3rd EU HCV Policy Summit

Securing Wider EU Commitment to the Elimination of HCV

Policy Summit - 24.03.2021

Online event
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#HCVSummit

Follow the team

@HepBCPPA
Welcome and introductory comments

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

#HCVSummit
@HepBCPPA
Prof Heiner Wedemeyer
Co-chair HepBCPPA and Hannover Medical School, Germany
Prof George Papatheodoridis
Co-chair HepBCPPA and University of Athens Medical School, Greece
Prof Maria Buti
EU Policy Councillor, The European Association for the Study of the Liver
EASL HCV initiatives

Maria Buti MD

EASL Policy and Public Health Chairperson
EASL HCV initiatives

➢ Healthcare professionals
➢ Policy makers
➢ Patients
➢ Healthcare systems
➢ National associations
➢ HCV partners
Initiatives for healthcare professionals

- ILC 2021: WHO - eCDC- CDC - EASL joint symposium on viral hepatitis elimination
- EASL Clinical practice guidelines
AT AN INTERNATIONAL LEVEL
Call to Action for HCV Elimination

• **Simplification** of diagnosis and treatment in 1 single step

• **Integration** of HCV treatment with:
  – Primary care
  – Programs of other pathologies (TB, HIV, …)
  – Hard-to-reach settings (damage reduction)

• **Decentralization** of HCV services

• **Share care chores** with other healthcare professionals
Initiative for policy makers and patients

➢ EASL Eliminating Hepatitis C – an action plan:

EASL Recommends:

1. Increasing awareness amongst HCPs, patients, policy-makers, the media and the public (especially high risk groups), whilst combating the stigma and discrimination that is associated with HCV infection

2. Implementing harm reduction strategies, such as access to opioid substitution therapy, safe injecting equipment for drug users and safe sex education

3. Making DAAs available at reasonable prices, to avoid any further reimbursement restrictions and to allow governments to implement a comprehensive elimination strategy

4. Improving access to treatment and care by increasing the number of authorised prescribers, promoting telemedicine and by increasing input from AHPs during and after treatment

5. Treating every Hepatitis C patient at the earliest opportunity, especially those at high risk

6. Providing rapid testing, in all relevant settings, with priority given to high-risk persons
Initiative for policy makers and patients

➢ EASL Policy statement on drug use and global hepatitis elimination goal

A time for change - EASL call to action

In order to achieve the 2030 WHO viral hepatitis elimination goals, EASL recommends:
that all barriers to the uptake of healthcare services by PWID be removed by changing policies and discrimination that hinder access. This includes the decriminalisation of minor, non-violent drug offences and the adoption of an approach based on public health promotion, respect for human rights and evidence.

www.easl.eu
Initiatives with patient groups

➢ EASL Patient Forum

➢ Declaration of support of EASL policy statement on drug use

Description:

Declaration of support

We support the European Association for the Study of the Liver (EASL) in its endeavour to achieve the 2030 WHO viral hepatitis elimination goals and EASL Policy Statement on Drug Use and the Global Hepatitis C Elimination Goal recommending that all barriers to the uptake of the healthcare services by people who inject drugs need to be removed by changing policies and discrimination that hinder access, including the criminalisation of minor, nonviolent drug offences and to adopt an approach based on public health promotion, respect for human rights and evidence.
Initiatives with partners

➢ EASL support to the EURO-TEST survey on Impact of the COVID-19 on linkage to and retention in care for HIV, hep B and C and sexually transmitted infections in the WHO European Region

➢ EASL support to the CGHE Global survey on the impact of COVID-19 response on hepatitis prevention care and treatment

Hepatitis Elimination countdown clock

Working together to eliminate Viral Hepatitis by 2030

Join us to eliminate hepatitis by 2030
EASL Special Conference on Hepatitis Elimination in Brussels

➢ Save the date: 23-25 February 2022 -
THANK YOU

Follow EASL: @EASLnews and @EASLedu
Mr George Kalamitsis
Co-Chair, ACHIEVE Coalition and Chair, Liver Patients International
ACHIEVE COALITION

George Kalamitsis, ACHIEVE Co-Chair
Dr Antons Mozalevskis
WHO Europe
Mr Petros Kokkalis
Member of the European Parliament (MEP), Greece
Third EU HCV Virtual Policy Summit
“Securing Wider EU Commitment to the Elimination of HCV”
HCV Infections (2016)
132,000 (1.1%)

Diagnosed 34%
Annual Treated 1%
Annual Deaths 790
Deaths per Day 2
Year of Achieving HCV Elimination Targets (Extrapolated from 2019 Data)
Current WHO Target is 2030

- 90% Diagnosed: 2032
- 80% Treated: 2051
- 65% ↓ in Mortality: 2051
- 80% ↓ in Incidence: 2051

HCV - GREECE
HCV Infections (2016)
9,283,000 (1.2%)

Diagnosed
34%

Annual
Treated
2%

Annual
Deaths
40,000

Deaths
per
Hour 5

Deaths
per
Hour 5
Year of Achieving HCV Elimination Targets (Extrapolated from 2019 Data)

Current WHO Target is 2030

- 90% Diagnosed: 2051
- 80% Treated: 2051
- 65% ↓ in Mortality: 2051
- 80% ↓ in Incidence: 2051

