Session 4: 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

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Best practices at the national level

Introduction to breakout sessions

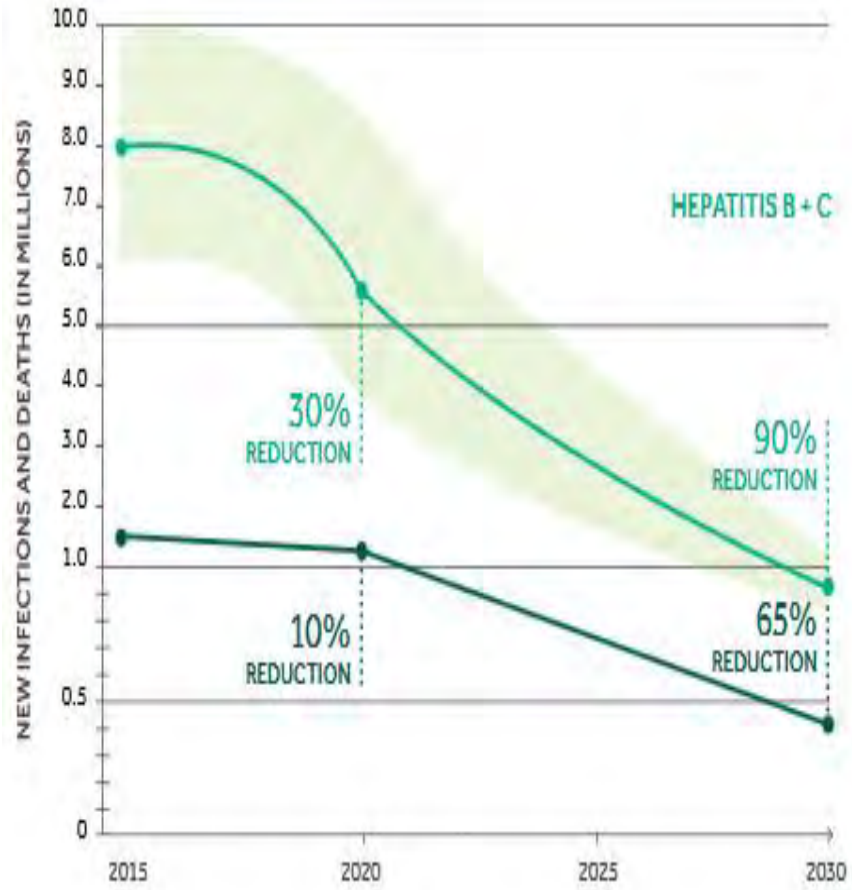
Prof. Mojca Maticic, MD, PhD

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

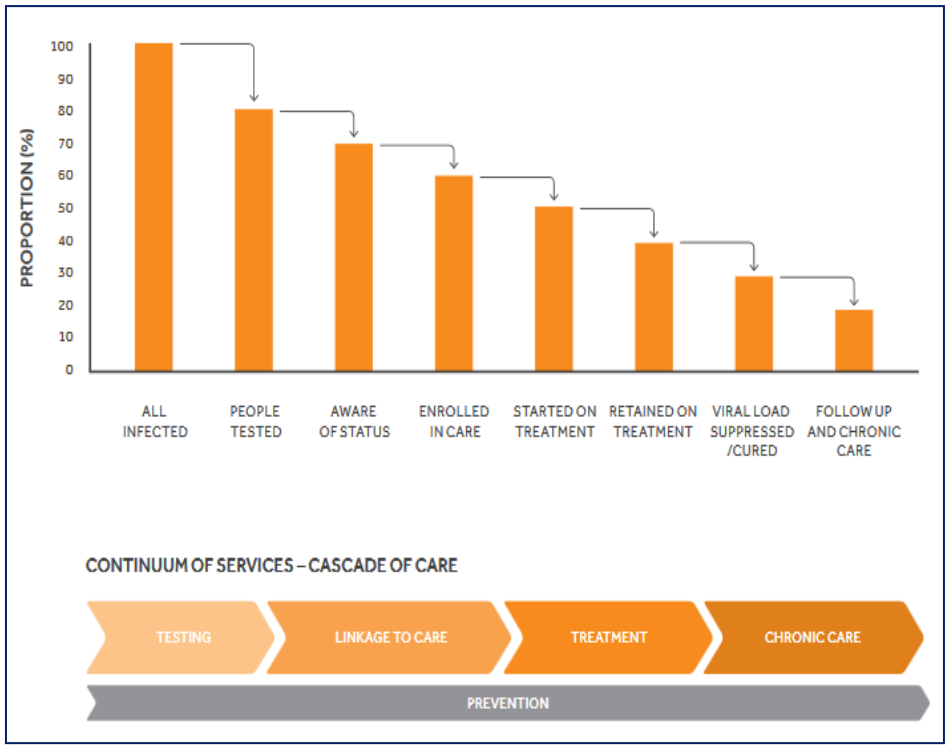
3rd EU HCV Policy Summit Digital : March 24, 2021

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

GOALS

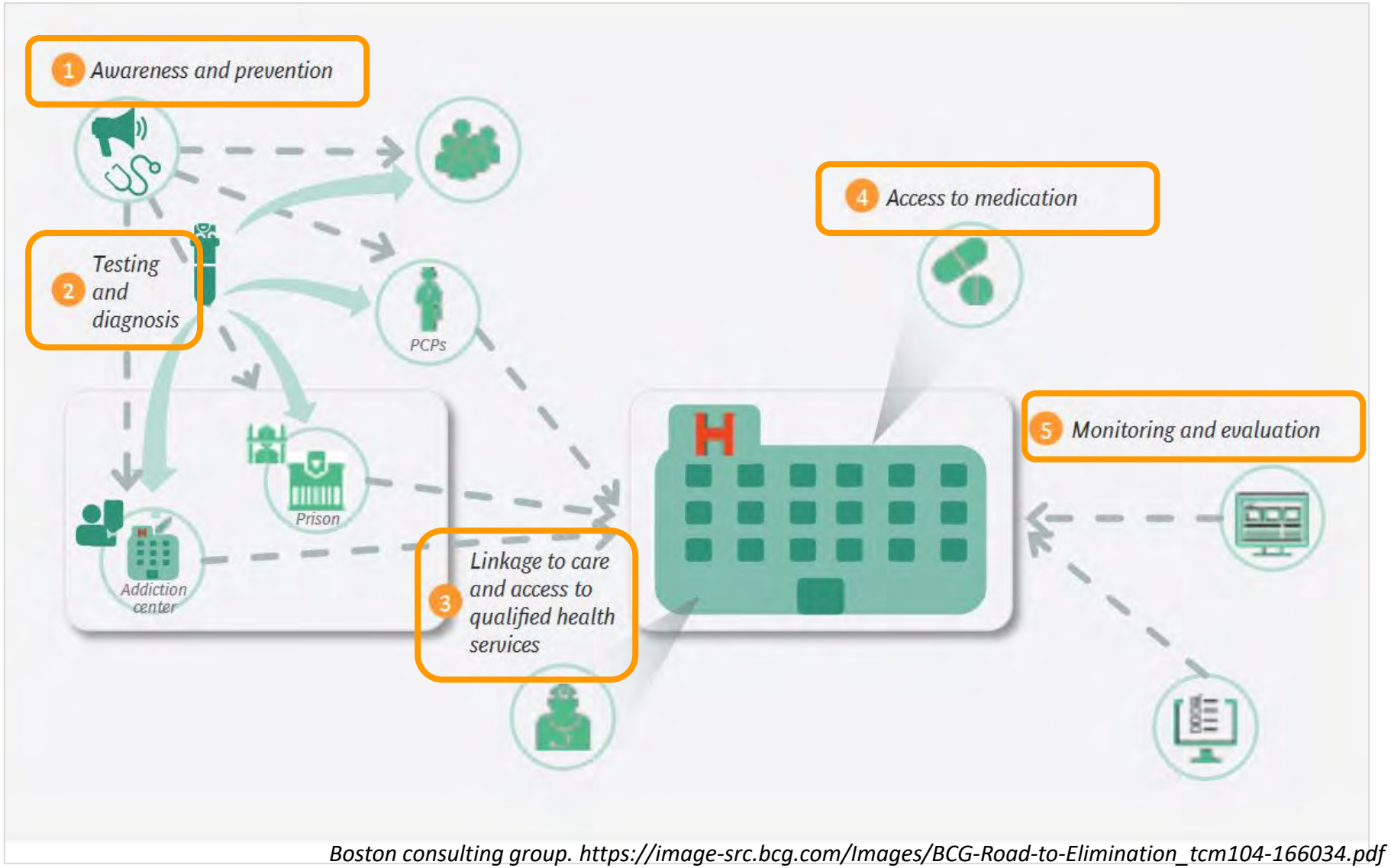


TOOLS



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

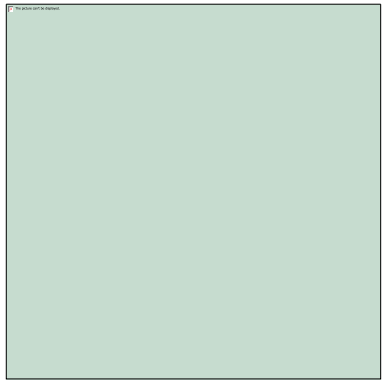
The road to HCV elimination is complex



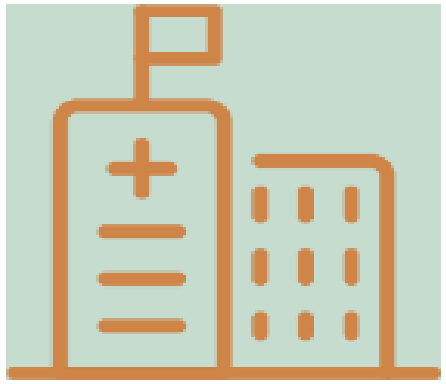
Boston consulting group. https://image-src.bcg.com/Images/BCG-Road-to-Elimination_tcm104-166034.pdf

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:

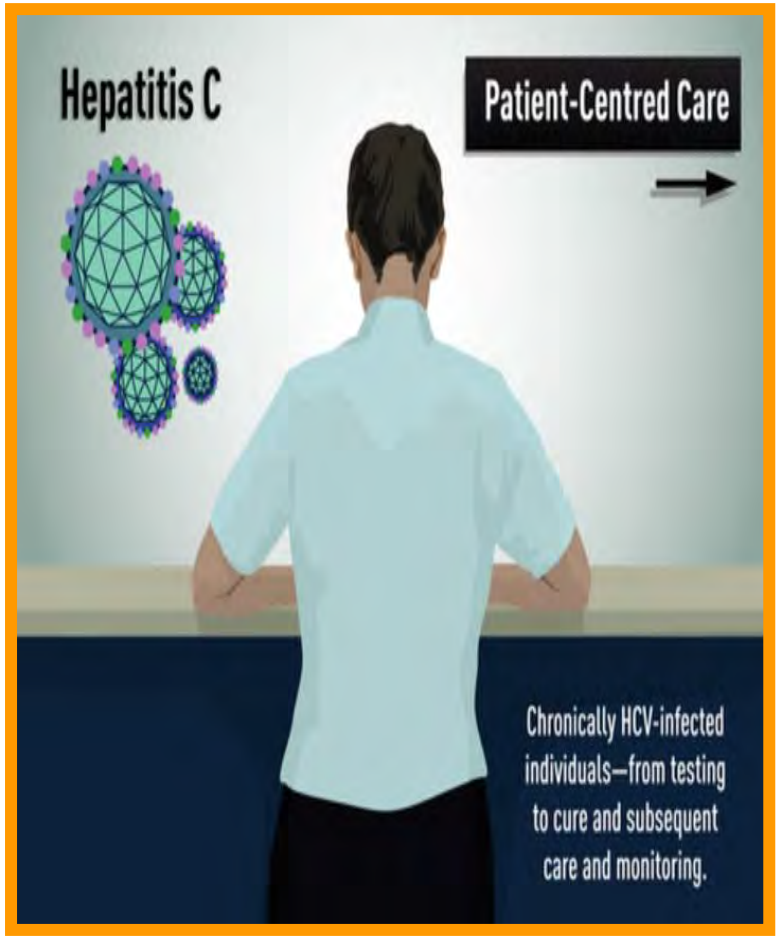
- HCV services put out of hospitals to regional and local level

Task-sharing:

- Involve GPs and nurses to manage uncomplicated HCV cases

Integration:

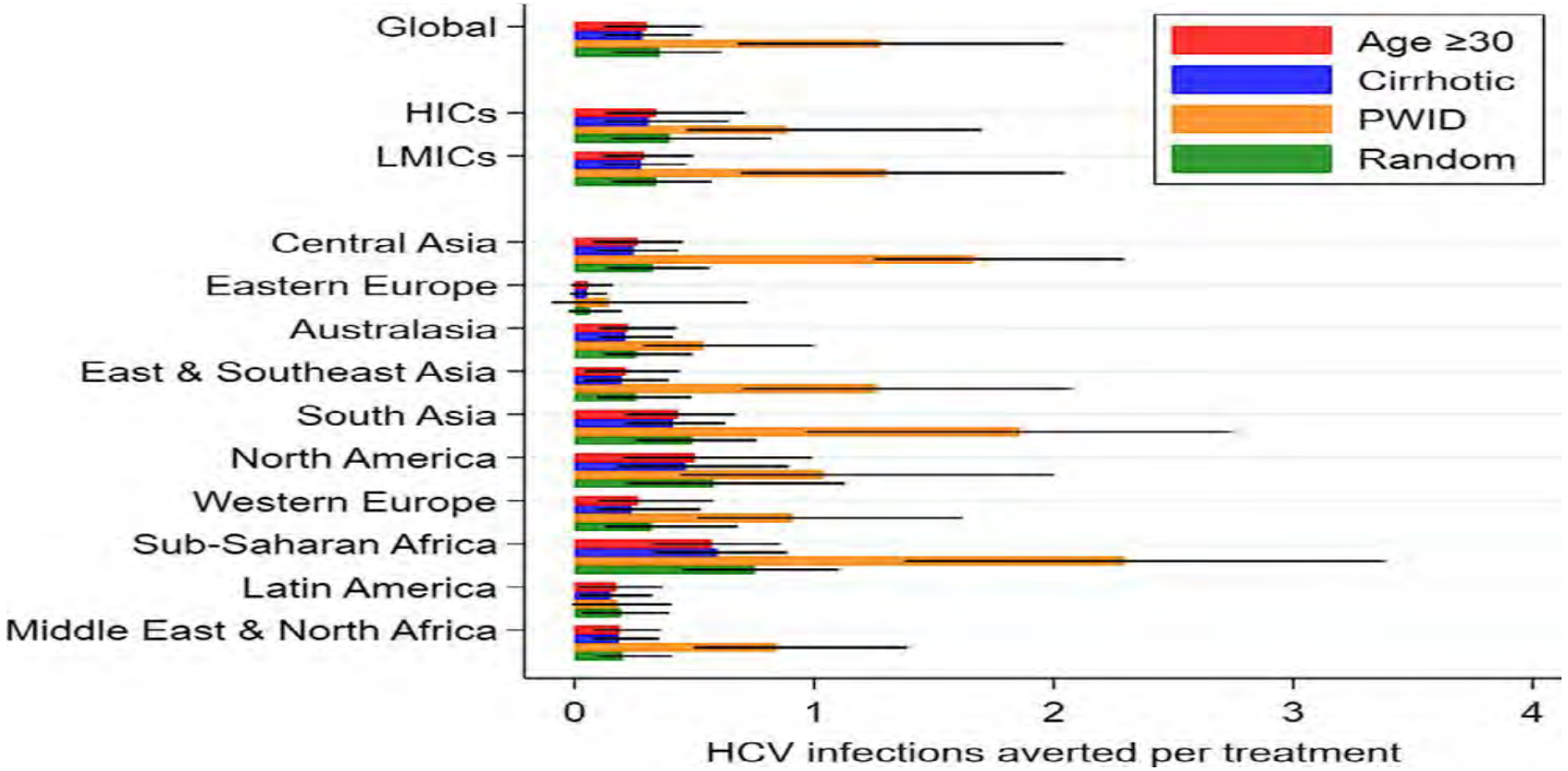
- HCV testing and treatment performed in primary care, harm-reduction services and other outreach services



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



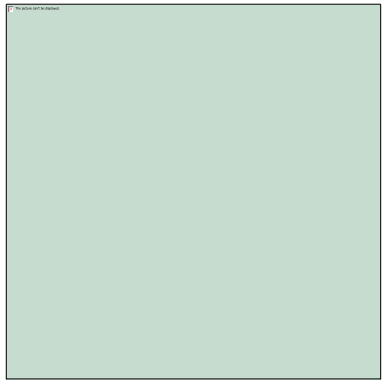
WHO's **treat-all strategy** could bring about appreciable prevention benefits, although **greater benefits** per treatment can be achieved through **targeting PWID**.

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

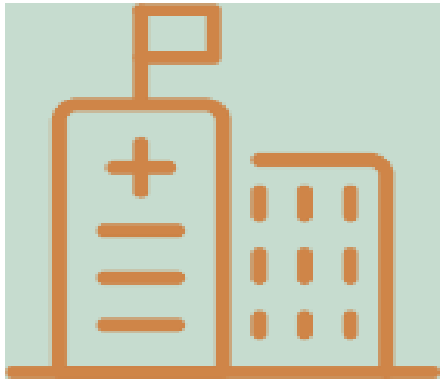
Overcomming the barriers and gaps on the way to HCV elimination

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:

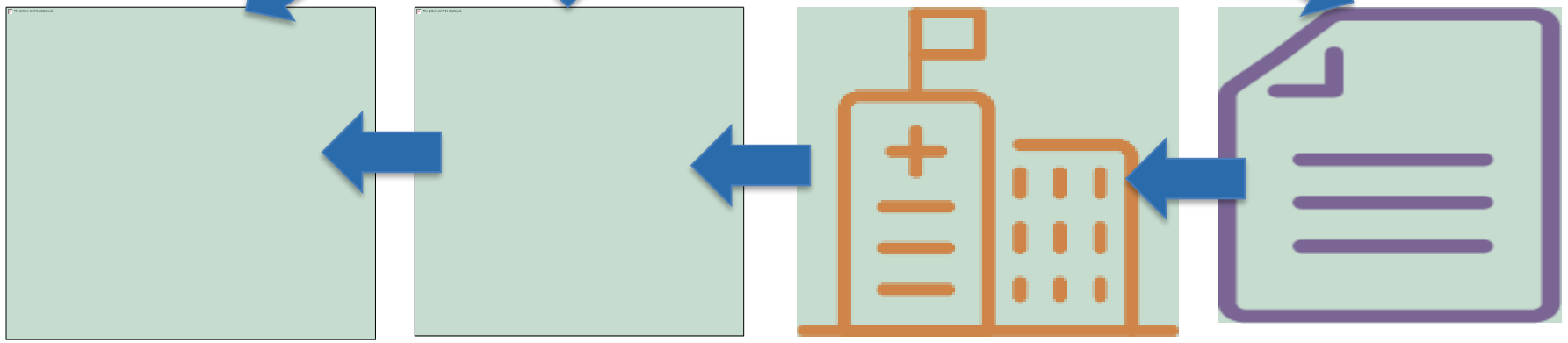
Clinical Practice Guidelines,
Patient Forum

EASL
European Association for the Study of the Liver

Public health level:

Position statements

Policy statements

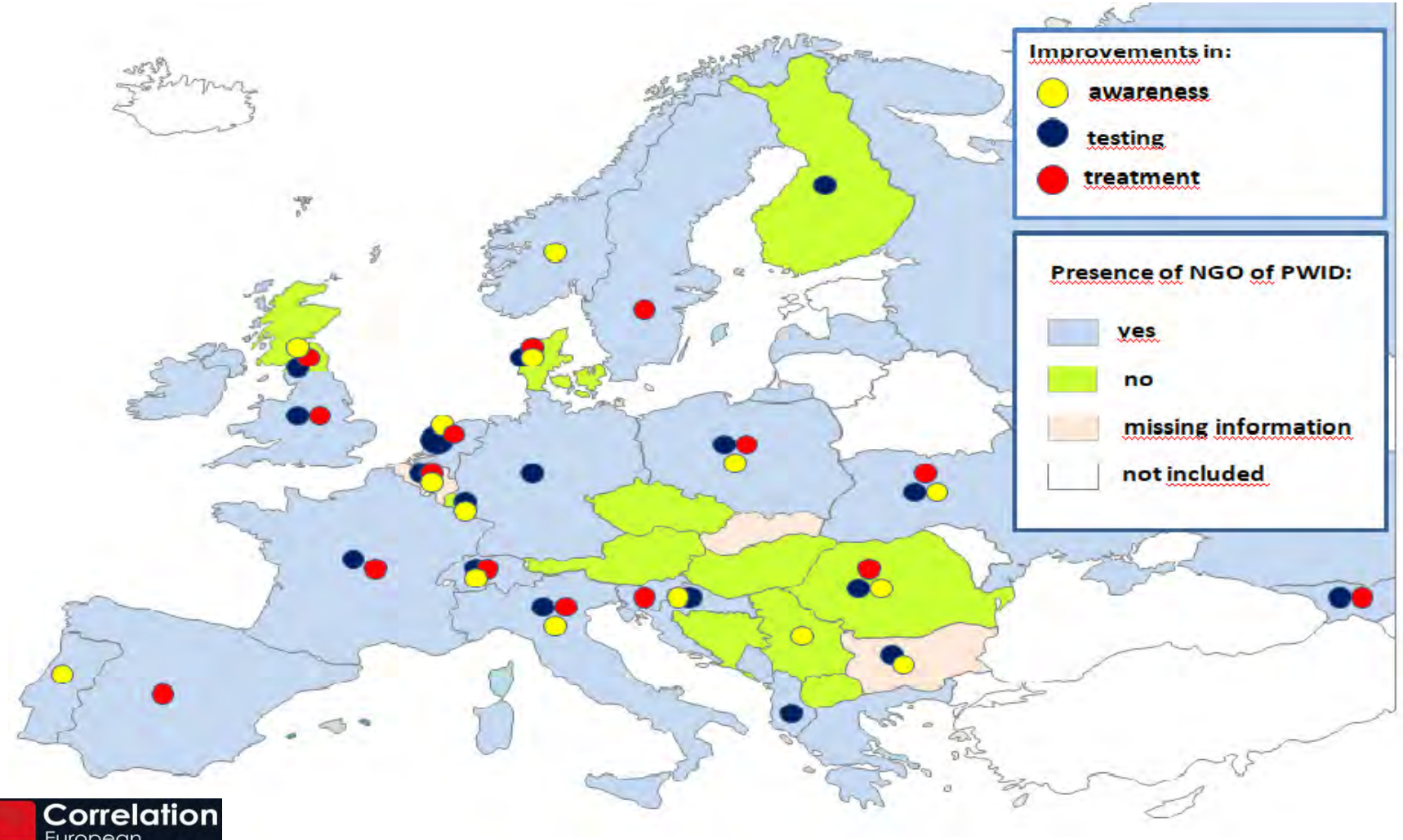


Patient | Practitioner | System | Policy

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

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

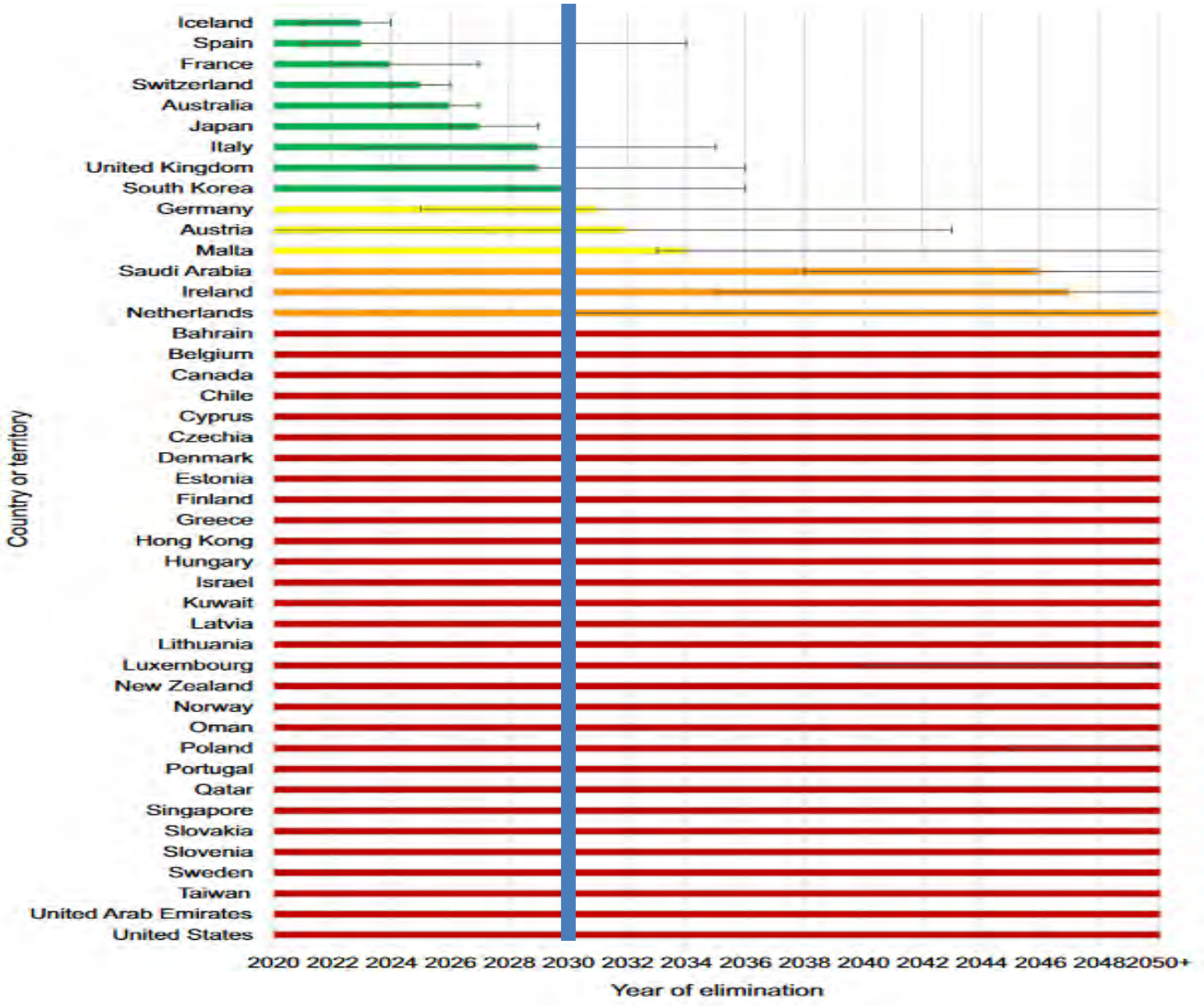
comparing the years 2018 and 2019 and



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

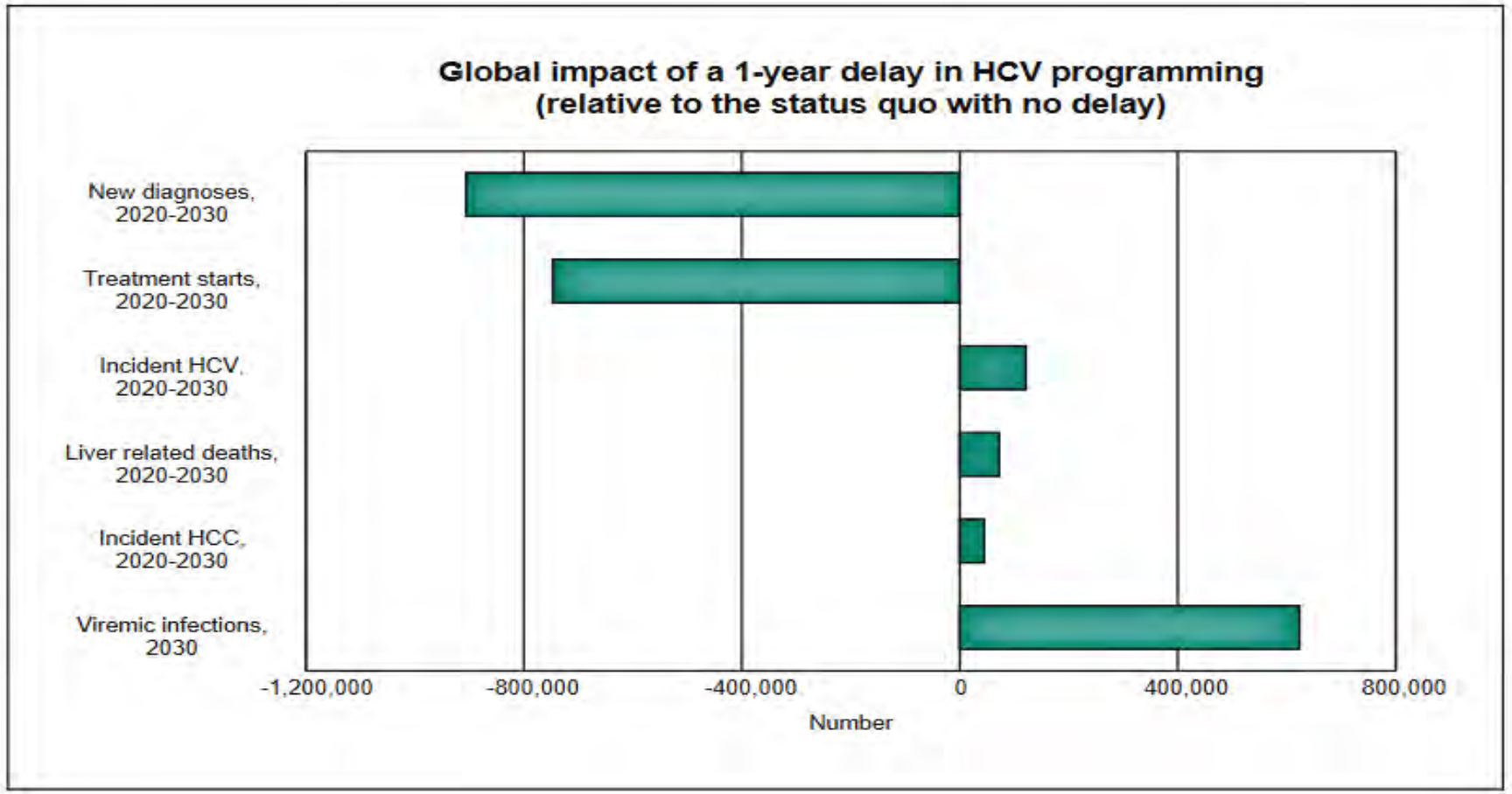
and

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:

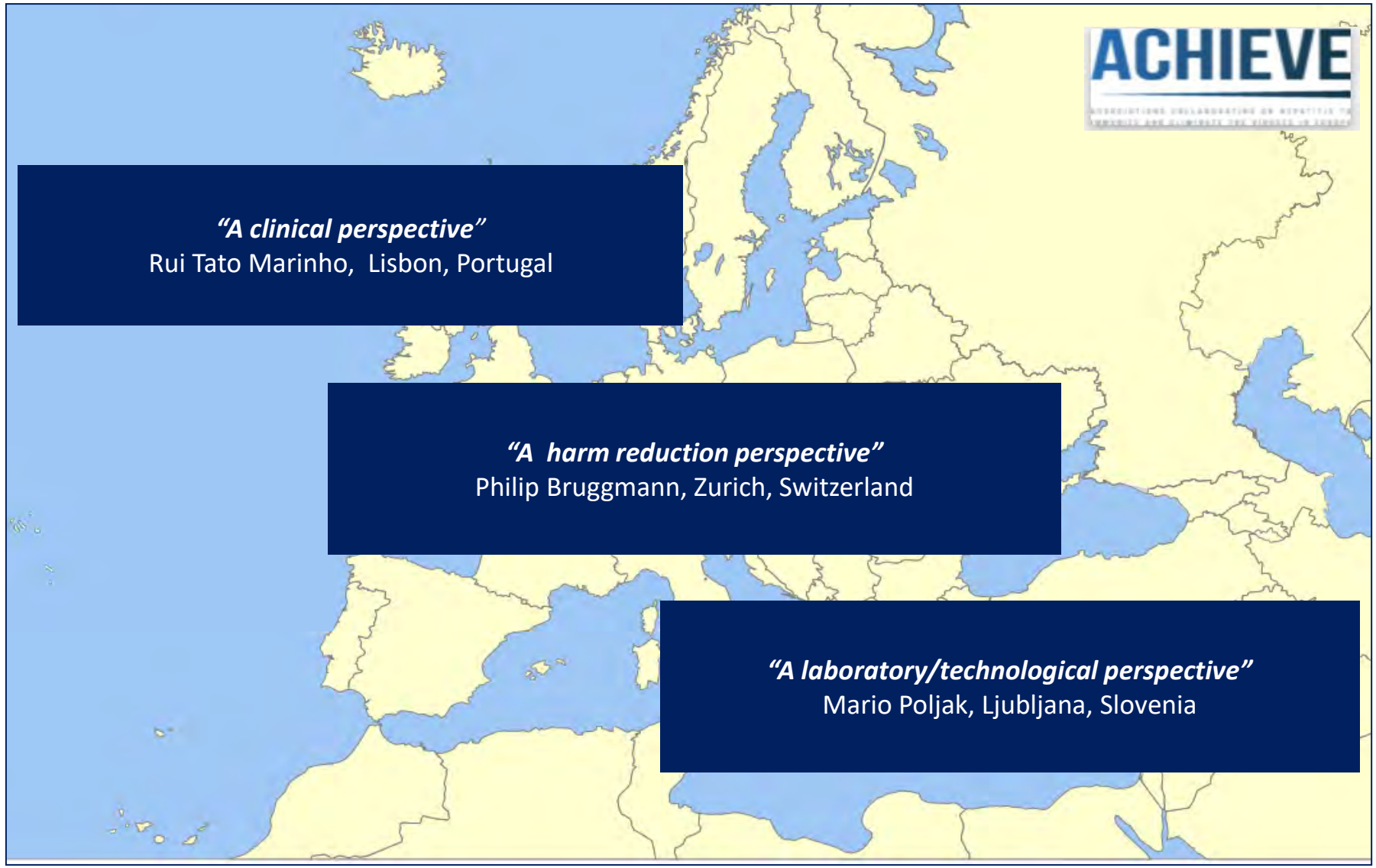
Ireland, Greece, Portugal, Montenegro

D: Best practice case studies:

Spain, Italy, Romania, Egypt

Breakout session A

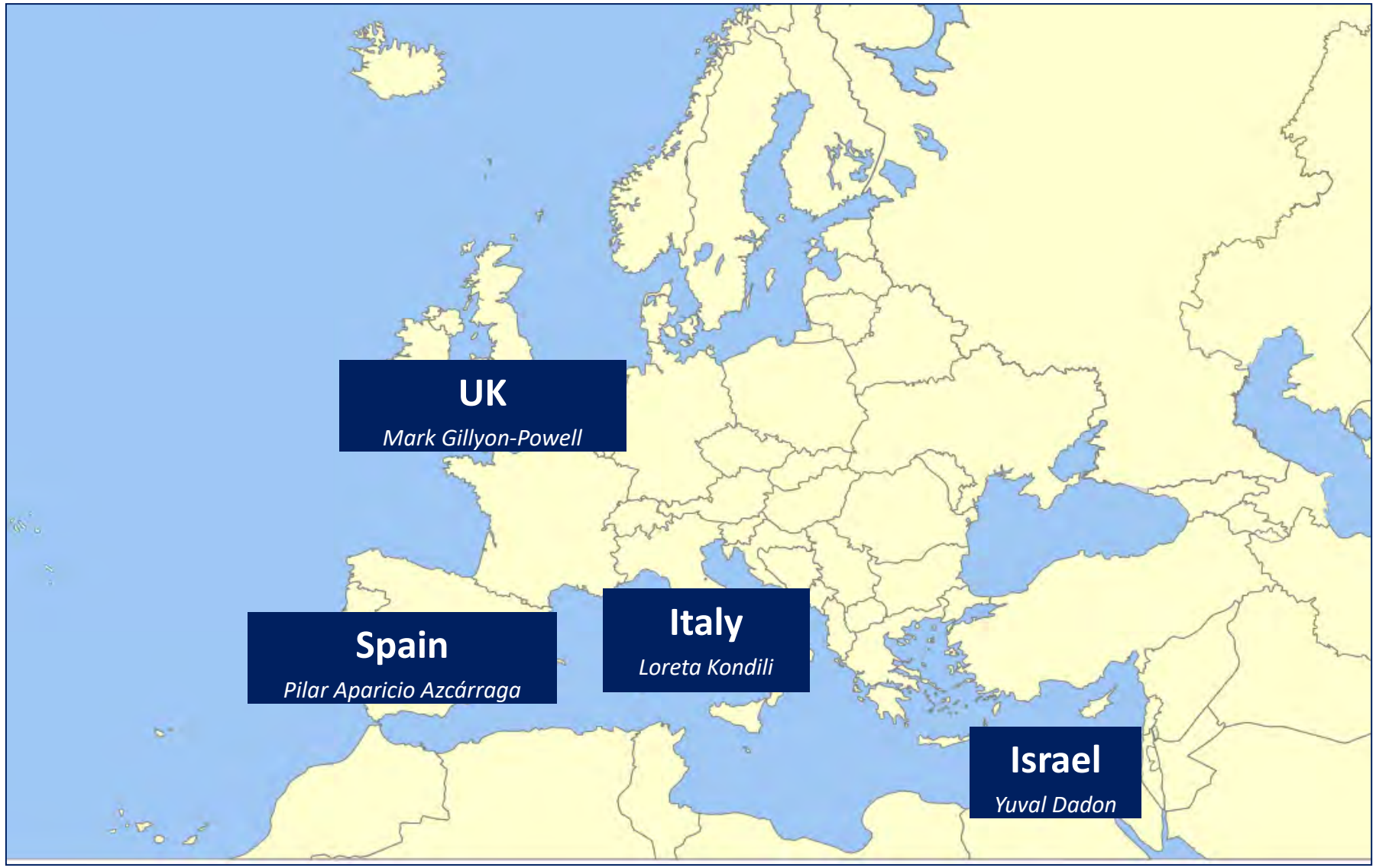
Lessons to be learnt from COVID-19 for elimination of HCV



Breakout session B

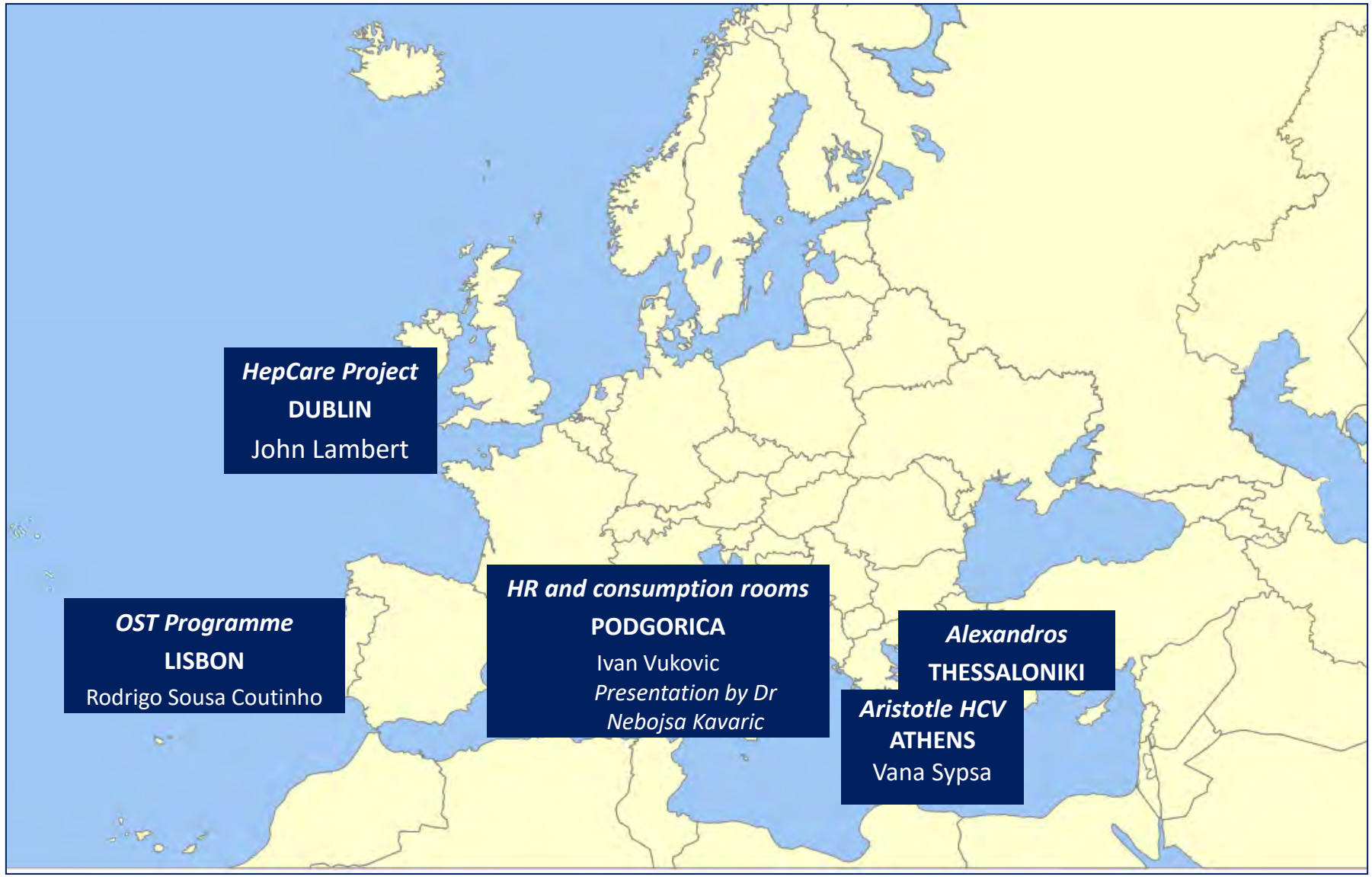
National elimination plans

Updates on progress



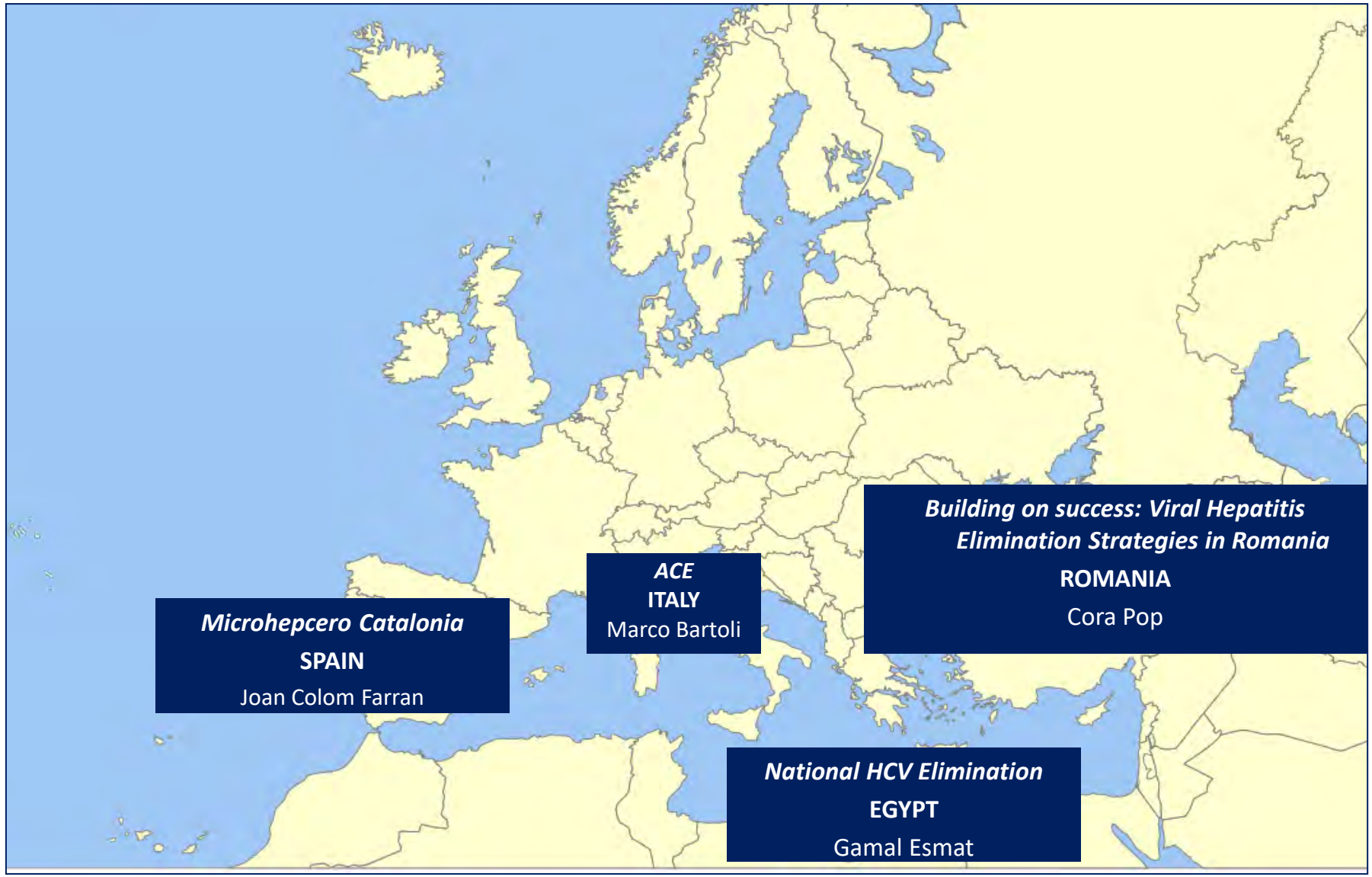
Breakout session C

Best practice case studies



Breakout session D

Best practice case studies



Breakout sessions:
Best Practices at the National level

Breakout session A
ACHIEVE Coalition – "Lessons to be learned from COVID 19 for the elimination of HCV"

Moderated by Prof David Goldberg, Public Health Scotland

- ***"A clinical perspective"*** *Prof Rui Tato Marinho, Santa Maria Hospital, Medical School of Lisbon, Portugal*
- ***"A harm reduction perspective"****, Dr Philip Bruggmann, Arud Centre for Addiction Medicine, Zurich, Switzerland*
- ***"A laboratory/technological perspective"****, Prof Mario Poljak, Slovenian HIV/AIDS Reference Centre, University of Ljubljana, Slovenia*
- *Discussion and Q&A*

Breakout session B
National Elimination Plans

Moderated by Dr Zobair Younossi, Inova Health Fairfax Medical Campus, VA USA

- ***"Update on progress in the UK",*** *Mr Mark Gillyon-Powell, Head of HCV Elimination Programme, NHS England*
- ***"Update on progress in Italy",*** *Dr Loreta Kondili Head of HCV Elimination Programme, National Health Institute, Italy*
- ***"Update on progress in Israel",*** *Dr Yuval Dadon, HCV National Plan Director, Ministry of Health, Israel*
- ***"Update on progress in Spain"*** *Dr Pilar Aparicio Azcárraga, Director of Public Health, Ministry of Health, Spain*
- *Discussion and Q&A*

Breakout session C
Best practice case studies from Ireland, Greece, Portugal and Montenegro

Moderated by Prof Antonio Craxi, University of Palermo, Italy

- ***"HepCare Project, Dublin",*** *Prof John Lambert, Mater Misericordiae Hospital,UCD Medical School Dublin, Ireland*
- ***"Aristotle HCV, Athens and Alexandros in Thessaloniki",*** *Prof Vana Sypsa, University of Athens Medical School, Greece*
- ***"OST Lisbon Programme for people who inject drugs",*** *Dr Rodrigo Sousa Coutinho, Ares do Pinhal, Lisbon, Portugal*
- ***"PWIDs: harm-reduction and supervised consumption rooms",*** *Mr Ivan Vukovic, Mayor of Podgorica, Montenegro*
  > Presentation by Dr Nebojsa Kavaric
- *Discussion and Q&A*

Breakout session D
Best practice case studies from Spain, Italy, Romania and Egypt

Moderated by Prof Laurent Castera, Department of Hepatology Hôpital Beaujon, University of Paris-VII, France

- ***"Microhepcero Catalonia: SLTC in migrant-vulnerable population",*** *Dr Joan Colom Farran, Public Health Agency Catalonia, Barcelona, Spain*
- ***"Dual testing of HCV and Covid-19 (ACE)",*** *Mr Marco Bartoli, EpaC Onlus, Italy*
- ***"Building on success: Viral Hepatitis Elimination Strategies in Romania",*** *Prof Cora Pop, Ministry of Health, Romania*
- ***"Egypt: national best practice for HCV elimination",*** *Prof Gamal Esmat, University of Cairo, Egypt*
- *Discussion and Q&A*

Breakout Session A: ACHIEVE Coalition - Lessons learnt from COVID-19 for the elimination of HCV

Chair:
Prof David Goldberg, Public Health Scotland, UK

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BREAKOUT SESSION A: ACHIEVE COALITION

Lessons learnt from COVID-19 for the elimination of viral hepatitis

Professor David Goldberg, Public Health Scotland - *Chair and Moderator*

Professor Rui Tato Marinho, Head of Department of Gastroenterology, Hepatology, Hospital S. Maria, 2018; Full Professor of Medical School of Lisbon – *Clinical Perspective*

Dr. Philipp Bruggmann, Arud Centre, Zurich – *Harm Reduction Perspective*

Professor Mario Poljak, Head of Laboratory for Molecular Microbiology and Slovenian HIV/AIDS Reference centre; University of Ljubljana, Faculty of Medicine- *Laboratory/ Technological Perspective*

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Prof Rui Tato Marinho

Santa Maria Hospital, Medical School of Lisbon, Portugal

Dr Philipp Bruggmann

Arud Centre for Addiction Medicine, Zurich, Switzerland

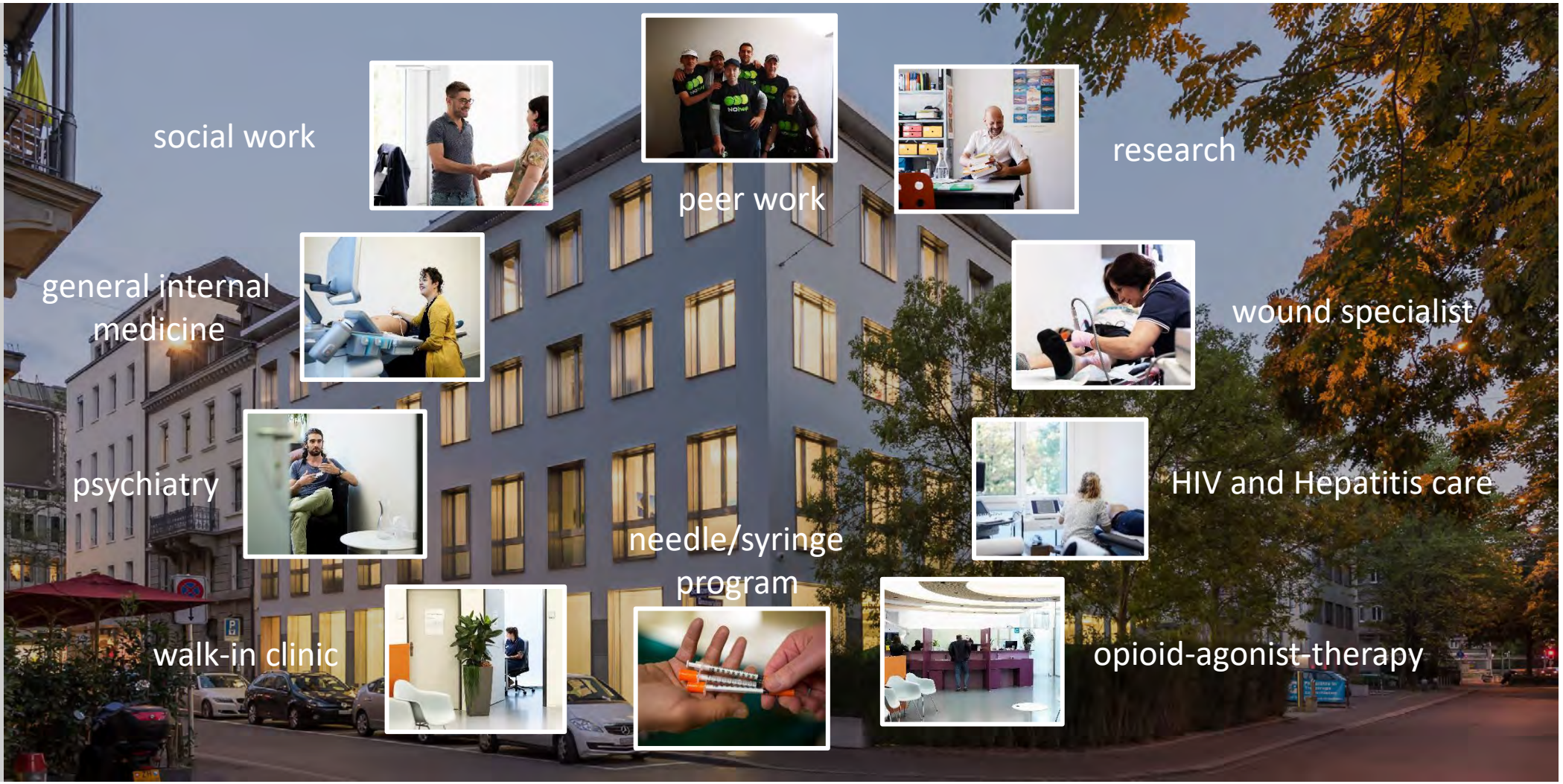
arud
Zentrum für Suchtmedizin

A harm reduction perspective

Philip Bruggmann

- Arud Centre for Addiction Medicine, Zurich, Switzerland

All under one roof – the Arud model in Zurich



www.arud.ch

People who use drugs and COVID-19

- High vulnerability for severe COVID-19
  - liver-cirrhosis
  - COPD
  - cardiovascular disease
  - HIV
- Elevated vulnerability for infection
  - Living situation

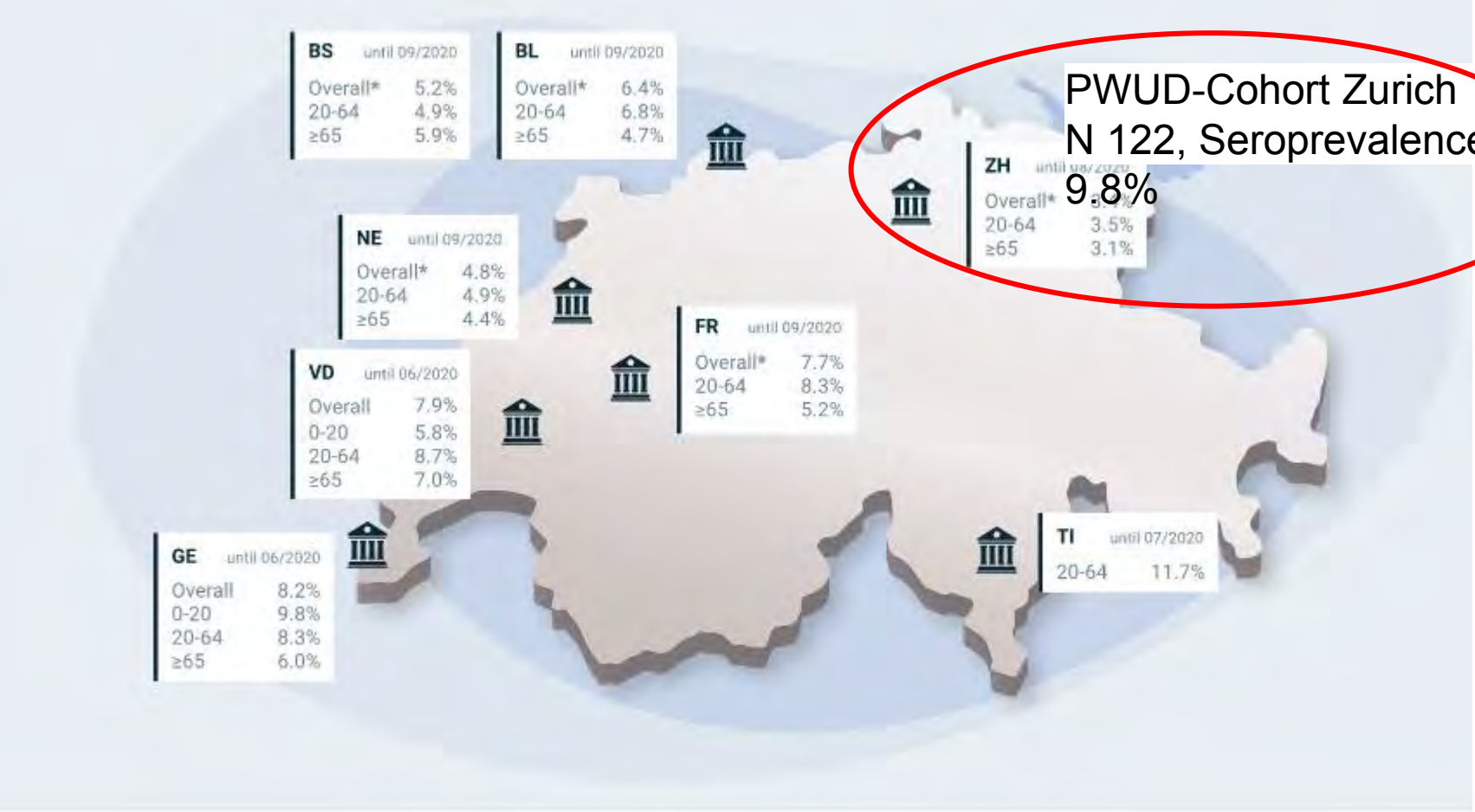
Harm Reduction during Corona-Pandemic

- Extended take-home dosages
  - Heroin from 1 to 7 days
  - OAT from 7 to 30 days

- Home-delivery of Opioid-Agonist-Treatment

- Enlarged supervised consumption rooms

Sars-CoV-2-antibody prevalence among PWUD



CORONA IMMUNITAS

COVID-19 influence on HCV-elimination

- Inhibited HCV care provision
  - ↓ treatment uptake
  - ↓ testing activities
  - ↓ peer work
  - ↓ awareness

- Increased symptoms of mental diseases
  - anxiety
  - depression

HCV influence on COVID-19 prevention

- HCV-network helped to put PWID in phase 1 of COVID-vaccinati

→ **lesson learnt:**

political will along with corresponding budgets is deciding to fight an infectious disease

arud

Prof Mario Poljak

Slovenian HIV/AIDS Reference Centre, University of Ljubljana, Slovenia

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3RD HEPATITIS C POLICY SUMMIT

BREAKOUT SESSION: LESSONS LEARNT FROM COVID-19 FOR THE ELIMINATION OF HCV

MARIO POLJAK

INSTITUTE OF MICROBIOLOGY AND IMMUNOLOGY
FACULTY OF MEDICINE, UNIVERSITY OF LJUBLJANA, SLOVENIA

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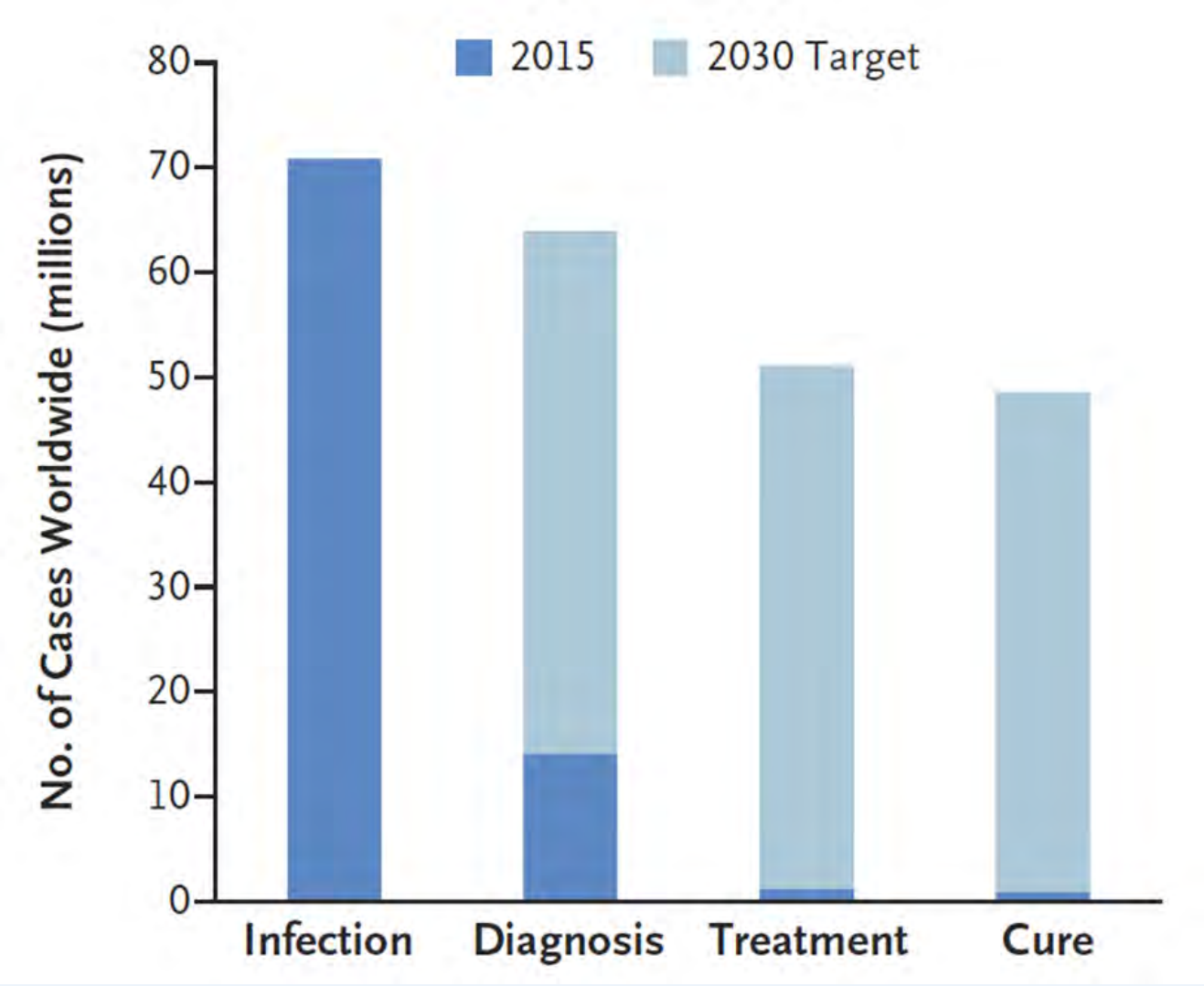
Global Elimination of Chronic Hepatitis

N Engl J Med 2019;380:2041

David L. Thomas, M.D., M.P.H.



