



ACHIEVE

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

Stories to inspire

How national, regional and local initiatives are helping to achieve viral hepatitis elimination

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ACHIEVE (Associations Collaborating on Hepatitis to Immunize and Eliminate the Viruses in Europe) is a multi-stakeholder coalition bringing together the hepatitis community in Europe, including patients, clinicians, NGOs working with at-risk groups and public health experts.

The following organisations are engaged as full members of the coalition through their representatives:

EASL International Liver Foundation, the World Hepatitis Alliance, the European Liver Patients' Association (ELPA), the Hepatitis B and C Public Policy Association, the Barcelona Institute for Global Health (ISGlobal), the European AIDS Treatment Group (EATG), the Correlation Network, and the Viral Hepatitis Prevention Board (VHPB). The coalition was officially launched on 6 June 2017 during an event in the European Parliament hosted by then-MEP Karin Kadenbach (S&D, Austria).

ACHIEVE is in regular dialogue with public institutions such as WHO Europe, the European Centre for Disease Prevention and Control (ECDC), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), and Health Protection Scotland.

The work of the coalition is financially supported by Abbott, AbbVie, CEPHEID and Gilead Sciences.



INTRODUCTION

ACHIEVE CHAIRS

The fight against hepatitis, a health target enshrined in the UN Sustainable Development Goals (SDGs), is not on track. If we want to meet the WHO goal of eliminating viral hepatitis by 2030 as a public health threat, all stakeholders will have to step up their efforts.

This is true not only globally, but also for the WHO European Region and, within that, European Union Member States. Better prevention, better detection of those infected, and better linkage to care for those outside the health system is needed. Beyond public health policy, reducing inequalities and supporting marginalised members of society will also be essential as viral hepatitis disproportionately affects the most vulnerable members of our societies.

A pan-European effort is needed to ensure that the WHO elimination target is met by 2030. Elimination of viral hepatitis is a unique opportunity which will end the suffering of millions of people. It will also curb the burden of related diseases, such as primary liver cancer which could reduce hepatitis-related deaths by more than 65%.

The following pages showcase initiatives to fight viral hepatitis from across Europe. Many of these examples are led by civil society. They offer inspiration to policymakers by demonstrating citizen-led efforts to achieve elimination. There are examples at local, regional or national level, with some initiatives targeting specific risk groups.

Of course, this is by no means an exhaustive list. Nonetheless, it is clear not only that many more of these types of initiatives are needed, but that more political support to develop and implement coordinated and horizontal policy actions is essential if elimination by 2030 is to be realised.

We hope that you will find these examples as inspirational as we do. They demonstrate societies' will to combat viral hepatitis. What is needed now is political action to match this desire. It is time to eliminate viral hepatitis!



Tatjana Reic
ACHIEVE Chair



Luis Mendao
ACHIEVE Vice Chair

MESSAGE OF SUPPORT

I am encouraged to read this collection of inspirational initiatives from across Europe which demonstrate a true determination to deliver viral hepatitis elimination. They highlight the scale of the challenge society faces in addressing the elimination, but also demonstrate how coordinated action can make a real difference.

These efforts now need to be complemented by supporting policies at an EU level. In 2017 the European Parliament adopted its Resolution on the EU's Response to HIV/ AIDS, Tuberculosis and Hepatitis C, calling on the European Commission and Member States to develop a comprehensive policy framework to fight these epidemics and deliver on the EU's commitments to achieve the UN SDGs. The European Commission's Staff Working Document¹ of 2018 provides a thorough situation analysis of what needs to be done ensure that the WHO goal of eliminating viral hepatitis as a public health threat by 2030 is met. The European Commission's document highlights:

- the need to scale up prevention and harm reduction if there is to be an impact on transmission;
- to increase treatment uptake, screening programmes would need to be scaled up to find undiagnosed individuals and link them to care;
- and that the social dimension of these diseases is a major factor affecting the ability to tackle them as epidemics and to eliminate them in the EU.

Based on this analysis, the European Commission needs to adopt a comprehensive EU action plan to eliminate viral hepatitis, HIV/ AIDS and tuberculosis early in the new legislature. Such a plan has to include effective horizontal policies and funding mechanisms across different sectors, both within the EU and beyond. It also needs to spell out the responsibilities that the European Commission and relevant agencies, Member States and stakeholders will have. Given that we only have 10 years left to achieve the WHO target of eliminating hepatitis C by 2030, time is of the essence and we must act now.



Dr. Cristian-Silviu Busoi MEP
Chair of the European Parliament Committee on Industry, Research and Energy (ITRE) and former Vice-Chair of the Committee on Environment, Public Health and Food Safety (ENVI)

¹ on Combatting HIV/AIDS, viral hepatitis and tuberculosis in the European Union and neighbouring countries - State of play, policy instruments and good practices

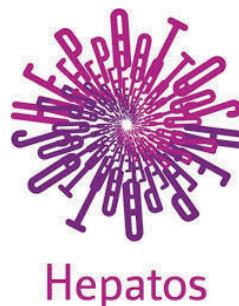


CASE STUDIES

- 1 **Mobile InfoHep Centre** - CROATIA
- 2 **Fixpunkt e.V.** - GERMANY
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- 4 **Emergis** - NETHERLANDS
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WHAT?