Year of 2015-2055
The EU’s response to HIV/AIDS, Tuberculosis and Hepatitis C

European Parliament Resolution of 5 July 2017

<table>
<thead>
<tr>
<th>No.</th>
<th>Call</th>
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<tbody>
<tr>
<td>1</td>
<td>Calls for a comprehensive EU Policy Framework addressing HIV/AIDS, tuberculosis and viral hepatitis</td>
</tr>
<tr>
<td>2</td>
<td>Calls for strengthening work with communities and vulnerable people ... the provision of services to the affected populations</td>
</tr>
<tr>
<td>3</td>
<td>Calls for the launch a multidisciplinary plan, which will standardise screening, testing and treatment protocols</td>
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<tr>
<td>4</td>
<td>Calls on the Commission and the Member States to ensure sustainable funding of national viral hepatitis elimination plans</td>
</tr>
<tr>
<td>5</td>
<td>Calls for an EU-wide harmonised infection surveillance programme that can detect outbreaks of viral hepatitis</td>
</tr>
</tbody>
</table>
• The European Parliament insists on the implementation of the Sustainable Development Goals

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

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

• EP will insist that a new plan be submitted.

• EP insists on funding research through projects such as Horizon

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

• **Committee Mandate**
  - References Hepatitis B and C as preventable risk factors for cancer
  - Identification of measures to increase vaccination and treatment for infections...

• **Contributed to the European Commission’s** Europe’s Beating Cancer Plan
  - Ensuring access to Hep. B vaccination and treatment for cancers associated with Hep. C

• Development of **BECA Committee Europe’s Beating Cancer Plan report**
  - Working document highlights focus on cancer prevention
  - Expected draft in May

ECDC Mandate

• European Commission presented a proposal to expand the legal mandate of ECDC:
  - “To reinforce surveillance: a strengthened, integrated surveillance system will be created at EU level, using artificial intelligence and other advanced technology”
  - “To improve data reporting: Member States will be required to step up their reporting of health systems indicators (e.g. hospital beds availability, specialised treatment and intensive care capacity, number of medically trained staff etc.)”

• Opportunities in tackling viral hepatitis
  - Improve the monitoring and surveillance of communicable diseases
  - Fill information gaps
  - Monitor progress towards elimination

• EP ENVI Committee
  - Expected adoption in July 2021
THANK YOU
Keynote addresses

Chair:
Prof Rafael Esteban Mur, Co-Chair HepBCPPA and University Hospital Vall d'Hebron, Barcelona, Spain
Mr John F Ryan
Director of Public Health, Country Knowledge, Crisis Management, DG SANTE, European Commission
Presentation by Mr Stefan Schreck
Third EU HCV Virtual Policy Summit
“Securing Wider EU Commitment to the Elimination of HCV

The clock is ticking

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

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

24 March 2021
WHO goal:
Elimination of viral hepatitis as a major public health threat by 2030

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

Action plan for the health sector response to viral hepatitis in the WHO European Region
Hepatitis at global level:

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

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

Progress is fragile

Accelerating access to hepatitis C diagnostics and treatment:
https://www.who.int/publications/i/item/9789240019003
Hepatitis in the EU, the EEA an the UK:

+/- 4.7 million cases of chronic hepatitis B.

+/- 3.9 million cases of chronic hepatitis C.

Prevention of hepatitis B and C in the EU, EEA and the UK:
ECDC monitoring framework for hepatitis B and C – some key findings:

• Vaccination is a key element in hepatitis B prevention strategies

• All countries have blood screening/heamovigilance systems in place to prevent hepatitis B and C via blood transfusions

• Some countries work with people who inject drugs and men who have sex with men

• +/- 1/3 of EU/EEA countries have no plan/strategy for hepatitis prevention

• Significant data gaps

Monitoring the responses to hepatitis B and C epidemics in the EU/EEA Member States
European Commission action on (hepatitis B) vaccination


• **HA-REACT Joint Action** addressed gaps in prevention of HIV/AIDS, TB and hepatitis among people who inject drugs.

  • Tested over 1,000 PWID for HIV or for hepatitis B and C
  • Distributed 44,500 condoms and 213,700 syringes / needles
  • Counselling services to 725 patients
  • Trained 1,300 health care workers in prison and community settings.
  • Mobile unit offering harm reduction services for PWID
  • Training on testing of HIV and HCV in Latvia and Hungary

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

- Support development of national hepatitis strategies, screening and treatment guidelines

- Introduce an integrated care model of hepatitis C care for at-risk populations, including PWID

- Tested more than 2,600 people in Romania, Spain, Ireland and the UK
  - over 1,000 (41.3%) were infected with viral hepatitis C
  - 650 (60.5%) were linked to care and 299 (43.5%) put on treatment

- Educated over 500 health care professionals

- Trained 29 peers for peer support

http://www.ucd.ie/medicine/hepcare/
Integrate - integrating prevention, testing and linkage to care strategies across HIV, viral hepatitis, TB

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

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

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

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

• Benefit on major non-communicable diseases
Prevention

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

Early detection

• Identification of asymptomatic infections
• Routine screening for hepatocellular carcinoma in individuals with chronic liver disease
Thank you!
Mr Alexis Goosdeel
Director, European Monitoring Centre for Drugs and Drug Addiction
The Elimination of Viral Hepatitis as a Public Health Threat in the EU: Keeping People Who Inject Drugs in Focus

Alexis GOOSDEEL, EMCDDA Director

Third European policy summit dedicated to the elimination of the Hepatitis C Virus (HCV) in Europe "Securing Wider EU Commitment to Eliminate HCV"
A high proportion of new HCV and HBV cases (transmission) occur among PWID
HCV-ab PREVALENCE IN PWID