Global continuum of care for HCV infection and 2030 WHO elimination targets

<u>HCV diagnostics</u>

- complicated & costly

- simplified & cheaper

Fully integrated, automated sample-to-result molecular analysers and platforms installed initially for COVID-19 testing can be successfully occupied for large scale hepatitis testing

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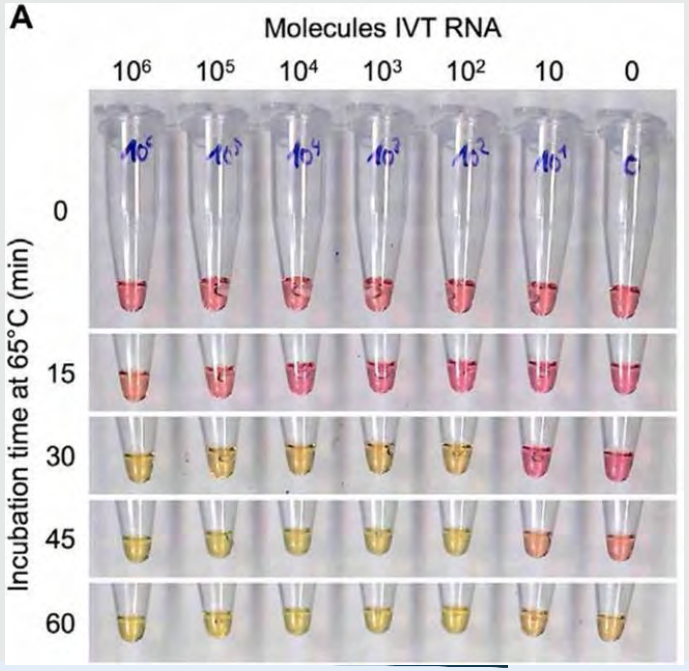
Innovation around molecular COVID19 portable testing tools and recycling of neglected technologies can be easily converted to drive forward the detection of HCV in both point-of-care and field settings

A colorimetric RT-LAMP assay and LAMP-sequencing for detecting SARS-CoV-2 RNA in clinical samples

Viet Loan Dao Thi[1,2]*, Konrad Herbst[3†], Kathleen Boerner[2,4†], Matthias Meurer[3†], Lukas PM Kremer[3,5,6], Daniel Kirrmaier[3,5], Andrew Freistaedter[1,2], Dimitrios Papagiannidis[3], Carla Galmozzi[3,6], Megan L. Stanifer[2], Steeve Boulant[2,5], Steffen Klein[1,2], Petr Chlanda[1,2], Dina Khalid[2], Isabel Barreto Miranda[2], Paul Schnitzler[2], Hans-Georg Kräusslich[2,4], Michael Knop[3,5,6]*, Simon Anders[3]*

Sci Transl Med 2020;12:eabc7075



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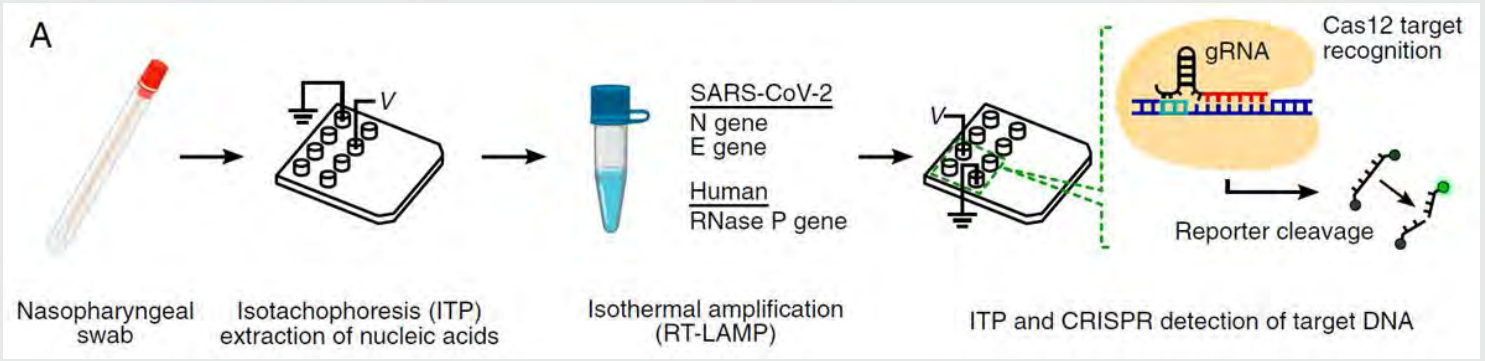
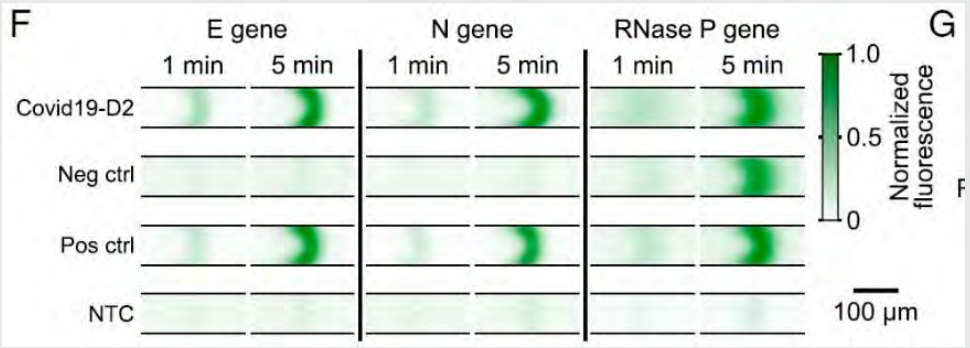
Innovation around molecular COVID19 portable testing tools and recycling of neglected technologies can be easily converted to drive forward the detection of HCV in both point-of-care and field settings

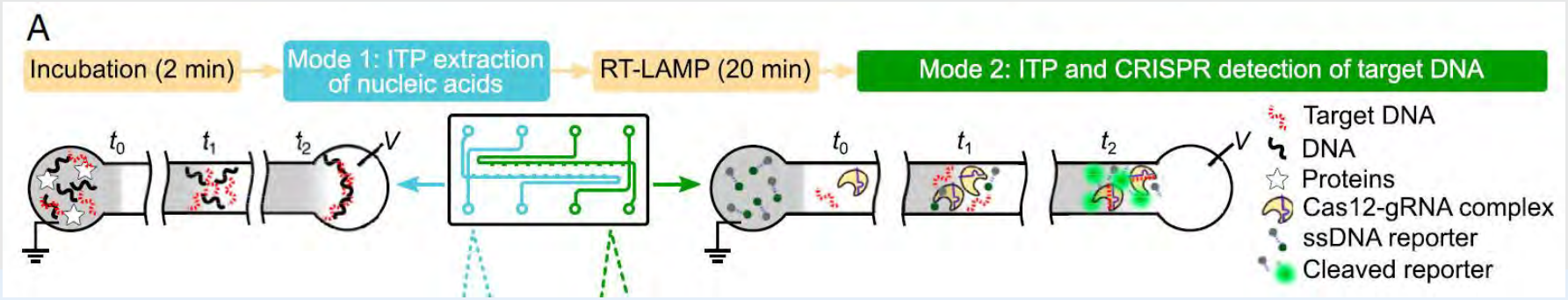
Electric field-driven microfluidics for rapid CRISPR-based diagnostics and its application to detection of SARS-CoV-2

Ashwin Ramachandran[a], Diego A. Huyke[b], Eesha Sharma[c], Malaya K. Sahoo[d], ChunHong Huang[d], Niaz Banaei[d,e], Benjamin A. Pinsky[d,e], and Juan G. Santiago[b,1]

[a]Department of Aeronautics & Astronautics, Stanford University, Stanford, CA 94305; [b]Department of Mechanical Engineering, Stanford University, Stanford, CA 94305; [c]Department of Biochemistry, Stanford University, Stanford, CA 94305; [d]Department of Clinical Pathology, Stanford University, Stanford, CA 94305; and [e]Department of Medicine, Division of Infectious Diseases and Geographic Medicine, Stanford University, Stanford, CA 94305







Total assay time: 35 min

Plastic chips could be produced through the injection molding process for $2-4 each.

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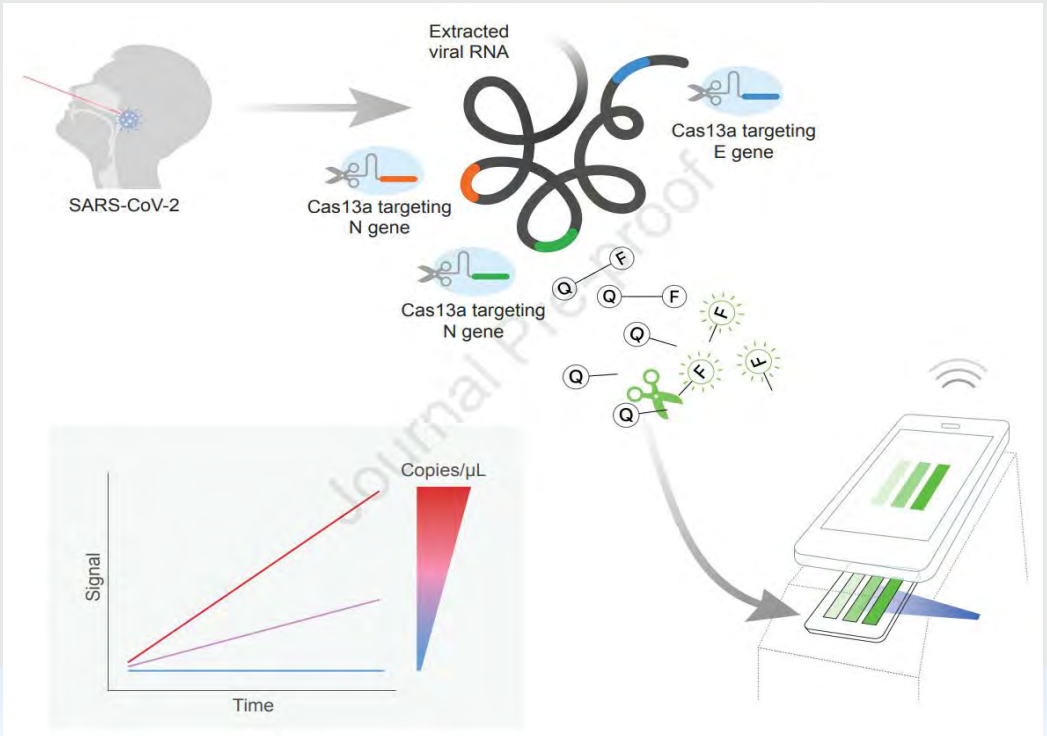
Innovation around molecular COVID19 portable testing tools and recycling of neglected technologies can be easily converted to drive forward the detection of HCV in both point-of-care and field settings

Amplification-free detection of SARS-CoV-2 with CRISPR-Cas13a and mobile phone microscopy

Parinaz Fozouni[1,2,3,4,24], Sungmin Son[5,24], María Díaz de León Derby[5,6,24], Gavin J. Knott[7,8], Carley N. Gray[1,4], Michael V. D'Ambrosio[5], Chunyu Zhao[9], Neil A. Switz[10], G. Renuka Kumar[1,4], Stephanie I. Stephens[1,4], Daniela Boehm[1,4], Chia-Lin Tsou[1,4], Jeffrey Shu[1,4], Abdul Bhuiya[5,6], Max Armstrong[5], Andrew R. Harris[5], Pei-Yi Chen[1,4], Jeannette M. Osterloh[1], Anke Meyer-Franke[1], Bastian Joehnk[11,12], Keith Walcott[11], Anita Sil[2,3,11], Charles Langelier[9,13], Katherine S. Pollard[1,3,9,14,15], Emily D. Crawford[9,11], Andreas S. Puschnik[9], Maira Phelps[9], Amy Kistler[9], Joseph L. DeRisi[2,3,9,16], Jennifer A. Doudna[1,7,17,18,19,20], Daniel A. Fletcher[1,5,6,9,21,22,23*], Melanie Ott[1,2,3,4,25*]



The assay achieved ~100 copies/µL sensitivity in under 30 minutes and accurately detected a set of positive clinical samples in under 5 minutes.

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- Highly trained increased laboratory workforce to support the delivery of COVID19 testing can transfer their skills to support other molecular testing, such as for hepatitis;
- Possibility to jump in into de novo established laboratory facilities in post-COVID-19 time or near to end of COVID-19 time is great opportunity not to be missed

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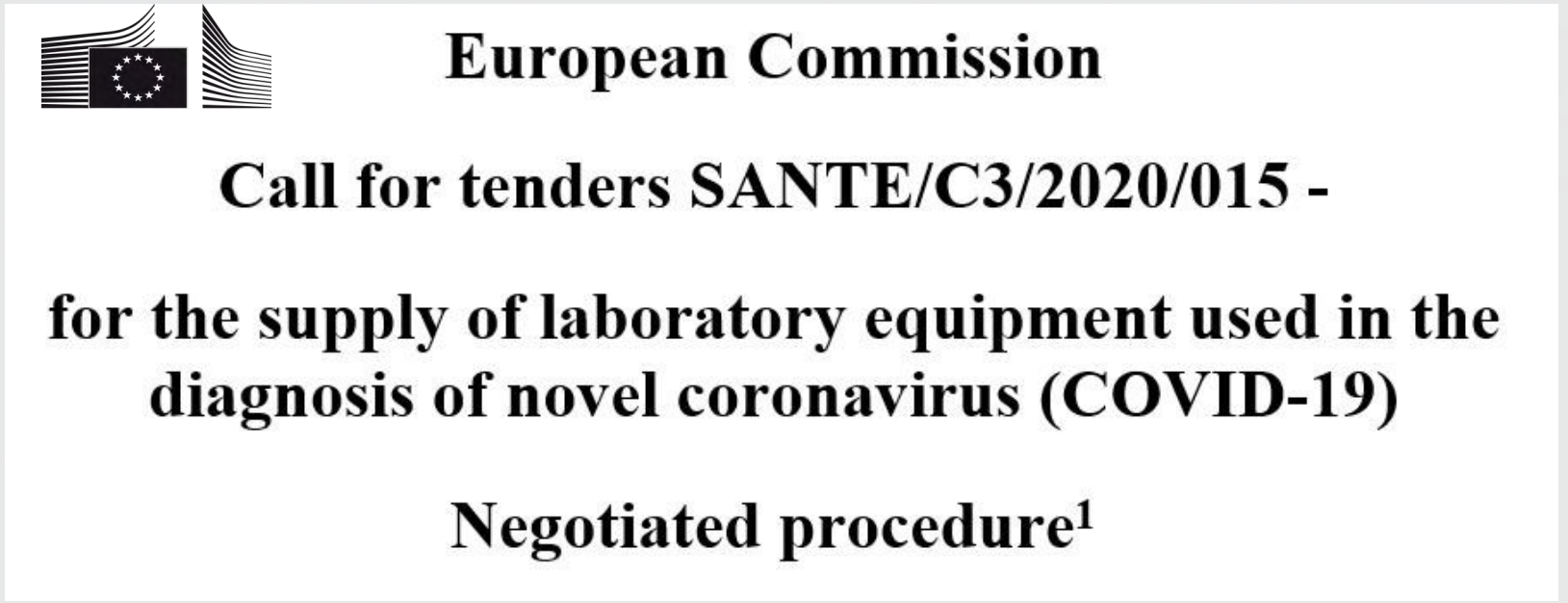
- Experience from recent pan-European centralized tenders for COVID-19 testing tools and vaccines should be utilised to successfully conclude similar pan-European tenders in hepatitis;
- The global implementation of a “test-and-treat” strategy for the elimination of hepatitis C is possible, but requires greater coordination and cooperation of different governmental agencies and manufacturers.



European Commission

Call for tenders SANTE/C3/2020/015 -

for the supply of laboratory equipment used in the diagnosis of novel coronavirus (COVID-19)

Negotiated procedure[1]

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Discussion and Q&A

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Breakout Session B: National Elimination Plans

Chair:
Dr Zobair Younossi, Inova Health Fairfax Medical Campus, USA

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Mr Mark Gillyon-Powell

Head of HCV Elimination Programme, NHS England

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HCV Elimination – Progress in England

EU HCV Policy Summit - 24 March 2021

Mark Gillyon-Powell JP

NHS England and NHS Improvement

Background, pre-DAA

HEP C ODNS AND CLINICAL LEADS

North

1, North East & Cumbria
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Dr Stuart McPherson

2, Greater Manchester & Eastern Cheshire
Pennine Acute Hospitals NHS Trust & Central Manchester University Hospitals NHS Foundation Trust
Dr Andrew Ustianowski
Dr Martin Prince

3, Cheshire & Merseyside
Royal Liverpool & Broad Green University Hospital NHS Trust
Dr Paul Richardson
Professor Anna Maria Geretti

4, South Yorkshire
Sheffield Teaching Hospitals NHS Foundation Trust
Dr Ian Stone

5, Humberside and North Yorkshire
Hull & East Yorkshire NHS Trust
Dr Peter Moss

6, West Yorkshire
Leeds Teaching Hospitals
Dr Mark A Atkinson

7, Lancashire and South Cumbria (in development)

Midlands & East

8, Leicester
University Hospitals of Leicester
Dr Martin Wiselka

9, Birmingham
University Hospitals Birmingham NHS Foundation Trust
Professor David Mutimer

10, Nottingham
Nottingham University Hospitals NHS Trust
Dr Stephen Ryder

11, Eastern Hepatitis Network
Cambridge University Hospitals NHS Foundation Trust
Dr William Gelson

London North West

12, West London
Imperial College Healthcare Trust
Prof Mark Thursz

North Central London

13, North Central London
Viral Hepatitis Network
Royal Free London NHS Foundation Trust
Prof William Rosenberg

London North East

14, Barts
Barts Health (Royal London Site)
Prof Graham Foster

London South

15, South Thames Hepatitis Network (STHepNet) Kings & St George's
Kings College Hospital NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust
Dr Kosh Agarwal
Dr Dan Forton

South

16, Surrey Hepatitis Services
Royal Surrey County Hospital NHS FT
Dr Michelle Gallagher

17, Sussex Hepatology Network
Brighton & Sussex University Hospitals – Royal Sussex County Hospital (RSCH)
Dr Jeremy Tibble

18, Oxford University Hospitals NHS Trust
Oxford
Dr Jane Collier

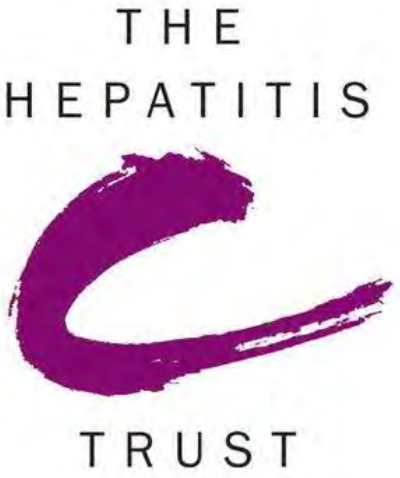
19, Wessex Hep C ODN
University Hospital Southampton NHS Foundation Trust
Dr Mark Wright

20, Bristol and Severn Hep C ODN
University Hospitals Bristol NHS Foundation Trust
Dr Fiona Gordon

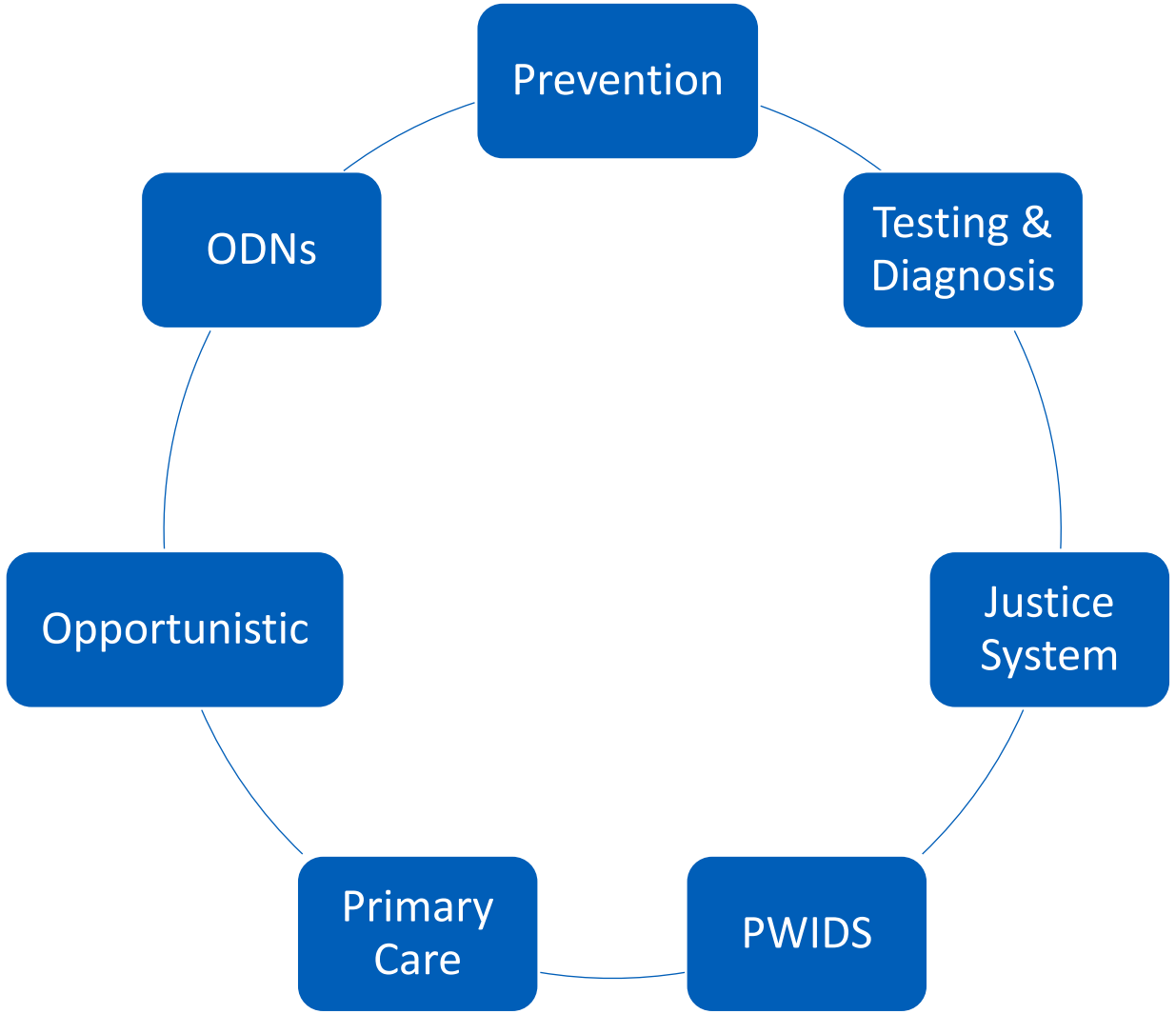
21, South West Peninsula Hepatitis C ODN
Plymouth Hospitals NHS Trust
Professor Matthew Cramp

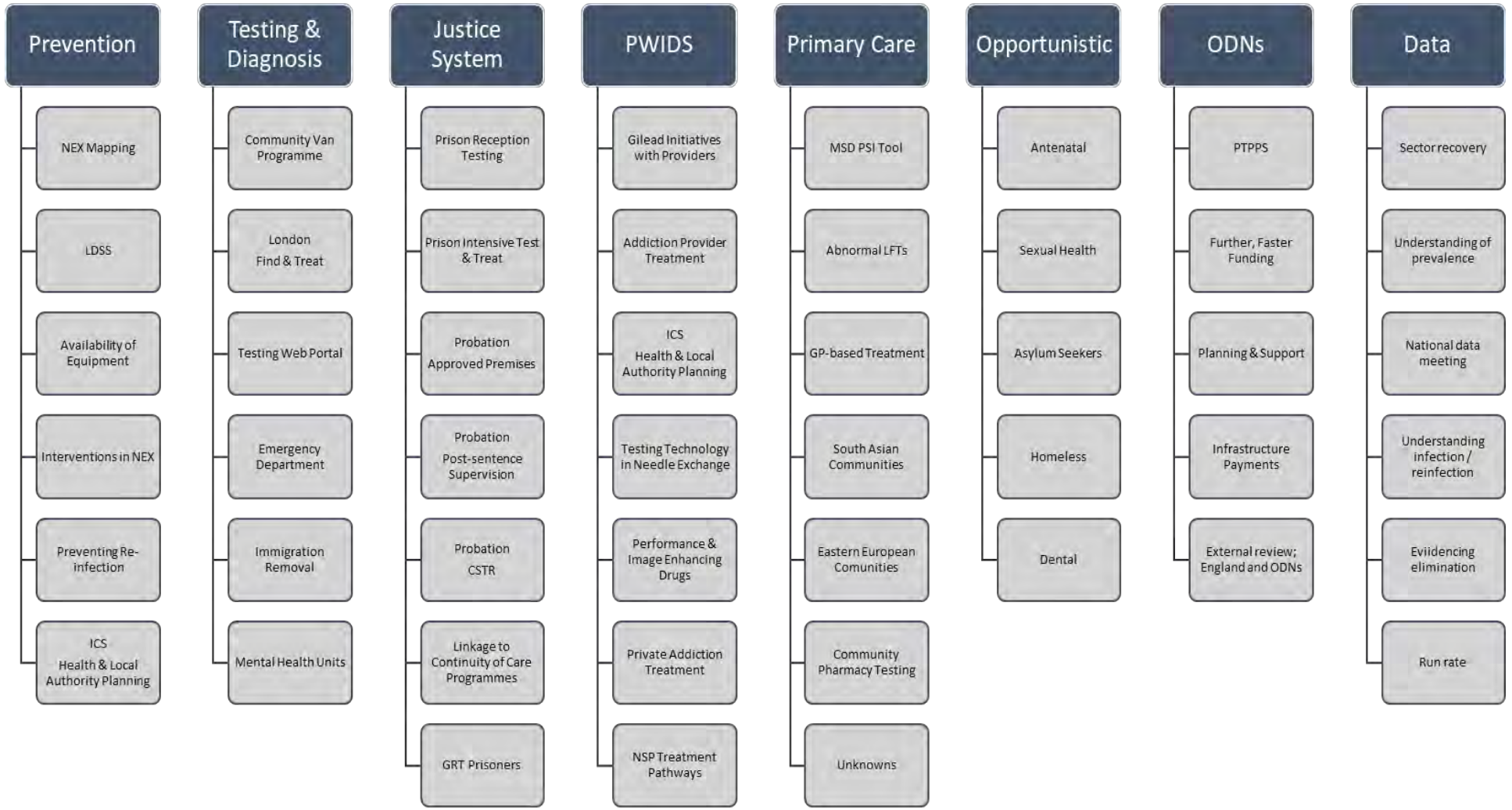
22, Kent Network via Kings
Kings College Hospital NHS Foundation Trust
Dr Kosh Agarwal

Post DAA

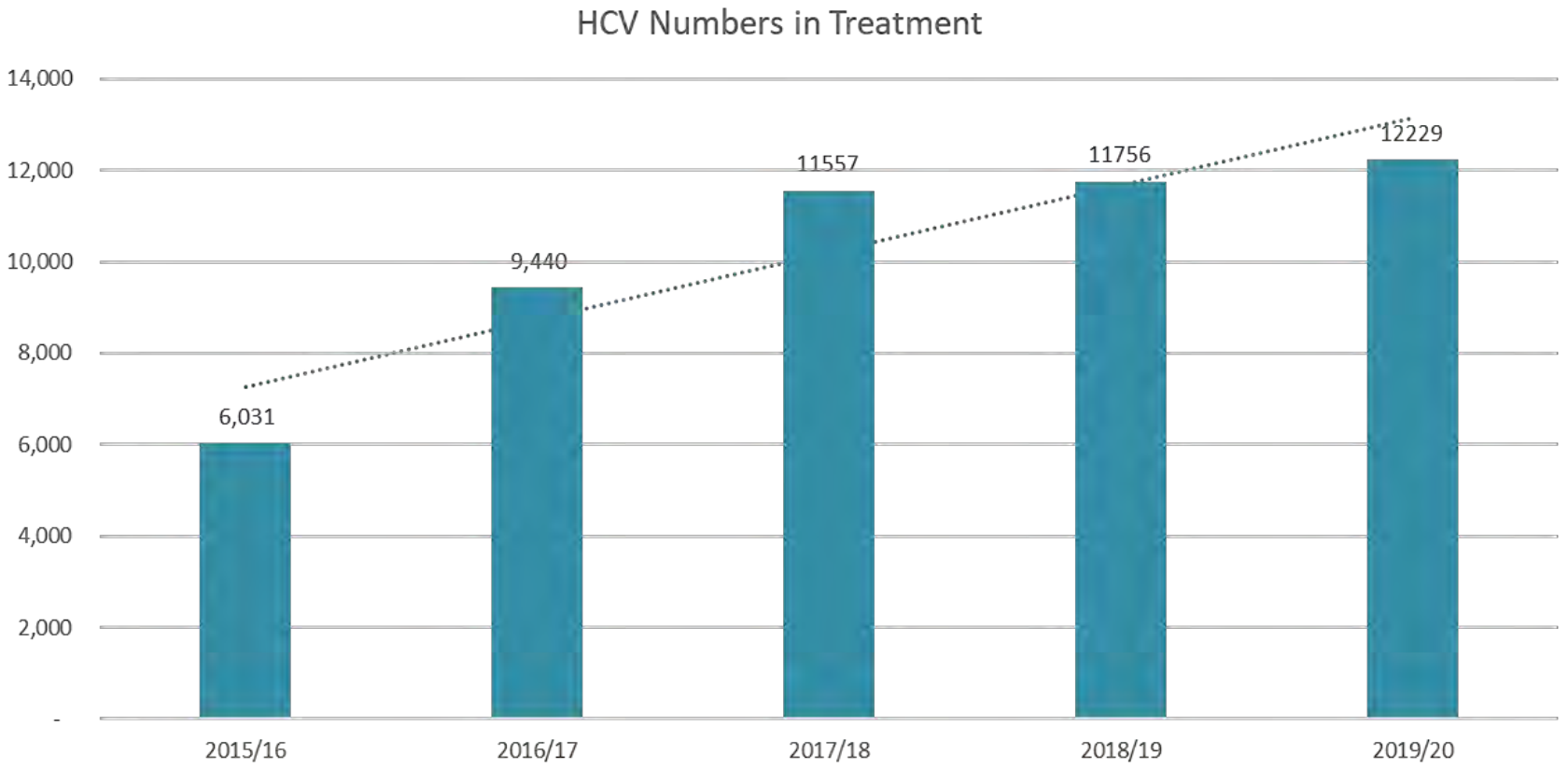


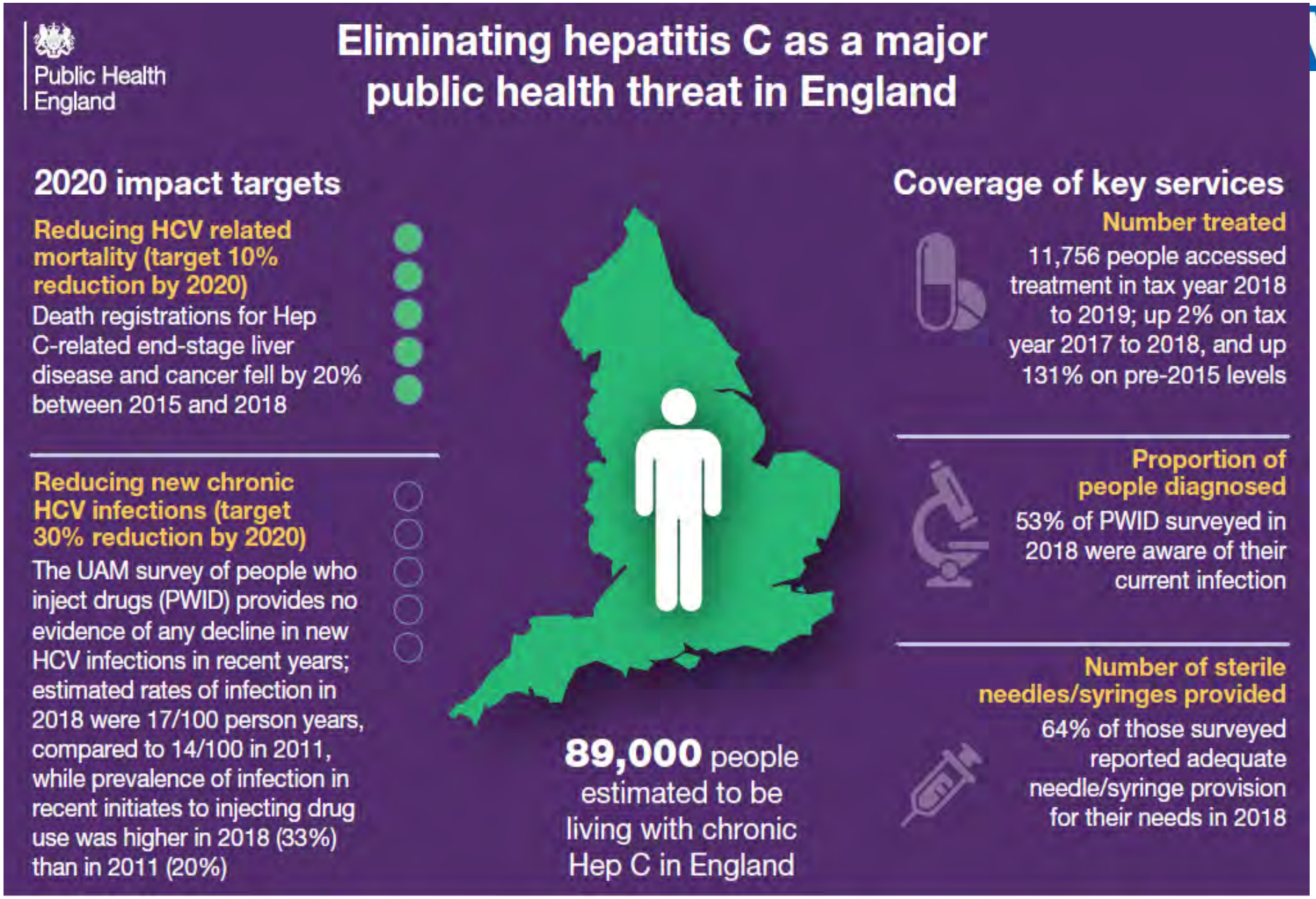
The Elimination Map




Prevention
NEX Mapping
LDSS
Availability of Equipment
Interventions in NEX
Preventing Re-infection
ICS Health & Local Authority Planning
Testing & Diagnosis
Community Van Programme
London Find & Treat
Testing Web Portal
Emergency Department
Immigration Removal
Mental Health Units
Justice System
Prison Reception Testing
Prison Intensive Test & Treat
Probation Approved Premises
Probation Post-sentence Supervision
Probation CSTR
Linkage to Continuity of Care Programmes
GRT Prisoners
PWIDS
Gilead Initiatives with Providers
Addiction Provider Treatment
ICS Health & Local Authority Planning
Testing Technology in Needle Exchange
Performance & Image Enhancing Drugs
Private Addiction Treatment
NSP Treatment Pathways
Primary Care
MSD PSI Tool
Abnormal LFTs
GP-based Treatment
South Asian Communities
Eastern European Comunities
Community Pharmacy Testing
Unknowns
Opportunistic
Antenatal
Sexual Health
Asylum Seekers
Homeless
Dental
ODNs
PTPPS
Further, Faster Funding
Planning & Support
Infrastructure Payments
External review; England and ODNs
Data
Sector recovery
Understanding of prevalence
National data meeting
Understanding infection / reinfection
Eviidencing elimination
Run rate

Over 50,000 treated by Apr ’20 *(51,013)*




Public Health England
Eliminating hepatitis C as a major public health threat in England
2020 impact targets
Reducing HCV related mortality (target 10% reduction by 2020)
Death registrations for Hep C-related end-stage liver disease and cancer fell by 20% between 2015 and 2018
Reducing new chronic HCV infections (target 30% reduction by 2020)
The UAM survey of people who inject drugs (PWID) provides no evidence of any decline in new HCV infections in recent years; estimated rates of infection in 2018 were 17/100 person years, compared to 14/100 in 2011, while prevalence of infection in recent initiates to injecting drug use was higher in 2018 (33%) than in 2011 (20%)
89,000 people estimated to be living with chronic Hep C in England
Coverage of key services
Number treated
11,756 people accessed treatment in tax year 2018 to 2019; up 2% on tax year 2017 to 2018, and up 131% on pre-2015 levels
Proportion of people diagnosed
53% of PWID surveyed in 2018 were aware of their current infection
Number of sterile needles/syringes provided
64% of those surveyed reported adequate needle/syringe provision for their needs in 2018