The Mobile InfoHep Centre is a mobile medical vehicle, designed to directly link patients to care services and equipped with the latest diagnostic tools. It is manned by an expert team consisting of local public health experts, local physicians and civil society volunteers. Besides carrying out awareness raising activities, the mobile unit provides testing services, pre and post-test counselling, liver elastography and a physician point of contact to link diagnosed patients to appropriate treatment and care. This innovative model is the first of its kind and, to date, it remains the best and the most complete system of linkage to care in the Balkan region.



WHY?

It is estimated that in Croatia 40,000 people (0.9% prevalence) are currently infected with hepatitis C. However, an average of only 200 newly diagnosed cases are officially reported every year. Lack of awareness, stigma and political turmoil mainly account for the low rate of identified patients in this part of the Balkans. A large rural population, lack of awareness of risk factors and symptoms, low GDP and geographical isolation (a significant part of the national territory consists of over 1,200 small islands) also affect accessibility to appropriate healthcare facilities and specialist care.



HOW?

The medical vehicle is equipped with the latest testing tools, including:

- Free and anonymous saliva testing for HCV and HIV antibodies (100 samples can be tested at the same time and test results are available after 20 to 40 minutes)
- A mobile PCR machine which can confirm the RNA of the virus and which can run up to four tests at the same time and deliver results within 40 minutes.
- Transient elastography (Fibroscan) to assess the liver damage of patients diagnosed as positive.

The team also provides peer education to local GPs on how to identify people at risk and on the best treatment options. The team also provides counselling to those infected and their families and engages in awareness raising activities to educate people about liver health and avoiding the risks associated with viral hepatitis infection.



COOPERATION

Hepatos works closely with organisations which have specific access to risk groups, such as rehabilitation centres for people who are injecting drugs (PWIDs) and prisoner and veteran organisations. This allows them to tailor their message to the different audiences in order to build trust. All activities are also carried out in collaboration with local public health experts, local civil society organisations and physicians from local or regional hospitals.

ACHIEVEMENTS

Since the mobile unit started its activity, the number of annually reported diagnoses from the Split - Dalmatia County (SDC) region increased significantly, from only 39 people reported in 2012 to 102 in 2018. At the same time, the number of annually treated patients in Croatia increased from 300/year in 2016 to 440 in 2018. This significant increase in the diagnosis rate has encouraged experts to promote and implement these good practices outside the SDC region and across the whole country.

LEARNINGS

Inter-sectorial collaboration, joint action and teamwork have proven to be excellent and successful public health tools to raise awareness and educate people and health-care professionals.

- Close collaboration with local health authorities and clinicians has proven essential to link people to appropriate screening and care.
- The mobility of the unit allowed the team to target hard-to-reach populations and high-risk groups such as addiction recovery communities, rural communities, islands, war veterans, the homeless and prisoners.
- Tailored approaches have helped generate trust among different population groups and have resulted in higher response rates to testing and treatment.
- When addressing a highly stigmatised disease with the general population, NGOs have proven to have a considerable advantage compared to health authorities.
- Starting off the conversation by discussing liver health in general has frequently helped to overcome initial scepticism.

FUNDING

In addition to donations of equipment, Hepatos receives government funding for the mobile sessions throughout Croatia. Hepatos also organises mobile screening sessions in other countries of the Balkan peninsula, including Serbia, Bosnia and Montenegro, which are funded through donations.

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Tatjana Reic, Hepatos President

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WHAT?

Fixpunkt e.V. is a harm reduction service provider established in 1989 in Berlin. Fixpunkt provides large-scale harm reduction services including needle syringe distribution, counselling, a drop-in centre, a drug consumption room and outreach activities.



Fixpunkt started their hepatitis-related activities at the beginning of the 1990s, in the framework of a HIV prevention programme. Services on viral hepatitis started in 1996 with hepatitis A and B testing and vaccination, to which hepatitis C antibody testing was later added. Testing for hepatitis C is now part of its daily activities.

WHY?

Injecting drug use is one of the main risk factors for contracting hepatitis C. The hepatitis C virus can easily spread when a person comes into contact with surfaces, equipment, or objects that are contaminated with infected blood. Sharing or reusing needles and syringes therefore increases the chance of spreading the virus. In addition, any equipment, such as cookers, cottons, water, ties, and alcohol swabs, can easily become contaminated during the drug preparation process.

HOW?

Fixpunkt's hepatitis-related activities cover:



AWARENESS AND PREVENTION

Fixpunkt provide direct information both via handout materials and through pre- and post-test counselling. In particular, the risks of hepatitis C and the necessary precautionary measures are explained, while people who are injecting drugs use other services for example when receiving sterile syringes or in the drug consumption room.



TRAINING

Fixpunkt arrange annual mandatory training sessions on basic hepatitis C literacy for their staff and an intensive drug counselling course for newcomers.



TESTING

At Fixpunkt, patients can get hepatitis B and C testing and hepatitis A and B vaccination, rapid hepatitis C diagnostic tests, venipuncture, RNA and hepatitis C core antigen assay by qualified staff and supervised by a doctor and, if required, laboratory testing. Testing data are collected for reporting and research purposes.



