br>- Myths on HCV ("My HCV is encapsulated")<br>- Fear that drawing blood will damage veins | - The service is too far away (location) and/or the opening hours do not fit client<br>- It takes too long time to get tested<br>- Language barrier<br>- Lack of/poor available transportation to the service<br>- Two step testing (HCV serology and HCV RNA)<br>- HCV services restricted to those in addiction care | - Fear of stigma if tested positive and stigma/shame of using drugs<br>- Negative experiences with health care personnel/stigmatised when tested for HCV | - Fear of losing custody of children (to child services)<br>- No HCV treatment available if tested positive<br>- Fear of HCV testing/knowing results<br>- Fear of deportation (for migrants)<br>- Fear of HCV treatment side effects |
| **Perception of HCV** | | **Competing problems** | |
| - Perceive risk of HCV as low and not as serious as HIV<br>- Cultural attitudes towards infection/no need to avoid infection | | - Other health problems (e.g. mental health problems)<br>- Lack of sufficient food, housing and/or financial resources | |

### Conclusion

Identifying and tackling barriers and stigma is key in increasing access to HCV testing for PWID.
Removal of some barriers may require changes to wider national health and legal systems, while others can be solved by implementing simple regulations or change in practice and by increasing knowledge among staff and clients.

7th International Symposium on Hepatitis Care in Drug Users, Cascais, Portugal, 19-21 September 2018
Contact: sperle.heuser@rki.de
Poster Number: 161

Identifying barriers

European Monitoring Centre for Drugs and Drug Addiction

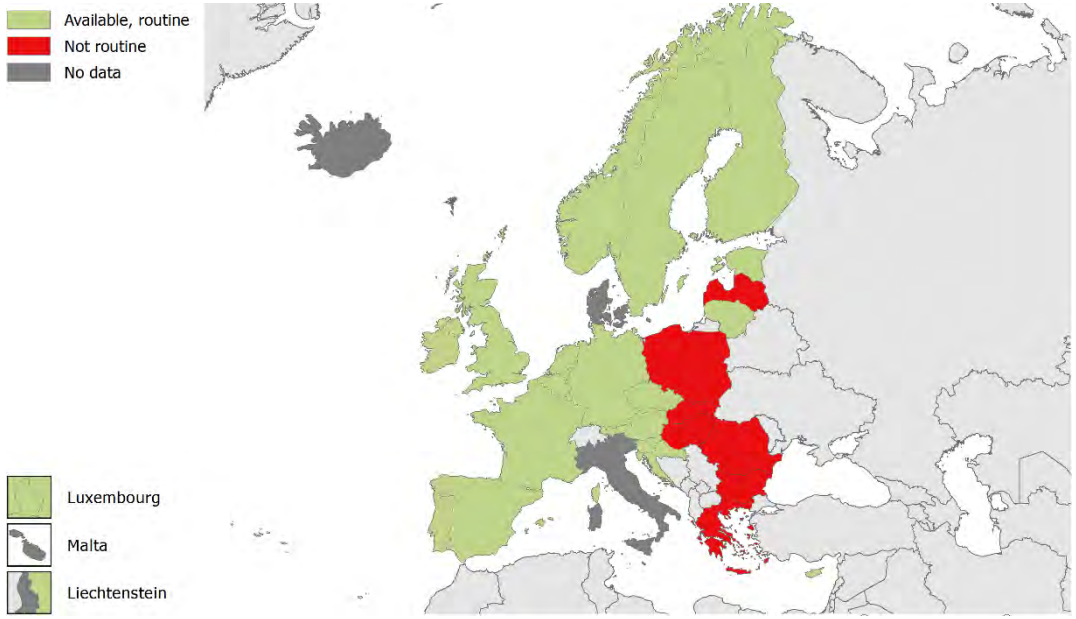
## Hepatitis C: new models of care for drugs services

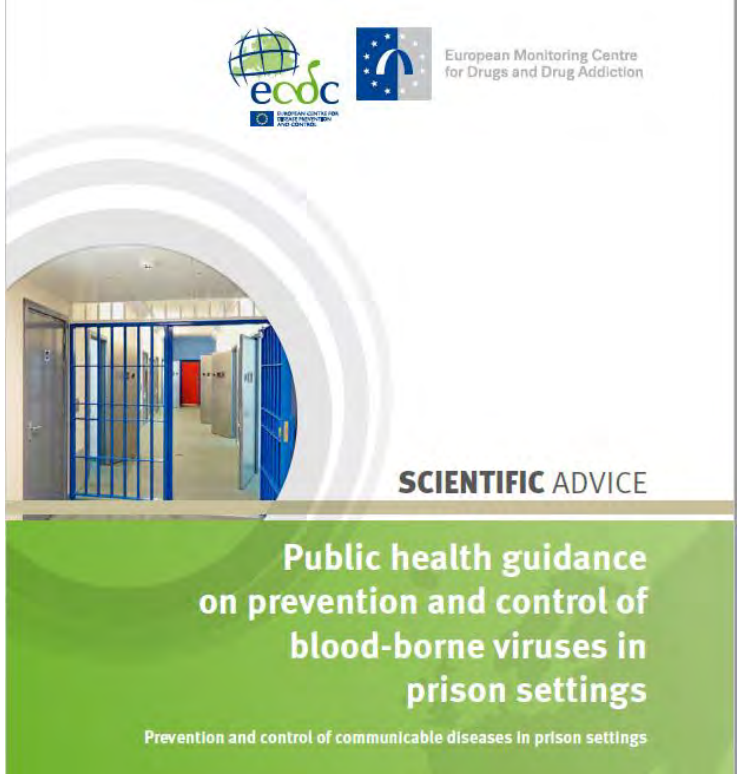
Learning from documented models of care


https://www.emcdda.europa.eu/system/files/publications/11481/poster-barriers-to-hcv-testing.pdf
https://www.emcdda.europa.eu/publications/topic-overviews/hepatitis-c-models-of-care_en#panel5

# Testing among prisoners

HBV and HCV testing offered routinely in prisons in EU/EEA countries, 2019




HCV prevalence in prisoners: 2.2%–45.8%

ECDC guidance recommends that testing is offered to all people in prisons

Evidence indicates that provider-initiated testing at entry likely yields higher uptake.

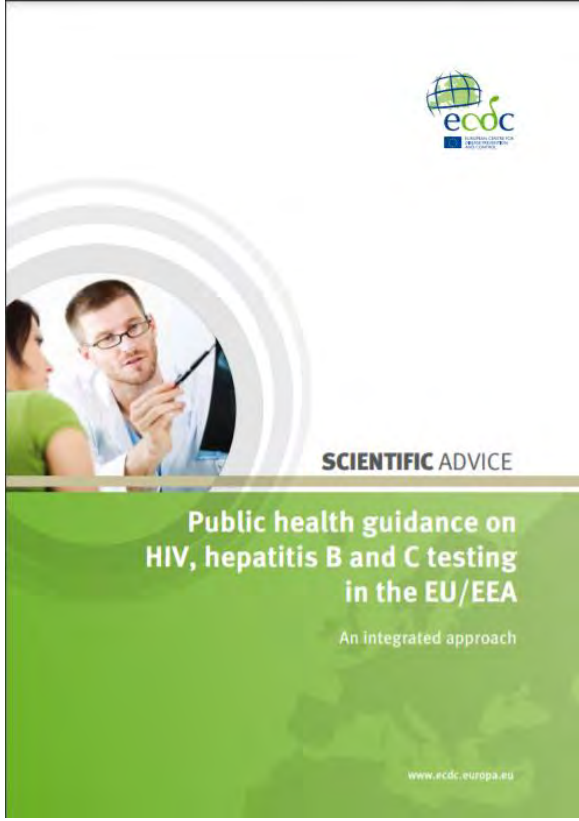
Testing during prison stay also important

**Sources**:
The elimination barometer for viral hepatitis among PWID in Europe. Technical report, EMCDDA.
Public health guidance on prevention and control of blood-borne viruses in prison settings, ECDC
https://www.ecdc.europa.eu/sites/default/files/documents/Guidance-on-BBV-in-prisons.pdf
Systematic review on active case finding of communicable diseases in prison settings
https://www.ecdc.europa.eu/sites/default/files/documents/Systematic-review-on-communicable-diseases-in-prison-settings-final-report.pdf
Monitoring of the responses to the hepatitis B and C epidemics in EU/EEA Member States, 2019, ECDC
https://www.ecdc.europa.eu/en/publications-data/monitoring-responses-hepatitis-b-and-c-epidemics-eueea-member-states-2019

# ECDC testing guidance

- Primary care
- Hospital settings – e.g. emergency rooms
- Other settings:
  - Drug services
  - Prisons
  - STI clinics
  - Migrant clinics
  - Pharmacies
  - Community settings
  - Antenatal clinics

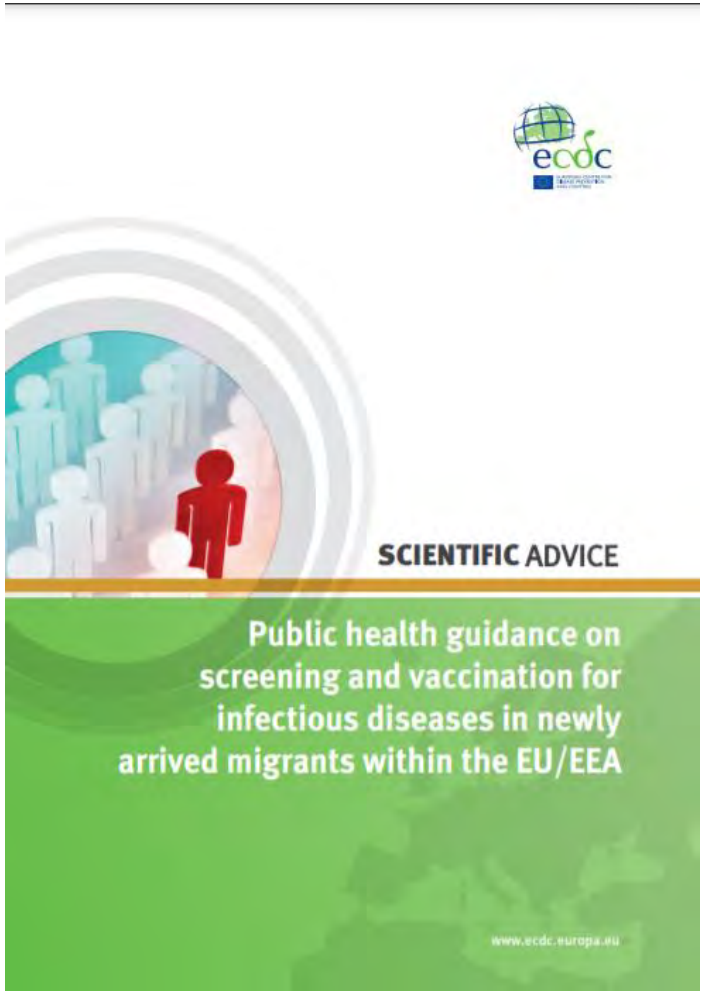
Testing coverage and test positivity rates often high in these settings




*Non-medical providers*
*Rapid testing*
*Dry blood spot testing*

Source: Public health guidance on HIV, hepatitis B and C testing in the EU/EEA, ECDC
https://www.ecdc.europa.eu/sites/default/files/documents/hiv-hep-testing-guidance_0.pdf

# Testing among migrants




Migrants account for an estimated 14% of all HCV cases in the EU/EEA

Offer HCV screening to migrant populations from endemic countries (≥2%)

Source: Public health guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA, ECDC
https://www.ecdc.europa.eu/sites/default/files/documents/Public%20health%20guidance%20on%20screening%20and%20vaccination%20of%20migrants%20in%20the%20EU%20EEA.pdf

# Challenges and solutions

- HCV often asymptomatic
- Low levels of awareness of need to test
- Socially marginalised populations
- User fees
- Legal context
- COVID-19

- Testing and linkage to care where people are
- De-medicalise testing
- Opportunistic testing e.g.
  - When testing for COVID-19 infection
  - When doing seroprevalence surveys for COVID-19

# Conclusions

- Among countries reporting data, almost three-quarters of people with chronic HCV are not diagnosed

- Scale up testing among priority populations - make testing available where people are

- Learn from good practices

- Improve data collection and reporting

# Thank you!

Lina.Nerlander@ecdc.europa.eu

# Panel discussion and Q&A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# Session 3:
# COVID-19 and HCV

**Chair:**
**Prof Harry LA Janssen, Toronto Western and Toronto General Hospital, University Health Network, Toronto, Canada**


#HCVSummit
@HepBCPPA

# Prof Alessio Aghemo,

## Humanitas University Hospital, Milan, Italy


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# COVID-19 and HCV

## *Impact on HCV elimination*

**Alessio Aghemo, MD, PhD**

**Department of Biomedical Sciences, Humanitas University**
**Division of Internal Medicine and Hepatology, Department of Gastroenterology**
**Humanitas Research Hospital, Rozzano, Italy**