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

Source: EMCDDA Rapid Communication DRID, 2019
INTERVENTIONS AMONG PWID

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

➢ Treatment:

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

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

➢ Large scale implementation requires a well-funded inclusive policy

* In modelling work, no real-life evidence yet
WHO TESTING AND POLICY TARGETS PWID

Source: EMCDDA, preliminary data
Policies should promote an integrated approach with HR services at the centre

It is cheaper to prevent a case than to (re)treat a case

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

It is within harm reduction services that PWID are better diagnosed, linked to care and treated

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

The elimination strategy is an opportunity to strengthen HR services and to prevent and treat other infectious diseases like HIV

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

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

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

The elimination strategy is an opportunity to prevent cases, cure patients and save resources if HR services are given the institutional support they need as essential services
Sustainable Development Goals 2030
GOAL 3: Good Health and Well-being

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

Prevention → Testing → Treatment and Care
Our objective
➢ To support EU Member States’ efforts in improving national practices in areas of harm reduction (HCV, DRD, etc.)

How?
➢ By producing a comprehensive toolbox with high-quality materials to support implementation

These structured tools provide a methodology to
➢ identify current barriers and facilitators to evidence-based action
➢ plan and implement effective responses

For whom?
➢ National and local decision makers & professionals working in the field
DRUGS SERVICES: ADVANTAGES

Definition: harm reduction and drug treatment facilities

✓ Opportunity to timely *identify* chronic carriers through active screening

✓ Ideal place make diagnostics and adequate treatment widely available (including treatment as prevention)

✓ Qualified and interested staff to organise efficient chain of care, including through peer workers

✓ Europe-wide treatment monitoring network

  e.g. in 2016: covering 4000 outpatient units treating 100,000 people who inject heroin
A high proportion of PWID entering treatment report not having been tested for HCV (LYP/ever)

Toolbox: HCV testing & referral to care

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

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

- Materials for action
  - Information material for drug services to raise awareness among staff
  - Knowledge Questionnaire
Module 1: The diagnostic process

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

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

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

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

Piloted in Luxembourg (Jan) and Poland (June);
Launch of the manual: beginning of 2020
Module 2: How to successfully reach PWID
11 case studies illustrating new Models of care

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

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

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

Compilation of 11 case studies from Europe illustrating **new models of HCV testing and treatment** that complement and replace traditional referral models
Module 3: Materials to support action

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

COMING BACK TO ESSENTIALS

...WITH THE EU FACING

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

...WE NEED MORE THAN EVER

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

Session 1: Progress in HCV elimination in Europe

Chairs:
Prof Massimo Colombo, San Raffaele Hospital, Milan, Italy
Prof Markus Peck-Radosavljevic, Klinikum Klagenfurt, Klagenfurt, Austria
Dr Homie Razavi
Centre for Disease Analysis, USA
Progress in HCV elimination in the European Union

H. Razavi
24 March 2021
By 2019, eight countries were on track to eliminate HCV by 2030 and another 14 countries before 2050 – COVID-19 has caused delays in all programs.
In 2019, 14% of all diagnosed patients were being treated, accounting for 5.6% of all HCV infections – not enough to reach the WHO 2030 elimination targets.

Polaris Observatory (https://cdafound.org/polaris-observ-access) Accessed 17 March 2021
In the EU, newly diagnosed cases peaked in 2016 and the number of treated patients peaked in 2017. Overall, total HCV infections and mortality have decreased.

With few national screening programs, it is harder to find new undiagnosed cases in EU.

Most countries have diagnosed HCV cases, but few are calling them in for treatment.

Screening & treatment programs in high-risk populations are bringing down prevalence.

More advanced patients are being treated, even with no restrictions, reducing mortality.
Unfortunately, the COVID-19 pandemic has resulted in a 55% reduction in treatment in 2020 across the EU (as compared to 2019)

Polaris Observatory (https://cdafound.org/polaris-observ-access) Accessed 17 March 2021
Low and middle-income countries have already demonstrated that large scale HCV testing and treatment programs are feasible

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

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

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

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

**Egypt:**
48 million adults were screened in 2018-2019 & 3.5 million were treated in 2015-2019.
Changing the viral hepatitis elimination targets to absolute numbers allows countries that have a low burden to achieve the new targets

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

<table>
<thead>
<tr>
<th>The EU countries meeting the current WHO Viral Hepatitis Elimination Targets</th>
<th>The EU countries meeting the absolute Viral Hepatitis Elimination Targets</th>
</tr>
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<tbody>
<tr>
<td>France</td>
<td>France</td>
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<tr>
<td>Spain</td>
<td>Spain</td>
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<tr>
<td>Austria</td>
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<td>Germany</td>
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<tr>
<td>Italy</td>
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<tr>
<td>Netherlands</td>
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The idea of absolute targets is not to stop the hepatitis programs. It is to recognize the low endemicity of HCV in the country.
Absolute targets may also be more appropriate in EU where injection drug use continues to be a main risk factor for new HCV infections.

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

Conclusions

• Prior to 2020, a number of countries in the EU were making progress toward HCV elimination – France, Spain, Austria, Belgium, Denmark, Finland, Germany, Netherlands, Norway and UK.

• HCV prevalence and mortality has been decreasing as the result of the national programs despite removing treatment restrictions.