TREATMENT AND CARE

Since treatment in community settings is not allowed in Germany, Fixpunkt refer those who have been tested positively to external medical doctors specialised in infection medicine and drug dependence medicine, depending on the situation. In addition to that, Fixpunkt offers disease self-management support, such as alcohol consumption and diet counselling.

To provide these services, Fixpunkt rely on quite an extended network that includes not only healthcare specialists but also and foremost local authorities and other political and administrative bodies. Fixpunkt is also highly involved in advocacy activities at every level, from local health authorities to government representatives and, as a result have developed close cooperation with high-level politicians responsible for health issues and who follow the impact of harm reduction services.



LEARNINGS

The Fixpunkt experience demonstrates that strong political and administrative support are crucial. In particular, a clear political framework and a developed network of relevant stakeholders are essential for any organisation to achieve its objectives.

FUNDING

Fixpunkt e.V. receives regular funding for its hepatitis-related activities, mostly from government resources.

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WHAT?

The HepCheck study sought to investigate the characterisation of hepatitis C (HCV) burden among individuals who attended an intensified screening programme for hepatitis C in homeless services in Dublin.

HepCheck Dublin was undertaken as part of a larger European initiative called HepCare Europe. HepCare Europe is an EU-funded service innovation project and feasibility study, rolled out in four European cities (Dublin, London, Seville and Bucharest), and aimed at developing, implementing and evaluating interventions to enhance identification and treatment of hepatitis C among vulnerable populations.



WHY?

Homelessness is associated with an increased prevalence of risk factors for hepatitis C such as injecting drug use. Facing pressing needs such as food, warmth and shelter, homeless individuals tend to delay reaching out to health services. This means they frequently wait until symptoms have become acute requiring emergency care and hospitalisation. Late diagnosis and treatment can be all the more frequent in the case of hepatitis C, whose early symptoms are not easily detectable without adequate screening.

HOW?

The target population of the study was homeless individuals accessing the SafetyNet Primary Care services in Dublin. Individuals using homeless services and hostels were informed of screening for hepatitis C in SafetyNet clinics and encouraged to attend. Those who reported having already been diagnosed with hepatitis C were advised to attend a SafetyNet clinic for assessment and referral for treatment if appropriate.

Screening took place in 11 SafetyNet affiliated GP practices, as well as SafetyNet in-reach locations such as coffee shops, needle exchanges, hostels, drop in centres, and the SafetyNet mobile health unit. The process consisted of three phases. These included

- Offering of a blood or rapid oral hepatitis C test,
- An in-depth questionnaire for those who reported positive that explored health and social risk factors, with the objective of identifying barriers to follow up, as well as
- Monitoring along the care pathway to ensure that the appropriate care was received.

LEARNINGS

This study demonstrates that standard referral methods (such as hospital-based appointments) are inadequate to engage the homeless population and even exacerbate barriers to treatment.

In particular, standard care fails to address the needs of those who are actively using or have a history of injecting drug use. People who are injecting drugs, especially those who are without stable accommodation, are a hard to reach group. They are thus less likely to access healthcare due to fear of discrimination and stigma. Furthermore, they have frequently low health literacy, leading to miscommunication with health professionals.



The study also shows that community-based primary-care services and infrastructures are ideally placed to support hepatitis C screening and facilitate vulnerable individuals in accessing treatment and care, since they are equipped for the special needs of this risk group. As a result of this easier entry into care, 42% of the participants saw a general practitioner once a week.

FUNDING

The study was partially supported with unrestricted grants to Dr. John Lambert and the Mater Hospital Infectious Diseases Research Fund from AbbVie and Bristol-Myers Squibb Ireland. The funding bodies had no role in study design, collection, analysis, and interpretation of data or in writing the manuscript.

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WHAT?

Emergis is a mental health care institution based in the Netherlands that treats over 13,000 people with psychiatric disorders each year. Emergis has a special department dedicated to offering support to people with a drug dependence (HKPD). In 2016-17 HKPD launched a hepatitis programme, run in correlation with their methadone substitution programme.



WHY?

Injecting drug use is one of the main risk factors for contracting hepatitis C. The hepatitis C virus can easily spread when a person comes into contact with surfaces, equipment, or objects that are contaminated with infected blood. Sharing or reusing needles and syringes therefore increases the chance of spreading the virus. In addition, any equipment, such as cookers, cottons, water, ties, and alcohol swabs, can easily become contaminated during the drug preparation process.



HOW?

HKPD follows its patients from testing to treatment and is well integrated within the cascade of care for hepatitis patients in their city and region. It is targeted at sex workers, documented migrants and people who experience homelessness. HKPD offers its patients:



INFORMATION

HKPD informs its patients through various distribution materials and face-to-face conversations, with the possibility of involving peers on a voluntary basis.



MONITORING

HKPD has a monitoring system that includes data on identified patients, and which is accessible to local health authorities.



TESTING

HKPD offers testing for patients and staff on a regular basis. HKPD uses antibody screening as its primary testing method while also providing venipuncture testing, and HCV core antigen test.



REFERRAL TO TREATMENT AND CARE

If a test is positive, HKPD directs a patient to the hospital to receive adequate treatment.