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| | |
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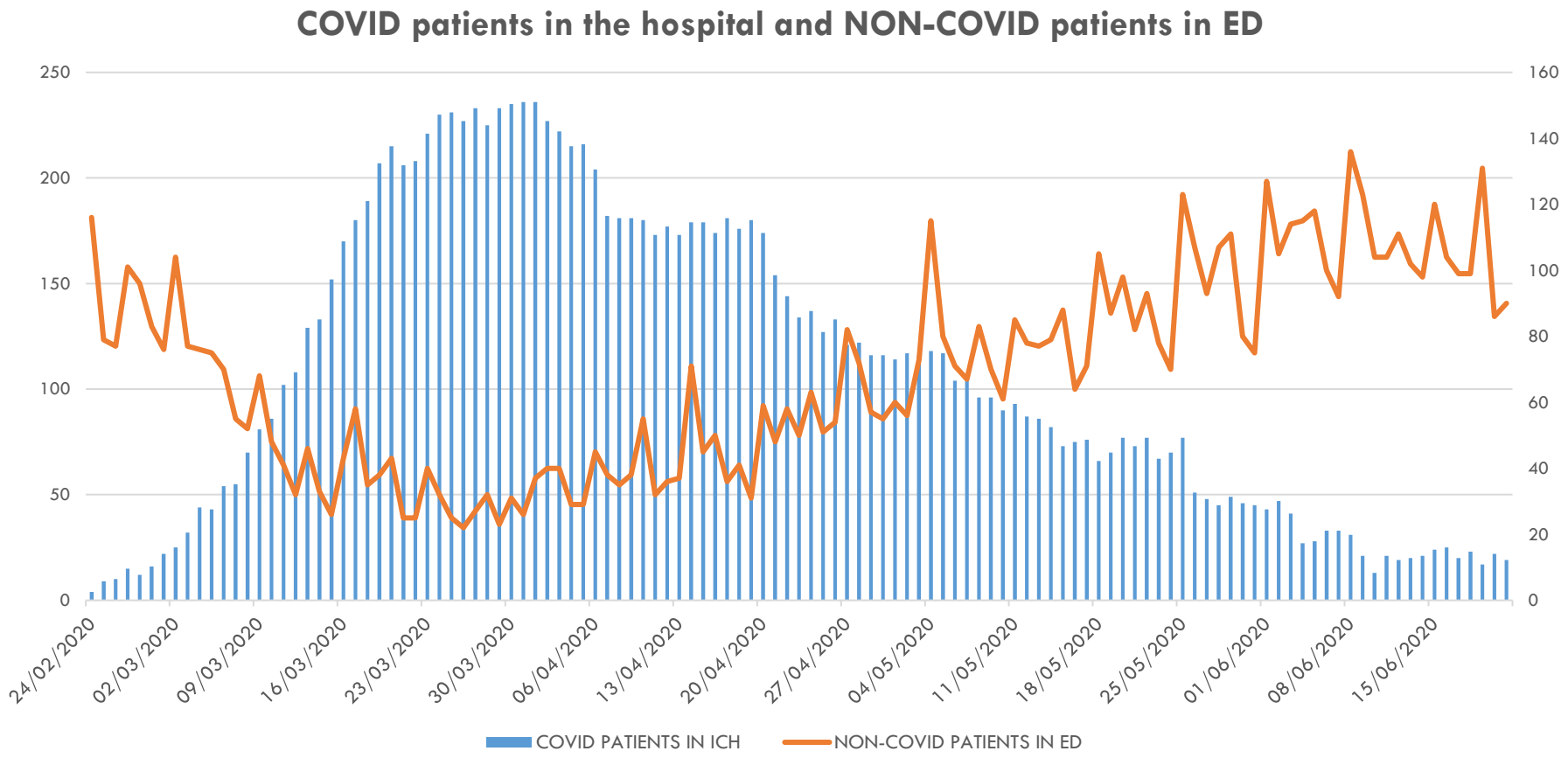
| Speaking and teaching: | Merck, Gilead Sciences, Abbvie, Mylan and Alfasigma |

# COVID-19 in Humanitas (Milano Italy)

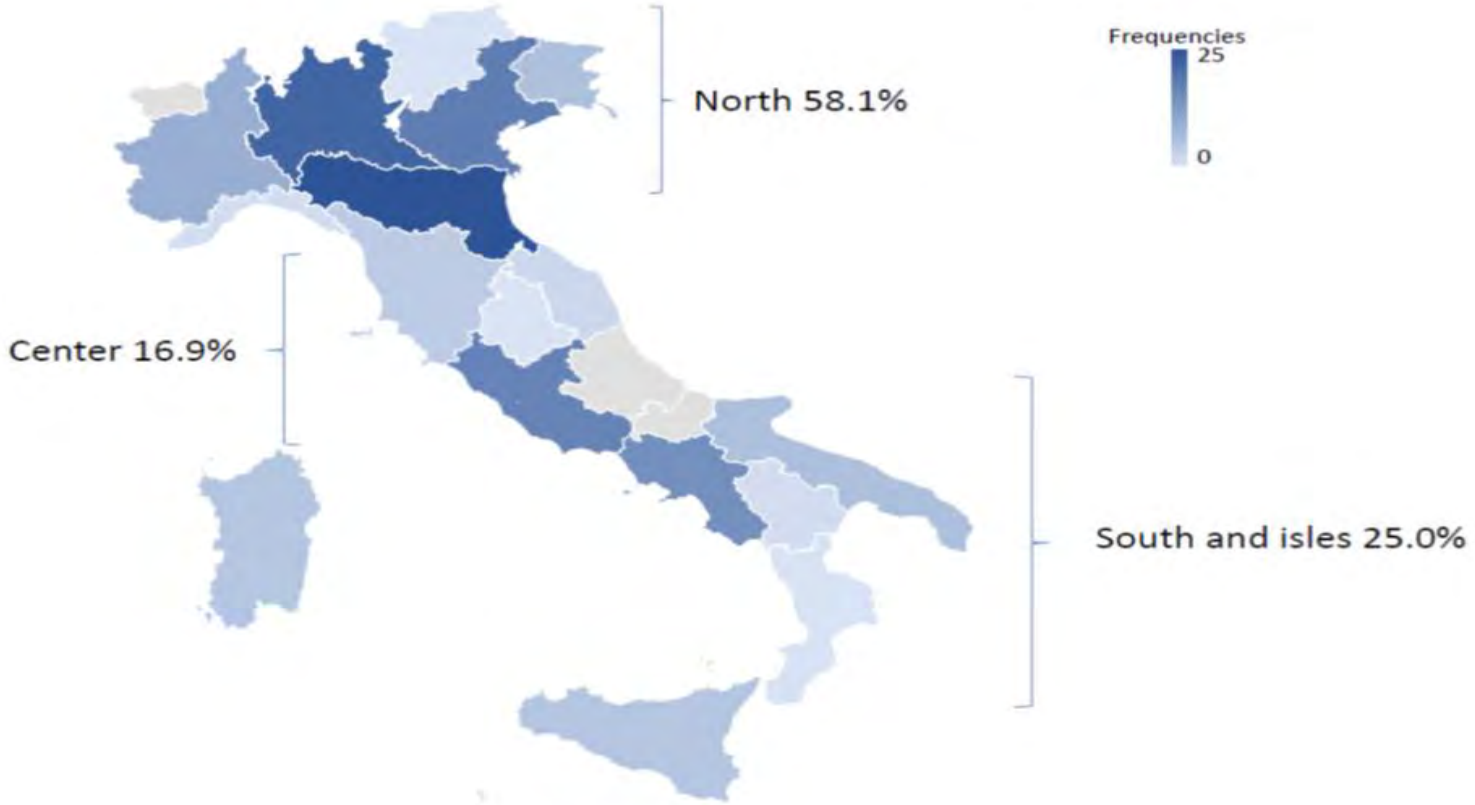


# How to Set Up a Liver Clinic During the Covid-19 Pandemia

| | Chronic hepatitis (viral and others) | Autoimmune and cholestatic disorders | Cirrhosis | HCC | Transplant |
|---|---|---|---|---|---|
| F2F clinic | Postpone monitoring for NASH, HCV, HBV | Postpone monitoring for PBC, PSC | Yes | Yes | Yes |
| Virtual clinics | Yes (AEs) | Yes | Yes (weight, symptoms) | Yes (AEs) | Yes (AEs) |
| Dispense drugs though territorial pharmacy | Yes | Yes | Yes | Yes | Yes |
| Treatment | Start pharmacological treatment only when urgent | Start immunosuppression when needed | Do not change routine practice | Start drug treatment when needed | Relevant decrease in donor availability |
| Invasive procedures and surgery | Avoid liver biopsy | Avoid liver biopsy | Maintain slots for invasive procedures in COVID-19-free facility | Reduce surgery (lack of ICU) | Maintain slots for invasive procedures in COVID-19-free facility |
| Diagnostics | | | HCC surveillance in COVID-19-free hospital | HCC monitoring in COVID-19-free hospital | |
| Special indications | | | | Continue HCC board meetings | |

*Sun J et al, Liver International 2020*

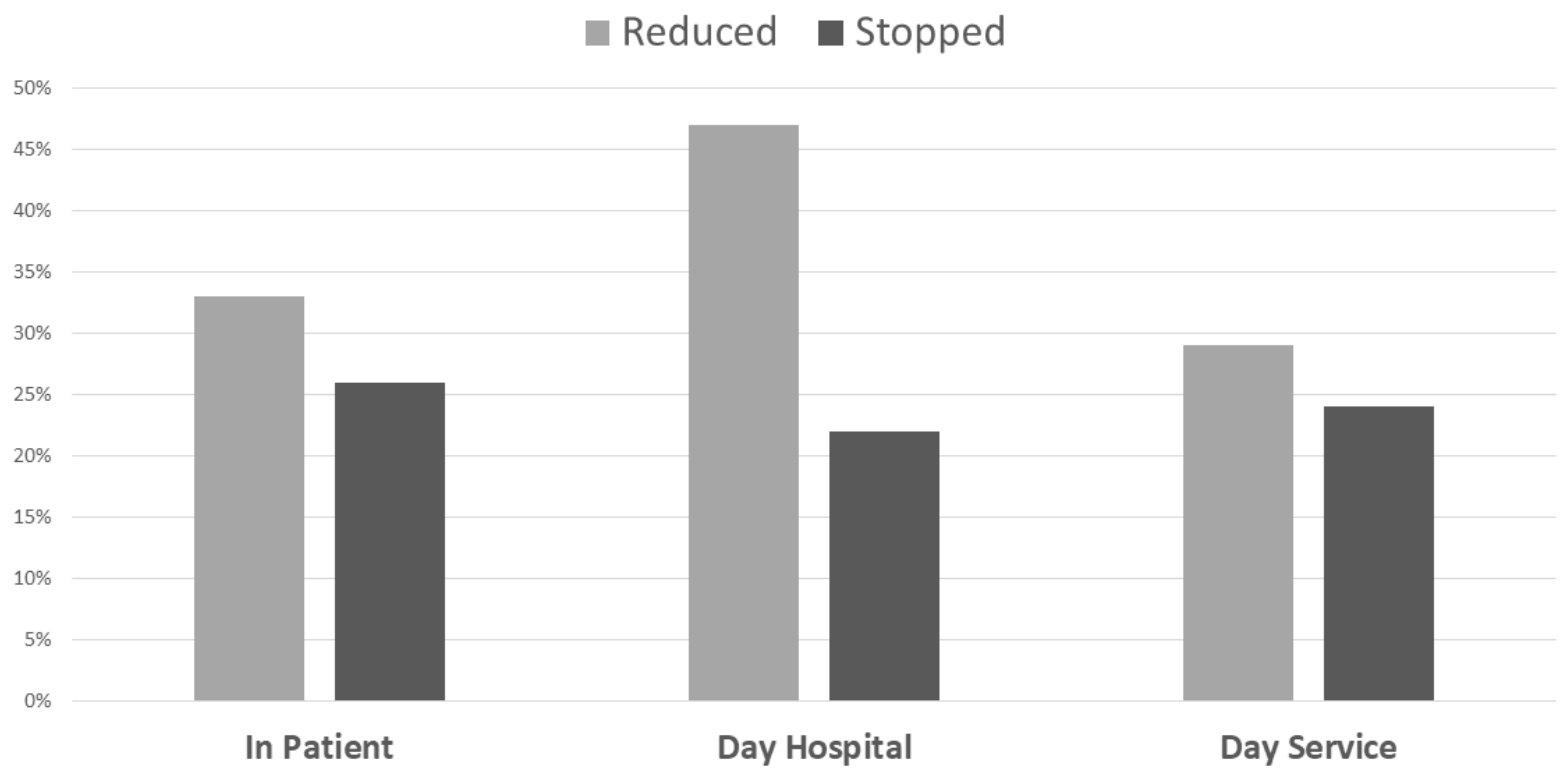
# The AISF Survey on Hepatological Activity in Italy




*Aghemo A et al, DLD in press*

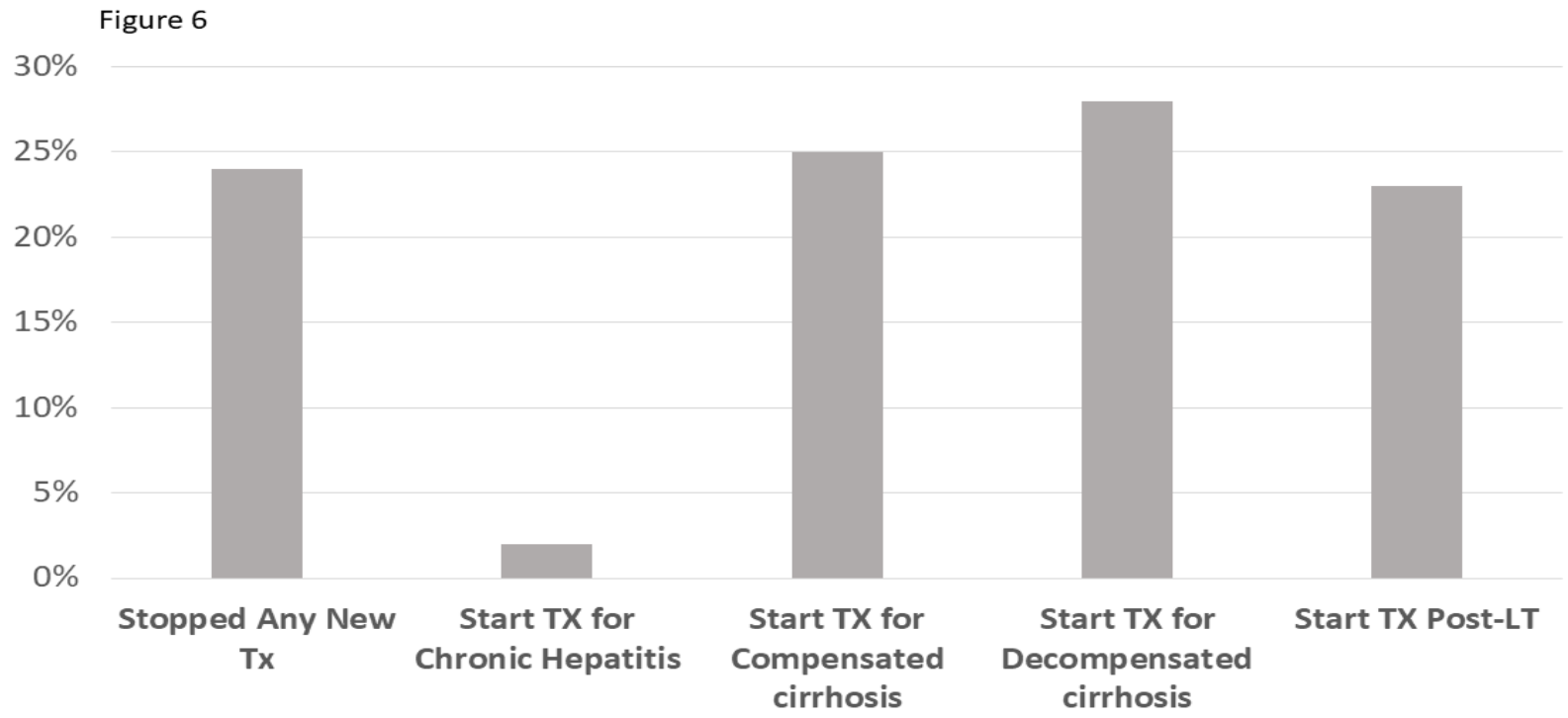
# The AISF Survey on Hepatological Activity in Italy