• HCV treatment has been declining in the EU since 2017 since most national HCV elimination programs lack a wide scale screening strategy – running out of patients.

• Simplified national screening programs have been demonstrated in numerous LMIC. National screening is not impossible but may not be justifiable given the low prevalence.

• The EU countries should consider supporting absolute HCV elimination targets since overall burden and incidence are low.

• Reducing incidence in the EU will be a challenge for the foreseeable future until HCV vaccines or HCV PrEP are available.
Appendix
As of 2016, one person died of hepatitis C or B every 17 minutes in the EU

<table>
<thead>
<tr>
<th>Status</th>
<th>Polaris Estimate</th>
</tr>
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<tbody>
<tr>
<td><strong>HCV Infections (2016)</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnosed</td>
<td>43%</td>
</tr>
<tr>
<td>Annual Treated</td>
<td>5%</td>
</tr>
<tr>
<td>Annual Deaths</td>
<td>19,200</td>
</tr>
<tr>
<td>2 deaths</td>
<td>2 deaths</td>
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<tr>
<td>per hour</td>
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<table>
<thead>
<tr>
<th>Status</th>
<th>Polaris Estimate</th>
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<tbody>
<tr>
<td><strong>HBV Infections (2016)</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnosed</td>
<td>25%</td>
</tr>
<tr>
<td>Treated</td>
<td>5%</td>
</tr>
<tr>
<td>Annual Deaths</td>
<td>11,800</td>
</tr>
<tr>
<td>1 deaths</td>
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<tr>
<td>per hour</td>
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<table>
<thead>
<tr>
<th>Status</th>
<th>%</th>
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<tbody>
<tr>
<td>Birth Dose</td>
<td>26%</td>
</tr>
<tr>
<td>3+ Dose</td>
<td>87%</td>
</tr>
<tr>
<td>HBIG</td>
<td>58%</td>
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<tr>
<td>Tx Pregnant Women</td>
<td>18%</td>
</tr>
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</table>

Polaris Observatory ([https://cdafound.org/dashboard/polaris/dashboard_regions.html](https://cdafound.org/dashboard/polaris/dashboard_regions.html)) Accessed 17 March 2021
Prof Jeffrey Lazarus
ISGlobal, Barcelona, Spain
HCV Care Continuum and Barriers

Prof. Jeffrey V. Lazarus [Jeffrey.Lazarus@ISGlobal.org]
Associate Research Professor, ISGlobal, Hospital Clínic
Associate Professor, Faculty of Medicine, Univ of Barcelona
Vice-chair, EASL International Liver Foundation
The continuum of viral hepatitis services and the retention cascade

Outcome: the Consensus HCV CoC

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

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

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

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

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

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

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

CoC – Sweden

A useful tool for comparison among countries and over time.

# HCV policies

Red circles denote the existence of a policy.

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

White denotes the absence of a policy.

Eliminate late presentation

Fewer visits please...

What is an ideal MoC for HCV?

Much can be learned from examining innovative MoCs, which suggest that an effective MoC for HCV infection should be:

- Simple
- Targeted
- Multidisciplinary
- Scalable
- Integrated
- Patient-centred and affordable.

*Source*: Lazarus JV et al. We know DAAs work, so now what? Simplifying models of care to enhance the hepatitis C cascade. *J Int Med* 2019.
Different models of HCV care are needed for different HCV subpopulations for testing and treatment

Lazarus JV et al. We know DAAs work, so now what? Simplifying models of care to enhance the hepatitis C cascade. J Int Med 2019.
Hepatitis C standards of care: A review of good practices

- In addition to DAAs, we need evidence-based good practices to help countries eliminate viral hepatitis C.
- The tools required for elimination have largely been established, and the issue at hand is more how they should best be implemented.
- Good practices that have become standard of care in some settings include:
  - Reflex testing
  - Point of Care testing (including RDT and DBS)
  - HCV care in prison settings
- Good practices that should become the standard of care:
  Dried blood spot testing, Decentralised and community-based testing services, Treatment provision in non-clinical settings, Peer support, Retrieving those lost to follow-up, **Integrated testing**, Clinician reminders, Telemedicine, and Task-shifting

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

Former Organization: Patient travelled

New Organization: The sample and meds travel

Drug Treatment Unit

Specialized Care

Test and Treat

Drug Treatment Unit

Specialized Care

Case 2. T’n’T, Copenhagen Denmark

- Running from April 2019.
- Parked behind the main train station in Copenhagen, Denmark’s largest open drug scene
- Peer-led by Brugernes Akademi, Denmark, with on-site nurses.
- GeneXpert® machine in the van.
- Linkage to care at hospital – medicine can be delivered to the van.
HCV (micro-) elimination in certain populations is also feasible in the short-to-medium term.