DISEASE MANAGEMENT

During treatment, HKPD medical staff assist patients, providing disease self-management support and liver health monitoring, and helping patients getting prescribed medication on time as well as prescription renewal.



COUNSELLING

HKPD also has dedicated and qualified staff (nurses and medical doctors) for pre- and post-test counselling.

LEARNINGS

HKPD's success relates to the services being embedded in the municipality, obtaining support from the local administration and health authorities. For example, they greatly value their collaboration with the local hospital, which is happy to assist, thus simplifying the process of providing appropriate care.

FUNDING

Emergis receives funding from various sources, mostly public, including statutory health insurance, governmental social programmes and, depending on the location, city councils.

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WHAT?

Prindsen is a low-threshold clinic established in Oslo in 2013 and designed to help people who inject drugs (PWIDs) who are infected with hepatitis C.

The clinic provides emergency housing, a needle exchange programme, a health clinic and a drug consumption room.

WHY?

PWIDs are at greater risk of contracting and transmitting hepatitis C unknowingly through sharing contaminated needles.

For the WHO elimination goal to be achieved by 2030, it will be essential to support this risk group to ensure their diagnosis, access to appropriate treatments and minimise reinfection.



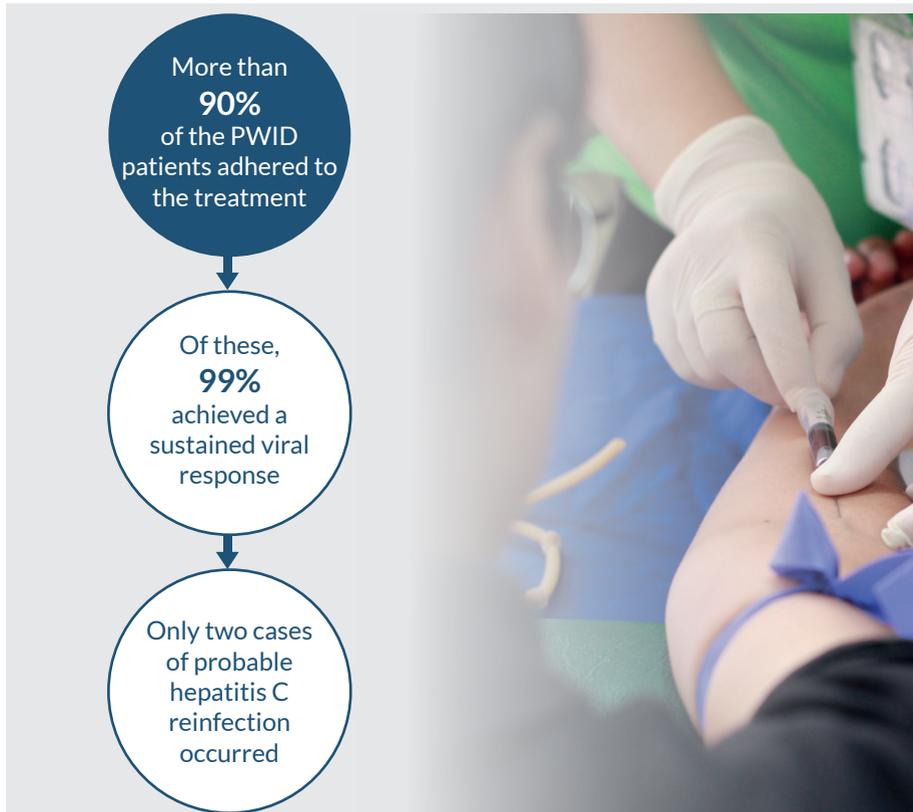
HOW?

Prindsen operates within the scope of the Oslo harm reduction services. The clinic is staffed by a general practitioner and two full-time nurses. Specialist advice can also be sought. The nurses test for viral hepatitis and liver damage and provide individually tailored hepatitis C treatment with an emphasis on flexibility and ambulatory work, responding to the patients' specific needs and lifestyle.





LEARNINGS



In view of the high treatment uptake and virologic response among the PWIDs attending the clinic, this example of a low-threshold clinic demonstrates that a tailored approach to the needs of PWIDs yields results and needs to be rolled-out to other urban areas in order to help eliminate viral hepatitis by 2030.

FUNDING

The clinic is publicly funded by the Oslo municipality.

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WHAT?

The Community Screening Network is a project promoted by GAT - Grupo de Ativistas em Tratamentos (Treatment Activist Group) in partnership with the Institute of Public Health of the University of Porto (ISPUP) and AIDS Healthcare Foundation (AHF). The Network was developed with a view to implementing a national integrated rapid screening network, with community-based organisations targeting key populations, such as people who inject drugs (PWIDs), sex workers, men who have sex with men (MSM) and migrants from high prevalence countries, while collecting data to enable second-generation epidemiological surveillance, complementing the intervention of the National Health Service. The Network's partner organisations also provide support in liaising with the National Health Service for access to treatment or prophylaxis.



Membro da Coligação
Internacional Sida 

The Network started with 13 partner organisations and 18 testing sites in 2015. By the end of 2018 it included 18 organisations and 25 testing sites.

WHY?