Dr Loreta Kondili

Head of HCV Elimination Programme, National Health Institute, Italy

#EliminateHCV
@HepBCPPA

Securing Wider EU Commitment to the elimination of HCV

Update on progress in Italy

Loreta Kondili

National Center for Global Health

Istituto Superiore di Sanità Rome Italy

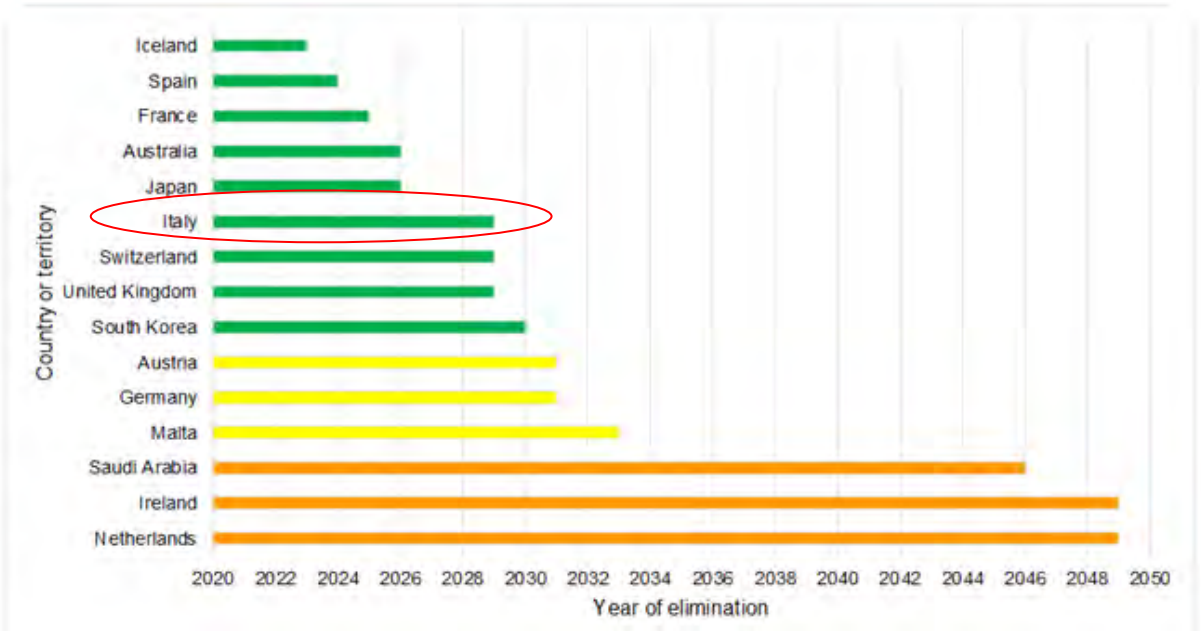
POLARIS OBSERVATORY

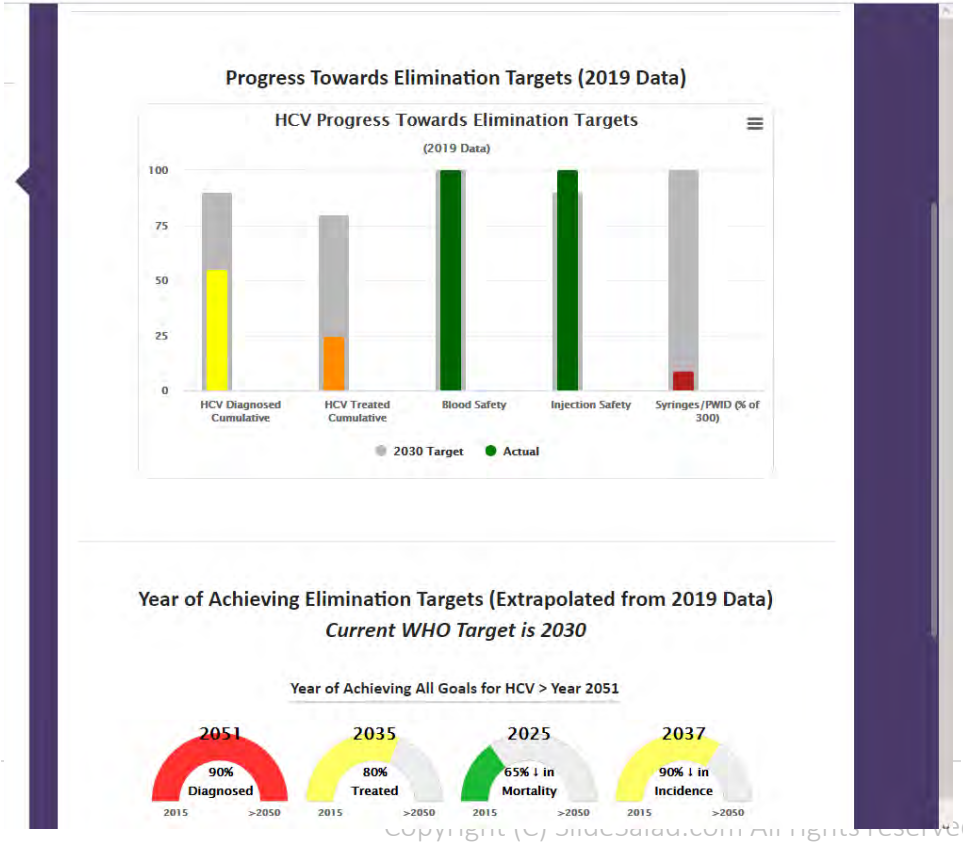
DONORS

2017- 2018

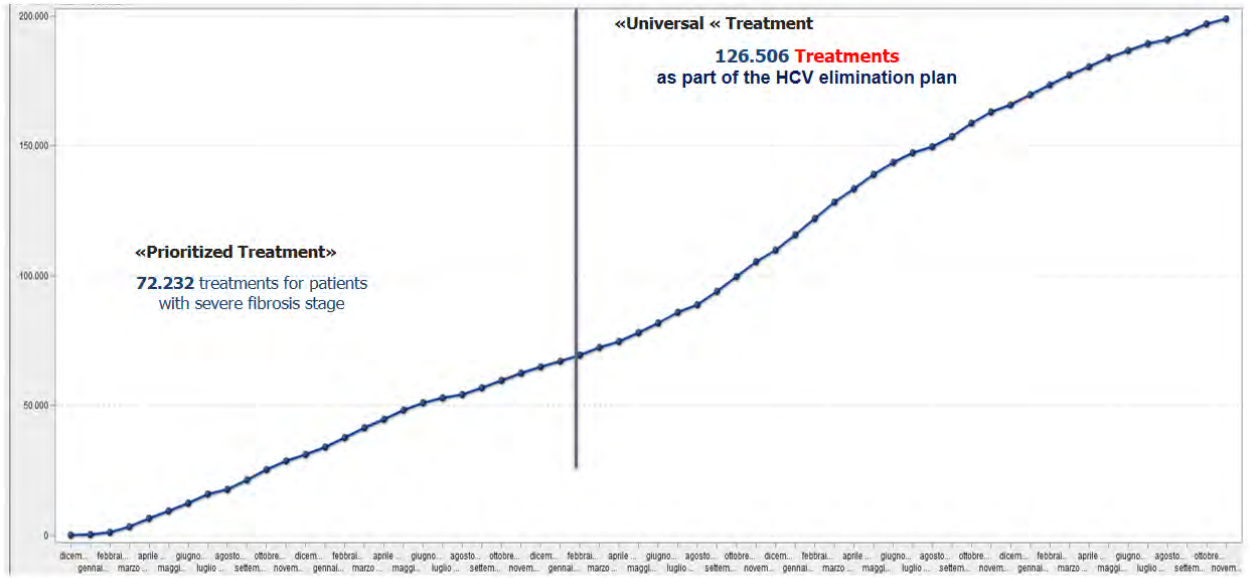
2019

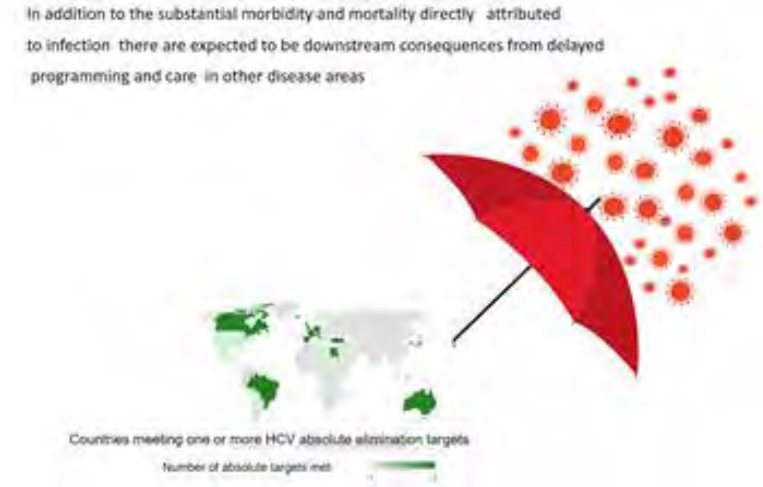
Only 20% of 45 high income countries are forecasted to reach the WHO elimination targets by 2030 and only 33% by 2050

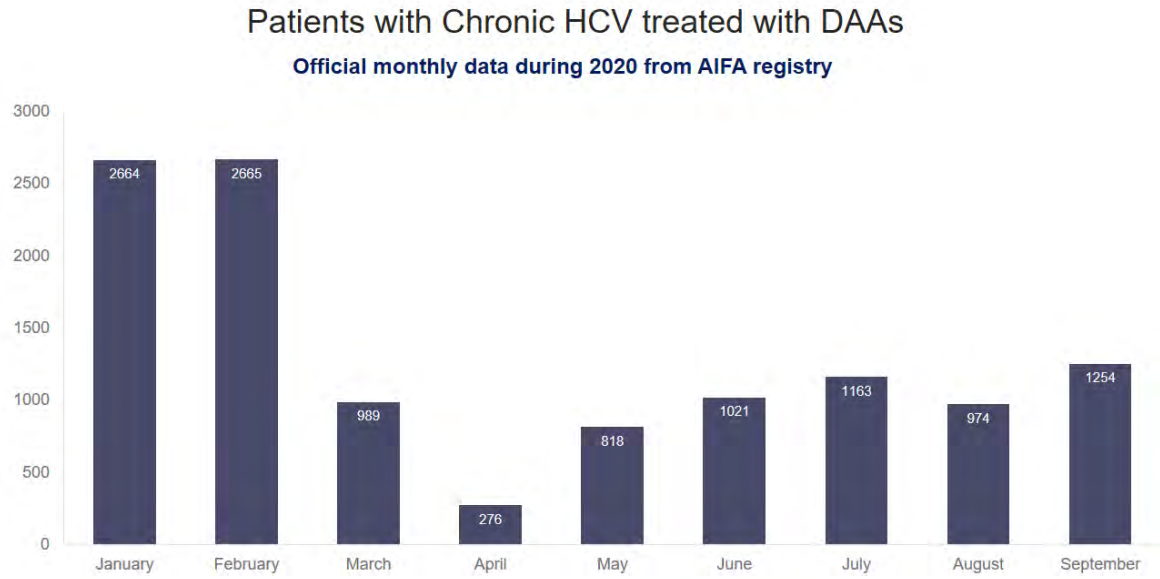




DAA treatment rate in Italy







http://www.agenziafarmaco.gov.it/content/aggiornamento-epatite-c
Kondili LA et al 2021 Liver International

Italian HCV Elimination Strategies and Health Policy Evolution

2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021

Prioritized access to antiviral treatment with new DAA therapy

Universal access is cost-effective vs prioritized access

Dedicated fund for innovative DAAs

Active screening is cost-effective vs treatment of diagnosed patients

Universal access to antiviral treatment with DAAs

Active Screening Approved

Expiration of dedicated funds for DAAs

WHO elimination targets	n. treatments 2018 56,499	n. treatments 2019 36,348
	Year in which the WHO targets are met	
Incidence	2028	2037
Mortality	2023	2025
Diagnosis	*	2037
Treatment	2029	2035
Year of elimination	2029	>2037
On Track for Elimination	Yes	No

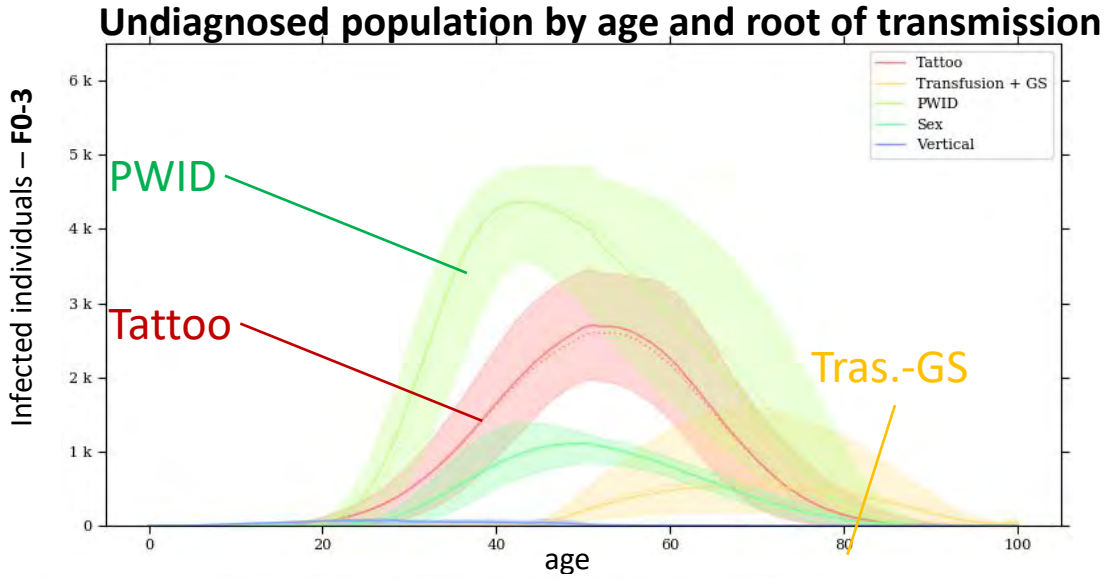
Continuous investment in anti-HCV therapy is necessary to achieve the elimination of HCV

Economic evidence can support the allocation of *ad hoc* funds for screening and anti-HCV treatment.

Where is the submerged HCV infected population in Italy?- Modelling results

(F0–F3, asymptomatic = undiagnosed/unlinked to care)

	Absolute Number
	Reference
Total	**410775**
Total F0-F3	**281809**
Total F4	128966
High risk groups	
PWID	
F0-F3	**146652**
F4	58001
Tattoo/body piercing	
F0-F3	**81153**
F4	11928
Sexual transmission	
F0-F3	**33871**
F4	2615
GS + transfusion	
F0-F3	**18038**
F4	54567
Vertical transmission	
F0-F3	**2095**
F4	1854



The asymptomatic population (F0-F3) is composed:

1) PWID: 52.1% (95% CI: 49.4%-53.8%)

2) TATTOO: 28.8% (95% CI:24.4%-31.4%)

3) SEX: 12.0% (95% CI:9.5%-14.9%)

4) GLASS SYRINGE + TRANSFUSION: 6.4% (95% CI: 3.3%-13.9%)

5) VERTICAL: 0.7% (95% CI:0.5%-1.0%)

Kondili LA et al Epidemics 2021

Evidence- based HCV health policy in Italy

PITER CEIS TOR VERGATA POLARIS

Direct costs and health effects, by scenario, 2018–2031

Scenario		Cost (€Millions), 2018–2031	QALYs Gained, 2018–2031	ICER Relative to Status Quo (€/QALY)	ICER relative to previous least costly scenario (€/QALY)
Status quo		5,463	–	–	
GHSS Targets	Graduated screening 1	5,974	144,000	3,552	3,552
	Graduated screening 2	6,028	125,000	4,532	*
	Screening 1948–1977	6,081	142,000	4,349	*
	Screening 1958–1977	6,083	128,000	4,831	*
	Universal screening	6,441	145,000	6,758	562,855

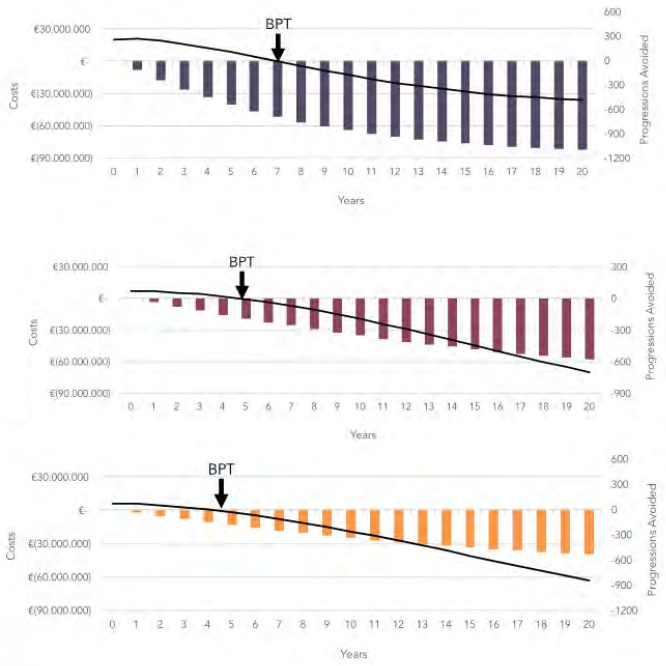
- **Graduated Screening 1**: start screening in birth cohorts 1968–87 in year 2020 –identify young population at higher probability of HCV transmission risk
- expand screening for birth cohorts 1948–67 starting from 2023 – identify older population at risk for disease progression.

Cost-Consequences Across Different Phases of Treatment

BPT – Break even point on Time

Parameter	2015-2016	2017-2019	Post Screening
Patient Population	F3+ Diagnosed	F0+ Diagnosed	F0+ All HCV-infected
Treatment Effectiveness	80-93% Genotype-dependent	98% Pan-genotypic	98% Pan-genotypic
Treatment Price	Assumption €15,000-€25,000	Assumption €9,000-€6,000	Assumption €6,000
Transition Probabilities	Data from literature, not scenario-specific		
Other Direct Medical Expenses	**Data from real-life PITER cohort, not scenario-specific**		

Results	2015-2016	2017-2019	Post-Screening
Avoided events of progression after 20 years	1099 (845-1351)	579 (433-754)	536 (404-687)
Cost-savings after 20 years, € million	-36.1 (0.02-183.20)	-70.2 (10.74-183.44)	-63.0 (18.03-37.40)
BPT years	7.0 (4.56-12.91)	4.8 (3.30-6.81)	4.5 (2.70-6.75)



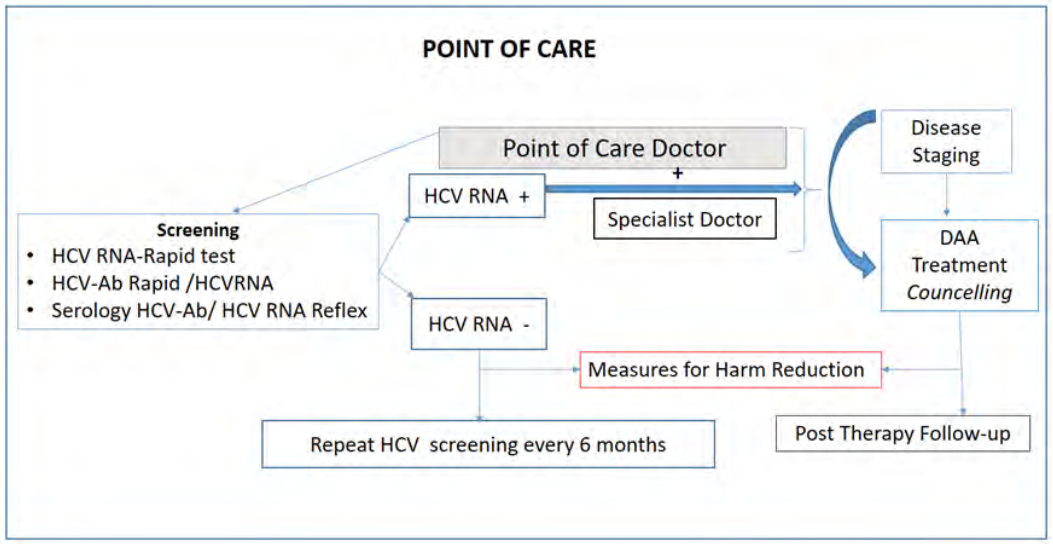
A Law Decree , recently approved , allocated 71.5 million Euro for
FREE OF CHARGE HCV SCREENING
for PWID, inmates and general population birth cohorts 1969-1889

Kondili LA, Gamkrelidze I, et al Liver International 2020; Kondili LA et al Ann Ist Super Sanita 2020
Marcellusi A et al Pharmacoeconomics 2019; Mennini FS, Marcellusi A et al Liver International 2021

HCV Screening pathway as indicated by the Law Decree in Italy (experimental project for 2 years)

Success in reaching the key populations

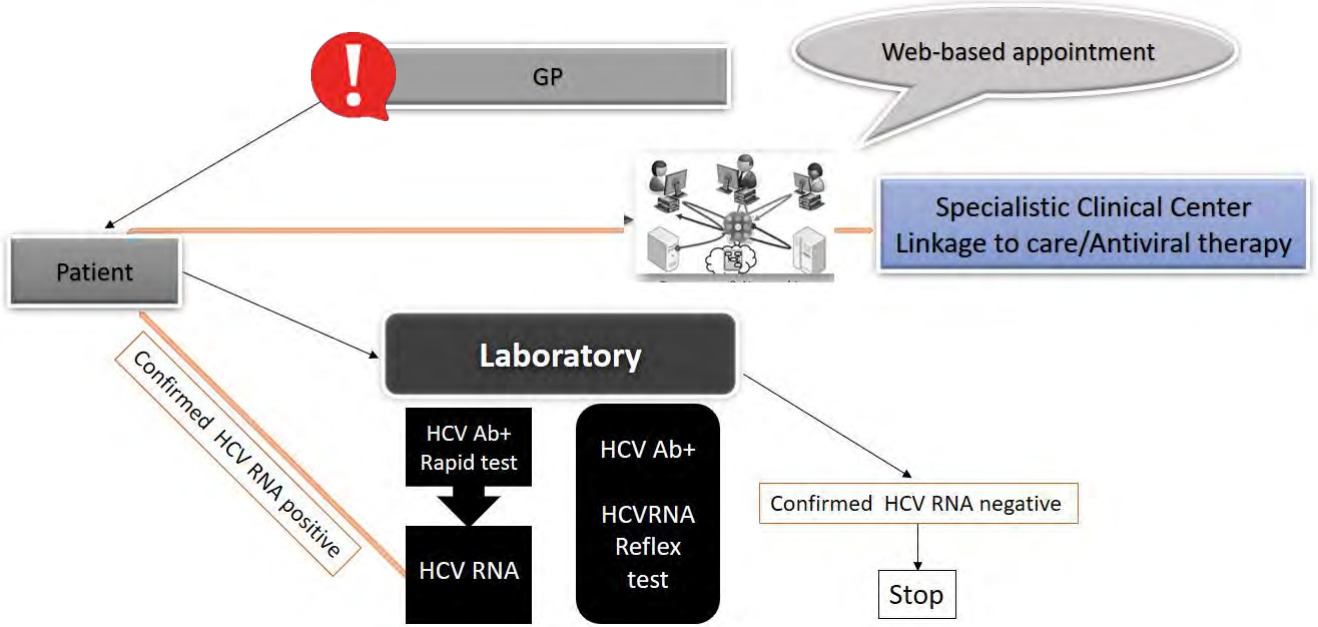
The point of care should be implemented
to simplify the patient pathway
to improve information
to promote prevention



General Practitioners Approach

- Commitment for training, information and collaboration
- between GPs and Specialists

- **Alerts to remind General Practitioner to test whole or cohorts of general population**



Systematic opportunistic hepatitis testing

Dr Yuval Dadon

HCV National Plan Director, Ministry of Health, Israel

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@HepBCPPA

MINISTRY OF HEALTH
For a healthier life

World Health Organization

THE NATIONAL PROGRAM FOR HEPATITIS C ELIMINATION

YUVAL DADON, MD MPH MBA

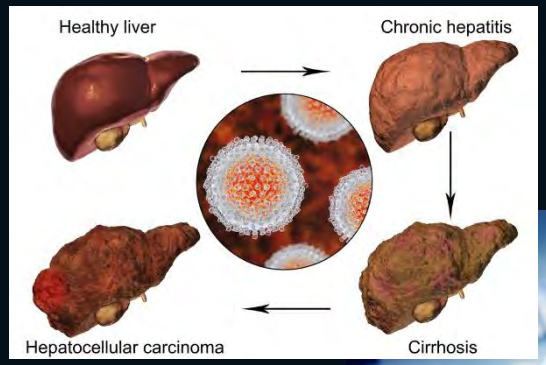
PROGRAM DIRECTOR
DEPUTY DIRECTOR OFFICE
MINISTRY OF HEALTH

Finally launching 17-FEB-2021

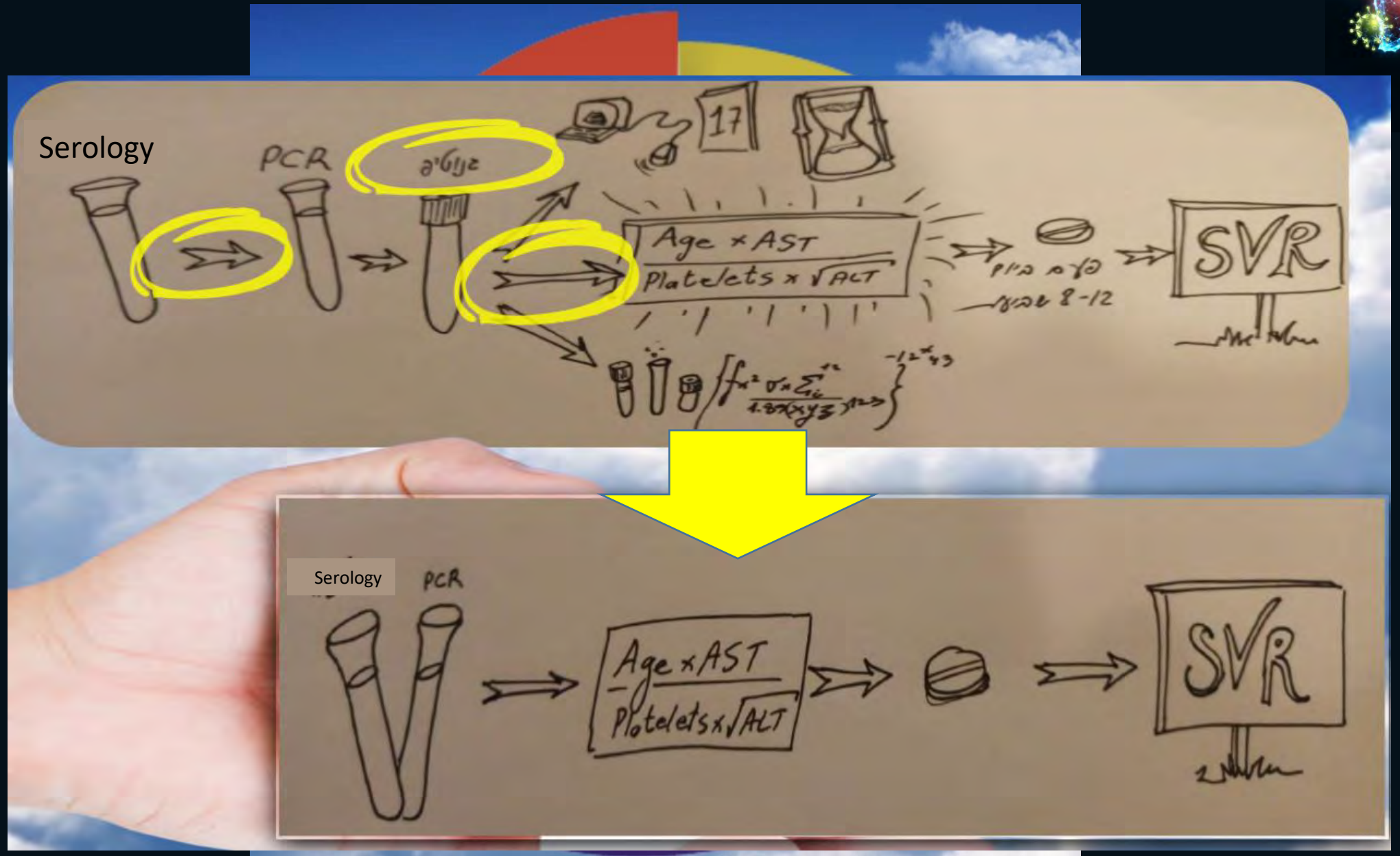
Epidemiology and Risk Groups

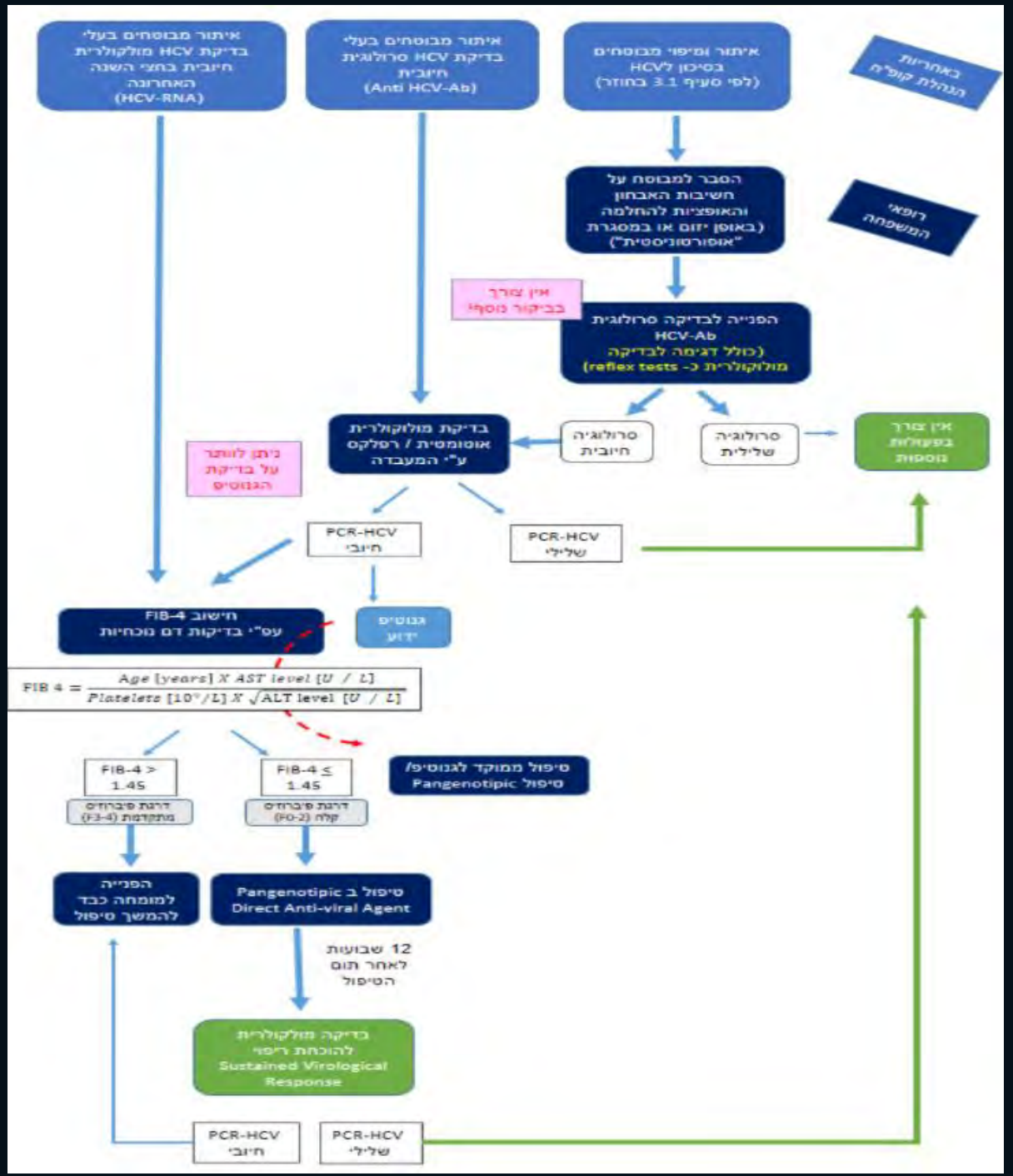
- Prevalence 1.5% - 6.5%
- 70% awaiting treatment
- 800K at risk
- Ex-USSR, PWID, Non-sterile procedures, HIV/HBV,

  Blood products <1992



Program Elements



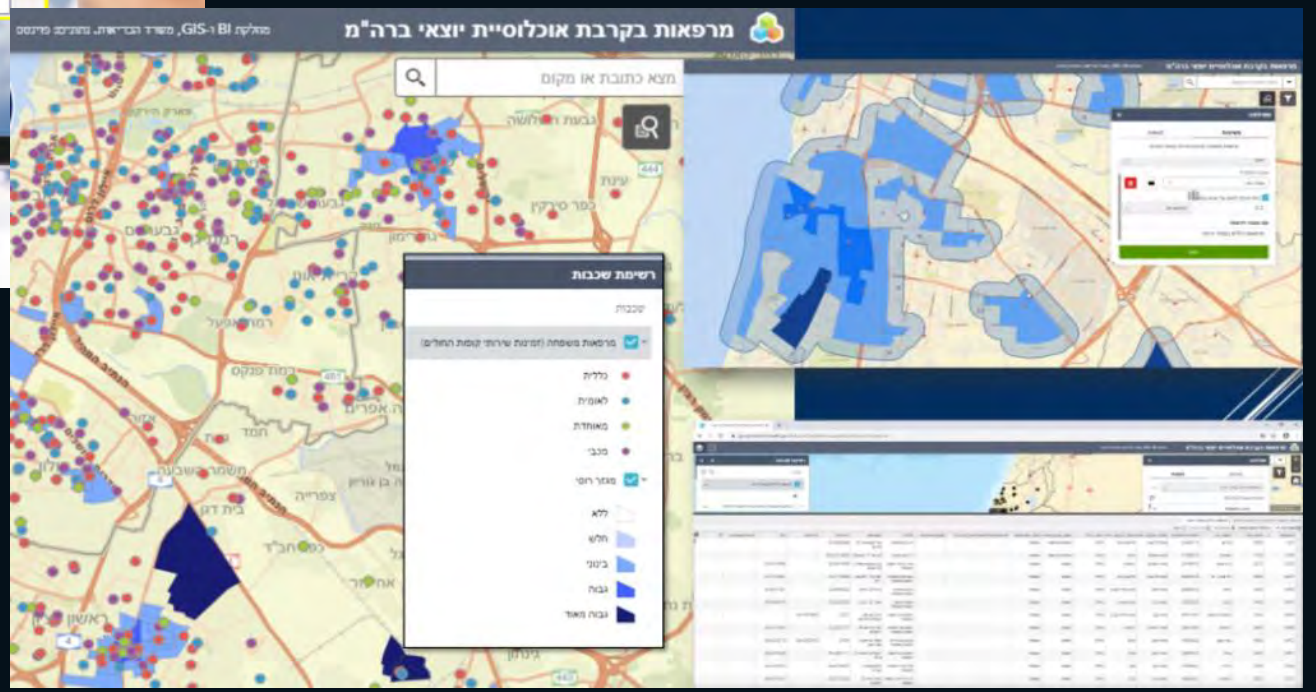


Identification

Workup & Treatment

Resolution (SVR)

Operational Excellences



משרד הבריאות

World Health Organization

A collaborative work will get us there!