- Decompenated cirrhotics
- Veterans
- Patients with haemophilia
- Patients with chronic kidney disease
- Transplant patients
- PWID
- HIV/HCV co-infected
- Incarcerated individuals


A paradigm change: 
The central role of people and communication

Source: Lazarus and France. A new era for the WHO health system building blocks? 2014
Putting it all together …

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

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

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

Contact: Jeffrey.Lazarus@ISGlobal.org
http://pathtozero.eiu.com/
Prof Sharon Hutchinson
Glasgow Caledonian University,
Glasgow, UK
Synergies of harm reduction and HCV elimination

Sharon Hutchinson

3rd EU HCV Virtual Policy Summit, 24th March 2021
Impact of harm reduction on acquisition of HCV infection among people who inject drugs (PWID)

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

- **Current OST associated with 50% reduction in HCV risk** (RR=0.5, 0.4-0.6)

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

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

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

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

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

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

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

Scale-up of DAA treatment and harm reduction needed in most settings in Europe to minimise HCV transmission among PWID.
Harm reduction services can increase HCV testing and treatment among PWID

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

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

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

- Evidence supports integration of HCV services in drug treatment settings

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

NHS Tayside ‘elimination’ plan*

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

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

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

(b) Impact on HCV prevalence among PWID in Scotland

<table>
<thead>
<tr>
<th>Year</th>
<th>Tayside</th>
<th>Rest of Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>13%</td>
<td>34%</td>
</tr>
<tr>
<td>2015-16</td>
<td>19%</td>
<td>32%</td>
</tr>
<tr>
<td>2017-18</td>
<td>20%</td>
<td>35%</td>
</tr>
</tbody>
</table>

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

Conclusions

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

Chairs:
Prof Angelos Hatzakis, Co-Chair HepBC PPA & University of Athens Medical School
Prof Nurdan Tözün, Acıbadem University School of Medicine, Turkey
Prof Stanislas Pol
Hôpital Cochin, Paris, France
Screening of the general population for HCV

EU HCV
24.03.2021
HCV diagnosis in the era of HCV elimination

Stanislas Pol, MD, PhD
Université de Paris
Département d’Hépatologie/Addictologie,
Hôpital Cochin

stanislas.pol@aphp.fr
Disclosures

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

**Grants**: Gilead, Roche, MSD
Interventions and targets

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

Global Report on Hepatitis, WHO, 2017
Elimination of hepatitis C in Iceland

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

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

Olafsson S et al., EASL 2019, Abs. THU-412
HCV screening: a multidisciplinary task

HCV care cascade by physician speciality

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

Rege S et al., EASL 2019, Abs. PS-066
**HCV screening: incitation**

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

- **58 Urban GP**
  - **8 control GP**
    - To screen at risk population
    - On demand screening: 31,738 eligible patients
  - **50 Educated GP**
    - £25 Subvention/patient:
      - Limit to 500 patients in 24 GP and no limit in 26
    - Targeted screening: 58,512 eligible patients

- Tested: 543 (1.7%) vs. 11,386 (19.5%)
- Non tested: 31,195 vs. 47,126
- Incidence ratio 3.7
  - p = 0.014

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

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

Paris, 26 September 2017

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

Universal (one-time in life) screening has been refused by the french High Authority of Health (HAS)
AntiHCV screening in the general population in last trimester 2019

Period 09-12/2019
10 143 participants screened for antiHCV

- Without medical prescription: n = 879 (8.7%)
- With medical prescription: n = 9 264 (91.3%)

Anti-HCV+
 n = 90 (0.89%)

- HCV RNA-: n = 60
- HCV RNA+: n = 9 (0.09%)

Excluded
- No sample: n = 20, treated n = 1

Treatment initiation
 n = 9 (100%)

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

HBV 0.57 %
HIV 0.34 %
Syphilis 1.42 %

5 220 questionnaires

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

HCV Screening in general population is not an accurate option

Pageaux GP, et al. AASLD 2020, Abs. 966
« Universal » screening in USA

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

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

Birth cohort screening makes sense

« Universal » screening in Egypt

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

<table>
<thead>
<tr>
<th>Variable</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening target population — no.†</td>
<td>32,207,165</td>
<td>30,298,399</td>
<td>62,505,564</td>
</tr>
<tr>
<td>Participated in screening — no. (%)‡</td>
<td>24,018,428 (74.57)</td>
<td>25,611,891 (84.53)</td>
<td>49,630,319 (79.40)</td>
</tr>
<tr>
<td>Previously treated for HCV infection with direct-acting antivirals since 2014 — no. (%)§</td>
<td>692,632 (2.88)</td>
<td>591,739 (2.31)</td>
<td>1,284,371 (2.59)</td>
</tr>
<tr>
<td>Screened for HCV antibodies — no. (%)§</td>
<td>23,325,796 (97.12)</td>
<td>25,020,152 (97.69)</td>
<td>48,345,948 (97.41)</td>
</tr>
</tbody>
</table>

HCV seropositive

| No. of adults | 1,252,443 | 976,885 | 2,229,328 |
| Percent (95% CI)¶ | 5.37 (5.36–5.38) | 3.90 (3.90–3.91) | 4.61 (4.61–4.62) |

1,501,307 participants $\rightarrow$ 76.5% HCV RNA+ $\rightarrow$ 91.8% started DAA $\rightarrow$ 65.1% completed

98.8% SVR

Waked I et al. NEJM 2020
« Universal » screening in USA

- * Age-based screening

- **At least once in adults > 18 years and in all pregnant women except in settings where HCV prevalence is <0.1% 

- **Any person who request HCV testing

- All persons with risk factors and periodic testing while the risk persist

- One-time HCV testing among persons with recognized risk factors or exposure

Persons with underlying medical conditions

- Beckett GA et al. MMRW Recomm Rec 2012
- ** Schillie S et al. MMRW 2020
Universal screening (once in 18-80 years is the most effective screening strategy and is cost-effective (€31,000/QALY)

Schillie S et al. MMRW 2020
Deuffic-Burban S et al. J Hepatol 2018

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

Universal screening is cost-effective

Cost-effectiveness of screening adults >18 years: incremental ICER $11,378 per QALY vs. baby-boomers policy
Risk-based screening in high-risk population