Figure 2A



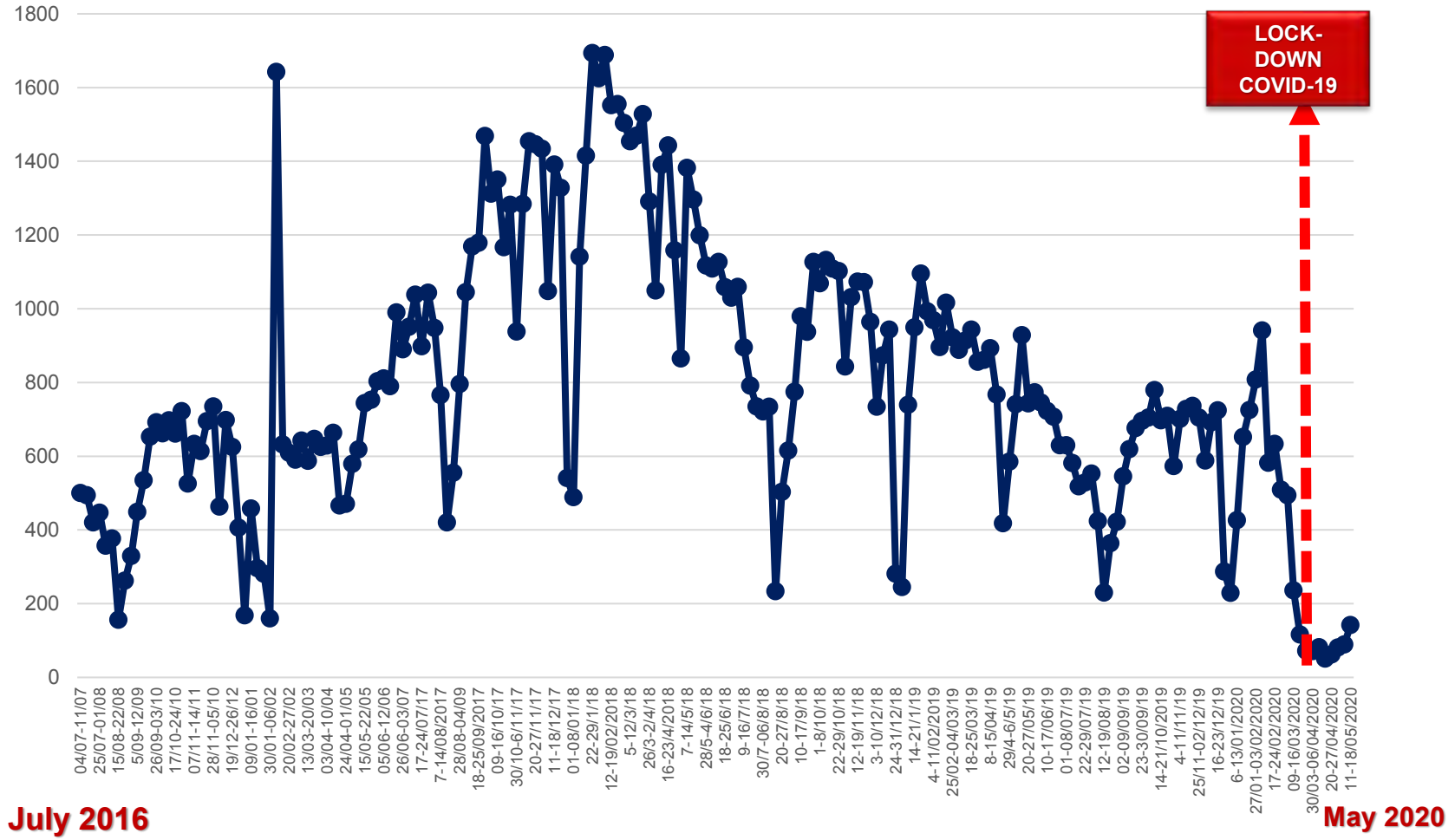

*Aghemo A et al, DLD in press*

# The AISF Survey on Hepatological Activity in Italy




*Aghemo A et al, DLD in press*

# Number of Anti-HCV Treatments Started in Italy

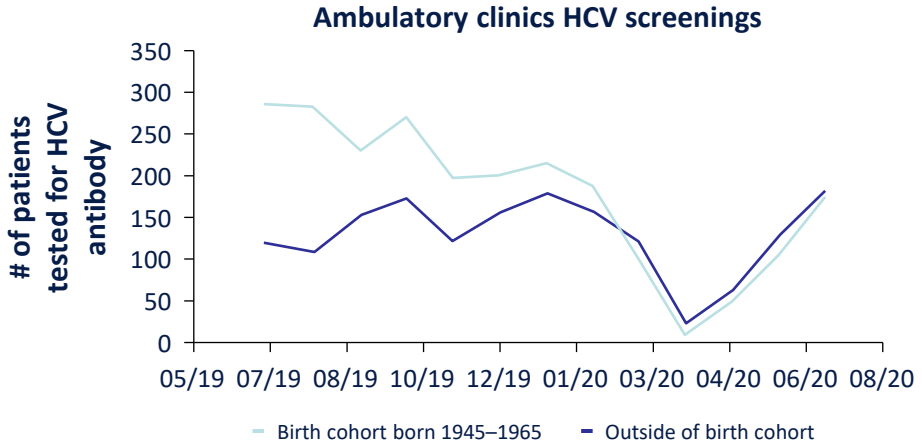


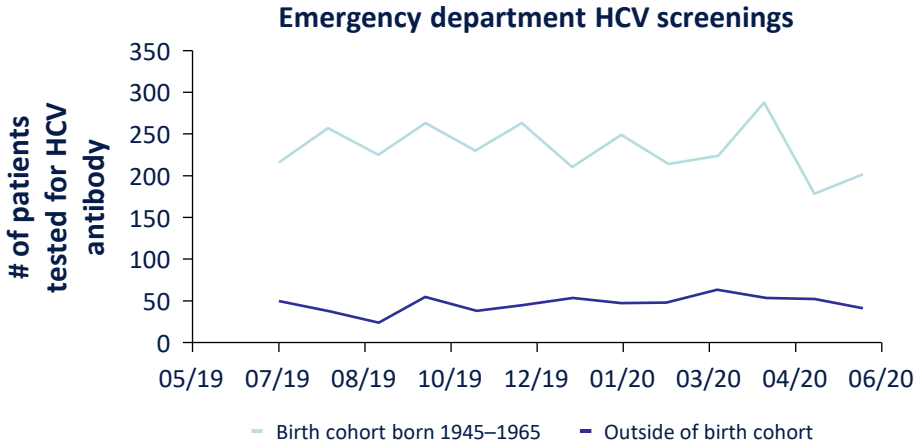

**AIFA 2016 -2020 – Epac onlus**

# Impact of COVID-19 on Hepatitis C Screenings in Ambulatory Clinics and Emergency Departments

Retrospective chart review of the number of HCV screenings completed from July 2019–July 2020 to assess the impact of the COVID-19 pandemic on HCV testing and linkage to care

- Across the study period, 7167 patients were tested for HCV antibodies: 298 tested positive and 127 had confirmed infection by reflex to the HCV RNA quantitative test
- On average, 431 patients were screened for HCV in ambulatory clinics from July 2019 –February 2020

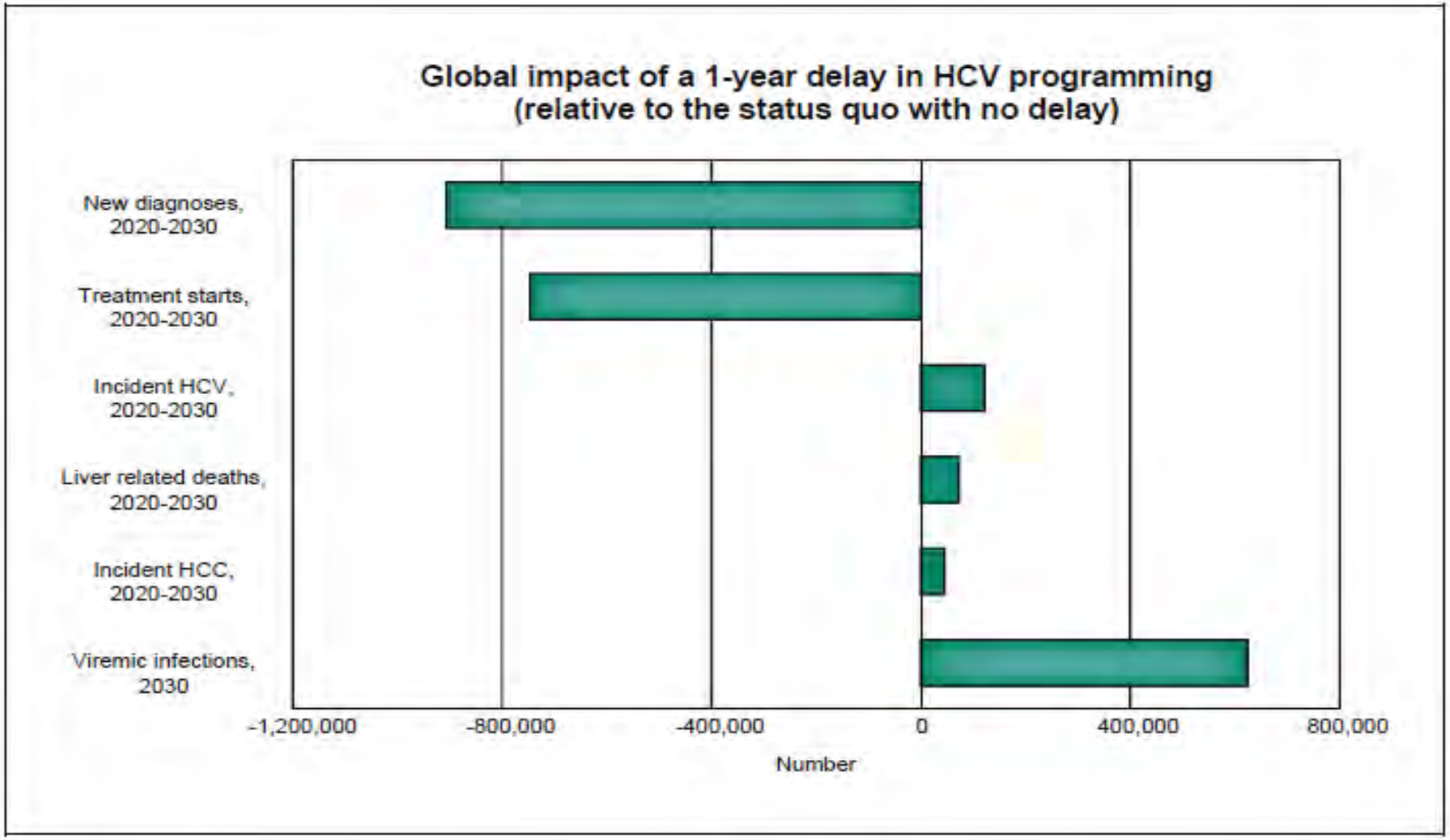



The COVID-19 pandemic has disrupted routine healthcare with the number of patients screened for HCV decreasing in **ambulatory** clinics

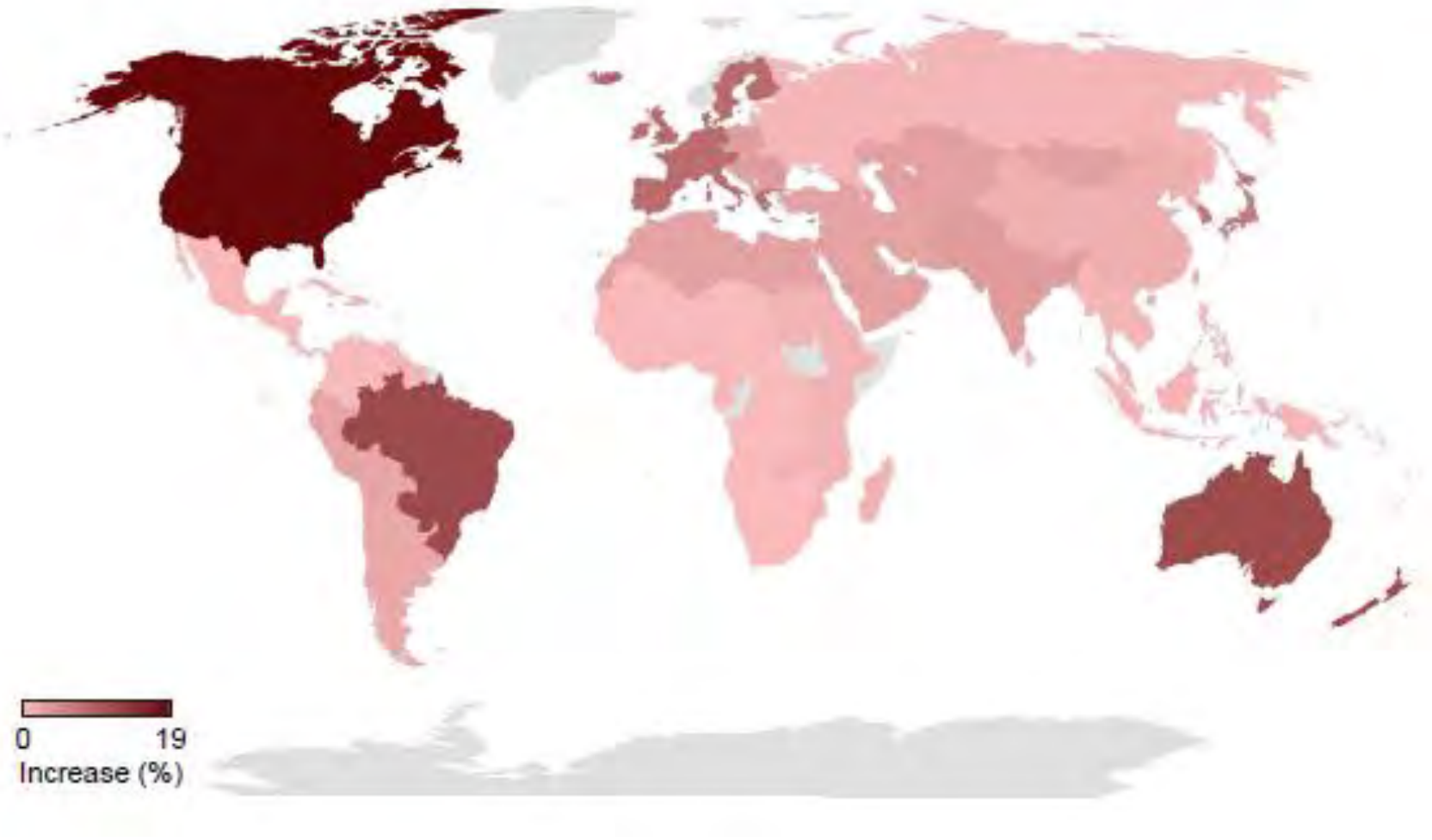
RNA, ribonucleic acid.