YUVAL.DADON@MOH.GOV.IL

Dr Pilar Aparicio Azcárraga

Director of Public Health, Ministry of Health, Spain

#HCVSummit
@HepBCPPA

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD

HCV
24.03.2021

Advances towards HCV Elimination in Spain

Dr. Pilar Aparicio
Director General of Public Health
Ministry of Health
Spain

Outline

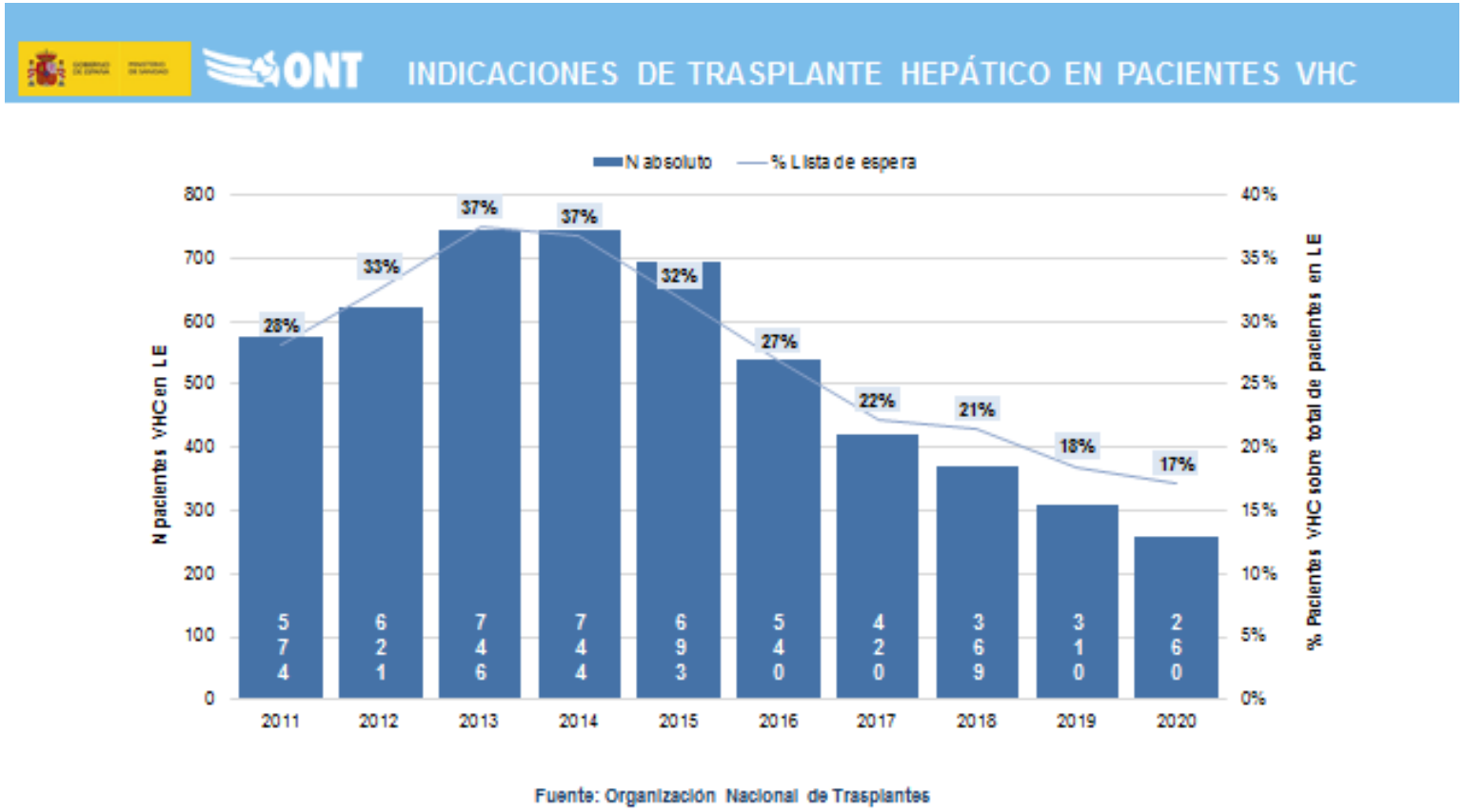
- Strategic Plan to Address Hepatitis C in the National Health System .

- Epidemiology of HCV infection in Spain:
  - Prevalence in general population; 2017-2018
  - Prevalence in high-risk settings; 2012-2018

- Public health & policy on HCV screening in Spain

Strategic Plan to Address Hepatitis C in the National Health System (PEAHC)

Example of results in the context of hepatic transplant in HCV patients



GOBIERNO DE ESPAÑA | MINISTERIO DE SANIDAD

Epidemiology of HCV infection in Spain

N= 7 675 participants

HCV Ab prevalence 0.85% (0.64%-1.08%)

HCV active infection 0.22% (0.13%-0.31%)

		ANTIBODIES				ACTIVE INFECTION			
	N	n	%	CI95% LL	CI95% UL	n	%	CI95% LL	CI95% UL
Sex									
Men	3 670	48	1.24	0.92	1.58	14	0.35	0.17	0.53
				0.28	0.66	3	0.08	0.01	0.18
				0.00	0.15	0	0.00	0.00	0.00
30 to 39 (1987-1978)	1 202	1	0.09	0.01	0.17	1	0.09	0.01	0.17
40 to 49 (1977-1968)	1 432	14	0.99	0.57	1.48	2	0.14	0.00	0.28
50 to 59 (1967-1958)	1 417	22	1.56	0.99	2.27	7	0.50	0.22	0.85
Other	489	7	1.30	0.44	2.44	2	0.34	0.00	0.96
Habitat									
(+prov. cap.)									
More than 500 000	1 310	10	0.70	0.27	1.19	4	0.24	0.01	0.52
Level of education									
1st grade or lower	2 340	38	1.71	1.22	2.24	12	0.54	0.28	0.84
2nd grade 1st cycle	1 478	9	0.62	0.28	1.05	1	0.07	0.00	0.21
2nd grade 2nd cycle	1 756	13	0.66	0.27	1.10	3	0.14	0.00	0.36
3rd grade	1 888	5	0.27	0.06	0.49	1	0.05	0.00	0.15
Social class									
I (Privileged)	1 717	7	0.40	0.16	0.71	2	0.12	0.00	0.29
II (Middle)			0.50	0.16	0.85	2	0.10	0.00	0.30
III (Under-privileged			1.20			13			48
TOTAL			0.85			17			31

7 675 **0.85** **0.22**

Prevalence of HCV Ab and active HCV infection

Age group	Prevalence of Ab	Prevalence of active infection
2-80 years	**0,69**% (IC 95%: 0,50%-0,87%)	**0,17% (IC 95%: 0,08%-0,28%)**
2-19 years	0,00% (IC 95%: 0,00%-0,00%)	0,00% (IC 95%: 0,00%-0,00%)
20-80 years	**0,85%** (IC 95%: 0,64%-1,08%)	**0,22%** (IC 95% 0,12%-0,32%)

Undiagnosed fraction 19%

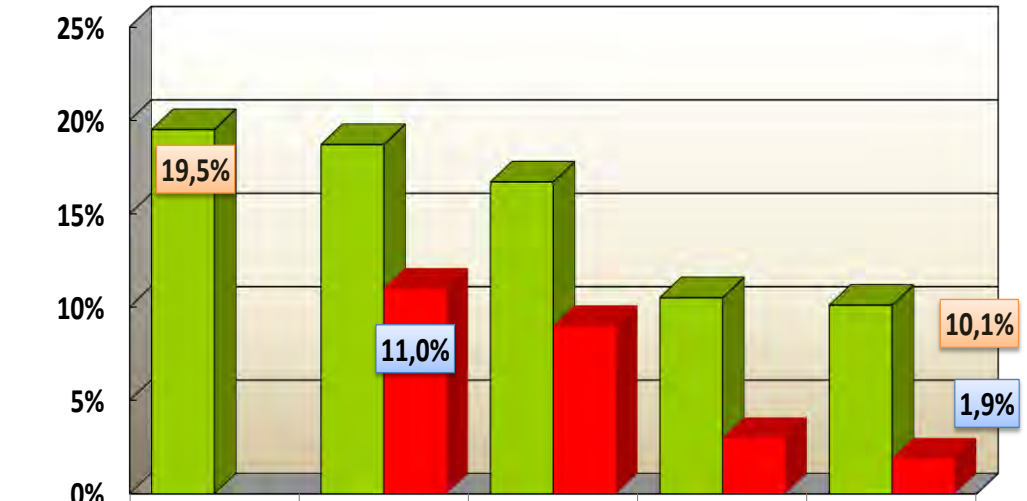
Undiagnosed fraction 29%

Epidemiology of HCV infection in Spain

In population terms, in Spain, in 2018:

- 34 753 283 million inhabitants aged 20 - 80 years
- Given an HCV active infection prevalence 0.22%
  - 76 839 persons with active HCV infection
- Given an undiagnosed fraction of 29.4%
  - **22 478 persons with undiagnosed active HCV infection**
  - 54 361 persons with diagnosed active HCV infection
    - 50% on DAA: 27 181
    - **17% with no evidence of linkage to care: 9 241**
    - 33% with no information: 17 939

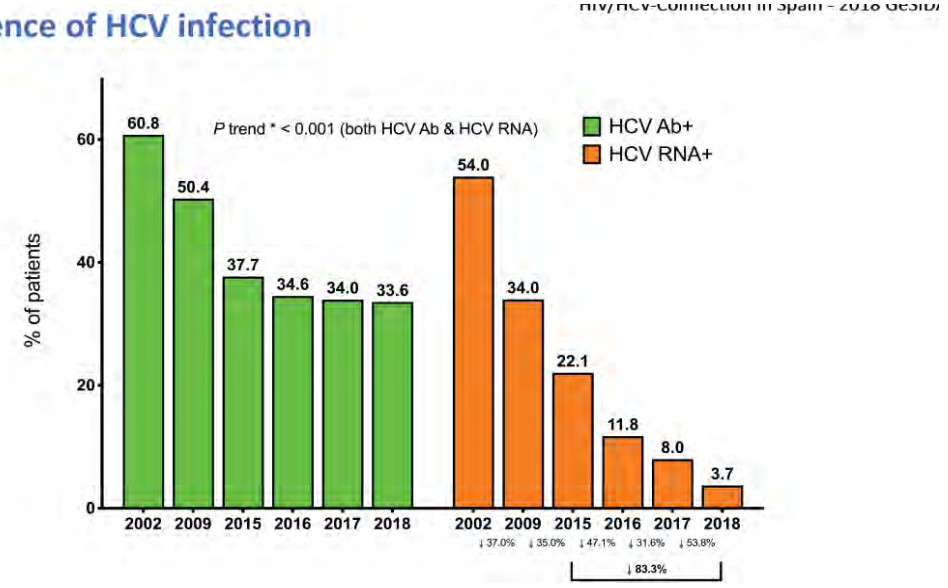
Prevalence in high-risk settings; 2012-2018



	2015	2016	2017	2018	2019 (*)
anti-VHC	19,5%	18,7%	16,7%	10,5%	10,1%
RNA VHC		11,0%	9,0%	3,0%	1,9%

HCV prevalence in HIV-positive population in Spain (GeSIDA studies)

HCV prevalence in Prison Settings in Spain (except Catalonia and Basque Country)



Guide for the screening of HCV infection

Screening is recommended exclusively for individuals with **exposures** or **situations** of risk for the transmission of HCV:

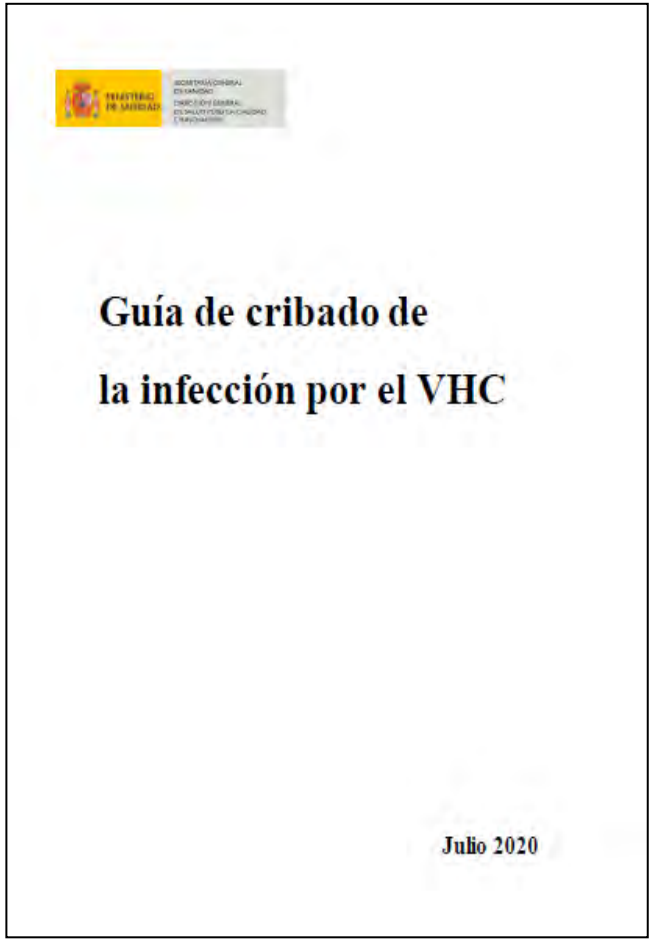
Exposures

- Injected or inhaled drug use
- High-risk sexual relations
- Co-infection with HIV or HBV
- Health or esthetic procedures performed without the proper safety precautions

Situations

- Admission to prisons
- Origin from countries with a medium or high prevalence of HCV infection.

Screening for HCV infection is not recommended in asymptomatic people without exposure or risk situations



Discussion and Q&A

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@HepBCPPA

Breakout Session C: Best practice case studies from Ireland, Greece, Portugal and Montenegro

Chair:
Prof Antonio Craxi, University of Palermo

EUHCV
Policy Summit - 24.03.2021
Online event

#HCVSummit
@HepBCPPA

Prof John Lambert

Mater Misericordiae Hospital, UCD Medical School, Dublin, Ireland

#HCVSummit
@HepBCPPA

HEPCARE EUROPE

Transitioning HCV Care into the Community

Professor John Lambert, Consultant Infectious Diseases,
Mater and University College Dublin, Ireland

Prof Walter Cullen, Professor of General Urban Practice,
University College Dublin

HEPCARE EUROPE

PRIOR TO HEPCARE- DUBLIN RESULTS FROM A HOMELESS SERVICES STUDY

- Study from 2014. Describes standard of care in homeless services at the time.
- Out of 547 people screened, 206 were Antibody positive, 51 were referred to the hospital, 33 attended, only 2 completed treatment.

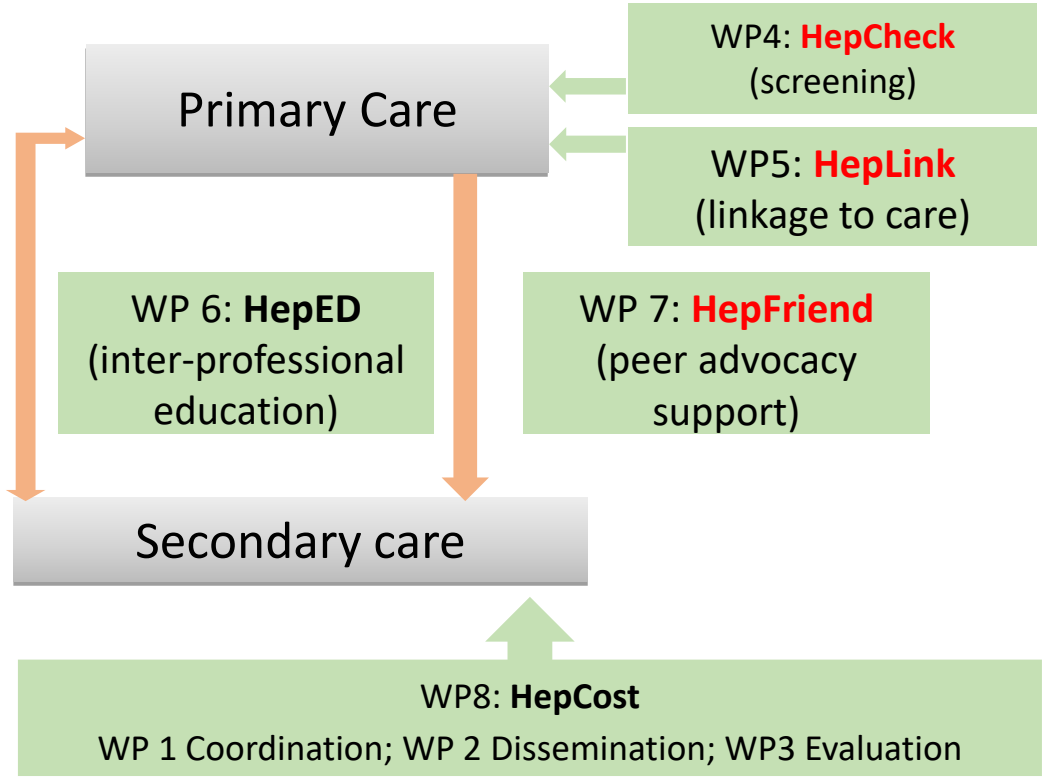
STANDARD OF CARE DID NOT WORK FOR VULNERABLE POPULATIONS

HEPCARE EUROPE

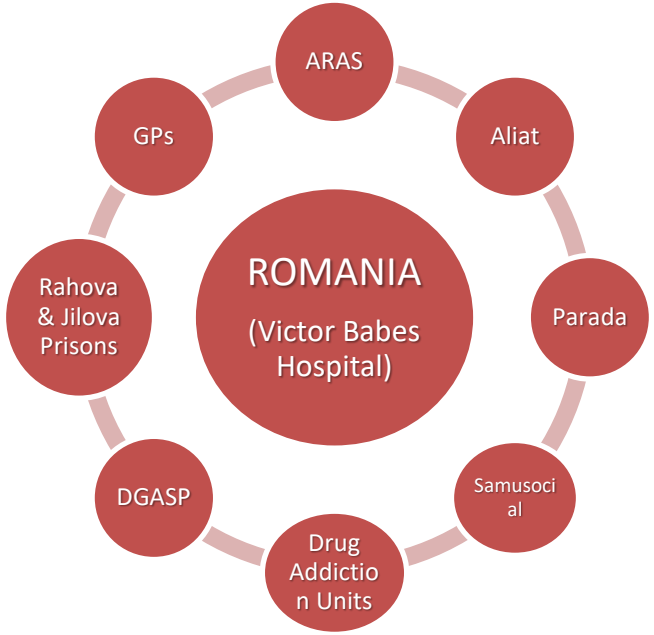
HEPCARE: A new Hepatitis C Care service model
Adaptable, Flexible and Replicable

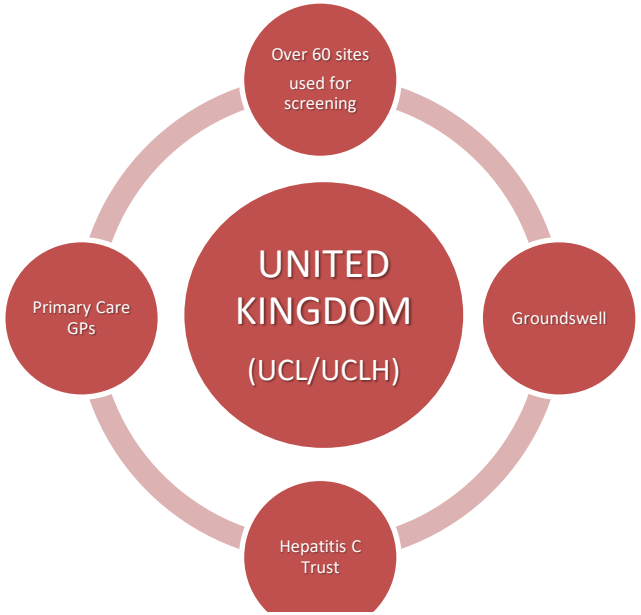
FLEXIBILITY & ADAPTABILITY
allowed its successful replication in 4 very different settings in the EU

Revolves around the PRINCIPLES of
- Intensified Screening (HEPCHECK)
- Linkage to care (HEPLINK)
- Intensified patient support (HEPFRIEND)
- Education (HEPED)
- Cost analysis (HEPCOST)

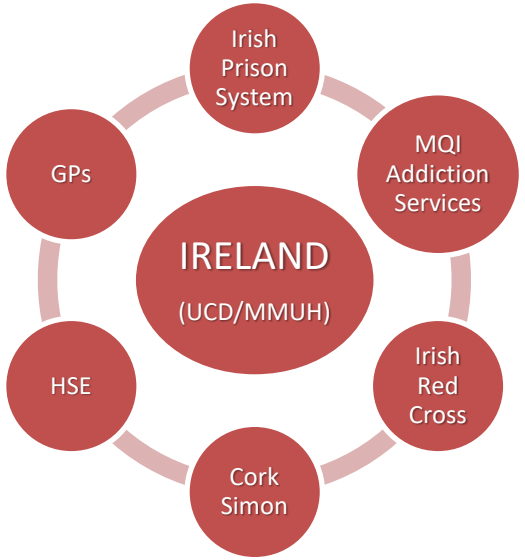


HEPCARE EUROPE





HEPCARE NETWORKS



Example of mobile unit (Safetynet Primary Care)

HEPCARE
EUROPE

INTERVENTIONS

- Intensified screening was conducted in the community. A mobile fibroscan was used in community sites.
- A specialist nurse intervention was developed for GPs and primary care centres. The nurse provided support to a large number of GPs to deal with HCV patients.
- Peer support was offered to patients needing additional support to link to care and complete treatment.
- Education was provided to patients, peer workers and health care professionals.
- A cost effectiveness analysis was conducted. The peer support intervention in the UK and nurse intervention in Ireland are cost effective.

CASCADE OF CARE

	Romania	Ireland	Spain	England	Total
No. of individuals recruited	525	812	636	635	2,608
No. of participants antibody test results recorded	525 (100%)	772 (95.9%)	636 (100%)	635 (100%)	2568 (98.5%)
No. of HCV Ab Positive Results	230 (43.8%)	257 (33.0 %)	197 (31.0 %)	390 (61.4%)	1074 (41.8%)
No. of participants Linked to Care *	151 (65.6%)	176 (68.5%)	104 (52.8%)	219 (56.1%)	650 (64%)
No. RNA positive HCV infection	71 (30.9%)	162 (63.0%)	108 (54.8%)	346 (88.7%)	687 (60.5%)
No. of participants Put on Treatment	24 (33.8%)	104 (64.2%)	56 (51.9%)	115 (33.2%)	299 (43.5%)
No still on treatment	4 (16.7%)	44 (42.3%)	20 (35.7%)	40 (34.8%)	108 (36.1%)
No Completed treatment (including virologic failure and death)	20 (83.3%)	58 (55.7%)	54 (96.4%)	71 (61.7%)	203 (67.9%)
Abandon treatment	0 (0%)	2 (2%)	2 (3.6%)	4 (3.5%)	8 (2.7%)
No. achieved SVR by data cut off point (vs nb put on treatment)	18 (75%)	57 (54.8%)	52 (92.9%)	69 (60%)	196 (65.5%)

EFFICACY OF DAA TREATMENT

	Romania	Ireland	Spain	England	Total
No Completed treatment (including virologic failure and death)	20	58	54	71	203
No. achieved SVR	18 (90%)	57 (98.3%)	52 (96.3%)	69 (97.2%)	196 (96.5%)

Challenges of HCV Roll out to the Community

- Number of community sites involved. Devolving care to the community is a challenge.
- Care for cirrhotic patients will still need some involvement from specialty care services.
- Integrated care is still the best way forward to support widespread community networks. Its not about either hospital or community care: both can work in partnership.
- There is still a large burden of HCV related disease in the community, not accessing care.
- The HCV patient may have a journey through many different services: hospital, GP, prison, drug treatment services, homeless services
- Most care is still being focused on the 'easy to treat' and not the high transmitters
- Services that care for HCV are not joined up: lack of vertical and horizontal health care system partnerships
- HCV is just one of many conditions to address in such individuals

HEPCARE EUROPE

HEPCARE EUROPE

- Lessons learned from HepCare Europe can be used as a model for future projects

  - Targeting multiple disease
  - Involving community in treatment
  - Reaching at risk populations

HEPCARE EUROPE

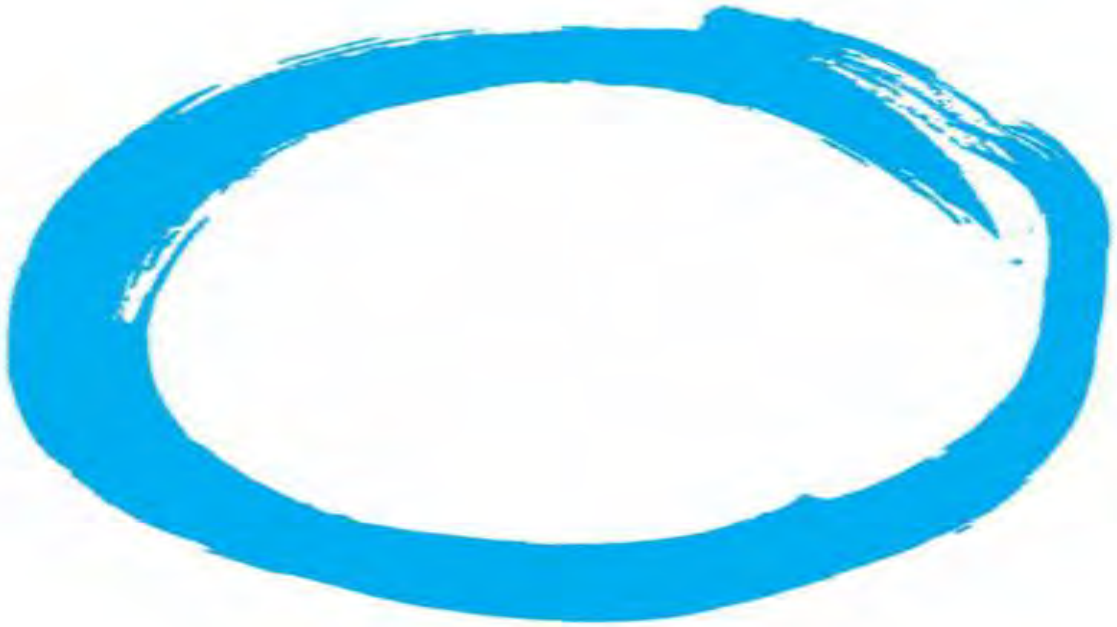
Next Steps?