The most cost-effective

- (HIV coinfected)
  - MSM
  - Prisonners
  - Migrants
  - PWID
  - PWID under OST

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

Remy A-J. BEH 2017

Prevalence: >3-fold higher than the general population
Limited screening

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

Hill A et al. J Viral Erad 2017
Early screening in migrants

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


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

HBV infection
- HBsAg+ (n=257)
  - Chronic HBV infection (n=70)
    - Initiated NUC therapy (n=55)
      - Achieved HBV-DNA suppression at 12 months follow-up (n=47)

HCV infection
- Anti-HCV+ (n=24)
  - HCV-RNA+ (n=18)
    - Initiated DAA treatment (n=15)
      - Achieved SVR12 (n=14)

HIV infection
- HIV+ (n=57)
  - Initiated cART (n=57)
    - Achieved viral suppression at 12 months follow-up (n=34)
Screening in hidden or forgotten population

« Profile »-based screening: mental illness

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

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

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

Kesat V, Etats-Unis, AASLD 2019, Abs. 539
Risk-based screening in high-risk population

The most cost-effective

**PWID**

(HIV coinfected)

**MSM**

**PWID under OST**

**Prisonners**

**Migrants**

- **Prevalence:** 4.3-6.7%
  - Screening in 36-70%:
    - 46% HCV RNA+
    - 3.9-46% treated
- **Prevalence:** >3-fold higher than in the general population

**Mental illness**

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

**Limited screening**

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

Hill A et al.  J Viral Erad 2017

Remy A-J. BEH 2017
Screening in “low-risk” population

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

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

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

Characteristics of the 12 HCV patients screened

\[
\begin{align*}
\text{HBsAg+} &= 0.26 \\
\text{Anti-HBc+} &= 4.32 \\
\text{HBV DNA+} &= 0.13 \\
\text{Anti-HCV+} &= 0.44 \\
\text{HCV RNA+} &= 0.07
\end{align*}
\]

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

Consider combining anti-Covid19 screening with HBsAg & anti-HCV testing?
To adjust the screening tools to delocalized situations

Saliva or blood rapid antibody test

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

Point-of-care PCR test

Automated orders: antiHCV+ = HCVRNA

Test and treat

Screening of the general population for HCV

• Screening of the general population is the best policy, is cost-effective but is not usually recommended by health authorities at least in low-endemicity regions.

• Screening should be mainly based on risk factors and has to be delocalized with a reflex testing which allows a «test and treat» policy.

• HCV elimination is feasible if screening and access to care are facilitated by the health care system without fibrosis restriction and with harm reduction policies.
Dr Lina Nerlander
European Centre for Disease Prevention and Control
European Centre for Disease Prevention and Control

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

Dr. Lina Nerlander
HCV policy summit, March 24 2021
Sustainable development goals (SDGs)

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

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

ECDC works to monitor progress towards the SDGs

WHO European Action Plan sets specific targets for hepatitis

Action plan for the health sector response to viral hepatitis in the WHO European Region (2017)
Hepatitis monitoring system for the EU/EEA

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

Source: Monitoring of the responses to the hepatitis B and C epidemics in EU/EEA Member States, 2019, ECDC
Data availability for hepatitis continuum of care, EU/EEA 2019

WHO target for proportion diagnosed: 50%

Proportion diagnosed = \( \frac{\text{Numbers diagnosed}}{\text{Numbers chronically infected}} \)

Only 16 countries had sufficient data on both.
Proportion of people living with HCV who have been diagnosed in the EU/EEA, 2017 (n=16 countries)

*Data represent England and Scotland only

**Source:** Monitoring of the responses to the hepatitis B and C epidemics in EU/EEA Member States, 2019, ECDC

Data limitations and the way forward

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

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

ECDC work on improving data:
- EU Hepatitis Network
- Technical support to countries
- Facilitate collaborations with clinicians
- Support countries to do surveys of prevalence
- Mathematical modelling

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

Current indicator (proportion diagnosed) challenging to interpret across countries

Developed additional indicators with advisory group
- Numbers undiagnosed per 100,000 population
- Diagnosed in reporting year per 100,000 population
Are people diagnosed in time?

ECDC monitors:
Proportion of newly diagnosed people with end stage liver disease

- Only 10 countries were able to report data

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

- Validity concerns – work ongoing

Source: Monitoring of the responses to the hepatitis B and C epidemics in EU/EEA Member States, 2019, ECDC
Testing is sub-optimal among people who inject drugs (PWID)

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

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

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

Improving testing among PWID

Identifying barriers

Learning from documented models of care

Testing among prisoners

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

HCV prevalence in prisoners: 2.2%–45.8%

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

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

Testing during prison stay also important

Sources:
The elimination barometer for viral hepatitis among PWID in Europe. Technical report, EMCDDA.
Public health guidance on prevention and control of blood-borne viruses in prison settings, ECDC
Systematic review on active case finding of communicable diseases in prison settings
Monitoring of the responses to the hepatitis B and C epidemics in EU/EEA Member States, 2019, ECDC
ECDC testing guidance

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

Testing coverage and test positivity rates often high in these settings

Non-medical providers
Rapid testing
Dry blood spot testing

Source: Public health guidance on HIV, hepatitis B and C testing in the EU/EEA, ECDC
Testing among migrants

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

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

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

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

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

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

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

- Learn from good practices

- Improve data collection and reporting
Thank you!