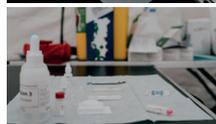
In 2015, when the project started, although rapid tests existed for hepatitis B and C, only one community organisation was providing rapid testing services for these infections, despite 10 HIV testing projects on the field providing HIV tests to key populations, publicly funded by the National AIDS Programme. Data on HIV, HCV, HBV and syphilis infections among key populations were also scarce, and there were no financial resources for creating testing sites to increase hepatitis B and C testing among these groups.

HOW?

The Network provides training in community-based screening for health professionals and lay providers, rapid testing kits, medical consumables, screening and data collection tools and support in complying with regulatory obligations. The objective of this process is to harmonise knowledge and data collection procedures. Training has a theoretical and a practical component.

As mandated by Portuguese law, laboratorial supervision is also coordinated centrally with a reference laboratory, in a standardised process, available for member organisations that wish to use it.

All organisations administer the same cohort questionnaire (baseline, follow-up and refusal) to users either using an online form or a pen and paper questionnaire. The latter requires responses to be uploaded into the online form. The resulting database is managed by ISPUP. Every month, each organisation receives a report with selected variables, which can be customised to their preference. Data can also be jointly analysed to better understand the dynamics of these infections in the country.





The screening sessions are divided into five main steps:

RECEPTION The procedures around data collection are explained to service users, and they are invited to participate in the cohort. If they accept, the standardised questionnaire is used, and should they refuse they are asked to respond to the refusal questionnaire, which has minimal questions to assess which test(s) should be offered to each person.

PRE-SCREENING COUNSELING *Pre-test counselling is voluntary and focuses on explaining how the tests and testing sessions proceed, and what risks and preventive behaviour are associated with each infection. People are invited to ask questions or to speak about the infections or other specific concerns they may have.*

SCREENING Organisations offer combined point-of-care testing for the Hbs antigen and anti-HCV antibodies, along with HIV and syphilis rapid testing. The tests to be performed are chosen according to individual criteria, which maximises opportunities for early diagnosis in key groups. All tests used are finger-prick rapid tests.

LINKAGE TO TREATMENT AND CARE *Following a reactive test, a referral to a specialty appointment in a hospital is offered. A member of staff of the team that screened the person usually offers to accompany the person to the first appointment to help navigate the hospital and deal with any barriers that may arise. If necessary, the person is also referred to complementary support services (social, migration, drug treatment services among others). In the case of a negative result, the relevant prevention interventions are made available according to the reported risk behaviour(s).*

CONTINUOUS ASSISTANCE AFTER DIAGNOSIS some organisations of the Network also offer more structured support until the person feels comfortable navigating the system alone, or in case the person needs continuous specialised support. For instance, in 2018 GAT (the screening network promoter) initiated a new project in its testing centres, whereby a trained peer would offer continuous support in linkage to care, adherence and retention in care.

LEARNINGS

The project clearly demonstrates that community-based testing interventions are successful in reaching key populations and finding previously undiagnosed infections for viral hepatitis, as well as for HIV and syphilis. From January 2016 to December 2018, member organisations performed 20,095 hepatitis B tests and 18,749 hepatitis C tests, with respectively 429 (2.1%) and 503 (2.7%) reactive results. Over 70% of persons with reactive results accepted to be linked to care through the organisations that tested them.

Additionally, results show the added value of investing in integrated testing for HIV, viral hepatitis and syphilis, instead of single disease testing, among key populations.

The project has also generated data that shows that the participation of peer workers does not compromise quality of the testing process, even in integrated testing scenarios: preliminary results demonstrate that peers and lay workers performed similarly to certified health professionals in offering the correct test(s) and performing them, and also that peers had slightly higher rates of acceptance of referral to care when testing PWIDs, for example.

FUNDING

The project was initially funded by the EEA Grants, with co-funding to GAT from Gilead Sciences. After the initial stage, it has maintained its activity through private grants from several companies.

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WHAT?

HepaMed is a programme launched in 2018 by the Romanian Ministry for European Funds and co-financed by the 2014-2020 “Capital Uman” Operational Programme. The aim of the programme is to educate healthcare practitioners about prevention and treatment of hepatitis. The programme comprises three series of training courses: the first addressed infectious disease specialists, the second family doctors and the third will be rolled out in 2020 and will target nurses. For the purposes of this publication, we are focussing on the programme for family doctors.



WHY?

In Romania hepatitis prevalence is relatively high among people with no specific risk profile such as people who inject drugs (PWIDs), the homeless, migrants or prisoners. For these people, family doctors are the first and often the only point of contact with the healthcare system, especially in rural areas. Family doctors therefore play a crucial role in diagnosing patients and referring them to the right specialists. However, family doctors often don't have adequate knowledge of viral hepatitis, the appropriate use of diagnostic tests and interventions to treat patients with viral hepatitis. Therefore, educating family doctors on the risk factors for viral hepatitis (e.g. patient recipient of a blood donation before 1990) as part of the anamnesis, on disease symptoms, on the diagnostics tools available, as well as on therapy and referral options, is essential to identify the undiagnosed and ensuring that they can access appropriate care.

HOW?