- Taking the Lessons Learned from HepCare Europe
- Integrating Diseases into one initiative
- Scaling up ‘Testing and Treatment of Multiple Diseases’
- Reaching Vulnerable Populations not Accessing Care
- Expanding to new geographic areas with ‘high burden’ of disease
- Strengthening Cross border initiatives (mobile health units)

HEPCARE EUROPE

UNAIDS | 2011–2015 STRATEGY

GETTING TO ZERO



UNAIDS

HEPCARE EUROPE

Prof Vana Sypsa

University of Athens Medical School, Greece

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Best practice case studies:

ARISTOTLE HCV-HIV, Athens & ALEXANDROS, Thessaloniki in Greece

Vana Sypsa

Assoc. Professor of Epidemiology and Medical Statistics

Medical School, National and Kapodistrian University of Athens, Athens, Greece

EUHCV Policy Summit - 24.03.2021 Online event

People Who Inject Drugs (PWID): A key population for HCV elimination

- High prevalence of HCV infection
- Ongoing transmission among active PWID
- Barriers in linkage to HCV care and retention to treatment
- Presence of other comorbidities

Challenges

1. Reaching a hard-to-reach population
   High coverage - Reach those in most need (active PWID, not linked to other services)

2. Linkage to HCV care

3. Retention in HCV treatment

Addressing these challenges in Greece

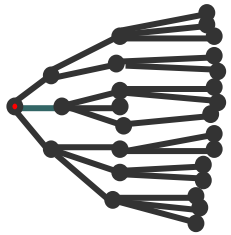
ARISTOTLE HCV-HIV (Athens)

ALEXANDROS (Thessaloniki)

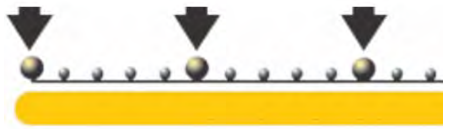
1 Reaching a hard-to-reach population

High coverage - Reach those in most need (active PWID, not linked to other services)

Community-based (in the centre of Athens and Thessaloniki)



Peer-driven recruitment: chain referral from members of the target population (RDS)



Multiple recruitment rounds → PWID have the chance to participate multiple times

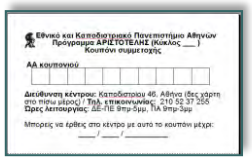
Incentives → rapid recruitment, high coverage, reach deep into the network of PWID

2 Linkage to HCV care

All necessary procedures performed on-site in a single visit

Patients are entered to the national chronic hepatitis C registry for treatment approval

A network of collaborating clinicians is set up and visit the study site – Peer navigators assist patients



Monetary incentives

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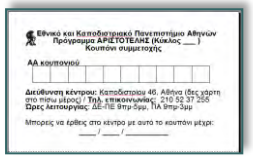
3

Retention in HCV treatment

Follow-up of patients during treatment



Monetary incentives

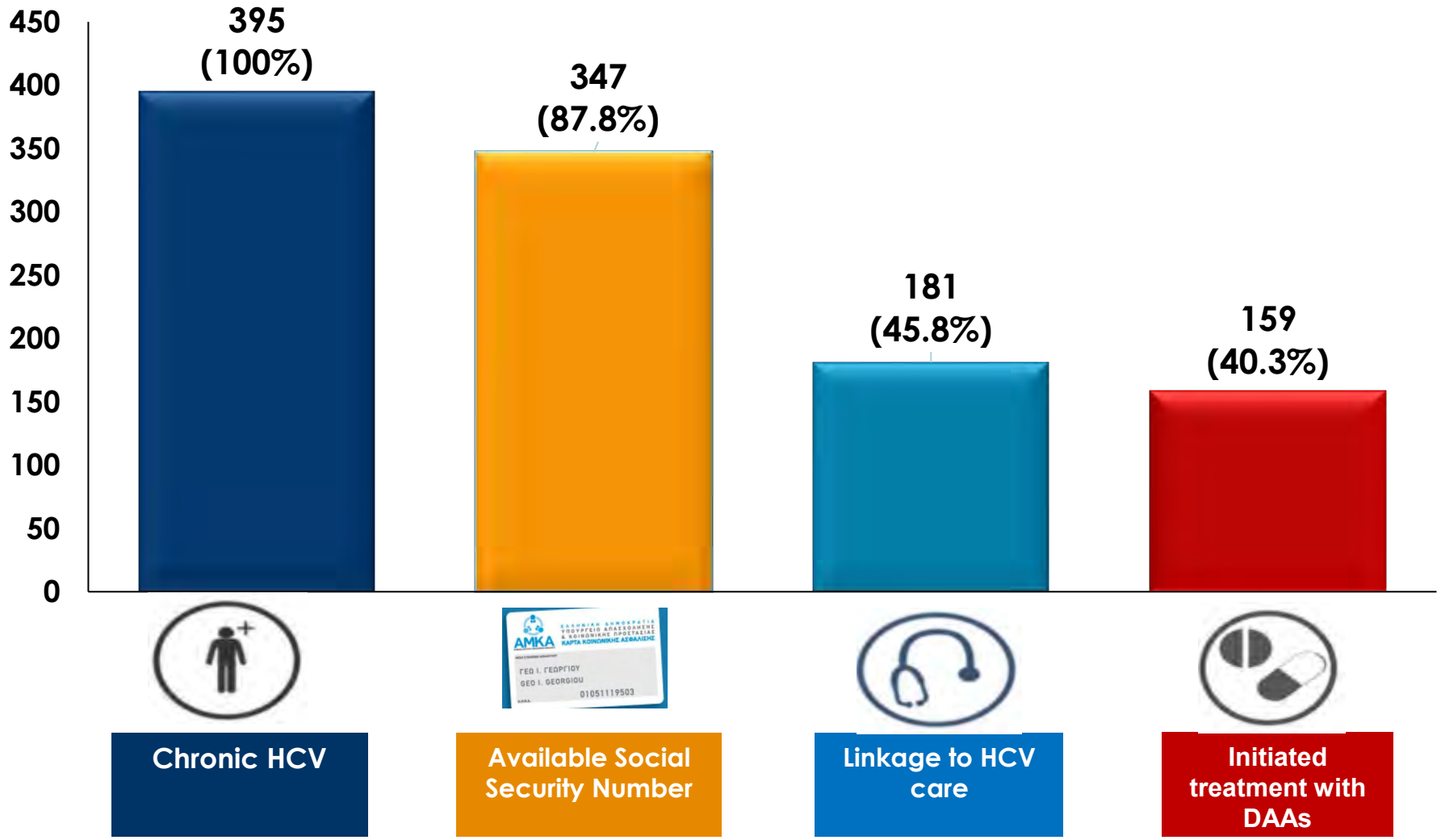
Counseling

Participants

ARISTOTLE HCV-HIV (April 2018-March 2020)	ALEXANDROS (Sep 2019 - ongoing)
1,635 participants **1,943 visits** **(82% population coverage)**	**981 Participants** **1,370 visits**
75% active PWID **27%** homeless	**55%** active PWID **16%** homeless
77% not linked to opioid substitution treatment programs	**80%** not linked to opioid substitution treatment programs
76% anti-HCV(+)	**62%** anti-HCV(+)

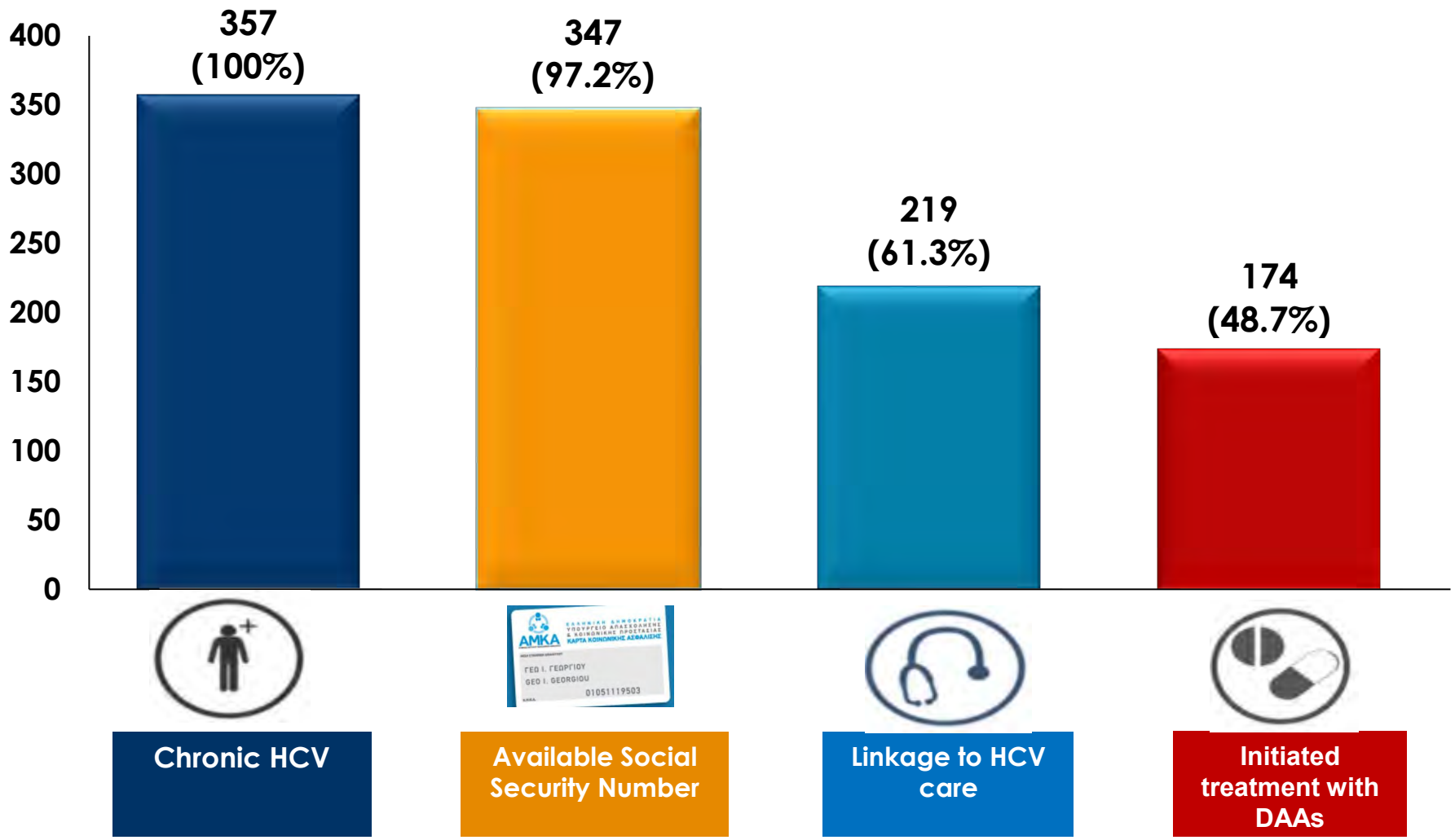
The impact of ARISTOTLE HIV-HCV program: Cascade of HCV care

(for PWID with HCV monoinfection who fulfilled treatment criteria)



The impact of ALEXANDROS program: Cascade of HCV care (ongoing program)

(for PWID with HCV monoinfection)



Discussion

The interventions were successful as they were designed to address the population of PWID:

Community-based

Peer-driven recruitment

Testing, linkage and retention to care provided on-site with the help of a network of clinicians and dedicated staff/peer navigators

In Thessaloniki, ALEXANDROS allowed the early identification of an HIV outbreak among PWID

Funding

ARISTOTLE HCV-HIV and ALEXADNROS received funding from:

Gilead

Abbvie

MSD

Hellenic Scientific Society for the Study of AIDS and STDs

Dr Rodrigo Sousa Coutinho

Ares do Pinhal, Lisbon, Portugal

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MOBILE OUTREACH PROGRAMME

MICROELIMINATION OF HEP C VIRUS IN SEVERE DRUG USERS

3rd EU HCV Virtual Policy Summit
|24 March 2021|

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Mais Cidadão

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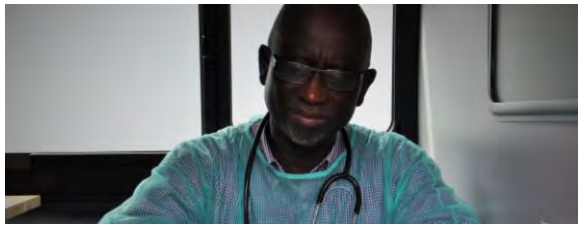


To reach opioid drug users (with polydrug use or not) who do not attend conventional drug addiction treatment centers or other health and social services

<u>MOP users profile:</u>

Personal disorganization

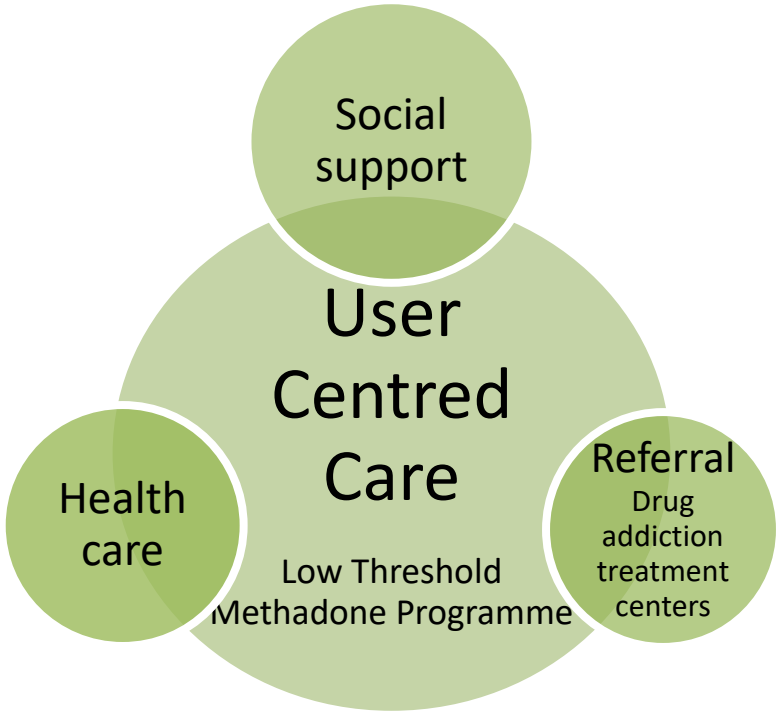
Physical impairment or disease

Psychiatric diseases

Psychological vulnerabilities

Social exclusion

High-risk behaviours



Homeless ±10%

PWID (±20%)

HCV Ab (67%)

HCV RNA (68%/67%)

HCV+HIV (13,5%)

HIV (15%)

TB (1%)

MOBILE OUTREACH PROGRAMME

ARES DO PINHAL

365 days

8.30am to **7.30**pm

2 Mobile Units

Mobile Office

Service car

5 Stops

MOP Main Features

- Easy accessibility (close to problematic neighbourhoods and/or to main transport interfaces)
- Prompt response to any request and simplified admission procedures (if indicated)
- Low-threshold methadone program and NSP
- Screening for Infection diseases
- Administration/monitoring of medication (namely psychiatric and infeccion diseases) in the MOP
- Referral to all healthcare and social services
- Abstinence of drugs use is not required

MOP-L is frequented by +- **1300** heroin/polydrug users on a daily basis

MICROELIMINATION OF HEP C VIRUS IN THE MOP - **CHALLENGES**

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System level

Bureaucracy/Acessibility

To many stages to attain HCV medication

- The more the number of stages the less the chances of success

Provider level

- **Are skeptical about their compliance to treatment**
- **Moral judgments and prejudice**
- **Have difficulty to understand that treatment is not a priority**

Client level

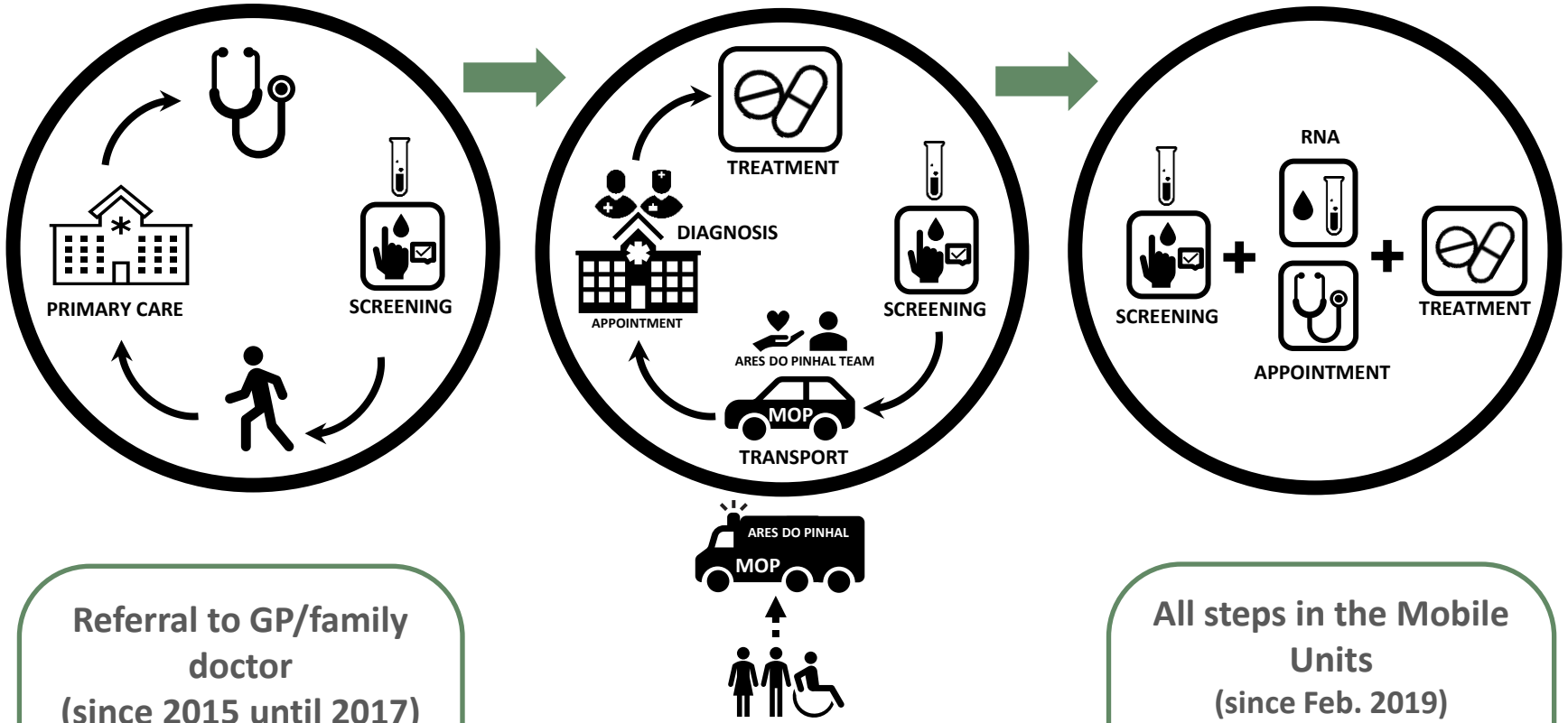
- **Lack of concern about their health condition**
- **To be HCV+ ➡ Not a menace (silent disease ➡ no symptoms…no disease)**
- **Requirement of many travels to healthcare services (many stages)**
- **Fear of disrupting their daily routine**
- **Stigma**
- **Difficulties towards formal procedures in the healthcare attendance services**

Protocols with Hospitals

Peer Navigator

Awareness sessions

MICROELIMINATION OF HEP C VIRUS IN THE MOP - **TACKLING THE CHALLENGES**



Referral to GP/family doctor
(since 2015 until 2017)

- Not effective
- Many steps and slow process.

(Low adherence: < 1%)

Protocol with hospital specialized services

(since Oct. 2017)

- Appointments arranged with the Hospitals including patients transport UM➡Hospitals
- Follow up monitored by MOP
- DOT in the Mobile Units

(adherence: ± 45%)

All steps in the Mobile Units
(since Feb. 2019)

- Appointments with Hepatologist;
- Blood collection;
- DOT

(adherence ± 80%)

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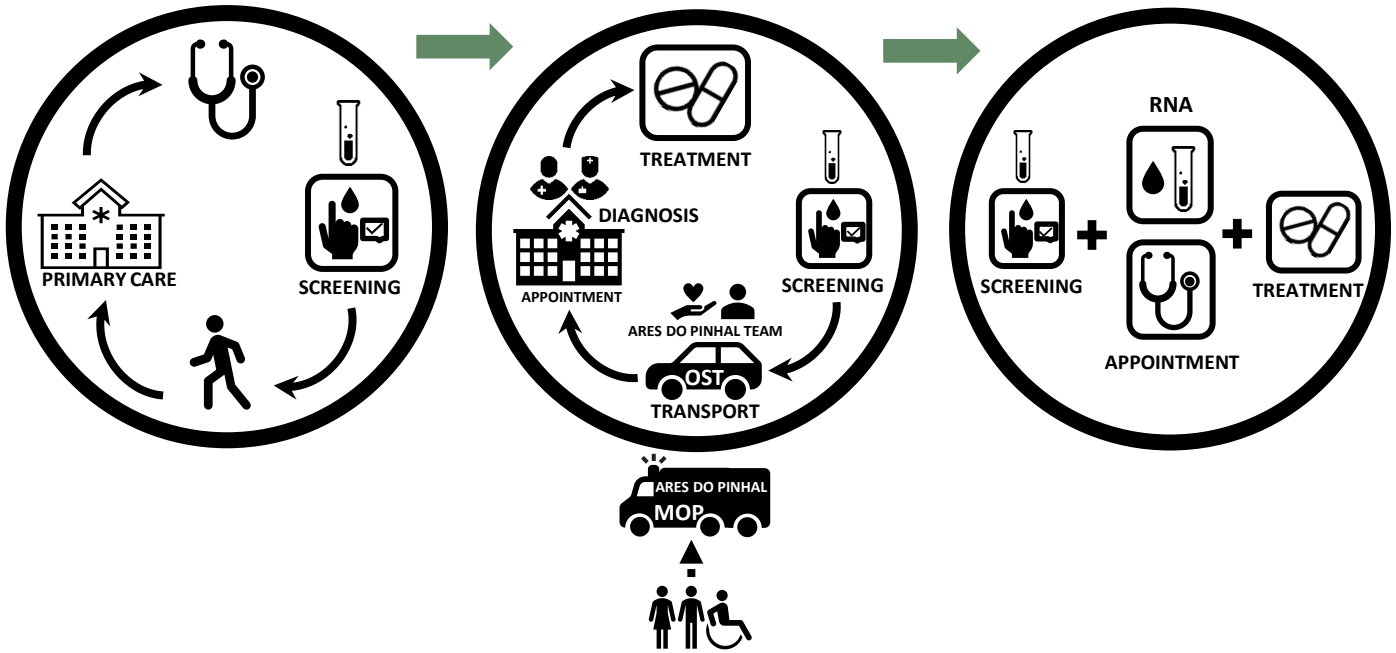
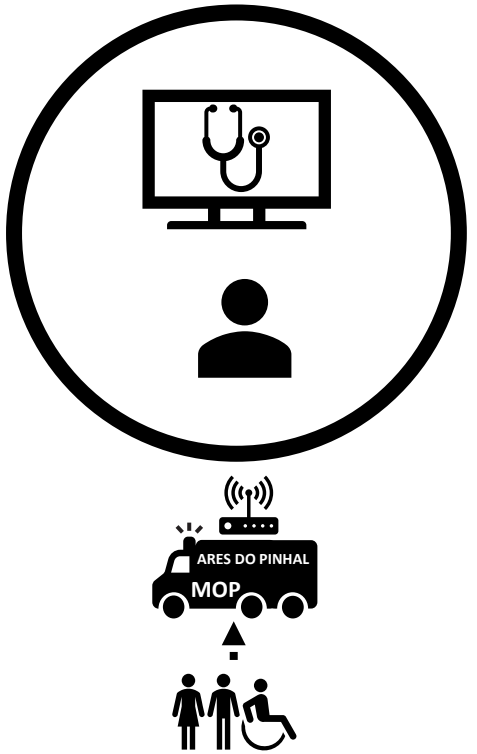
HEPATITIS C PATIENT CENTRED MODEL OF CARE



Cascade of care for hepatitis C before and during the MOP, Lisbon, 2015-2021							
Model	**Duration**	**Scheduled**	**Consulted**	**Adherence**	**Treatment ongoing**	**Treatment complete**	**Pending lab results**
Link to family doctor	2015 - 2017	307	30	~0.10	-	-	-
Transport to Hospital Appointment	Oct 2017-Ongoing	273	123	~0.45	0	79	0
Appointment by Hepatologist in MOP van	Feb 2019-Ongoing	213	172	~0.81	3	76	42

MICROELIMINATION OF HEP C VIRUS IN THE MOP WITHIN COVID19 PANDEMICS

Appointments with Hepatologists at the MOP - Multimedia Van.



THANK YOU

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MOP supported by

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email

rodrigo.coutinho@aresdopinhal.pt

website

www.aresdopinhal.pt

Mr Ivan Vuković

Mayor of Podgorica, Montenegro

Presentation by Dr Nebojša Kavarić

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The Urban fight against the Hep C Epidemic - Contributions from Fast-Track Cities Podgorica, Capital of Montenegro

Nebojsa Kavaric MD, PhD

Coordinator of the Commission for Health Protection and Promotion for the territory of the Capital City Podgorica

Montenegro

670,000 citizens

Podgorica, Capital of Montenegro

250,000 citizens

Annual number of tourists in Montenegro

1,500,000-2,000,000

Basic MNE HCV information

- Hepatitis B and C are the main causes of viral hepatitis in Montenegro

- No clear picture of the size of the problem.

- 2.200 chronic HBV inf.
- 2.000 HCV positive antibodies.

Current situation

- People who use drugs and harm reduction program are recognized by the Local Plan for Social Inclusion through a vulnerable group of people with HIV and at risk of HIV (they automatically fall here). Like potentially people with HCV...

- At the same time, the population is recognized by the National Strategy for HIV.

- More than 500 unique PWID users are covered annually through harm reduction programs in Podgorica

Future directions of action

- We know that all the challenges in achieving global goals in the elimination of hepatitis and AIDS start with harm reduction programs and a large scope of testing.

Future directions of action

- At this time, supervised consumption rooms have not been identified as possible options to harm reduction in PWID individuals.

- But, in future plans, we will strongly consider the concept of supervised consumption rooms, which can be an important option for harm reducing, especially in Podgorica and more developed municipalities on the coast.

- We believe that this concept, with all the cultural and social characteristics of our society, can be considered and developed with the NGO sector.

Future directions of action

New projects

- Health House - will be a place where more services will gather so that the most vulnerable have access to the necessary services, where the city will provide psychosocial support, counseling, education and referral to other services. The project is being prepared with an NGO

- Commission for Health Protection and Promotion, an expert consultative body that will significantly improve all activities related to the improvement of the environment and communication with citizens regarding promotional and preventive activities related to public health

Conclusions:

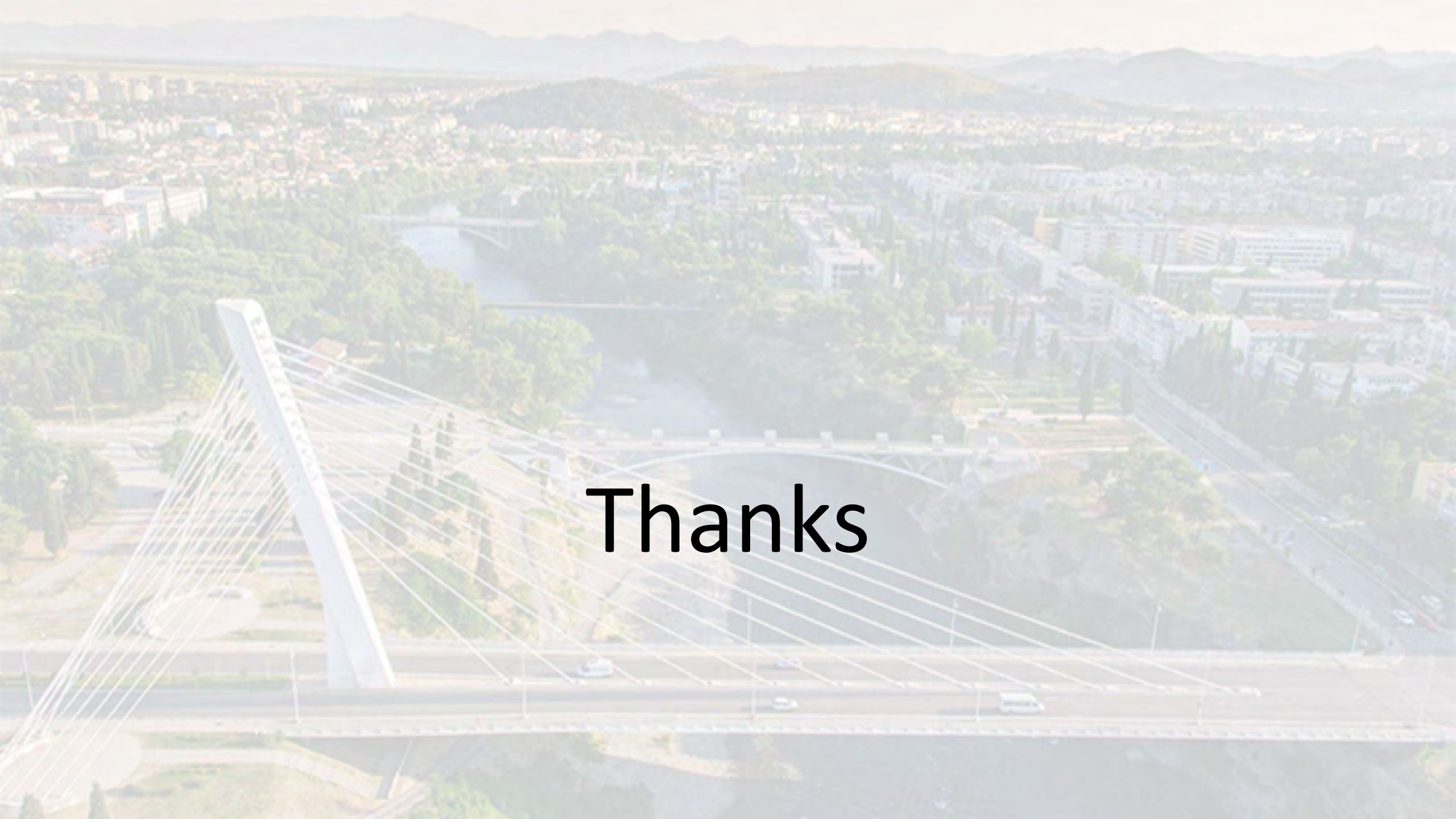
- The response to HCV, HIV must be multi-sectoral, multidisciplinary and must include educational activities, testing, counseling, prevention, treatment, reduction of stigma and discrimination, creation of a supportive environment.

Conclusions:

- In the future, the Capital City will, through its legal obligations, give priority to a better quality of life for its citizens, through intensive work on improving the environment for the protection and improvement of health.

Conclusions:

- Many other projects promoting healthy lifestyles with NGO partners,
- will strongly contribute to raising awareness of both citizens and decision-makers,
- which will affect the improvement of public health in the Capital,
- in which activities related to HCV will certainly be one of the priorities.



Thanks

Discussion and Q&A

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Breakout Session D: Best practice case studies from Spain, Italy, Romania and Israel

Chair:
Prof Laurent Castera, Hôpital Beaujon, University of Paris-VII, France

EUHCV
Policy Summit - 24.03.2021
Online event

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Dr Joan Colom Farran

Catalonian Public Health Agency, Barcelona, Spain

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Breakout session 5. Best practices case studies

The case of Catalonia: SLTC in migrants and other vulnerable populations

Dr. Joan Colom Farran
Director of the Program for Prevention, Control and Treatment of HIV, STIs and Viral Hepatitis and Director of the Program on Substance Abuse (Public Health Agency of Catalonia)

Plan for prevention and control of hepatitis C in Catalonia

Main aim:

Facilitate the design and implementation of the necessary measures to **reduce the incidence**, **the morbidity and the mortality associated** with HCV infection in Catalonia, in order to **eliminate the infection as a public health problem by 2030.**

- 6 general objectives
- 47 specific objectives
- 131 actions

General Objectives:

1. Obtain updated epidemiological information
2. Reduce the incidence of new HCV infections
3. Increase the detection of hidden infections
4. Coordinate health care to improve access to treatment
5. Improve the information and raise awareness among health professionals and citizens
6. Monitoring and evaluation

http://salutpublica.gencat.cat/ca/ambits/vigilancia_salut_publica/vih-sida-its-hv/Hepatitis-viriques/descripcio/

Catalan epidemiological data

General population[1]
Prevalence of HCV Ab: **1,1%**
Viremia: **0,47%**

PWID[2]
Prevalence of HCV Ab: **74%***
Viremia: **54,2%**

People co-infected with HIV/HCV[3]
Prevalence of HCV Ab: **24,7%**
Viremia: **1,8%**

People in prison[4]
Prevalence of HCV Ab: **3,6%**
Viremia: **1,1%**

Migrants: People from regions with high prevalence HCV Ab+
Eastern Europe: **7,1%**[6] Pakistan: **5,3%**[7]
Sub-Saharan & Africa: **3,1%**[6]

MSM[5]
Prevalence of HCV Ab: **2,7%**
(self declared)

Key populations

1. Lens S. Update of the prevalence and viraemia of hepatitis C in Catalonia, 2018; 2. HCV Ab : Bio-Behavioral Study 2019 (REDAN Project), CEEISCAT. People who inject drugs (PQID) recruited at Harm Reduction Centers. Viraemia: Extrapolation results from the study HepCDetect II: The hepatitis C care cascade among people who inject drugs in Catalonia: major gaps among migrants (Folch C., Saludes V., Reyes-Ureña J., Antuori A., Ibáñez N., Majó X., Colom J., Matas L., Casabona J., Martró E.; HepCdetect II Study Group). 3. Population Cohort of HIV PISCIS. CEEISCAT, 2018; 4. Department of Justice corresponding to December 2020. Available at: http://www.gencat.cat/justicia/estadistiques_serveis_penitenciaris/12_pob.html (accessed March 2021); 5. Catalan data from the Spanish national report (unpublished) from the European MSM Internet Survey (EMIS, 2017); 6. Lazarus JV, et al. Enferm Infecc Microbiol Clin 2019;37:222–30; 7. Falla et All. (2018) Estimating the scale of Chronic hepatitis C virus infections on the EU/EEA: a focus on migrant from anti-HCV endemic countries. BMC Infectious Diseases.

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PWID – People who inject drugs

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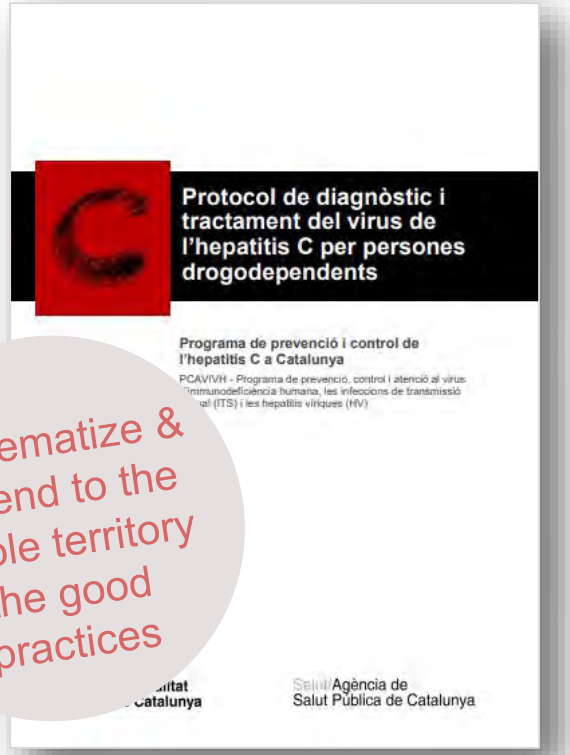
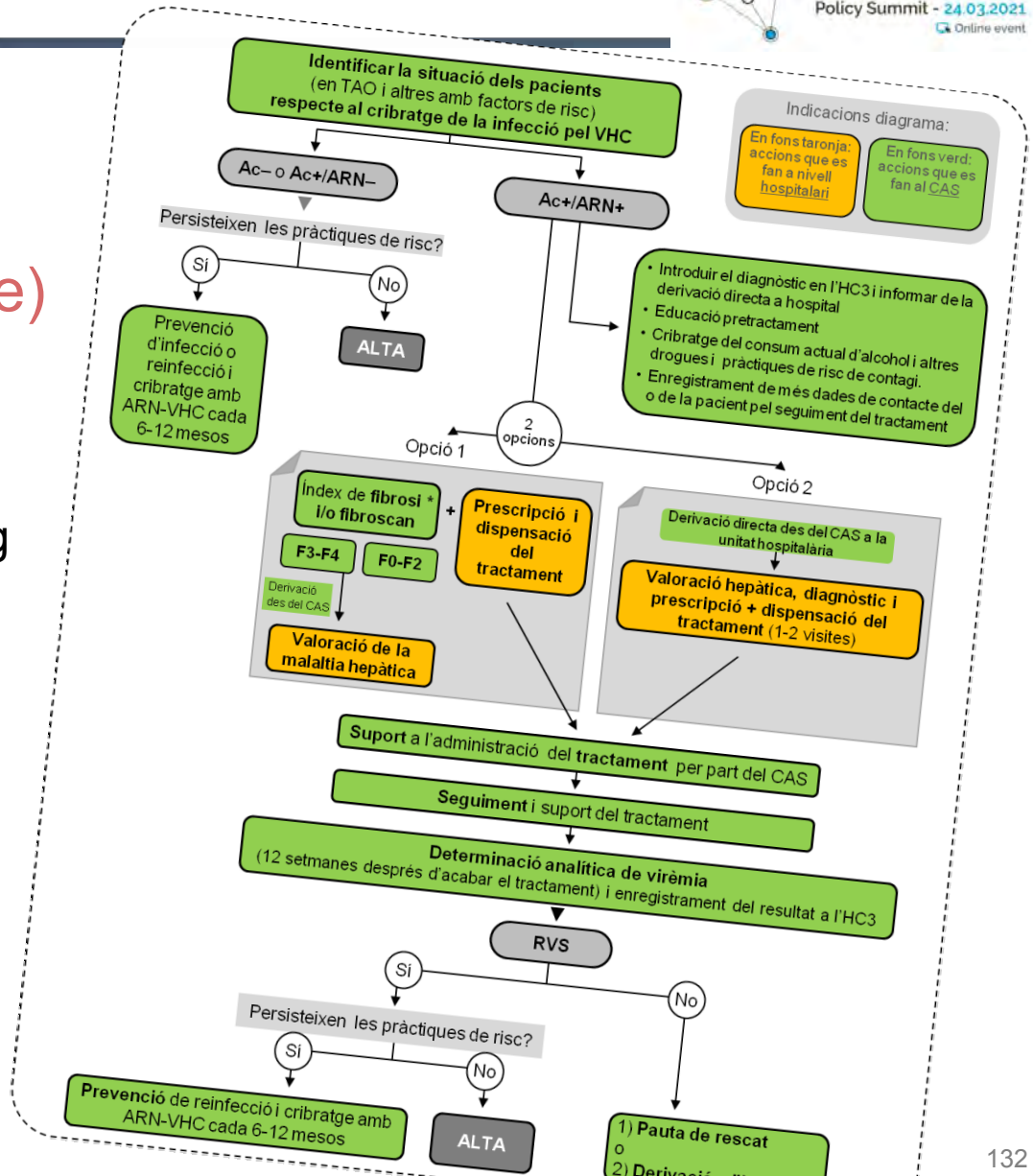
Protocol for increasing the detection of hidden infections (*test and treat*) and improving access to treatment (linkage to care)



Systematize & extend to the whole territory the good practices

Two key ideas:

- Diagnosing viremia and treating immediately: **test & treat**
- **In situ**: ideally in DAU (if not possible,1 or 2 visits to the hospital service, and the rest at DAU



DAU: Drug Addiction Unit

PWID – People who inject drugs

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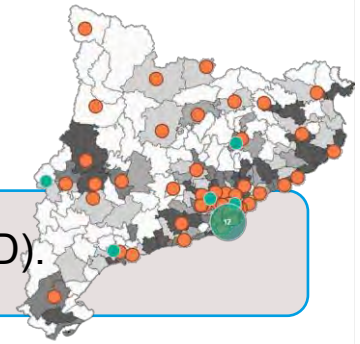
PREVENTION

Reduce the incidence of new HCV infections

- Reinforce Harm Reduction strategies: NSP & OST programmes, supervised consumption rooms



SCREENING

Rapid serology test + dry blood with viremia (Genexpert) **in situ** (DAU and HRD).