Lina.Nerlander@ecdc.europa.eu
Panel discussion and Q&A
Session 3:
COVID-19 and HCV

Chair:
Prof Harry LA Janssen, Toronto Western and Toronto General Hospital, University Health Network, Toronto, Canada
Prof Alessio Aghemo,
Humanitas University Hospital,
Milan, Italy
COVID-19 and HCV

Impact on HCV elimination

Alessio Aghemo, MD, PhD

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

<table>
<thead>
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<th>Category</th>
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<td>Grant and research support:</td>
<td>AbbVie, Gilead Sciences</td>
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<td>Advisory committees:</td>
<td>Merck, Gilead Sciences, AbbVie, Mylan, Intercept and Alfasigma</td>
</tr>
<tr>
<td>Speaking and teaching:</td>
<td>Merck, Gilead Sciences, Abbvie, Mylan and Alfasigma</td>
</tr>
</tbody>
</table>
COVID-19 in Humanitas (Milano Italy)

COVID patients in the hospital and NON-COVID patients in ED

COVID PATIENTS IN ICH
NON-COVID PATIENTS IN ED
### How to Set Up a Liver Clinic During the Covid-19 Pandemic

<table>
<thead>
<tr>
<th>Chronic hepatitis (viral and others)</th>
<th>Autoimmune and cholestatic disorders</th>
<th>Cirrhosis</th>
<th>HCC</th>
<th>Transplant</th>
</tr>
</thead>
<tbody>
<tr>
<td>F2F clinic</td>
<td>Postpone monitoring for NASH, HCV, HBV</td>
<td>Postpone monitoring for PBC, PSC</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Virtual clinics</td>
<td>Yes (AEs)</td>
<td>Yes (weight, symptoms)</td>
<td>Yes (AEs)</td>
<td>Yes (AEs)</td>
</tr>
</tbody>
</table>

- **Dispense drugs through territorial pharmacy:**
  - Yes

- **Treatment**
  - Start pharmacological treatment only when urgent
  - Start immunosuppression when needed
  - Do not change routine practice
  - Start drug treatment when needed
  - Relevant decrease in donor availability

- **Invasive procedures and surgery**
  - Avoid liver biopsy
  - Avoid liver biopsy
  - Maintain slots for invasive procedures in COVID-19-free facility
  - Reduce surgery (lack of ICU)
  - Maintain slots for invasive procedures in COVID-19-free facility

- **Diagnostics**
  - HCC surveillance in COVID-19-free hospital
  - HCC monitoring in COVID-19-free hospital

- **Special Indications**
  - Continue HCC board meetings

---

*Sun J et al, Liver International 2020*
The AISF Survey on Hepatological Activity in Italy

Aghemo A et al, DLD in press
The AISF Survey on Hepatological Activity in Italy

Figure 2A

<table>
<thead>
<tr>
<th>Service</th>
<th>Reduced</th>
<th>Stopped</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Patient</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>Day Hospital</td>
<td>45%</td>
<td>35%</td>
</tr>
<tr>
<td>Day Service</td>
<td>25%</td>
<td>20%</td>
</tr>
</tbody>
</table>
The AISF Survey on Hepatological Activity in Italy

Figure 6
Impact of COVID-19 on Hepatitis C Screenings in Ambulatory Clinics and Emergency Departments

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

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

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

RNA, ribonucleic acid.
Impact of COVID-19 on Global HCV elimination efforts.

Blach S et al, J Hepatol 2021
Impact of COVID-19 on Cumulative Liver Related Deaths (2020-2030)

Blach S et al, J Hepatol 2021
Number of Patients Starting DAAs in Italy
Covid-19: A Tool to Increase HCV Awareness
## HCV Screening in Southern Italy

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

*Masarone M et al, AISF 2021*
Positive Impact of The Covid Pandemia on HCV Management

Decentralization of cure
   Drug dispensing
   Non specialist care

Simplification of Treatment
   No monitoring

Increased focus on viral diseases

HCV Screening during COVID-19 Vaccination
3rd EU HCV Policy Summit
Securing Wider EU Commitment to the Elimination of HCV

Q&A
Session 4a: Introduction to breakout sessions on Best Practices at the National level

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

CONTINUUM OF SERVICES - CASCADE OF CARE

NEW INFECTIONS

DEATHS
The road to HCV elimination is complex

1. Awareness and prevention
2. Testing and diagnosis
3. Linkage to care and access to qualified health services
4. Access to medication
5. Monitoring and evaluation

Barriers and gaps on the way to HCV elimination

- Patient
- Practitioner
- System
- Policy
A PATIENT centered care for HCV

Simplification:
• Diagnostic and treatment algorithms – 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

WHO’s treat-all strategy could bring about appreciable prevention benefits, although greater benefits per treatment can be achieved through targeting PWID.
Overcoming the barriers and gaps on the way to HCV elimination

Barriers and gaps need to be addressed and solutions need to be found and subsequently funded

“Secure Wider EU Commitment to the elimination of HCV”
Overcoming barriers and gaps on the way to HCV elimination

**Patient level:**
- Clinical Practice Guidelines,
- Patient Forum

**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

Countries on track to reach the WHO elimination 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

Immediate action to improve HCV screening and treatment is needed to make the WHO's elimination targets attainable by 2030.