# Impact of COVID-19 on Global HCV elimination efforts.



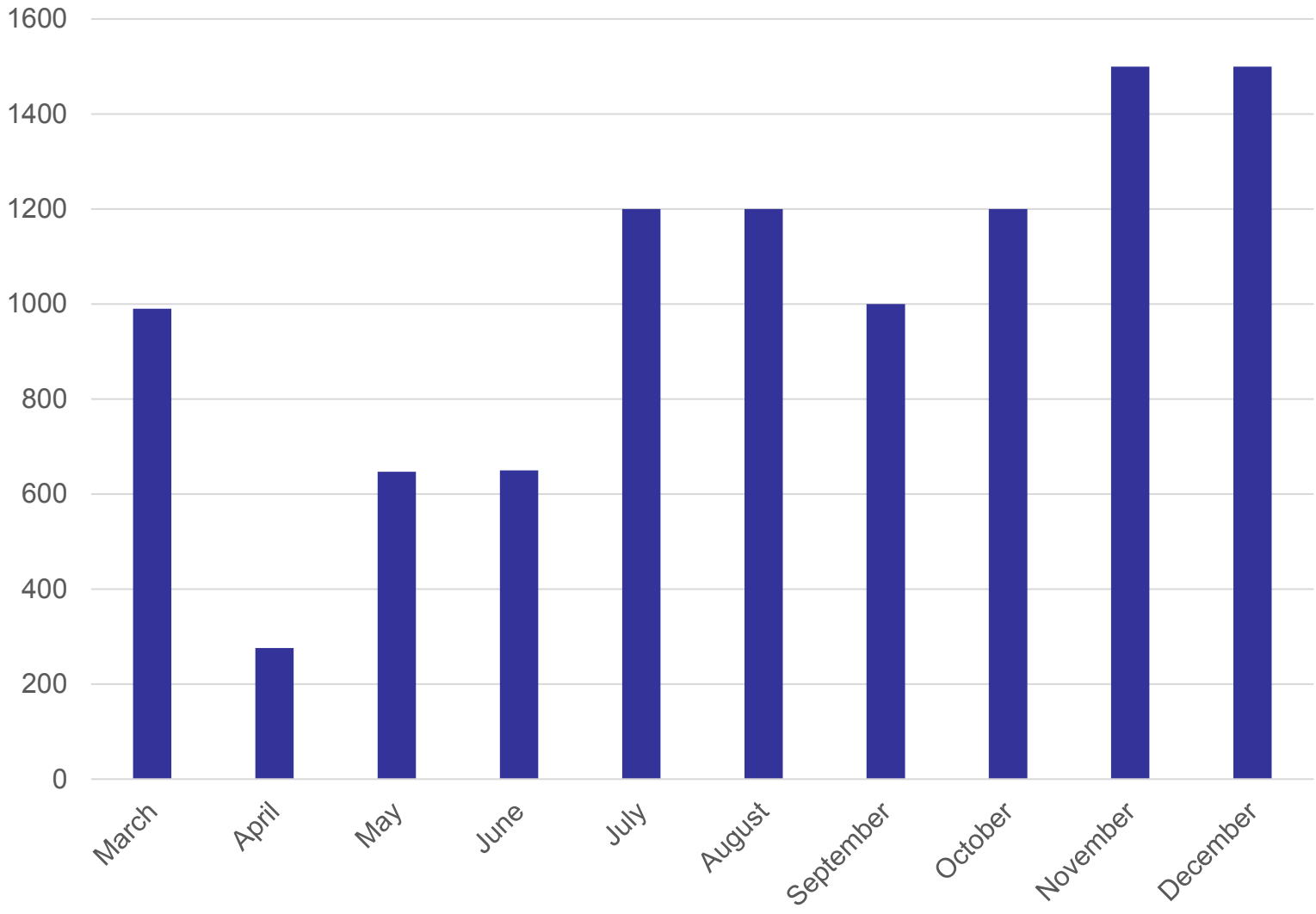

*Blach S et al, J Hepatol 2021*

# Impact of COVID-19 on Cumulative Liver Related Deaths (2020-2030)




*Blach S et al, J Hepatol 2021*

# Number of Patients Starting DAAs in Italy



# Covid-19: A Tool to Increase HCV Awareness


# HCV Screening in Southern Italy

| Variable | overall | Males | Females | p |
|---|---|---|---|---|
| HCV Quick test positive | **54/2740 (1.9%)** | 17 (30.4%) | 37 (66.1%) | - |
| HCV Ab confirmation pos | **41 (1.5%)** | 14 (82.4%) | 27 (73.0%) | 0.68 |
| Quick test false HCV Ab positive | **13 (0.4%)** | 3 (17.6%) | 10 (27.0%) | |
| Age (SD) | **64.31 (15.17)** | 65.94(12.98) | 63.57(16.18) | 0.59 |
| Clinical Cirrhosis | **4 (0.14%)** | 3 (17.7%) | 1 (2.7%) | 0.14 |
| HCV infection already known | **36/41 (87.8%)** | 13 (76.5%) | 23 (62.2%) | 0.36 |
| HCVRNA positive | **5/2740 (0.18%)** | 1 (5.9%) | 4 (10.8%) | 0.56 |
| Previous AVT therapy | **32/36 (88.8%)** | 13/13 (100%) | 21/23 (91.3%) | 0.29 |
| SVR | **31/32 (96.9%)** | 12/13 (92.3%) | 19/19 (100%) | 0.84 |
| HCV Known but not treated | **2/36 (5.5%)** | 0/13 | 2/23 (8.7%) | 0.27 |

*Masarone M et al, AISF 2021*

# Positive Impact of The Covid Pandemia on HCV Management

**Decentralization of cure**

Drug dispensing

Non specialist care

**Simplifcation of Treatment**

No monitoring

**Increased focus on viral diseases**

**HCV Screening during COVID-19 Vaccination**

# Q&A


#HCVSummit
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# Session 4a: Introduction to breakout sessions on Best Practices at the National level

**Chair:**
**Prof Mojca Maticic, University Medical Centre Ljubljana, Slovenia**

EUHCV
Policy Summit - 24.03.2021
Online event

#HCVSummit
@HepBCPPA


# *Best practices at the national level*

Introduction to breakout sessions

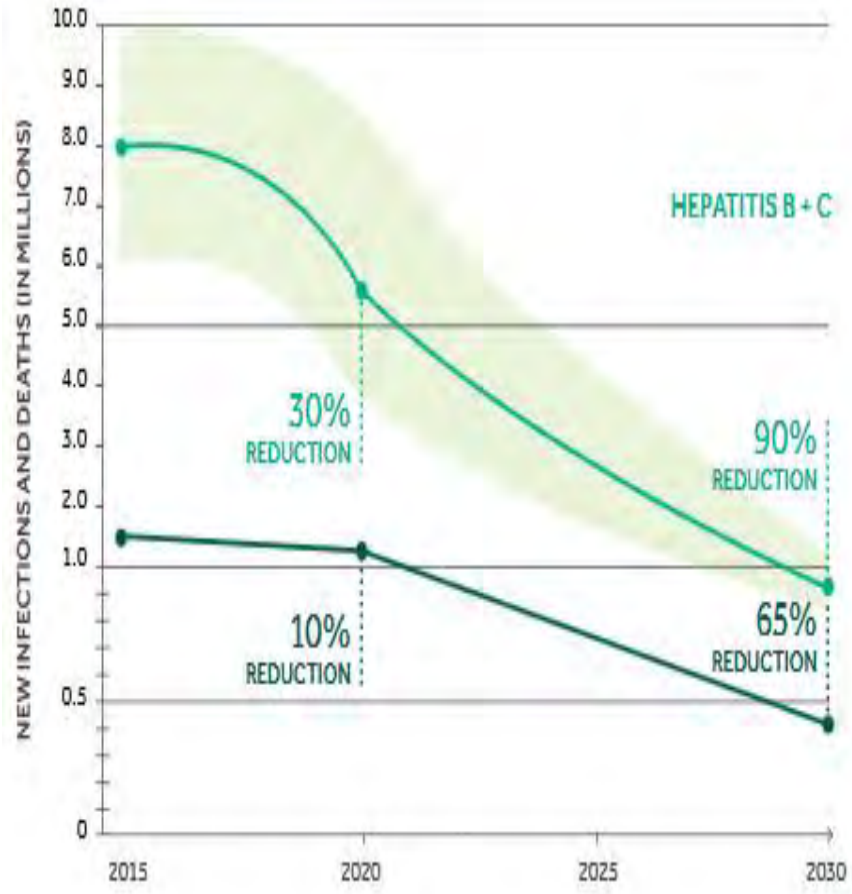
**Prof. Mojca Maticic, MD, PhD**

University Medical Centre Ljubljana
Faculty of Medicine, University of Ljubljana
Slovenia

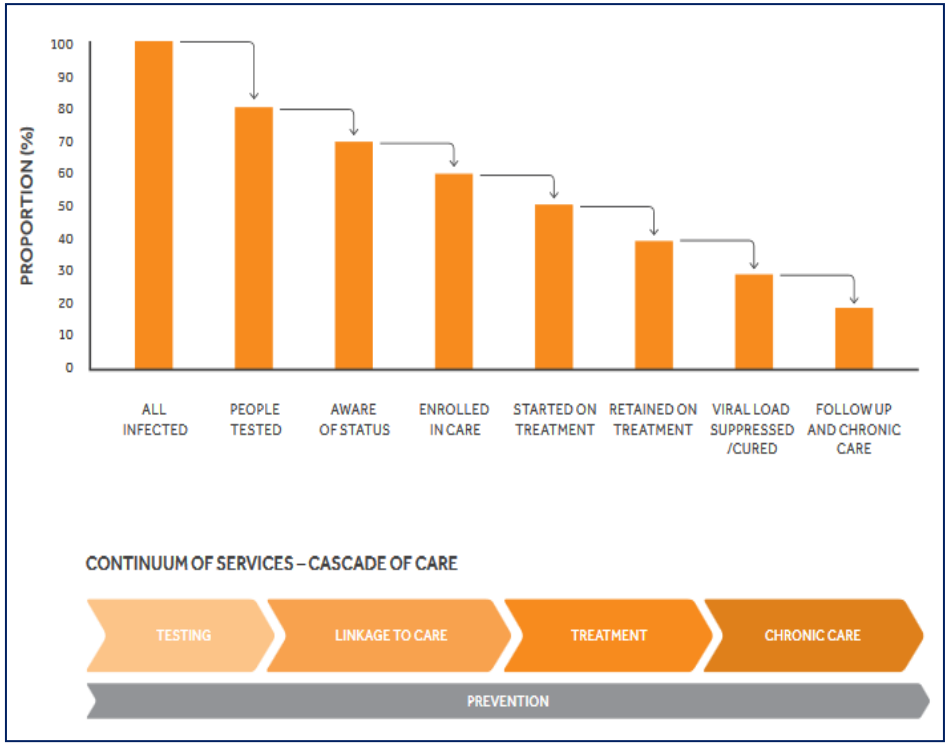
3rd EU HCV Policy Summit Digital : March 24, 2021

# WHO strategy 2016 - 2030:
# Elimination of viral hepatitis as a public health threat

## GOALS

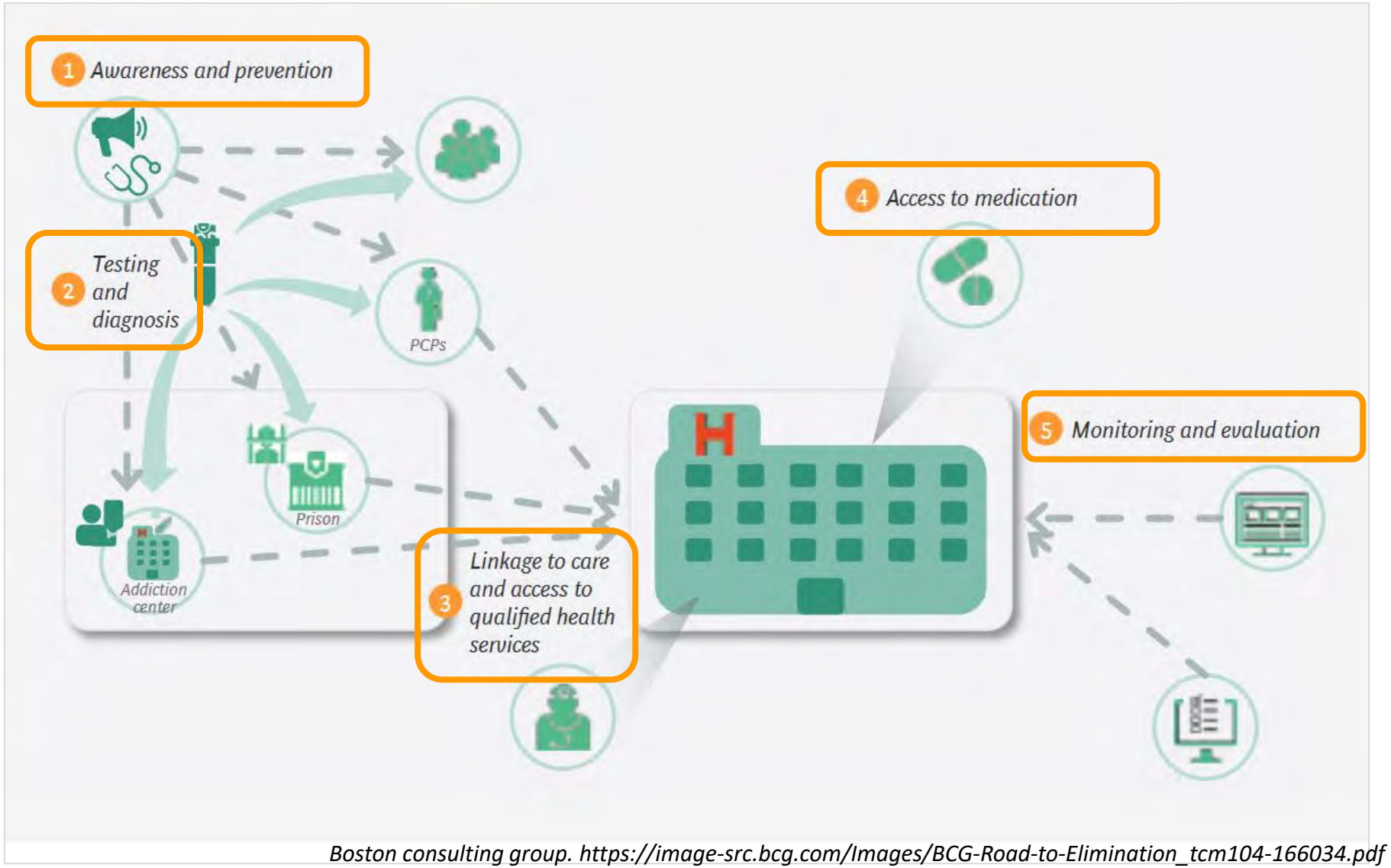



## TOOLS




*WHO. http//apps.who.int/gb/ebwha/pdf_files/WHA69/A69_32-en.pdf?ua=1*

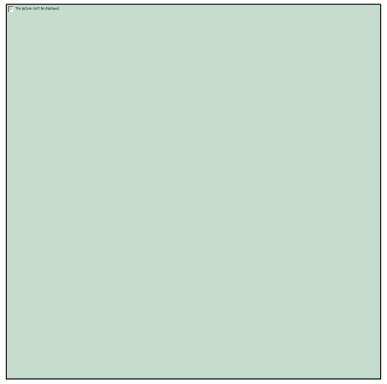
# The road to HCV elimination is complex