Liver Assessment & TREATMENT

Diagnosis + Fibroscan + Treatment in situ

HRC "La Mina" + Hospital Clínic of Barcelona

2019: >700 users. 50% accepted the screening.

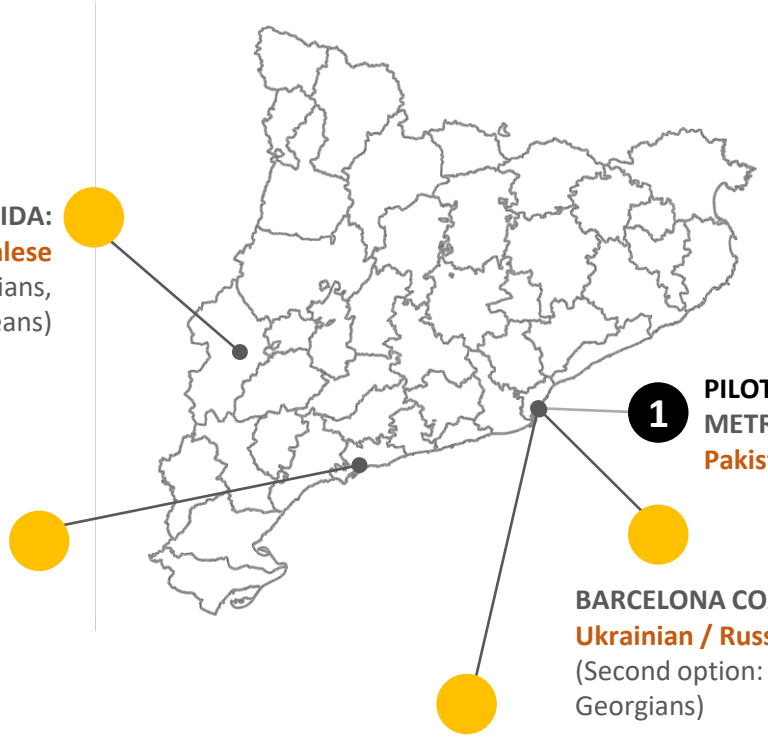
54,2% Viremia: → **70%** initiated antiviral treatment → **73%** SVR12 rate / **15%** reinfection rate

Treatment prevention: Detections & treatment of potential HCV transmitters

DAU: Drug Addiction Unit; HRC: Harm Reduction center
NSP: needle and syringe exchange programme; OST: opioid substitution therapy

Migrants

Rapid HCV antibody and DBS testing in community centres and events



LLEIDA:
Romanians and Senegalese
(Second option: Nigerians, Malians, Guineans)

TARRAGONA:
Romans and Russians
(Second option: Senegalese, Nigerians, Malians, Ghanaians)

1 **PILOT: BARCELONA CITY & METROPOLITAN AREA:**
Pakistani

BARCELONA COAST: Pakistani, Ukrainian / Russian
(Second option: Armenians, Georgians)

SOUTH METROPOLITAN AREA (L'Hospitalet de Ll.): Pakistani and Georgians
(Second option: Ukrainians / Russians, Nigerians)

Community intervention: screening, link to health care and early access to HCV treatment (and HBV and HIV opportunistically).

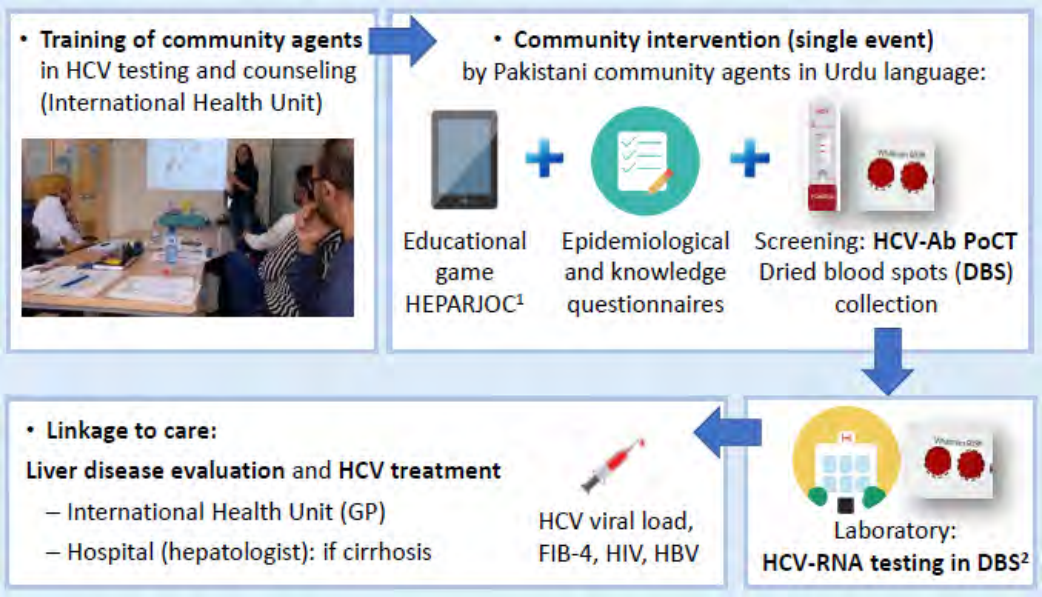
- **Collaboration with Immigration Services** of the territory.
- **Figure of the mediator / peer educator**.
- **Educational workshop + screening rapid tests** (+ dried blood collection).
- **Facilitation of access circuits to healthcare and treatment** with the collaboration of the healthcare agents involved in the territory.

Migrants

EUHCV Policy Summit - 24.03.2021 Online event

Hepatitis C micro-elimination pilot strategy in Pakistani migrants in Catalonia through the implementation of a community intervention

Aim: To implement and evaluate an HCV micro-elimination strategy **based on a community intervention** that brings together education, screening and simplified access to treatment in the **Pakistani migrant population** (the fifth most common country of origin and endemic for hepatitis C virus −HCV− infection) . (N=520)



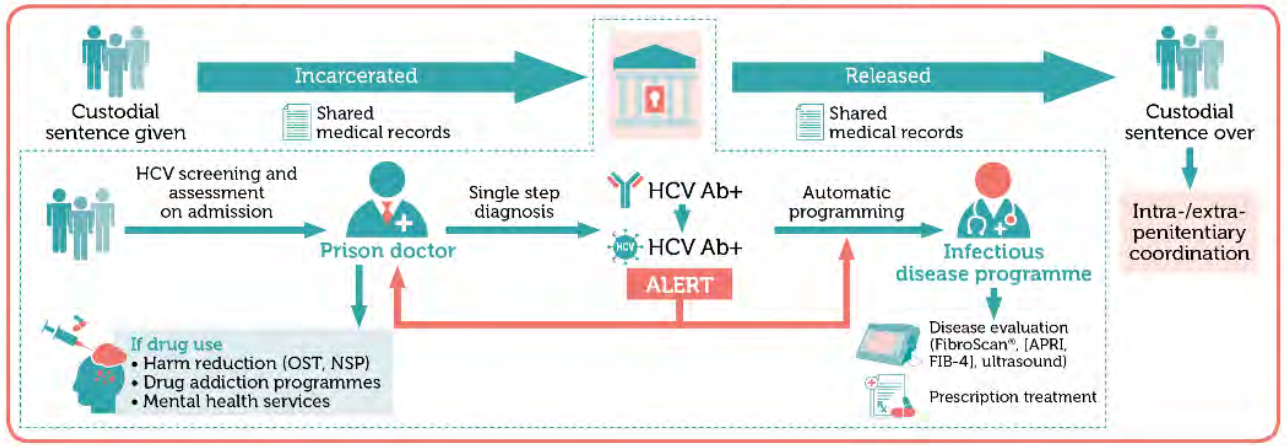
Excellent acceptability (both males and females). **High prevalence observed (Ab: 4,6% / HCV-RNA: 1,2%)**

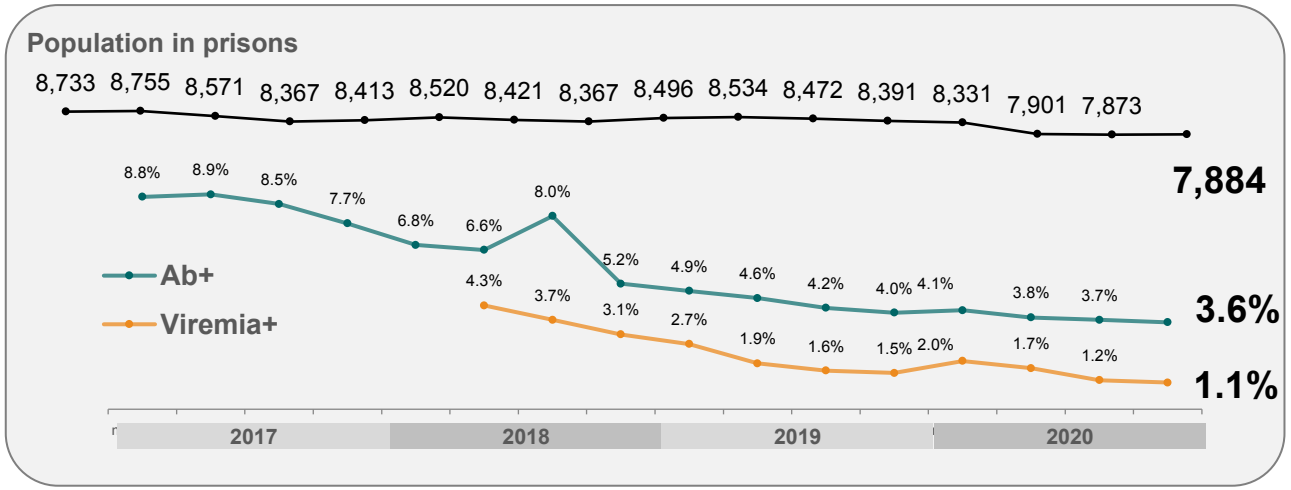
* HepCLink. E. Martró (IGTP), 2019 - 2020

People in prison

Hepatitis C elimination program in Catalan prisons (2016)

- **Systematic HCV screening** upon admission to prison (84%)
- **Treatment in the center**
- **Link to a community specialist upon release (liaison nurse)**
  - Decrease in the loss of post-release follow-ups
  - Improvement of links with specialists



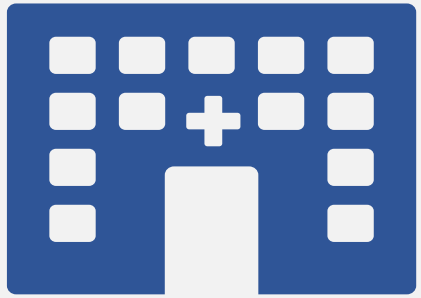


Public health approach to hepatitis C elimination

EUHCV Policy Summit - 24.03.2021 Online event

From healing….

Clinic

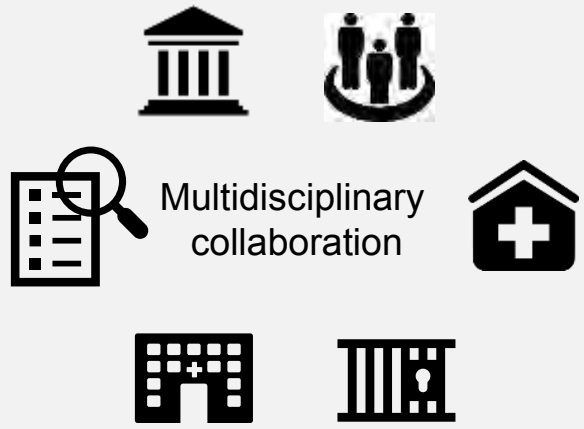


Prevention → Screening → Treatment → Chronic disease

Individual health

…..to elimination

Public health



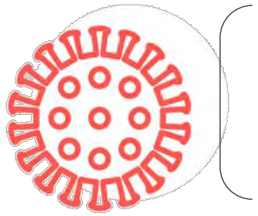
Prevention → Screening → Treatment → Chronic disease

Collective health

Treatment as prevention!

Challenges and conclusions

- **Public Health perspective**: integrative and community model.
- **Micro elimination strategies in vulnerable populations**, designed according to their environment
- **Overcome the barriers of the system.**
- **Simplification all the processes.** Adaptation of the health structure to the patients instead of “adapting the patient to the health structure”.
- **Use Good Practices to make them scalable.**
- **Leadership at all levels.**
- **The coordinated support of all actors is essential.**



Take advantage of the windows of opportunity that appear with COVID-19 (massive tests to detect COVID-19, telecare, use of TICs ...

Thank you!

Dr. Joan Colom Farran
Director of the Program for Prevention, Control and Treatment of HIV, STIs and Viral Hepatitis and Director of the Program on Substance Abuse (Public Health Agency of Catalonia)

Mr Marco Bartoli

EpaC Onlus, Italy

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Associated screening for HCV and SARS-Cov2 infection in an urban area of Southern Italy: the “Casola di Napoli” cohort study

Authors: Carmine Coppola[1], Mario Masarone[2] ,Marco Bartoli[3], Laura Staiano[1], Pietro Torre[2], Massimiliano Conforti[3], Daniela Amoruso[1], Ivan Gardini[3], Marcello Persico[2]

Affiliations:

1: Department of Hepatology, Gragnano Hospital, Naples, Italy;

2: Internal Medicine and Hepatology Division, Department of Medicine and Surgery,”Scuola Medica Salernitana”, University of Salerno, Italy;

3: EpaC Onlus, Italian Liver Patient Association, Turin, Italy.

Introduction

- The spread of SARS-Cov2 pandemic led to a substantial **reorganization of the available resources** for the management of other potentially curable diseases.

- This is the case of the **HCV infection** that, in Italy, had recently seen **important milestones towards its elimination** which, now, **risk being nullified**.

- Covid-19 pandemic caused a **deep reduction in treatment rates and stopped most of the HCV-testing initiatives**; but, conversely, **the pandemic could be an opportunity to promote HCV testing**

Aim: the 1° Italian HCV-FREE Community that also stops the Covid-19 pandemic

How: **joining the screening** for both the diseases, in order to effectively respond to important clinical needs

- Burden of **COVID-19**
- **Update Epidemiology of HCV infection** in general population of southern Italy
- Show that **micro-elimination activities are winning strategies**.

Methods

- We installed a stable testing center in the main square
- Invited the whole population (> 6years old):
  - Mayor social messages
  - Posters in all the commercial activities
  - widespread announcement with megaphones throughout the country (twice per day)


Protezione Civile dell'Unione
dei Comuni dei Monti Lattari

Methods

The people voluntarily underwent to

- A contemporary screening for **HCV-Ab** and for **SARS-Cov-2 IgG/IgM rapid blood tests***

- All the positive people underwent **RT-PCR**
  - for **SARS-Cov-2-RNA**
  - for **HCV-RNA**
    - **Fibroscan & blood tests**
    - **Genotype**
      - **Treatment**

*rapid antigenic swab for COVID-19 was not available at that time

Results

From June 25 to July 12, 2020:

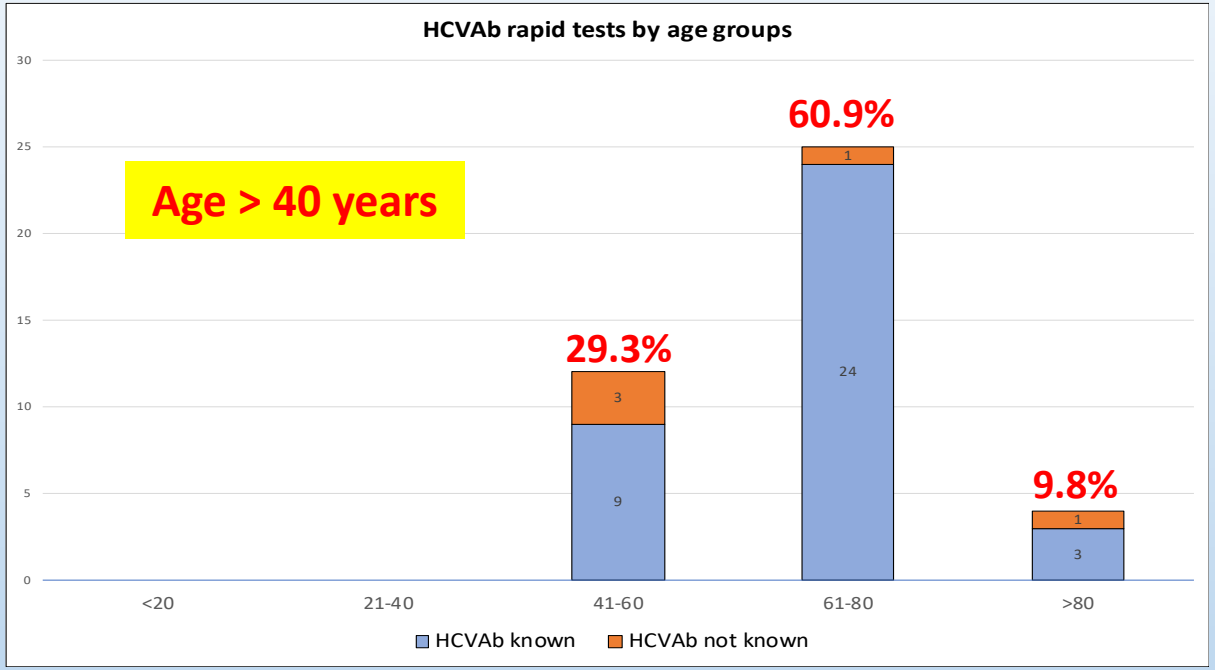
- 3.845 inhabitants
- 3.556* eligible for the screening (age>6yrs)
- **2.740 (77,05%) participated voluntarily**

- **39** pts (**1.4%) SARS-Cov2**-Ab IgM- or -IgG-positive
  - **0** pts positive for SARS-Cov2-RNA
- **41 (1.5%)** pts HCVAb-positive
  - **5 (0.18%)** pts HCVRNA-positive

* Some people theorically resident in Casola, do not live there

Results

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
HCV-RNA 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



2 HCV-RNA+ unknown
1 HCV-RNA+ treated, NO SVR
2 HCV-RNA+, aware but never treated

Age classes	N	HCV-Ab quick test	SARS-Cov2 IgM/IgG rapid blood test
<20 yrs	348 (12.7%)	0 (0%)	0 (0%)
21-40 yrs	721 (26.3%)	0 (0%)	2 (0.3%)
41-60 yrs	996 (36.4%)	12 (1.2%)	14 (1.4%)
61-80 yrs	604 (22.1%)	25 (4.1%)	20 (3.3%)
>81 yrs	69 (2.5%)	4 (5.8%)	3 (1.4%)

Conclusions

- The screening of a cohort of an urban area of Southern Italy showed a **seroprevalence** of **SARS-Cov2-Ab** and **HCV-Ab** of **1.4**% and **1.5**%, respectively, whereas only **0.18**% had an **active HCV** infection.
- This study shows how
  - the **pandemic** can be an **opportunity** to promote **testing activities** for **HCV**
  - **Micro-elimination** activities can strongly contribute to reach the goal al HCV elimination

This has been supported also by a grant from Gilead Sciences Europe Ltd

TOUR IN THE MAIN ITALIAN CITIES

- Joint screening HCV&Covid-19
- Testing point in the main squares with a mobile health unit
- Partecipation of clinicians and nurses of the local hospitals
- Wide communication campaign to promote the events

- Great partecipation of people: at 9AM we had to stop the bookings because more than 2-300 people were in queue

Thank you for the attention

Prof Cora Pop

Carol Davila University of Medicine and Pharmacy, Bucharest, Romania

Building on success: Viral Hepatitis Elimination Strategies in Romania

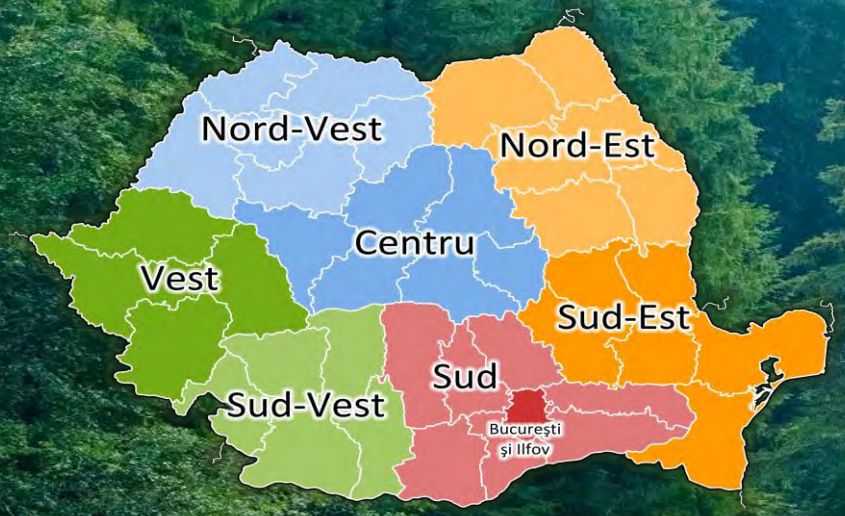
dr Cora Pop

Professor of Internal Medicine and Gastroenterology

Carol Davila University of Medicine and Pharmacy Bucharest

LIVE(RO)

EUHCV



- 19 mil inhabitans
- 50% rural
- 8 development regions
- 10-15% opportunistic screening
- >40% diagnosis too late

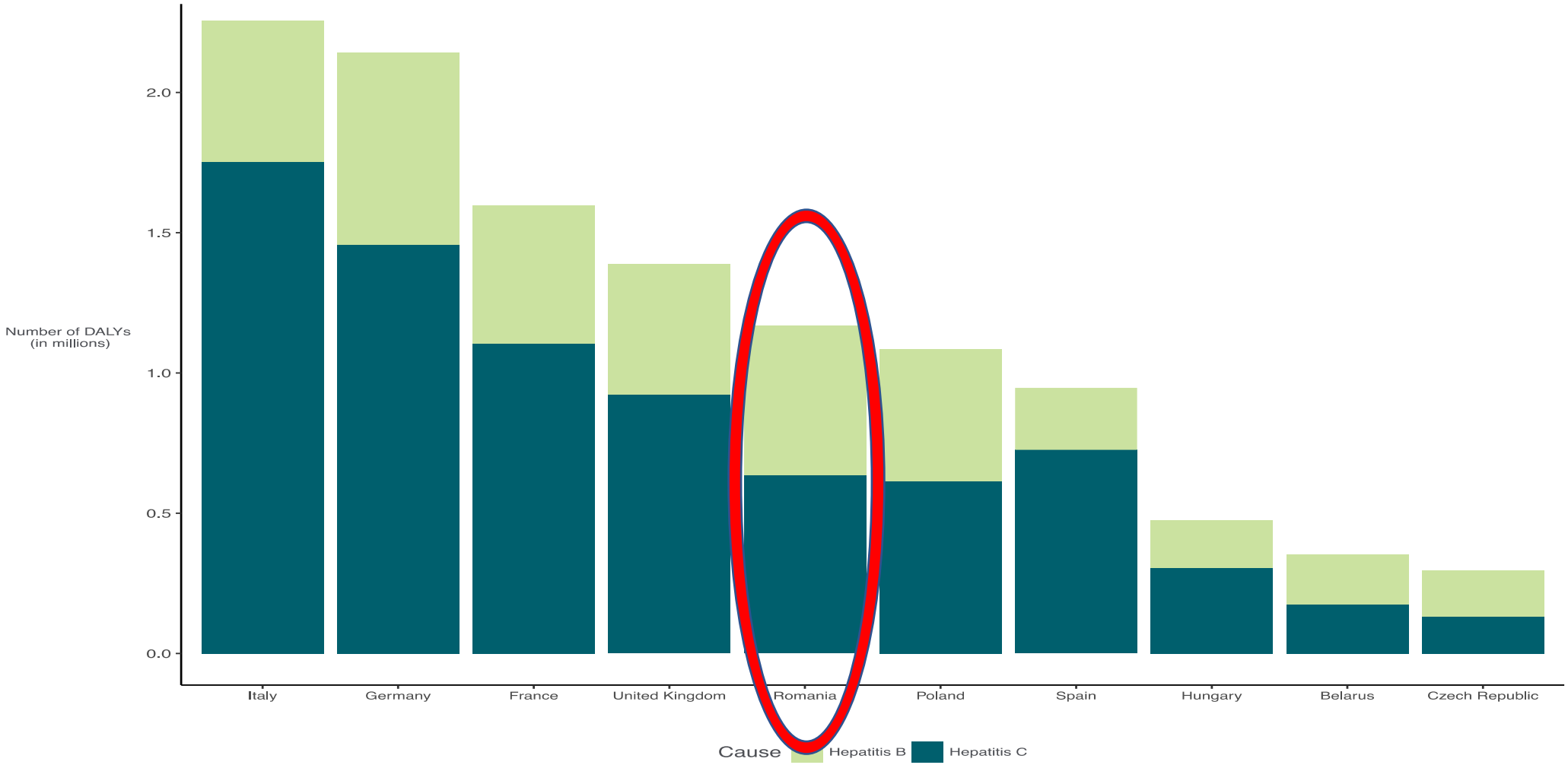
ROMANIA

Romania: Historical context

- 2000: HCV the most prevalent infectious disease
- 2014: no preventive services in the country for viral hepatitis
- 2010: high prevalence of HCV-related End-stage liver disease
- 2015: first DAAs program for HCV-related cirrhosis

	N or/and %	Comments
HCV Disease Burden		
Leading cause of • chronic hepatitis • liver cirrhosis	 • 64% • 59%	
HCC	49.5% out of HCC cases diagnosed in tertiary centers	
Special populations		
Chronic Kidney Disease	>11-⟶20%	
HIV/HCV co-infection	~40-50% out of HIV+ population	
HCV diagnosis rate	**16%**	**Low**
Treated	**60,000** **2002-2015** **Peg/RBV** **5850** ***2016*** ***DAAs***	*>56,500 treated between 2002-20015 w/ Peg/RBV (~50% SVR in real life)* *A very fey in clinical trials and EAP* *99% SVR*

Burden of disease of viral hepatitis in Europe 2016



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European Framework

EUHCV

Policy Summit - 17.02.16 - Brussels

Vision: "*a WHO European Region in which* ***the transmission of new viral hepatitis infections is halted, testing is accessible, and people living with chronic viral hepatitis have access to care and affordable and effective treatment.***"

Goal: Eliminate viral hepatitis as a major public health threat by 2030

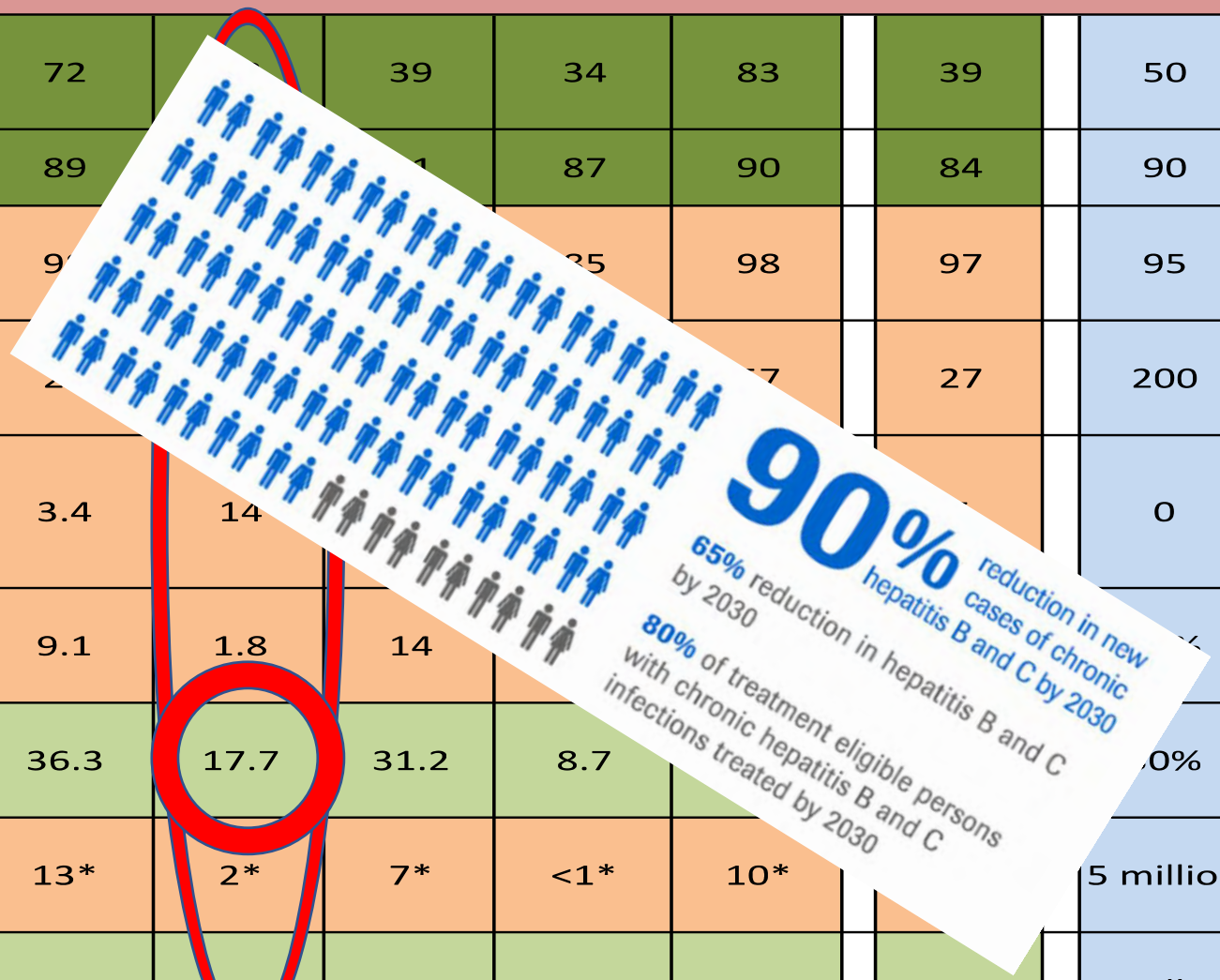
Five strategic directions:

1. Information for focused action
2. Interventions for impact
3. Delivering for equity
4. Financing for sustainability
5. Innovation for acceleration

Frameworks for action: universal health coverage; the continuum of services; and the promotion of a public health approach.