The HepaMed programme involved professional training to increase the competencies of family doctors in the prevention and treatment of hepatitis. The training sessions included courses on how to prevent hepatitis transmission, on screening and diagnosis, and on the treatment of both hepatitis and its complications. The biggest novelty of the programme was the introduction of a psychological component to learn how to provide psychological support to people infected with hepatitis, with the goal of increasing patients' adherence to treatment and helping them to adapt their lifestyle to their medical condition, ultimately improving their overall quality of life.

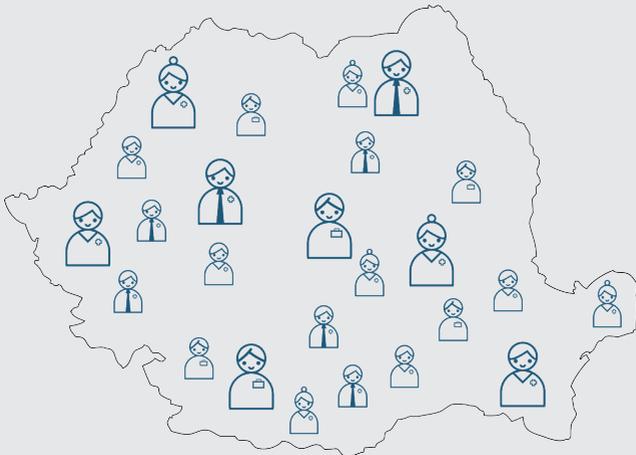


COOPERATION

The project is implemented by the Clinical Hospital of Infectious Diseases Cluj in partnership with the University of Medicine and Pharmacy “Iuliu Hațieganu” Cluj-Napoca, the Clinical Hospital of Infectious Diseases Braşov, the Ovidius University of Constanta and the Clinical Hospital of Infectious and Tropical Diseases Victor Babes Bucharest.

LEARNINGS & ACHIEVEMENTS

The project has managed to involve around 1,200 healthcare professionals from all over the country in training on prevention, diagnosis and treatment of viral hepatitis. An updated state-of-the-art good practice guide has been issued for each target group of the project (specialists, family doctors, and nurses). The project has also led to the exchange of national and transnational good practices, through participation in international conferences and the creation of an online platform.



FUNDING

Almost 85% of the project was funded through non-reimbursable financing provided by the European Social Fund. The remaining part was mostly funded through national grants (around 13% of the total budget), while the partnership only co-financed around 2% of the total budget for the project.

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WHAT?

The Scottish Hepatitis C Action Plan has been cited as an example of best practice by the WHO, the European Commission and the United Nations Drug Policy Unit.



WHY?

Faced with an estimated 38,000 people who had a chronic infection of viral hepatitis, most of whom (approximately 90%) had injected drugs, the Scottish government fully launched its Hepatitis C Action Plan in 2008. The objective of the Plan was to reduce the anticipated disease burden due to the virus.

Scotland aims to fulfil the elimination goal at the latest by 2024, which is six years earlier than the target set by the WHO. With its more rapid approach, Scotland seeks to ensure that fewer people will be sick or die from hepatitis C and follow-on diseases, such as liver cancer or failure. In addition, it is estimated that the overall costs to the health system are less, if elimination is reached earlier than 2030.

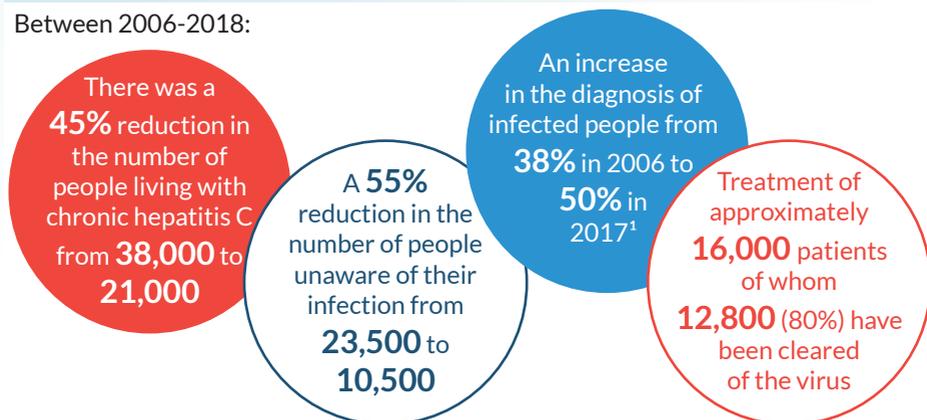
HOW?

The success of Scotland's HCV Action Plan is closely linked to the leadership and investment provided by the Scottish government, as well as the early and continued involvement of different stakeholders. The plan is three-fold, seeking to

- improve services to prevent the transmission of infection,
- identify those infected and
- ensure that diagnosed patients receive treatment.

RESULTS

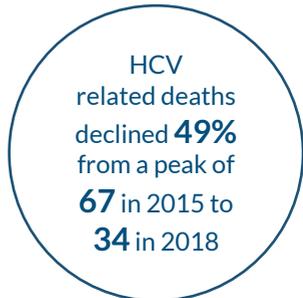
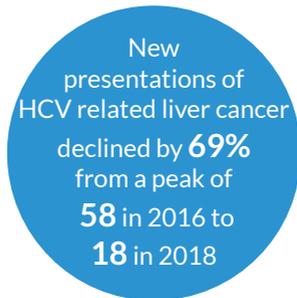
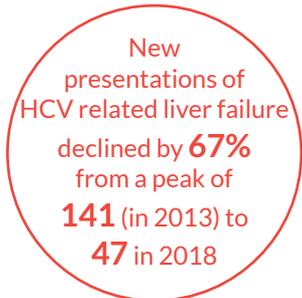
Between 2006-2018:



¹this figure does not even take into account the thousands of people who were diagnosed and successfully treated, and, thus, are no longer living with hepatitis C.