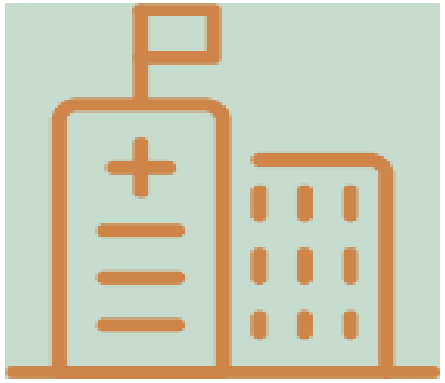

*Boston consulting group. https://image-src.bcg.com/Images/BCG-Road-to-Elimination_tcm104-166034.pdf*

# Barriers and gaps
# on the way to HCV elimination

Patient



Practitioner



System

Policy

# A PATIENT centered care for HCV

**Simplification:**

- Diagnostic and treatment algorythms – a”one-stop-shop”

**Decentralisation:**

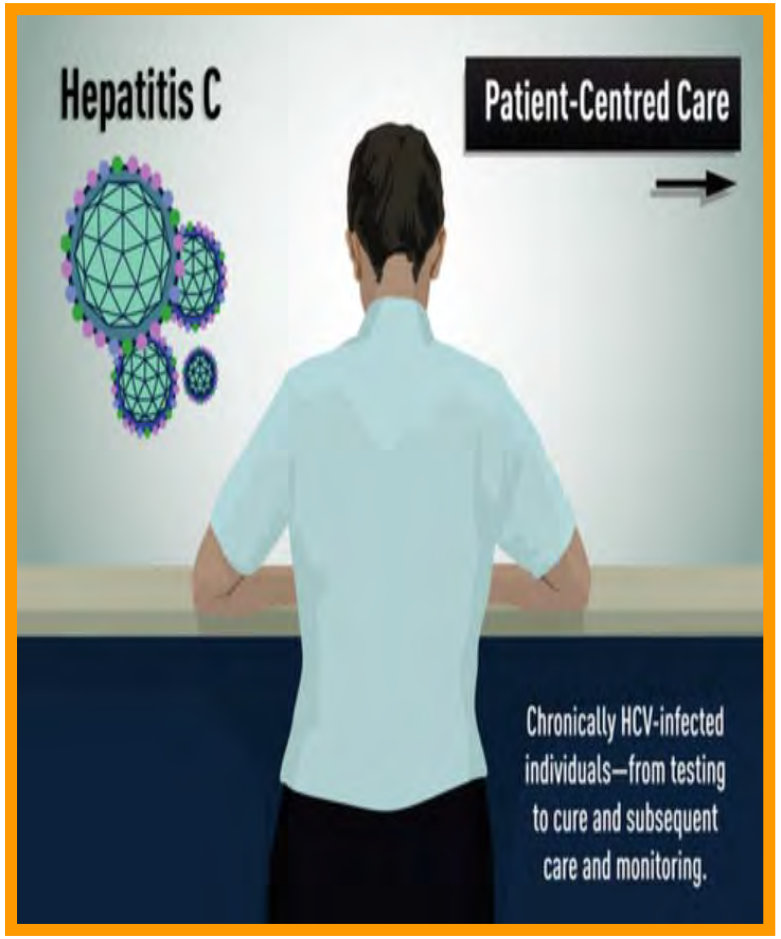
- HCV services put out of hospitals to regional and local level

**Task-sharing:**

- Involve GPs and nurses to manage uncomplicated HCV cases

**Integration:**

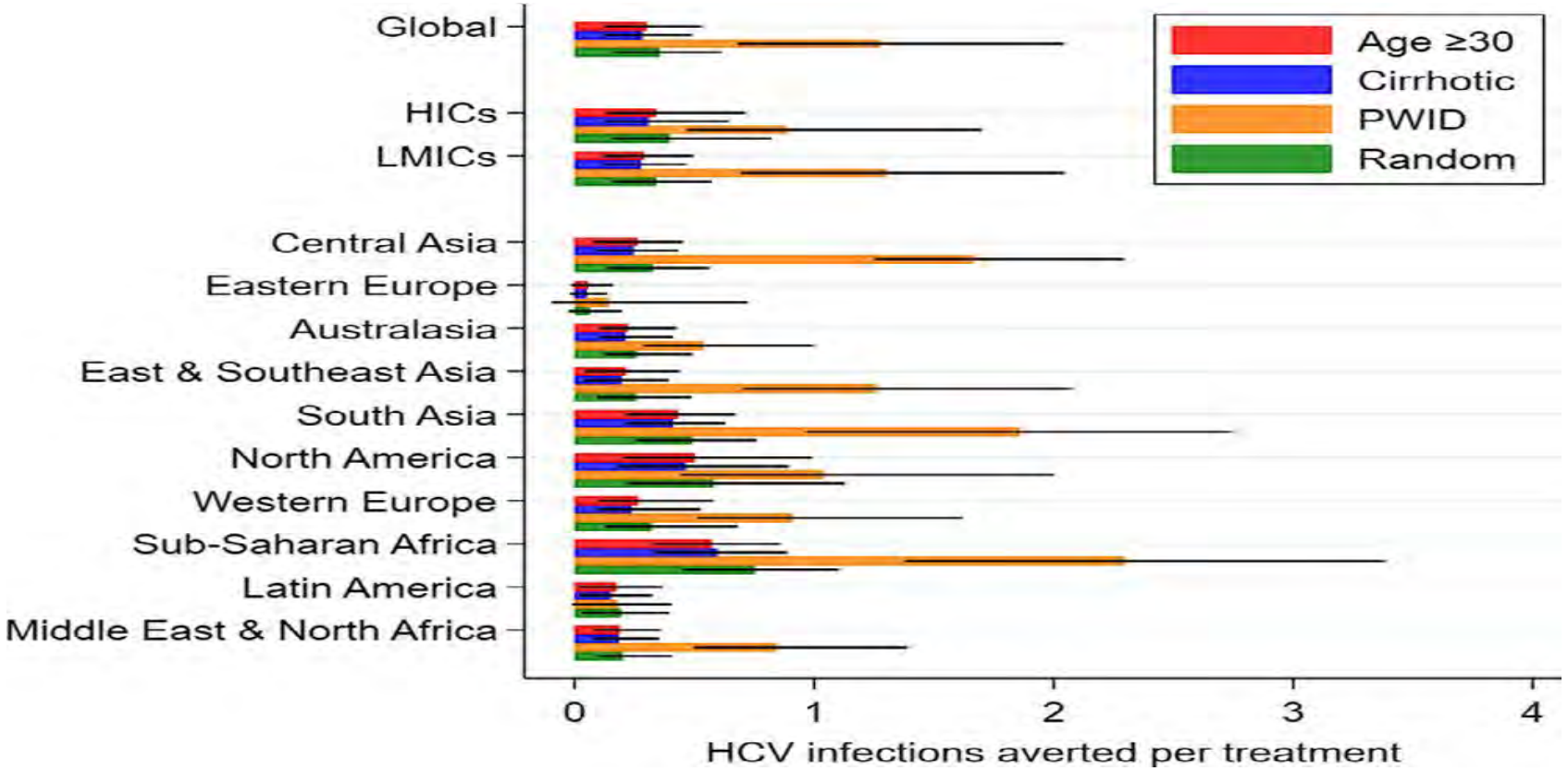
- HCV testing and treatment performed in primary care, harm-reduction services and other outreach services




*Lazarus JV, et al. J Internal Med 2019; 286: 503-25.*

Treatment-as-prevention

# Modelling the potential prevention benefits of a treat-all HCV treatment strategy at global, regional and country levels



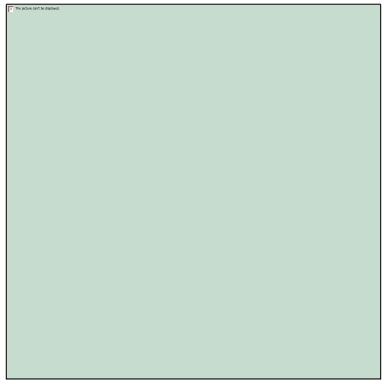

WHO's **treat-all strategy** could bring about appreciable prevention benefits, although **greater benefits** per treatment can be achieved through **targeting PWID**.

*Trickey A, et al. J Viral Hepat 2019;26:1388–1403.*

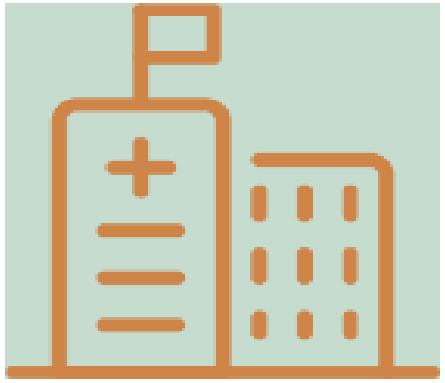
# Overcomming the barriers and gaps on the way to HCV elimination

Barriers and gaps need to be **adressed** and
**solutions** need to be found and subsequently **funded**

Patient



Practitioner



System

Policy

**“Secure Wider EU Commitment to the elimination of HCV”**

# Overcomming barriers and gaps on the way to HCV elimination

**Patient level:**

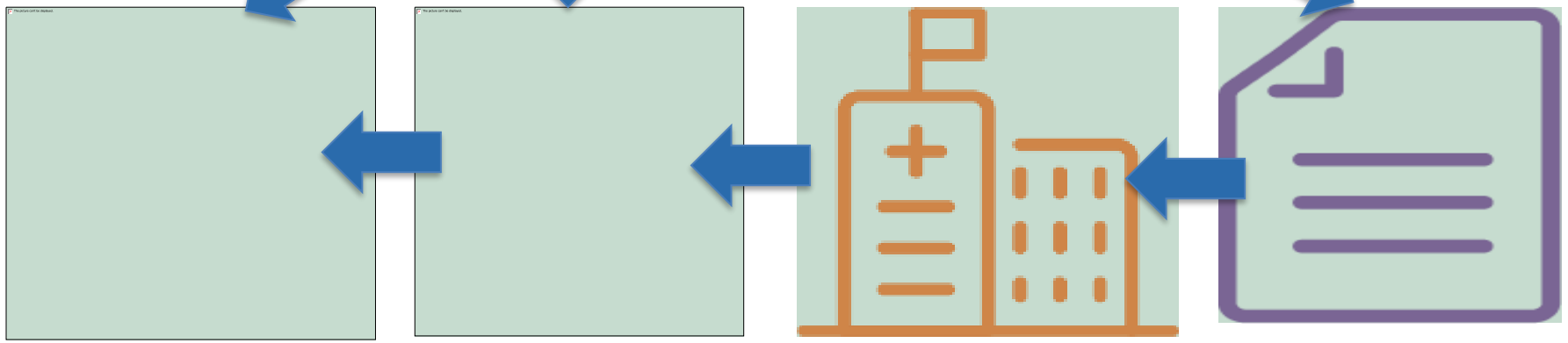
Clinical Practice Guidelines,
Patient Forum