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

“A clinical perspective”
Rui Tato Marinho, Lisbon, Portugal

“A harm reduction perspective”
Philip Bruggmann, Zurich, Switzerland

“A laboratory/technological perspective”
Mario Poljak, Ljubljana, Slovenia
Breakout session B

National elimination plans

Updates on progress

UK
Mark Gillyon-Powell

Spain
Pilar Aparicio Azcárraga

Italy
Loreta Kondili

Israel
Yuval Dadon
Breakout session C

Best practice case studies

HepCare Project
DUBLIN
John Lambert

OST Programme
LISBON
Rodrigo Sousa Coutinho

HR and consumption rooms
PODGORICA
Ivan Vukovic
Presentation by Dr Nebojsa Kavaric

Alexandros
THESSALONIKI

Aristotle HCV
ATHENS
Vana Sypsa
Breakout session D

Best practice case studies

Microhepcero Catalonia
SPAIN
Joan Colom Farran

ACE
ITALY
Marco Bartoli

Building on success: Viral Hepatitis Elimination Strategies in Romania
ROMANIA
Cora Pop

National HCV Elimination
EGYPT
Gamal Esmat
Session 4a. Introduction to breakout sessions on Best Practices at the National level

- There are four breakout sessions

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

- Please click on the session you would like to attend

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

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Securing Wider EU Commitment to the Elimination of HCV

Breakout Sessions are ongoing!

Please choose your preferred session in the virtual platform.
Session 5 will resume at 17:30 CET
Session 5:
What political response/leadership?

Chairs:
Dr Ricardo Baptista-Leite MP, UNITE, Global Parliamentarians Network to End Infectious Diseases
Dr Manuel Carballo, International Centre for Migration, Health and Development, Switzerland
Mr Cristian-Silviu Bușoi
Member of the European Parliament (MEP), Romania
3rd EU HCV Policy Summit
Securing Wider EU Commitment to the Elimination of HCV

Mr Cristian-Silviu Buşoi (video presentation)
Mr Kostas Bakoyannis
Mayor of Athens, Greece
Municipality of Athens tackles HCV and viral diseases
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
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
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
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)
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
The ultimate goal

Facilitate effective communication between

Policy Makers

Key Civil Society Entities

Tailor made impact on marginalized groups and communities
Thank you!
Mr Aldo Patriciello
Member of the European Parliament (MEP), Italy
3rd EU HCV Policy Summit

Securing Wider EU Commitment to the Elimination of HCV

Mr Aldo Patriciello (video presentation)
Mr Tomislav Sokol
Member of the European Parliament (MEP), Croatia
Prof Jeffrey Lazarus
ISGlobal, Barcelona, Spain
Call to Action

Prof. Jeffrey V. Lazarus [Jeffrey.Lazarus@ISGlobal.org]
Associate Research Professor, ISGlobal, Hospital Clínic
Associate Professor, Faculty of Medicine, Univ of Barcelona
Vice-chair, EASL International Liver Foundation
Call to Action

Call to Action for a Europe free of hepatitis C

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

Introduction

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

- In the European Union (EU), more people die each year from hepatitis C than from AIDS.[2]

www.hcvbrusselssummit.eu

#EliminateHCV #NoHep
@HepBCPPA
Call to Action Working Group

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

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@HepBCPPA
Action Points

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

1) Ensure that data on the impact of the COVID-19 pandemic on efforts to eliminate hepatitis C is collected and analysed and that the findings are published in an official report

Relevant agencies such as the ECDC, EMCDDA and the WHO Regional Office for Europe should collaborate on regularly collecting assessing and publishing data from all Member States. The official report should include recommendations and a roadmap for getting elimination efforts back on track.

2) Make hepatitis C elimination in Europe an explicit and adequately resourced public health priority

Hepatitis C elimination should be pursued using appropriate means at all levels – through collaboration between individual citizens, civil society organisations, healthcare professionals, medical associations, researchers, the private sector, local and national governments, European Union institutions – including the European Commission, ECDC, EMCDDA and the WHO Regional Office for Europe. The new EU public health programme, EU4Health, must ensure that hepatitis C elimination is advanced through the adequate funding of projects which promote prevention, diagnosis and linkage to care in all countries.

3) Ensure every country has a published national viral hepatitis elimination action plan or strategy, and that key stakeholders are involved in developing and implementing these plans

Where national viral hepatitis elimination plans/strategies do not exist, developing and publishing a plan should be prioritised. Every country should ensure that patients, civil society groups and other relevant stakeholders – including at-risk groups – are directly involved in developing and implementing such plans. Surveillance and tracking of HCV cases and mortality, as well as agreed markers to monitor implementation, should be in place. Existing best practice examples and guidelines should serve as the basis for people-centred, health system-based strategies that emphasise tailored implementation at the local level.

4) Ensure integrated care pathways are included in national plans/strategies

Make the development of integrated care pathways a core component of viral hepatitis elimination plans/strategies, taking into account the specific health system barriers and other challenges related to the management of viral hepatitis infection, such as community-based care, for example, harm reduction services, which may not be linked to the national health system. Implementation of integrated care pathways should embed monitoring of their effectiveness over time.

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

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

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

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

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

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

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

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

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

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

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Panel discussion and Q&A
Concluding remarks
Prof Heiner Wedemeyer
Co-Chair HepBCPPA and Hannover Medical School, Germany
Prof George Papatheodoridis
Co-chair HepBCPPA and University of Athens Medical School, Greece
3rd EU HCV Policy Summit
Securing Wider EU Commitment to the Elimination of HCV

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