When a HCV cure became available as of 2014:



COOPERATION

The cooperation of a broad range of stakeholders was essential for establishment and successful implementation of the Action Plan. This stakeholder cooperation not only included public health and clinical experts, as well as different healthcare specialists and providers, but also patient representatives, and those with experience of working with people on the margins of society.

LEARNINGS

Scotland has managed to create a highly developed HCV service infrastructure: Its trained workforce is guided by nationally agreed guidelines, standards and targets, and functions in a coordinated and integrated way across different disciplines and agencies both within and outside the healthcare system.

Furthermore, its monitoring systems are tried, tested and robust. Since its inception, the champions of the Action Plan were clear that a robust evidence base was needed to both convince policymakers of the imperative need for action and, later on, to assess progress made. The evidence and data thus generated, helped to inform a large number of internationally acclaimed research projects on prevention, diagnosis and access to care.

FUNDING

The Action Plan received dedicated funding (£15 million) annually between 2009 and 2015, in addition to other general NHS funds.

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WHAT?

In Slovenia, the National Strategy for the Management of HCV Infection was developed in 1997 by the multidisciplinary National Viral Hepatitis Expert Board in close cooperation with the Ministry of Health, the National Health Insurance System, and non-governmental organisations. The strategy included HCV prevention, testing and treatment, and was incorporated into the existing public health system. The first hepatitis C treatment guidelines were established in 1997 and free, anonymous testing has been rolled out over the past decade.



WHY?

The prevalence of hepatitis C virus (HCV) infection in Slovenia (population: 2,000,000), is estimated at 0.3%, with an estimated 6,500 people testing HCV RNA positive. The majority of HCV-infected people are people who inject drugs (PWIDs). In 2014, it was estimated that HCV elimination could be achieved by 2030. However, in 2017, the National Viral Hepatitis Expert Board decided to accelerate progress by implementing several micro-elimination strategies focusing on sub-populations where HCV infection is most prevalent. Within these sub-populations, treatment and prevention interventions are delivered more efficiently using targeted methods.

HOW?

The sub-populations targeted by micro-elimination strategies included patient groups that are already regularly followed-up within the health-care system (patients with haemophilia, patients receiving haemodialysis, organ transplant recipients, patients with end-stage liver disease, and people living with HIV) as well as the wider patient population (including PWIDs). Through multi-stakeholder cooperation and an interdisciplinary approach, micro-elimination has been achieved in several sub-groups.





COOPERATION

All patients with haemophilia who tested HCV RNA positive during an obligatory screening programme in the 1990s were identified from both the national register of haemophiliacs and the database of HCV infected people. In the event that the HCV-infected patient with haemophilia had not yet been treated successfully for HCV, they were actively encouraged to visit a specialist and immediately begin treatment with direct-acting antiviral (DAA) drugs. By 2018, no HCV-positive haemophilia patients were detected in Slovenia, making it the first country to completely eliminate HCV infection in people with haemophilia.

Of the estimated 6,000 to 8,000 PWIDs, around 4,500 receive high-threshold services at 18 regional Centres for the Prevention and Treatment of Drug Addiction (CPTDAs).

To increase the proportion of PWIDs treated for HCV and to achieve optimal treatment adherence, efficacy and safety, a multidisciplinary National Healthcare Network for the treatment of HCV infection in PWIDs was established in 2007. Two years after the introduction of the multidisciplinary network, the number of PWIDs treated for hepatitis C increased more than fourfold. By using new DAA drugs, treatment efficacy in PWIDs equals that of non-injectors.

LEARNINGS

In Slovenia, elimination of HCV in certain sub-populations was achieved as a result of the establishment of the national strategy for the management of HCV infection over 20 years ago. It was supported by stakeholders, an interdisciplinary medical approach, and the availability and accessibility of new highly-effective and safe treatments. Although HCV elimination has been completed in several sub-groups, there is still a need for regular screening. Future HCV elimination initiatives include implementation of mobile units for HCV management in PWIDs and improvements in HCV management for incarcerated persons.

FUNDING

The whole continuum of services that provides for complex management of HCV infection in Slovenia, including treatment, has been fully publicly funded by the National Health Insurance System with just one condition: HCV treatment must be prescribed by specialists in viral hepatitis according to national guidelines.

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WHAT?

ASSCAT (Associació Catalana de pacients hepàtics) is a not-for-profit association based in Barcelona that provides information and counselling to hepatitis patients and their families, to make them aware of prevention and treatment and to help them establish contact with specialists and take informed decisions about their condition.

As part of its activities, ASSCAT is involved in an awareness raising and educational project about hepatitis among prisoners and prison doctors.



WHY?

Prison facilities represent a high-risk environment for hepatitis C infection because of a continued high incidence of drug use and high-risk sexual activity. Many inmates are already infected upon their arrival or get infected while in prison.