EASL
European Association for the Study of the Liver

**Public health level:**

Position statements

Policy statements

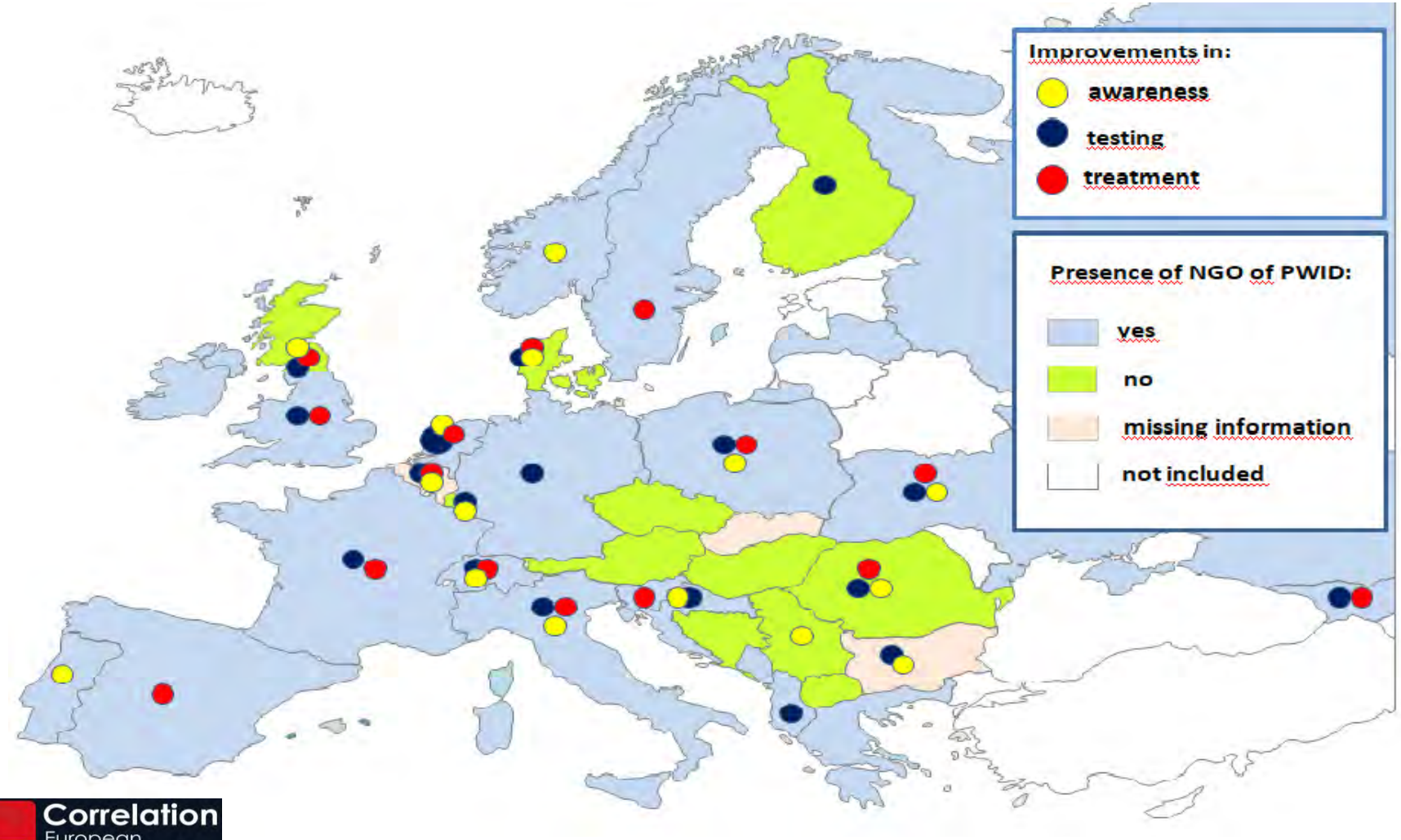


Patient | Practitioner | System | Policy

*EASL. Available at: https://easl.eu/easl/*

# NGOs of PWID reporting from 35 European countries: improvements in a continuum-of-care

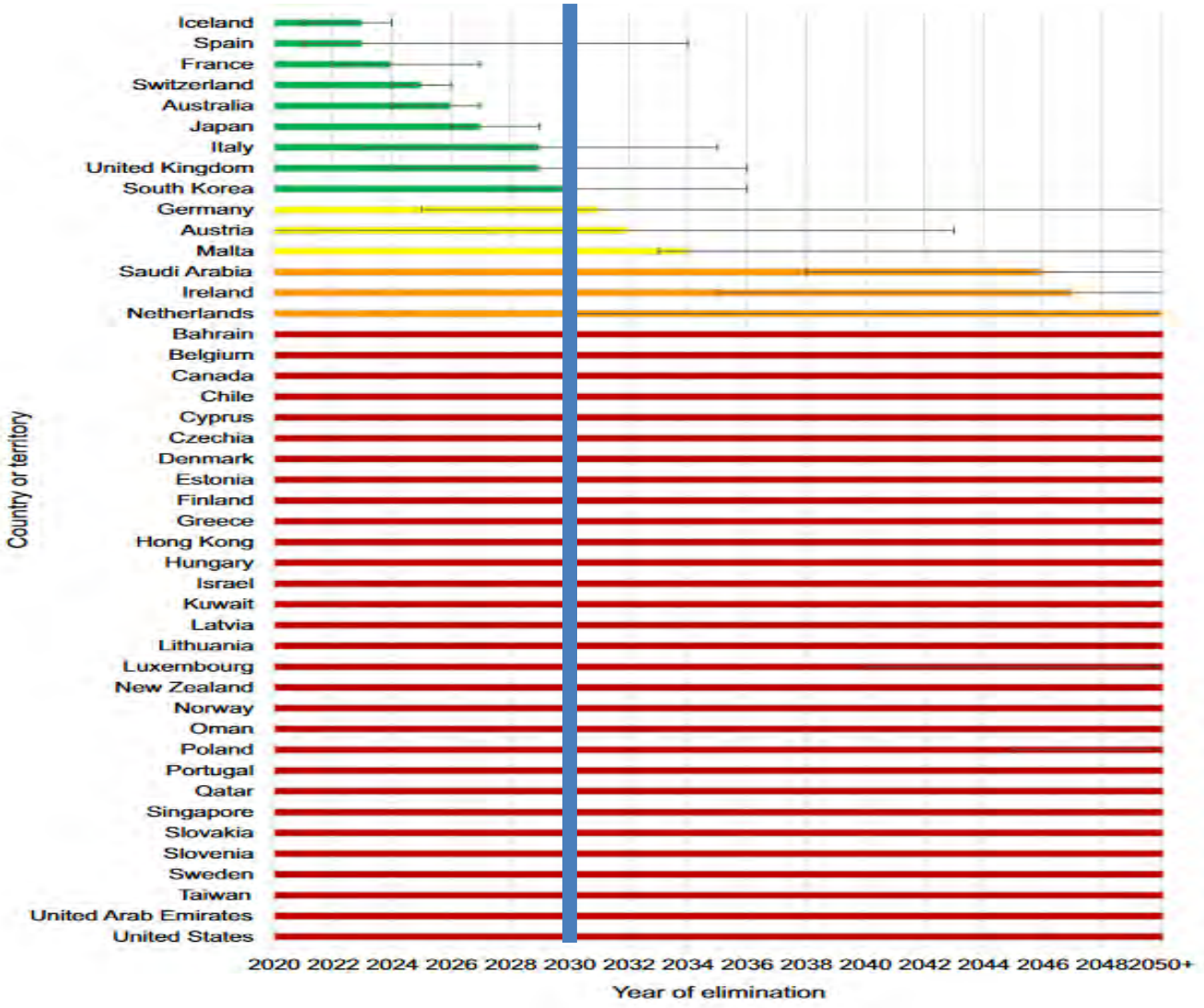
## comparing the years 2018 and 2019 and




Correlation
European
Harm Reduction
Network

*Maticic M, et al. Harm Reduct J 2020; 17: 89.*

# Countries on track to reach the WHO elmination targets by 2030 and beyond




**80%**
of high-income countries are **not on track** to meet the WHO elimination targets

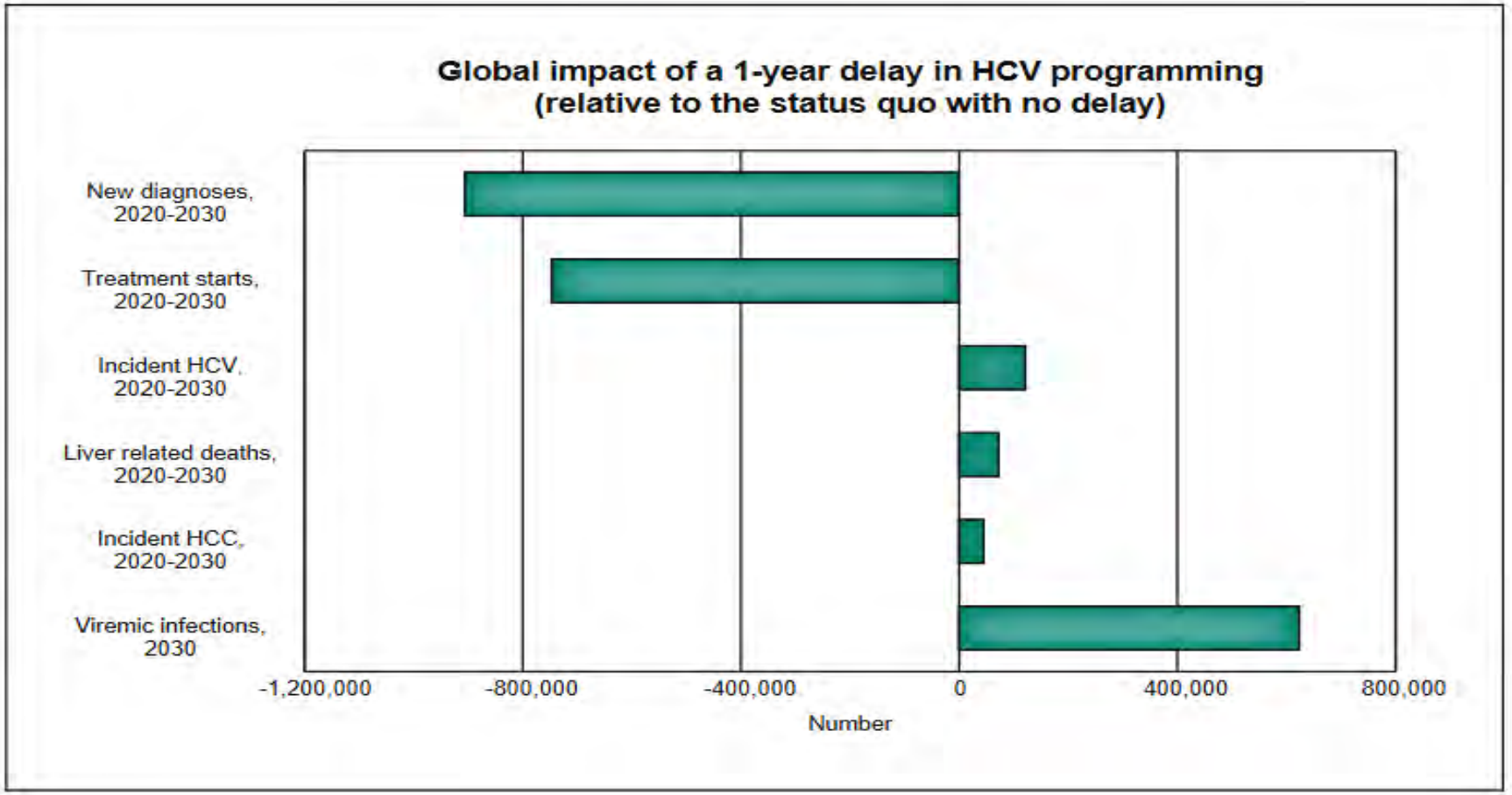
and

**67%**
of high-income countries are **off-track** by at least 20 years

*Razavi H et al. Liver Int 2020; 40: 522-9.*

# COVID-19

## Impact on global HCV elimination efforts




**Immediate action to improve HCV screening and treatment is needed to make the WHOs elimination targets attainable by 2030.**

*Blach S et al. J Hepatol 2020; 74: P31-6.*

Breakout sessions

# *Best practices at the national level*

A: Lessons to be learned from COVID-19 for the elimination of HCV (ACHIEVE)

B: National elimination plans:

UK, Italy, Israel, Spain

C: Best practice case studies:

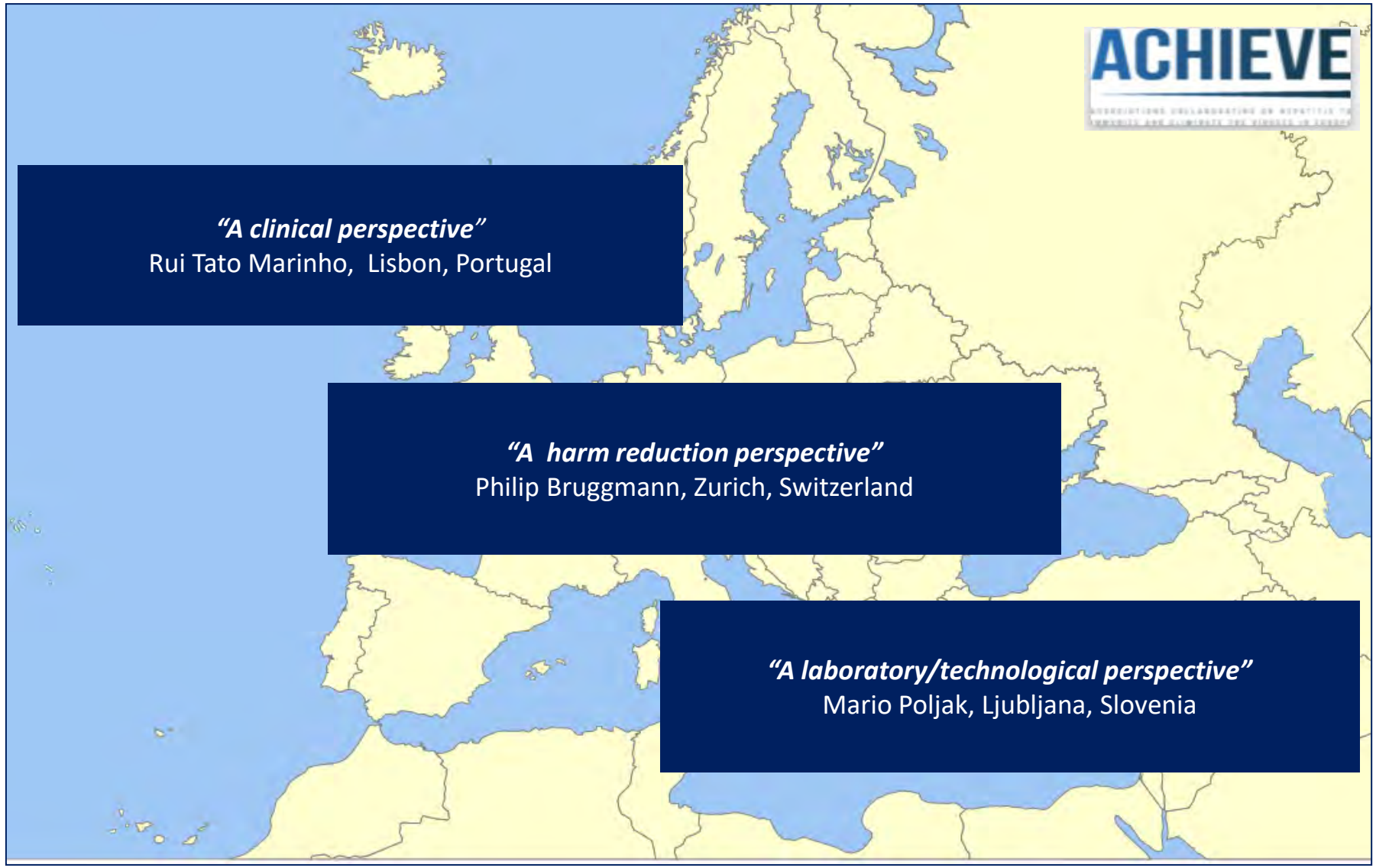
Ireland, Greece, Portugal, Montenegro

D: Best practice case studies:

Spain, Italy, Romania, Egypt

Breakout session A

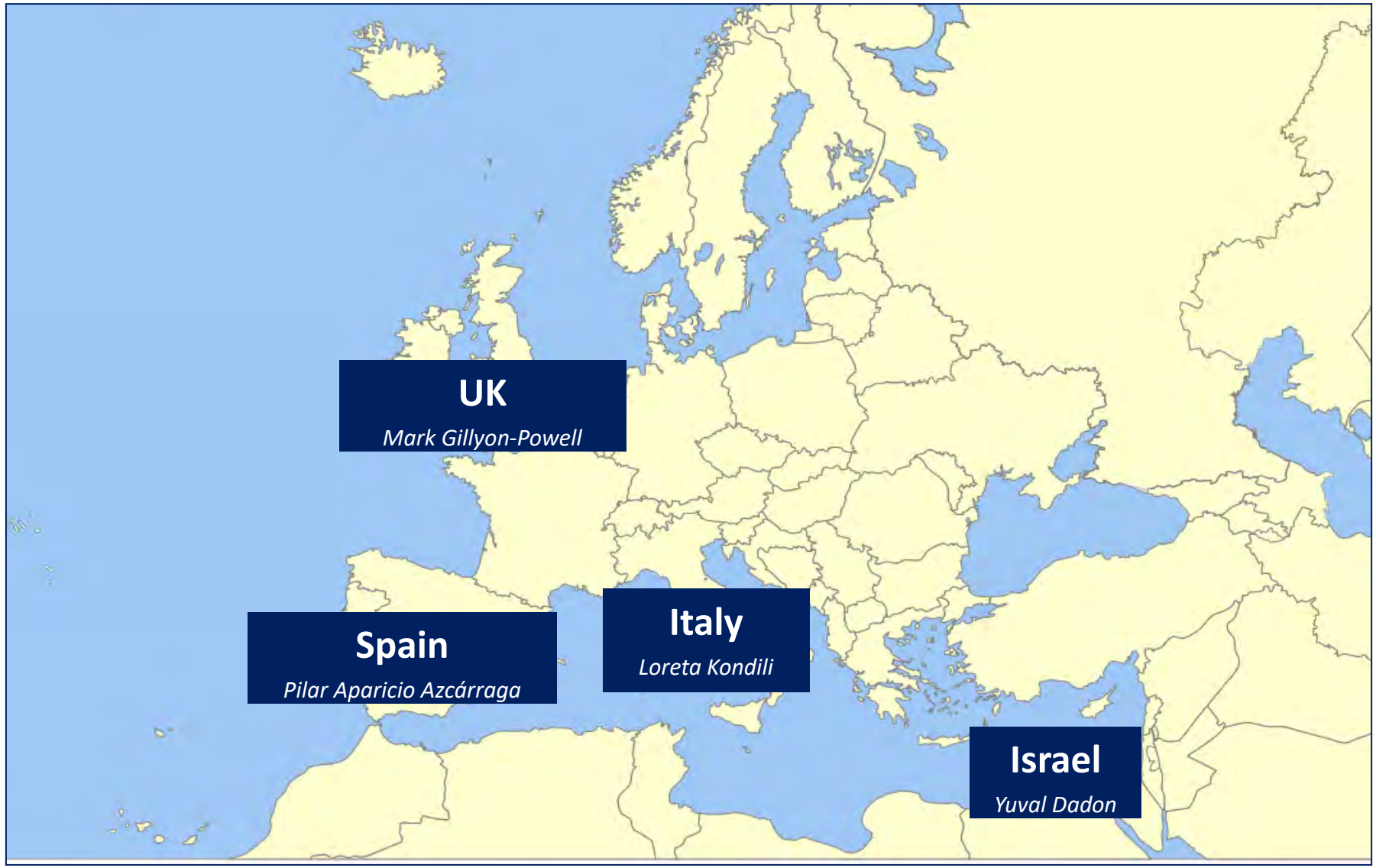
# *Lessons to be learnt from COVID-19 for elimination of HCV*



Breakout session B

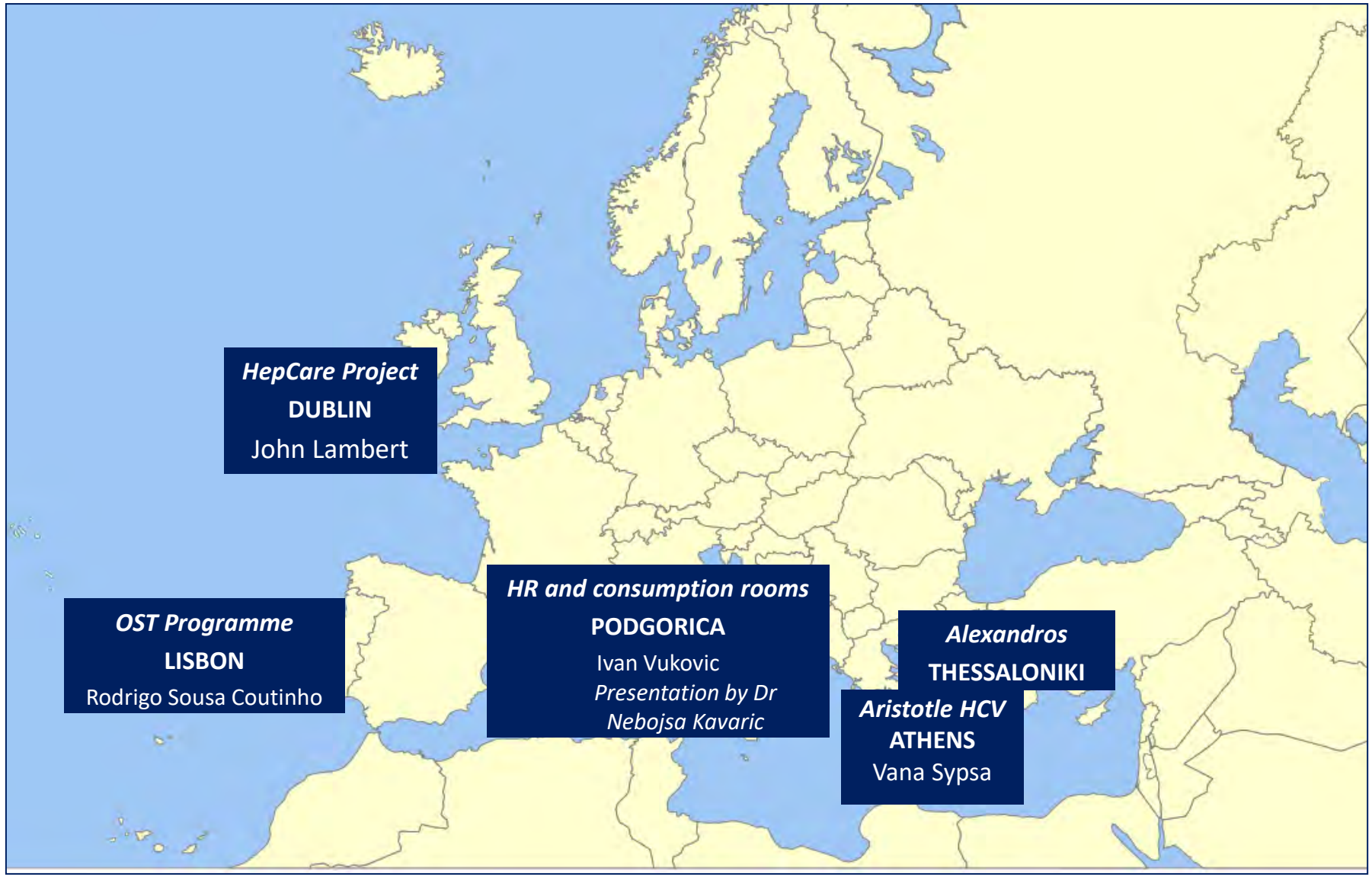
# National elimination plans

## Updates on progress



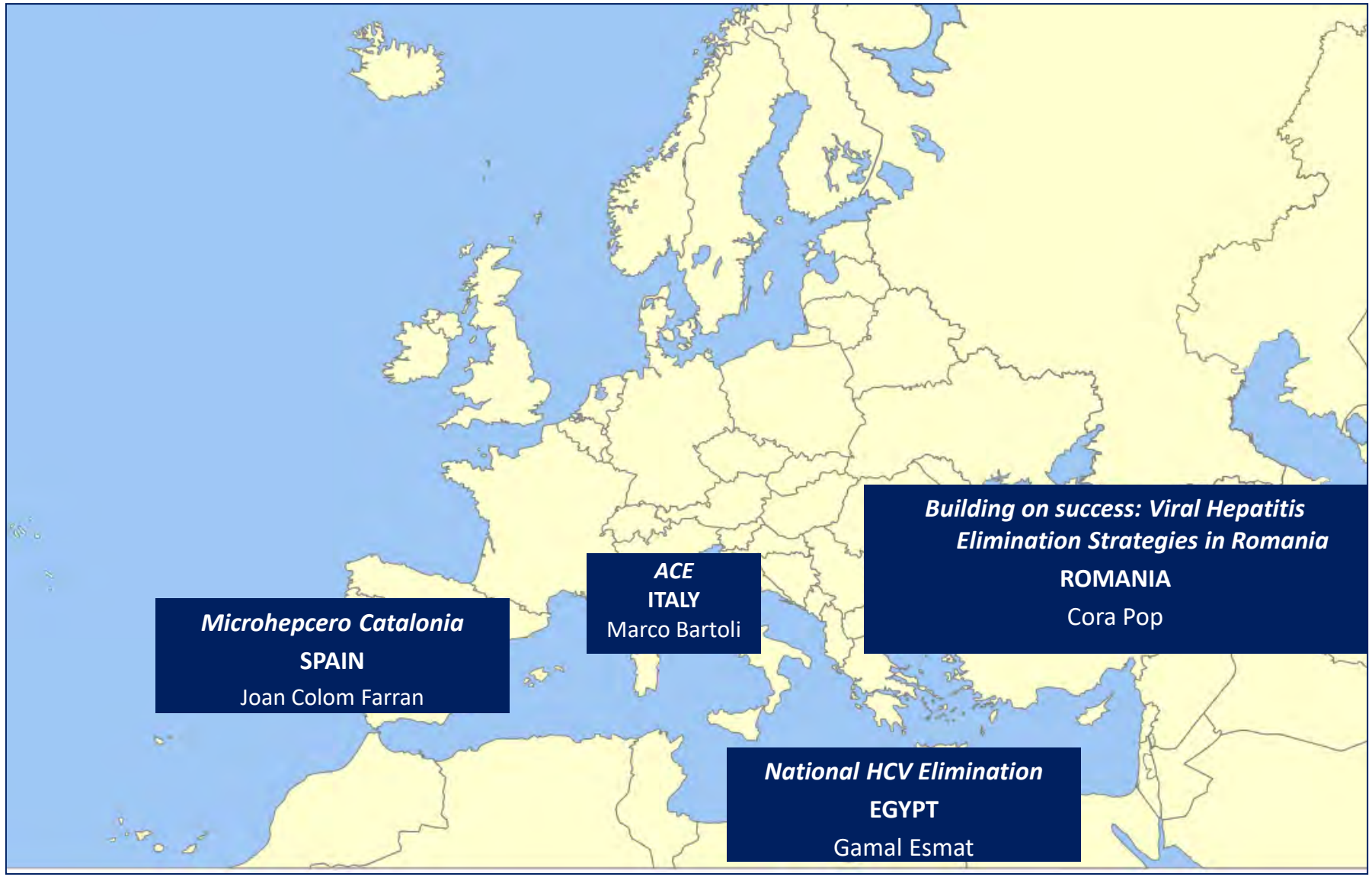
Breakout session C

# *Best practice case studies*



Breakout session D

# *Best practice case studies*



# Session 4a. Introduction to breakout sessions on Best Practices at the National level

- There are four breakout sessions

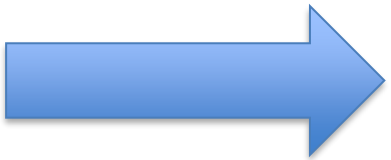
- The session titles will appear below the live stream of the current main session (ex: *Breakout session A: ACHIEVE Coalition – "Lessons to be learned from COVID 19 for the elimination of HCV")*

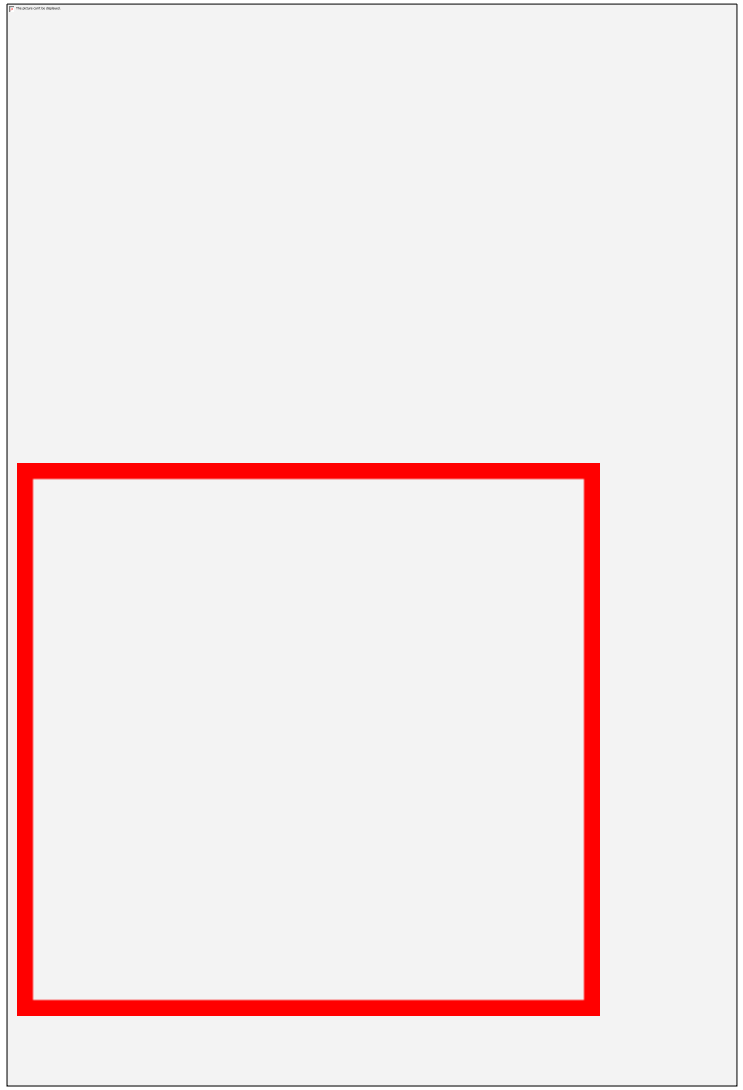
- Please click on the session you would like to attend

- Once the breakouts finish, click back on the main session link to re-join

# Breakout Sessions are ongoing!

**Please choose your preferred session in the virtual platform**





# Session 5 will resume at 17:30 CET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# Session 5: What political response/ leadership?