Targets from European action plan for Chronic Viral Hepatitis Eradication

Core Indicators									
Timely birth dose vaccine (%)	10	72		39	34	83	39	50	90
Third dose HBV vaccine(%)	76	89			87	90	84	90	90
Blood donations screened (%)	80	9			35	98	97	95	100
Needle/syringe distrubition (/100 IDU year)	6	2			17		27	200	300
Injection saftety (% resused needles)	3.7	3.4	14					0	0
Proportion of chronic HBV diagnosed (%)	0.3	9.1	1.8	14					90%
Proportion of chronic HCV diagnosed (%)	5.7	36.3	17.7	31.2	8.7			0%	90%
Treatment coverage HBV (%)	<1*	13*	2*	7*	<1*	10*		5 million	80%
Treatment coverage HCV (%)	2.2	11.1	12.1	4.9	7.1	4.8	7.4	3 million	80%

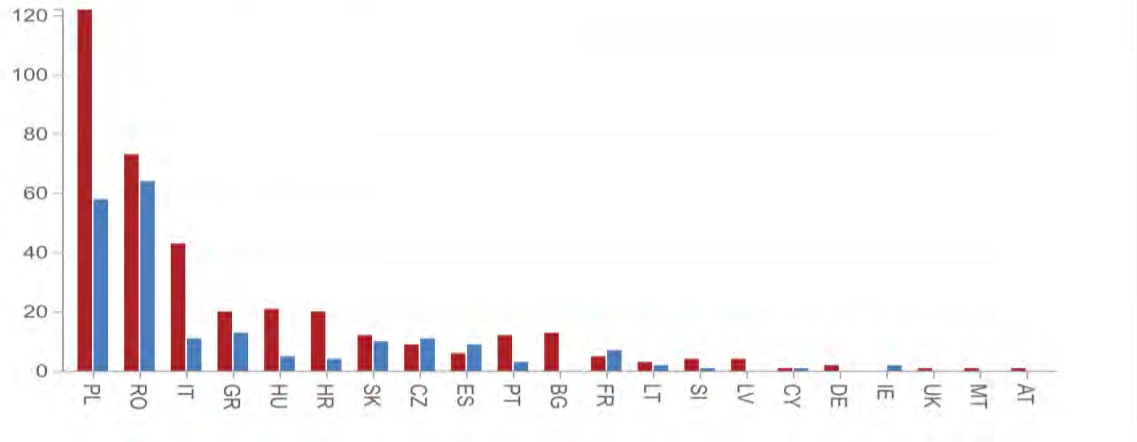


European Commission
Funding Programmes 2014-2020
for
Preventive Health Services

Major projects

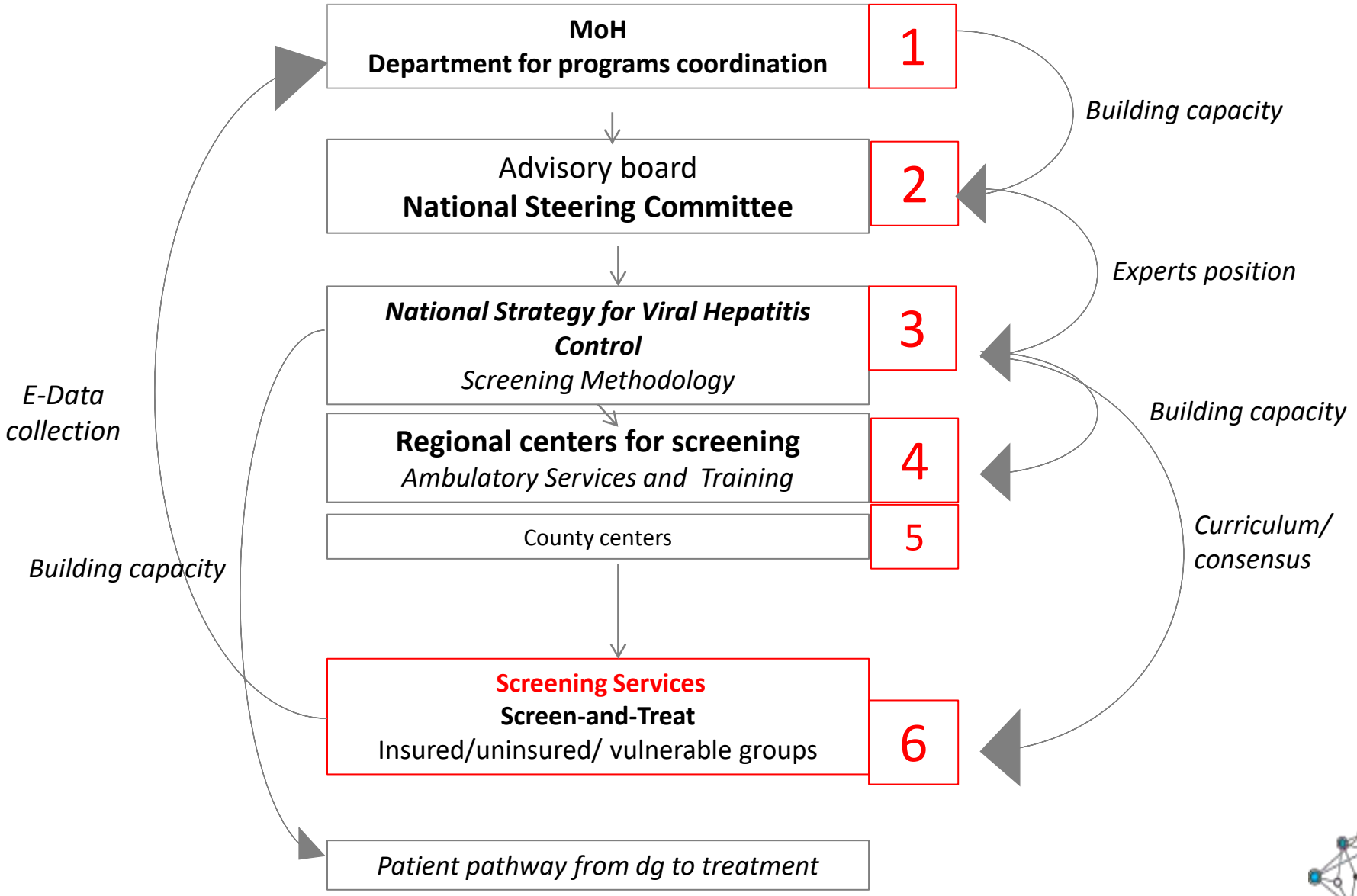
Major projects are large-scale investments with a value of more than EUR 50 million each, supported by the EU's cohesion policy funding. The projects directly benefit Member States and their citizens, by creating better infrastructure, a healthier environment, new jobs and new business opportunities.

Major Projects 2014-2020 submitted



…"Specific support will also be provided to social services, such as social assistance, health and care services"

Organizational Framework for Viral Hepatitis Elimination Program



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Romanian commitment for viral hepatitis control and elimination

Facts 2016-2021

2016
- Health Policy Decision from the Perspective of Stakeholders

2018
- National Plan for Control of viral hepatitis *approved*

2019
- Populational-based Screening program
  have started in the poorest – the prevalent regions

2021
- Screen–to–Treat for all - *including vulnerable/ uninsured*

National Plan Strategic Directions

Testing and diagnosing need to become routine

- Opportunistic testing so far, hence a reduced pool of known patients
- Until 2018, diagnostic and staging not in the basic service package
- From 2018, testing is available to insurees with referral from the family physician
- From 2018, diagnostic and staging available to insurees in hospitals (day care admission)
- From 2018, screening program in four regions under inception (funded from EU-grants)

Priorities

- Routine annual checks for adults to include HBV/ HCV testing
- Develop infrastructure for diagnosing and staging in public hospitals, including screening centers and mobile units
- Train and involve family physicians and community nurses
- Implement the screening program in four regions
- Collect screening data and use it to inform planning and guidelines

TARGET 2023

- ✓ National screening methodology
- ✓ Train 8.000 health professionals
- ✓ Test all health professionals
- ✓ Test 50% of risk groups population
- ✓ Diagnose 75% of patients with cirrhosis and HCC

SD 1. Information and communication

SD 2. Impactful interventions

SD 3. Equity of service provision

SD 4. Service delivery and financing

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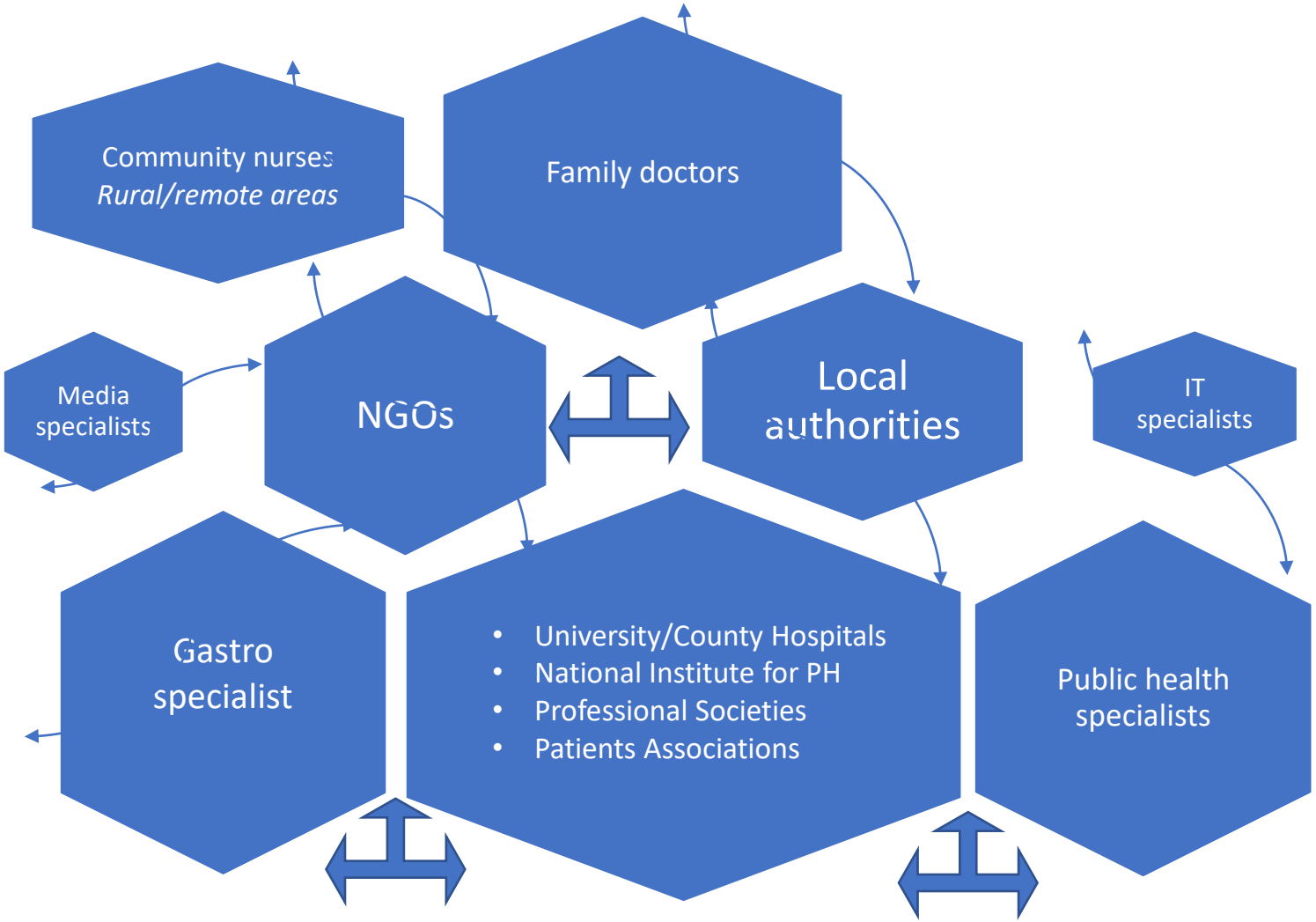
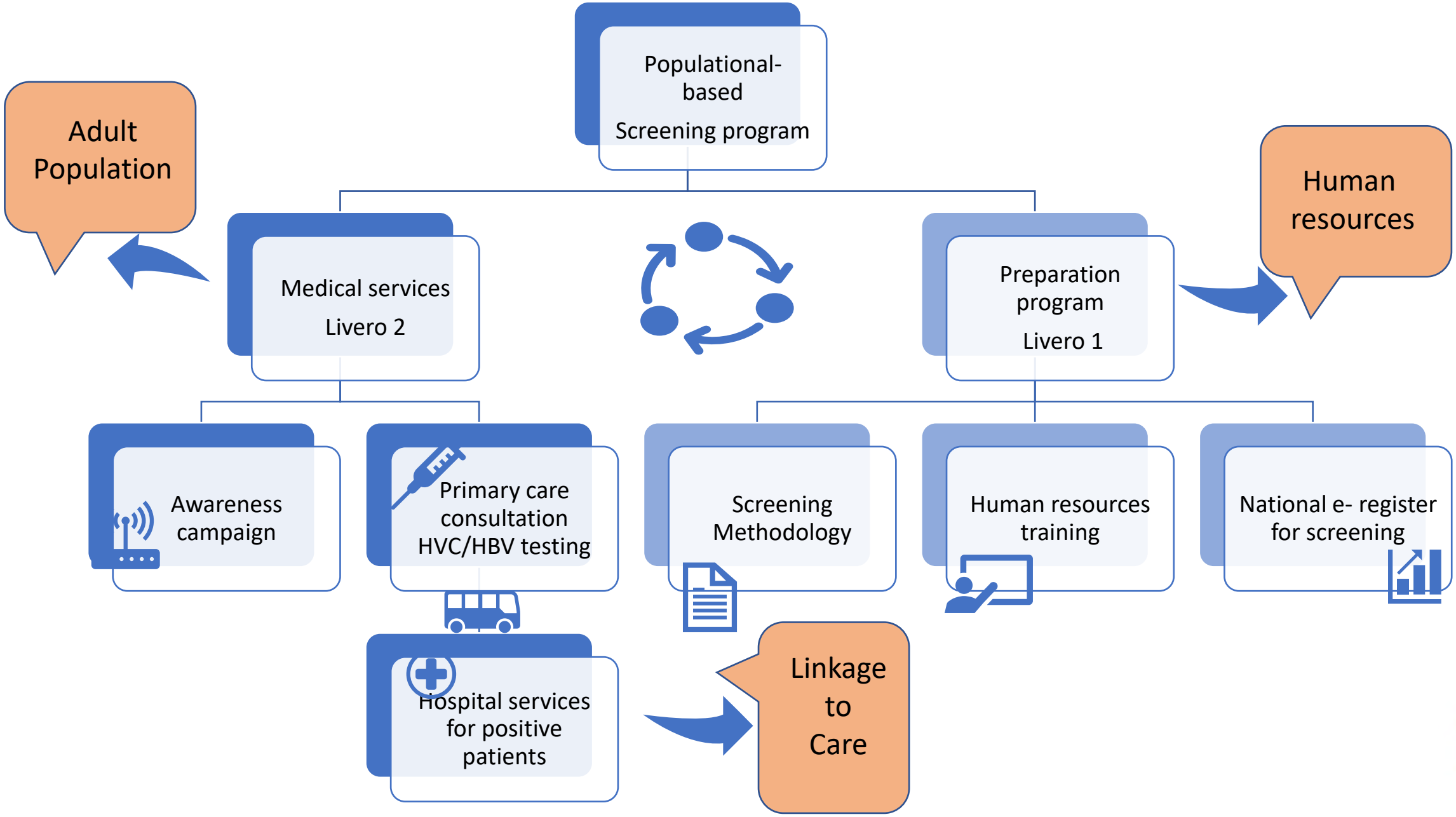
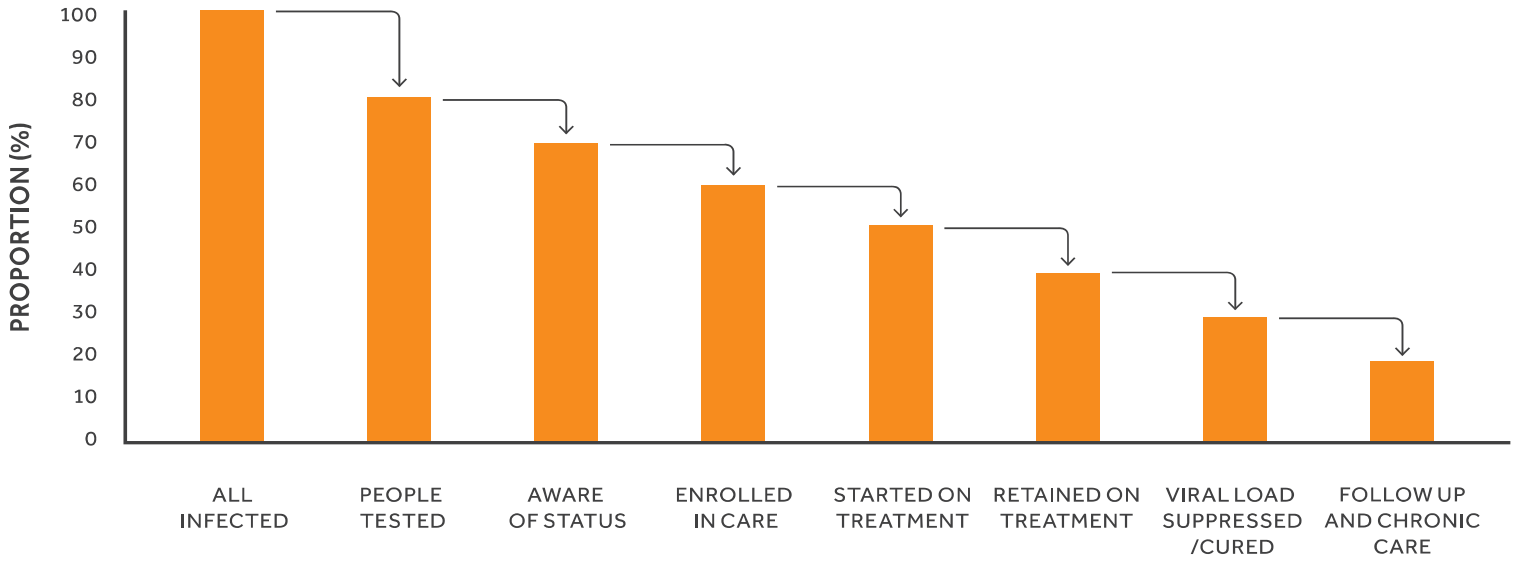
Human resources in Population-based Screening Program for Viral Hepatitis



Screening program for viral hepatitis



Conclusion
Complex interventions to eliminate chronic hepatitis
Before and after pandemic state



- Continue to work towards the WHO goal of eliminating viral hepatitis by 2030
- Trying to adapt the cascade-of-care to the COVID-19 situation
- Make modifications for safe delivery of services according to pandemic requirements

EUHCV

*Kali Zhou - Interventions to optimise the care continuum for chronic viral hepatitis: a systematic review and meta-analyses, The Lancet 2016

Prof Gamal Esmat

University of Cairo, Egypt

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The Success Story of HCV management in Egypt

World Health Organization

Prof. Gamal Esmat

Prof. Hepatology &Ex. Vice President of Cairo University, Egypt

Member of WHO Strategic Committee for Viral Hepatitis

www.gamalesmat.com

Magnitude of the problem

- Hepatitis C virus (HCV) is a major global health challenge with more burden in some countries like Egypt.
- Egypt **was** always considered to have the world's highest prevalence rates for HCV
- This extraordinary prevalence of HCV in Egypt is mostly due to the long lasted treatment campaigns against schistosomiasis conducted by the Egyptian Ministry of Health (MOH) during the period from 1950–1980.
- To combat such an epidemic, the Egyptian MOH launched on 2006 the National Committee for Control of Viral Hepatitis (NCCVH), to take the responsibility of managing the HCV epidemic in the country.
- The prevalent genotype in Egypt (genotype 4), was always one of the obstacles that prevent securing an effective therapy for HCV in the era of interferon.

Steps on the path of HCV elimination

Establishment of NCCVH

2006

2006 – 2014

Introduction of:

- Sofosbuvir/RBV **(SVR 82.7%)**
- Sofosbuvir/PegIFN/RBV **(SVR 93.9%)**

- Prioritization of advanced fibrosis and cirrhosis patients.

OCTOBER 2014

- Introduction of generic drugs.

- Main line of treatment is Sofosbuvir/Daclatasvir with without RBV **(SVR 94.7–95.4%).**

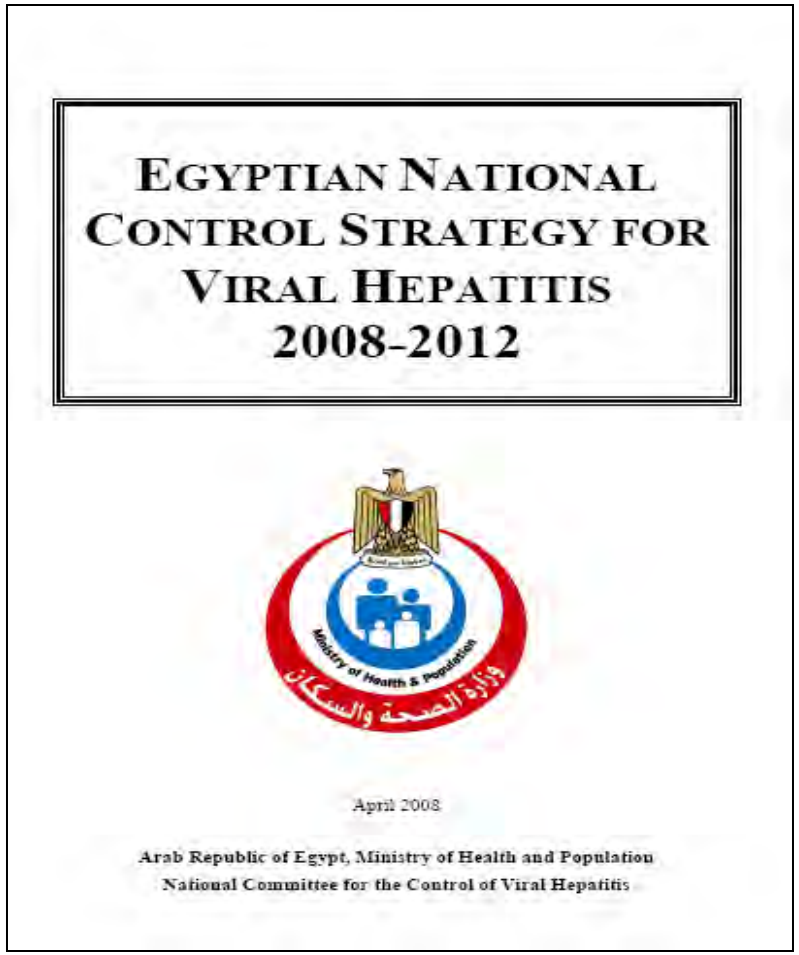
MAY 2015

DECEMBER 2015

October 2018

- In Sep mbitas with ribavi ed (SVR S I was prioritiz irment patie
- In Dec dipasvir o lines of t inor numb were treated u

Phase 1 Interferon Treatment for some Phase 2 DAA Treatment for All



- Increase policymakers' commitment to supporting the policy change necessary to prevent viral hepatitis transmission.
- Educate healthcare workers to prevent transmission of viral hepatitis in Egypt.
- Increase public awareness of viral hepatitis prevention.
- Promote safe injection practices in the community.
- Annual treatment of 200-350.000 patients by DAA.in 46 centers in 2015 aiming to reach 100 centers by the end of 2016

Egyptian National Plan of Action for the Preventton , Care & Treatment of Viral Hepatitis 2014–2018

Phase 3 Targeted screening for HCV in Egypt

Phase 4 Screening for All

- Families of HCV patients
- Healthcare providers
- Prisoners
- Students admitted to universities
- Patients attending intervention procedures in hospitals

مبادرة رئيس الجمهورية
للقضاء على فيروس سي
والكشف عن الأمراض غير السارية

Screening and Treatment Program to Eliminate Hepatitis C in Egypt

- Although participation in screening was voluntary, turnout was very high, with 49.6 million persons participating over a 7-month period.
- This is one of the largest disease screening campaigns in history.
- the present results show that the HCV seroprevalence among untreated persons is lower than that reported in the 2015 DHS(7.5% vs 4.5%)

- The economic burden of HCV infection in Egypt has been calculated previously, and it was estimated that the lifetime direct medical cost and indirect cost of disability and early death for a patient with HCV infection was in excess of $100,000 (in U.S. dollars).

- The cost of identifying and curing a patient in the current campaign was $131, which clearly shows the magnitude of cost saving by population screening.

Hepatitis C virus elimination: laying the foundation for achieving 2030 targets

- 2020 should also be remembered as a major milestone on the pathway towards elimination of hepatitis C virus (HCV) as a global public health threat

- *The World Health Organization (WHO)'s 2030 global elimination targets* for HCV are 80% of those eligible treated, 90% reduction in incidence of new infections and 65% reduction in liver- related mortality

- (October 2018 to April 2019) a remarkable 49.6 million **(79.4%)** people were screened

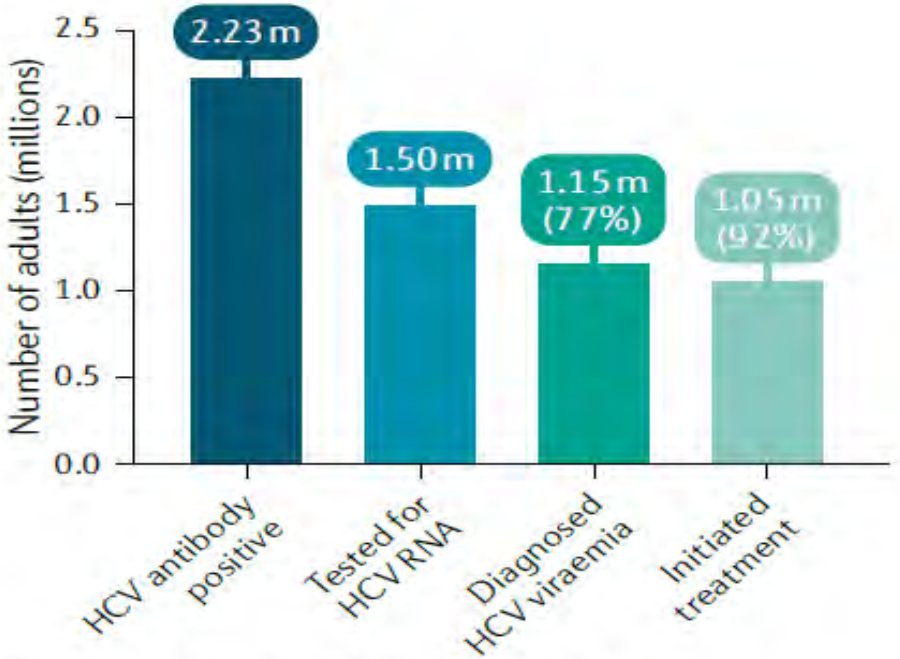
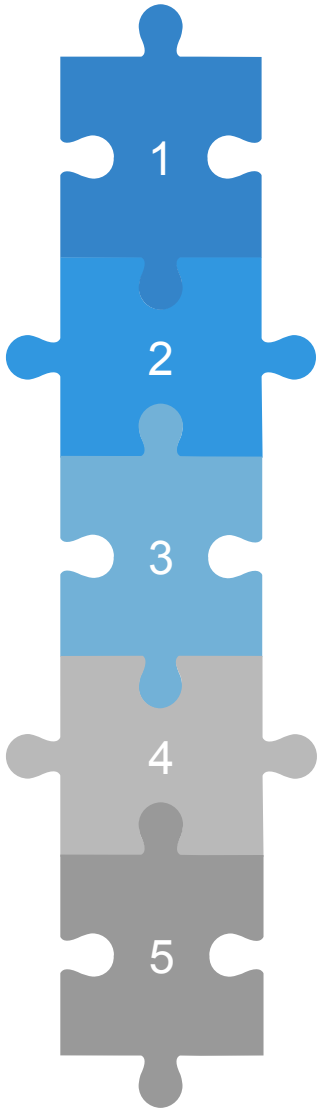


Fig. 1 | **Cascade of HCV care in Egypt.** Oct 2018–Sep 2019. HCV, hepatitis C virus. Data from REF.[6].

Just a few pieces to complete the puzzle



HCC surveillance in treated patients

- Accordingly, the targeted population includes ~400 thousand cirrhotic patients. (coverage is still around 10%)
- Cirrhotic patients are requested to perform abdominal ultrasonography and alpha-fetoprotein every four months.
- The program includes 92 screening centers, 63 radiology centers, 20 MRI centers, and 20 HCC multidisciplinary clinics.

Management of Treatment failures and difficult to treat populations

- Introduction of sofosbuvir/velpatasvir/ribavirin and SOF combined with velpatasvir and Voxilaprevir

Complimentary screening campaign with more emphasis on drop out cases

- A possible second check for those who were seropositive with HCV PCR negative results.
- Dropouts from the previous screening campaign could be targeted.
- Retesting of a selected sample from those with previously negative HCV antibodies to detect newly acquired HCV cases.

Need to have a new demographic health survey in 2021

Prevention and health education campaigns

To summarize…

- Egypt succeeded in establishing a useful model of care for HCV management in the country with the highest worldwide disease prevalence that was able to treat about 4 million patients.
- The sizeable Egyptian program relied on establishing a network of specialized viral hepatitis treatment facilities that provide integrated care for HCV patients.
- A sizeable nationwide screening program ‘100 Million Health campaign’ was conducted in Egypt over six months to screen more than 57 million citizens for HCV serology.
- One of the significant challenges facing Egypt after the successful HCV screening and treatment programs is the need to maintain this success by making more efforts towards prevention.

Discussion and Q&A

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Please wait. Session 5 will begin shortly.

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Session 5: What political response / leadership?

Chairs:
Dr Ricardo Baptista-Leite MP, UNITE, Global Network 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

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Mr Kostas Bakoyannis

Mayor of Athens, Greece

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

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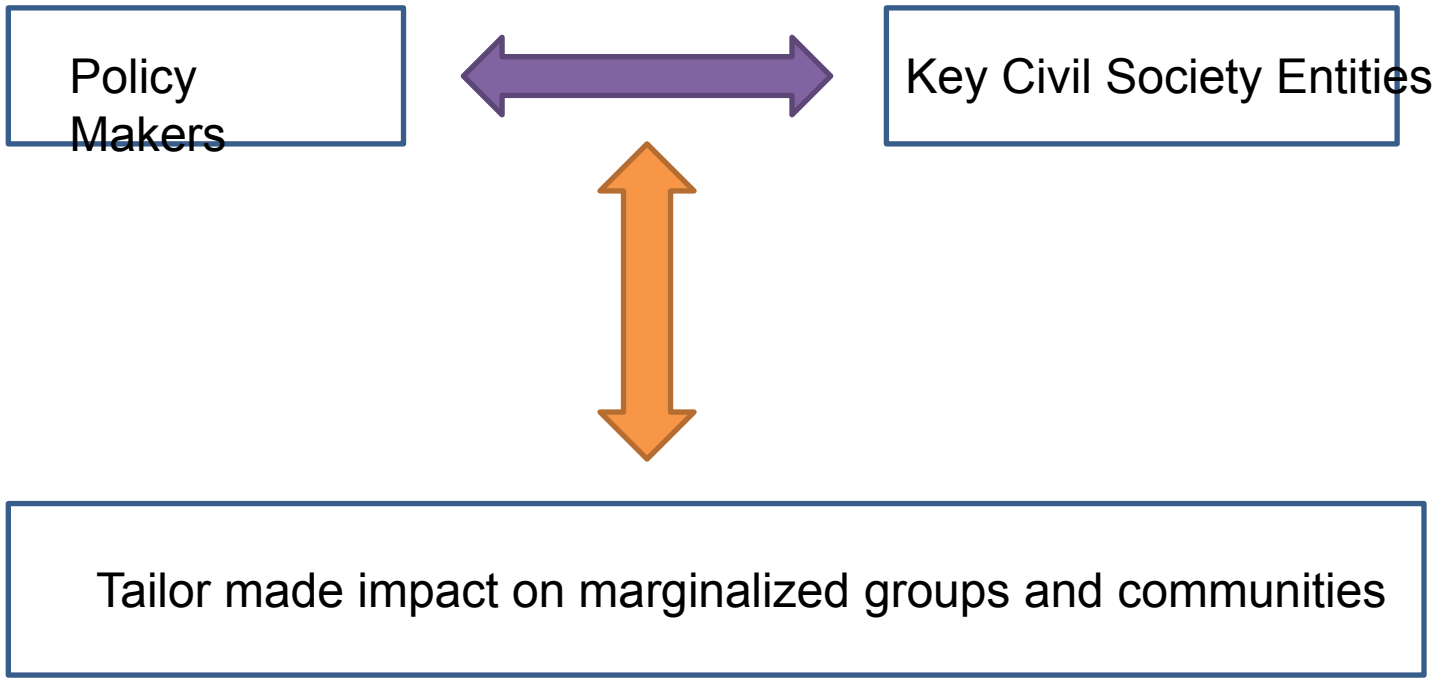
The ultimate goal

Facilitate effective communication between



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Thank you!

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Mr Aldo Patriciello and Mr Tomislav Sokol

Member of the European Parliament (MEP), Italy (video presentation) and MEP, Croatia

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Prof Jeffrey Lazarus

ISGlobal, Barcelona, Spain

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Panel discussion and Q&A moderated by session chairs

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Concluding remarks

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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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