HOW?

ASSCAT volunteers cooperate with an established network of prison doctors across Catalonia to educate prisoners about hepatitis C, its impact on the liver, possible follow up on diseases such as liver cirrhosis and liver cancer, as well as the different ways of contracting hepatitis C, and how infection can be avoided. The project involved the distribution of information materials as well as presentations on the prison premises: **ASSCAT organised on average one information session per month and prison doctors took an active part in delivering the presentations to their peers and to prisoners.**

In addition to these information sessions, prisoners were also given access to screening and therapy.

Catalan prisons have permanent medical staff working on the premises and prisoners are given the option of undergoing screening for hepatitis C as soon as they enter prison.

According to ASSCAT statistics, almost **99%** of prisoners have voluntarily opted for a hepatitis C test

LEARNINGS

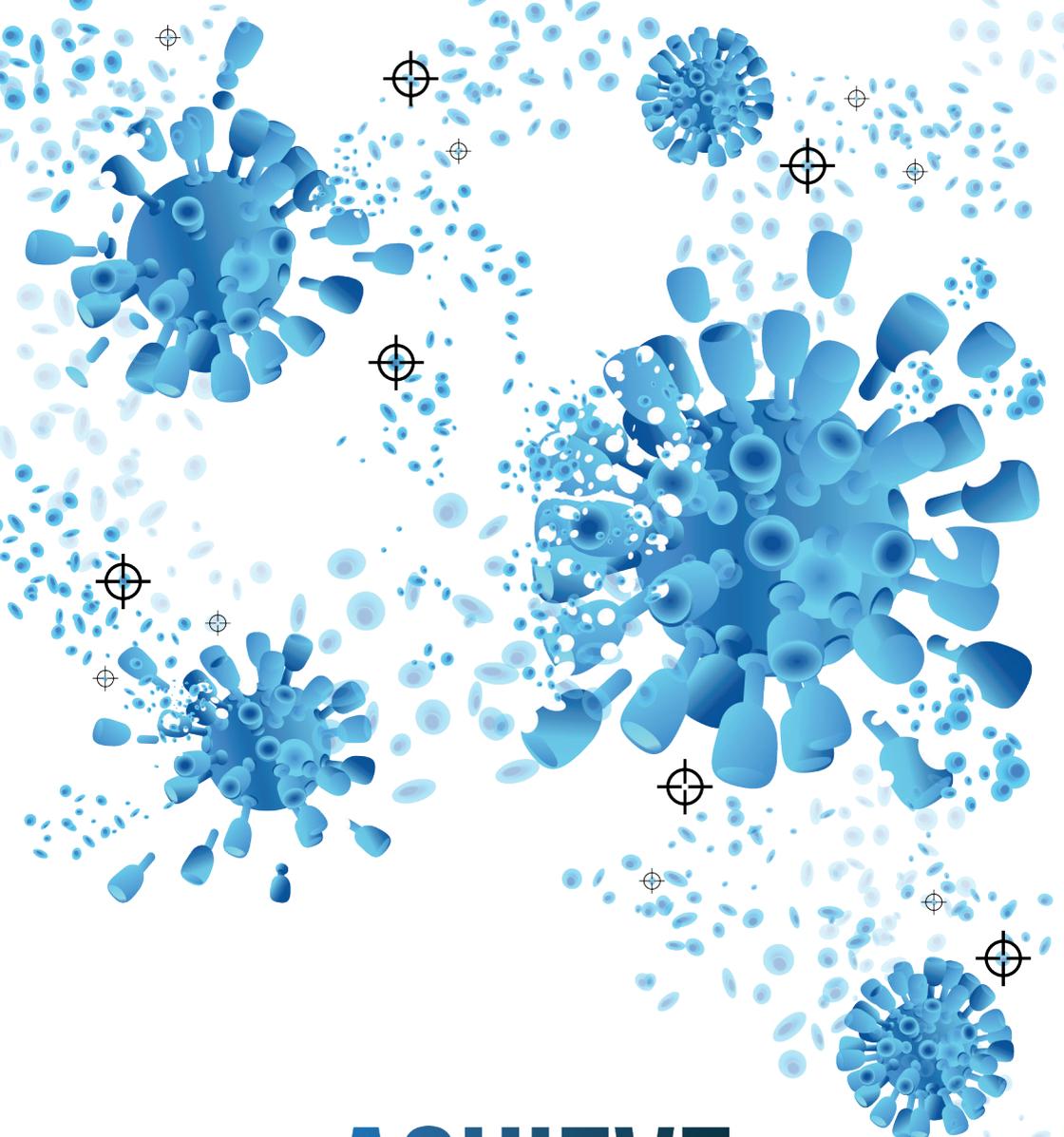
The project allowed ASSCAT to gather information on hepatitis C rates in Catalan prisons and to share best practices among prisons in the region. The established network of prison doctors allowed for continued monitoring of prisoners with hepatitis when transferred from one prison to the other, with a view to ensuring continuity of care. As a result of increased awareness and availability of screening and treatment, prevalence of hepatitis C infections decreased significantly.



FUNDING

The project was privately funded by a pharmaceutical company.

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ACHIEVE

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

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