**Chairs:**
**Dr Ricardo Baptista-Leite MP, UNITE, Global Parliamentarians Network to End Infectious Diseases**
**Dr Manuel Carballo, International Centre for Migration, Health and Development, Switzerland**

EUHCV
Policy Summit - 24.03.2021
Online event

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# Mr Cristian-Silviu Buşoi

## Member of the European Parliament (MEP), Romania

# Mr Cristian-Silviu Buşoi (video presentation)

# Mr Kostas Bakoyannis

## Mayor of Athens, Greece


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# Municipality of Athens tackles HCV and viral diseases

CITY OF ATHENS

# The city of Athens in the 21st Century

- Multicultural, similar to any other modern European metropolis
  - Total Population: 650.000 people
  - Total Population of Attica: 3.700.000 people
- Expresses the acceptance of diversity and equal recognition of each ethnic group
- Gives an opportunity for new ideas and opinions to rise via collaborations and dialogue
- This multicultural character consists the very essence of democracy

CITY OF ATHENS

# Challenges and latest data

- 10-year severe financial crisis that drove a dagger to the heart of many groups
- Protracted HIV crisis in the PWID groups during 2010 - 2011
- Create and bridge a wide range of different needs for each social group, while ensuring that the latter is performed smoothly and with respect for the human personality
- This bridging must be implemented by two main entities of each urban center
  - The health systems
  - The local government
- The key to success: holistic interventions from both sides, collaboration, tailor made solutions for each group
- Results from the “ARISTOTLE HCV HIV” program
  - 75% HCV prevalence among PWID
  - 1 out of 4 lives with HIV

National Hepatitis plan

CITY OF ATHENS

# Municipality of Athens

- At the forefront of defending and addressing these tailor made needs before COVID-19 pandemic

- Main field of actions
  - Harm reduction regarding the use of intravenous or psychoactive substances
  - Eradication of infectious diseases that arise from opioid use

- Main challenges
  - Facilitate the everyday needs of PWID
  - Reduce the infectious diseases to other groups or PWID

CITY OF ATHENS

# Our actions

- 16th of March 2020: Emergency Plan for PWID and marginalized groups against COVID-19

- Temporary Accommodation Hostel “IONIS” for PWID who lack shelter
  - In collaboration with OKANA, KETHEA and KYADA
  - Organizations in the harm reduction field
  - Maximum capacity: 70 people

- Memorandum of Collaboration against HCV | Rapid tests for the Temporary Accommodation Hostel “IONIS”
  - “ARISTOTLE HCV HIV program”
  - Hellenic Liver Patients Association “Prometheus”
  - Association for HIV Positive People “Positive Voice”
  - Multipurpose Homeless Center (Maximum capacity: 400 people)

CITY OF ATHENS

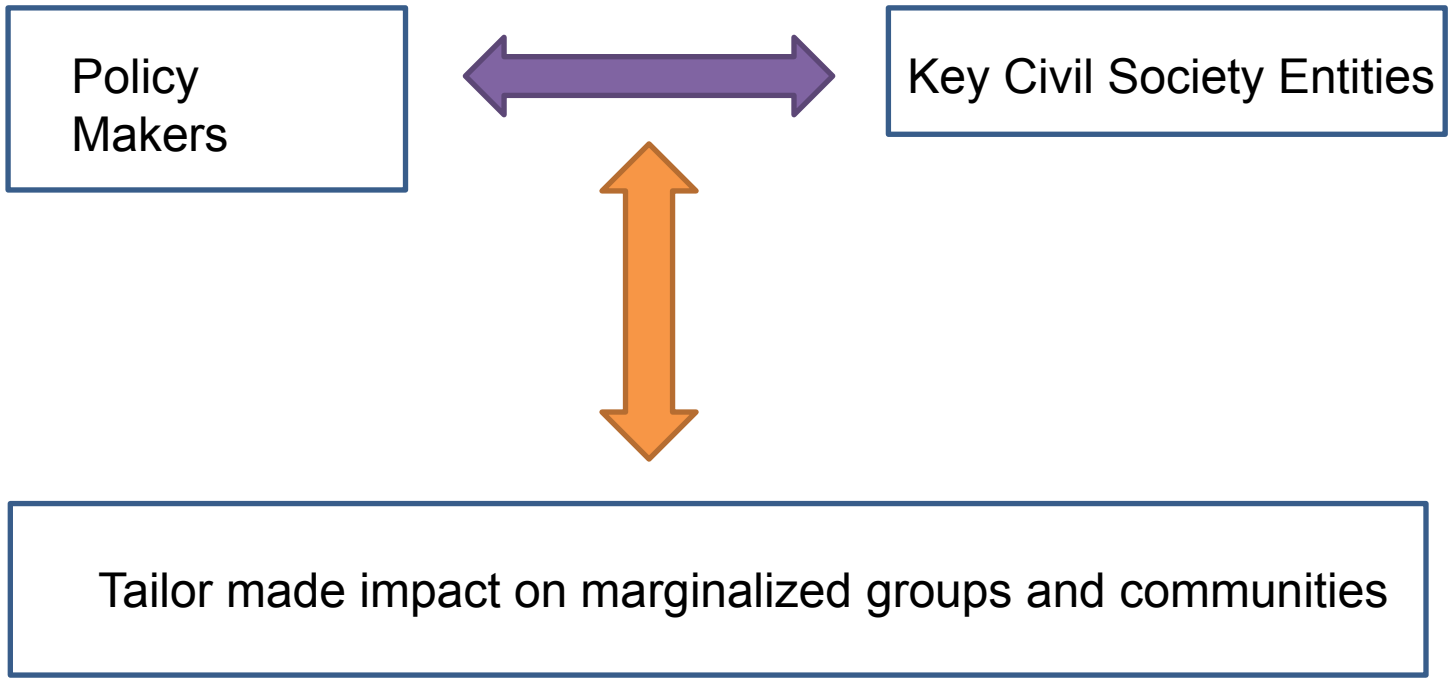
# Our actions

- Auspice in the innovative program “Prevention of Deaths from Opioid Overdose with Naloxone Distribution” for constituting a law of non-prescription in naloxone use.
  - Supported by Partnership of Healthy Cities of Vital Strategies of **Bloomberg Philanthropies** and implemented by:
  - The Hellenic Scientific Research Organization for AIDS and Sexually Transmitted Diseases
  - The Hellenic Liver Patients Association “Prometheus”
  - OKANA and KETHEA
  - Organizations in the harm reduction field
- Participation in the **Fast-Track Cities** Initiative against HCV, HBV, HIV and TB
  - A global partnership between cities and municipalities around the world
- Decisive key pressuring in the creation of a legal framework for Supervised Use Areas
  - Specialized areas where PWID can make safer use under the supervision of experts
- Secured the necessary resources to create new mobile units
  - Streetwork actions
  - Mobile Supervised Use Areas

CITY OF ATHENS

# The ultimate goal

## Facilitate effective communication between




CITY OF ATHENS

Thank you!

CITY OF ATHENS

# Mr Aldo Patriciello

## Member of the European Parliament (MEP), Italy

# Mr Aldo Patriciello (video presentation)

# Mr Tomislav Sokol

## Member of the European Parliament (MEP), Croatia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# Prof Jeffrey Lazarus

## ISGlobal, Barcelona, Spain


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Online event

3rd EU HCV Virtual Policy Summit DRAFT Programme
"Securing Wider EU Commitment to the elimination of HCV"
*Wednesday, 24 March 2021*
*14:00 – 18:30 CET*

# Call to Action

**Prof. Jeffrey V. Lazarus [Jeffrey.Lazarus@ISGlobal.org]**

Associate Research Professor, ISGlobal, Hospital Clínic
Associate Professor, Faculty of Medicine, Univ of Barcelona
Vice-chair, EASL International Liver Foundation

ISGlobal Barcelona Institute for Global Health
CLÍNIC BARCELONA Hospital Universitari
UNIVERSITAT DE BARCELONA

24 March 2021



@JVLazarus

# Call to Action

Call to Action for a

Europe free of

**hepatitis C**

EUHCV

www.hcvbrusselssummit.eu

We, the signatories of this Call to Action, launched at the 3rd European Union HCV Virtual Policy Summit *(Securing Wider EU Commitment to the Elimination of HCV)* on 24 March 2021, call on policymakers to commit to the elimination of hepatitis C throughout Europe. We, in turn, commit to reviewing progress on achieving the goals set out in this Call to Action on a regular basis and promoting it to key stakeholders at all relevant opportunities.

## Introduction

Despite the progress that has been made since the publication of the first European Union (EU) HCV Elimination Manifesto (Our vision for a Hepatitis C-free Europe) in 2016, [1] hepatitis C remains a major public health challenge in Europe:

Hepatitis C has a substantial morbidity and premature death burden, particularly in marginalised groups:

- In the European Union (EU) more people die each year from hepatitis C than from AIDS. [5]

www.hcvbrusselssummit.eu

#EliminateHCV #NoHep
@HepBCPPA

# Call to Action Working Group

- **Dr Jeffrey Lazarus**, ISGlobal, Spain, Vice-Chair of EILF
- **Prof Heiner Wedemeyer**, Co-Chair HepBCPPA and Hannover Medical School, Germany
- **Prof Maria Buti**, EU Policy Councillor, EASL
- **Prof Angelos Hatzakis**, Co-chair HepBCPPA and University of Athens Medical School, Greece
- **Marko Korenjak**, President ELPA
- **Eberhard Schatz**, Correlation Network

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# Action Points

*We share the vision that eliminating hepatitis C in Europe by 2030 will require policymakers to:*

1) **Ensure that data on the impact of the COVID-19 pandemic on efforts to eliminate hepatitis C is collected and analysed and that the findings are published in an official report**
   Relevant agencies such as the ECDC, EMCDDA and the WHO Regional Office for Europe should collaborate on regularly collecting assessing and publishing data from all Member States. The official report should include recommendations and a roadmap for getting elimination efforts back on track.
2) **Make hepatitis C elimination in Europe an explicit and adequately resourced public health priority**
   Hepatitis C elimination should be pursued using appropriate means at all levels – through collaboration between individual citizens, civil society organisations, healthcare professionals, medical associations, researchers, the private sector, local and national governments, European Union institutions – including the European Commission, ECDC, EMCDDA and the WHO Regional Office for Europe. The new EU public health programme, EU4Health, must ensure that hepatitis C elimination is advanced through the adequate funding of projects which promote prevention, diagnosis and linkage to care in all countries.
3) **Ensure every country has a published national viral hepatitis elimination action plan or strategy, and that key stakeholders are involved in developing and implementing these plans**
   Where national viral hepatitis elimination plans/strategies do not exist, developing and publishing a plan should be prioritised. Every country should ensure that patients, civil society groups and other relevant stakeholders – including at-risk groups – are directly involved in developing and implementing such plans. Surveillance and tracking of HCV cases and mortality, as well as agreed markers to monitor implementation, should be in place. Existing best practice examples and guidelines should serve as the basis for people-centred, health system-based strategies that emphasise tailored implementation at the local level.
4) **Ensure integrated care pathways are included in national plans/strategies**
   Make the development of integrated care pathways a core component of viral hepatitis elimination plans/strategies, taking into account the specific health system barriers and other challenges related to the management of viral hepatitis infection, such as community-based care, for example, harm reduction services, which may not be linked to the national health system. Implementation of integrated care pathways should embed monitoring of their effectiveness over time.

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# Action Points

5) **Support efforts to reduce the impact of hepatitis C on rates of liver disease and liver cancer through access to testing, treatment, screening and improved follow up**

   In line with *Europe's Beating Cancer Plan*, [10] support efforts to improve access to hepatitis C treatments to prevent liver cancer attributed to hepatitis C. Promote long-term follow up/screening programmes for hepatitis C patients to reduce the risk of liver disease and liver cancer.

6) **Remove barriers to people who inject drugs (PWID) accessing care, including decriminalisation**

   Political resistance to harm reduction services is a major barrier to appropriate access to hepatitis C prevention services for PWID, as are laws and policies which criminalise drug use, drug possession, and drug users. [12] In line with community statements and the European Association for the Study of the Liver's (EASL) policy statement, [12] we therefore call for the decriminalisation of minor, non-violent drug offences and call for political support for harm reduction services in all European countries.

7) **Address stigma and discrimination, and protect the human rights, particularly of marginalised communities at risk for hepatitis C**

   All hepatitis C elimination-related strategies must be consistent with fundamental human rights principles including non-discrimination, equality, participation, and the right to health. Stigma about hepatitis affects people accessing testing or treatment, and can cause fear of disclosure, all of which hinder elimination efforts. Even once hepatitis C is cured, stigma and discrimination can persist and have real consequences for the individuals affected. The links between hepatitis C and social marginalisation are well established, and particular care and attention should be focused on addressing stigma and discrimination in these populations.

8) **Pursue micro-elimination strategies to maximise impact on reducing incidence of hepatitis C**

   Micro-elimination strategies pragmatically target hepatitis C prevention and treatment to achieve the WHO targets in specific at-risk sub-populations (e.g., people living with HIV, people who inject drugs, people with haemophilia, people with liver disease), settings (e.g. hospitals, prisons, addiction centres), generational cohorts or geographic areas (e.g. a city or region). [13] This approach maximises the impact of limited resources and allows for countries to work towards the elimination of hepatitis C in a phased manner.

9) **Support the introduction of standardised continuum of care (CoC) monitoring in every European country**

   Strengthen efforts to harmonise and improve the surveillance of hepatitis C across the European Union to inform and evaluate hepatitis C elimination strategies, by asking every country to publish a continuum of care starting with prevalence estimates, and continuing through numbers diagnosed, linked to care, had treatment initiated, and achieved sustained virologic response.

# The Call to Action is endorsed by:


www.hcvbrusselssummit.eu

www.hcvbrusselssummit.eu

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# Panel discussion and Q&A

# Concluding remarks


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# Prof Heiner Wedemeyer

**Co-Chair HepBCPPA and Hannover Medical School, Germany**

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# Prof George Papatheodoridis

## Co-chair HepBCPPA and University of Athens Medical School, Greece


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