Hepatitis C Elimination in Europe

European Policy Guidelines

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INTRODUCTION

Hepatitis C

Hepatitis C is a liver disease caused by the hepatitis C virus (HCV). HCV is a bloodborne virus, with the most common modes of infection being through exposure to blood (e.g., injection drug use, unsafe injection practices, unsafe healthcare, and the transfusion of unscreened blood and blood products). HCV can cause acute and chronic hepatitis.

Around 15-45% of infected people spontaneously clear the virus within six months without any treatment and do not develop liver damage. The remaining 55-85% will develop chronic HCV infection, putting them at risk of cirrhosis of the liver within 20 years. This potentially places a significant burden on local health systems and economic sectors.

A public health problem

Hepatitis C is a worldwide public health problem but given its asymptomatic nature, it is a silent epidemic. In the WHO European Region[1], estimates show that 171,000 people die annually from viral hepatitis-related causes (approximately 2% of all deaths). Of this total figure 113,000 deaths are a result of hepatitis C itself.

It is estimated that in the European Region more than 15 million people are living with chronic hepatitis C infection.[2] In the European Union (EU28), latest estimates from 2015 show that 3.238 million people are HCV positive but only 36.7% have been diagnosed.[3]

Treatment

When treatment is required, thanks to scientific progress, the goal is to cure hepatitis C. This will depend on several factors such as the strain of the virus and the type of treatment administered to the patient. The standard of care for hepatitis C is changing quickly. Currently, Direct-Acting Antivirals (DAAs) are the preferred regimens.

They can achieve cure rates above 95% and treatment is shorter than with the older therapies (usually 12 weeks). These new medicines are much more effective, safer and better-tolerated than the older therapies (pegylated interferon and ribavirin).

1 The WHO European Region comprises 53 countries, covering a vast geographical region from the Atlantic to the Pacific oceans. Countries include: Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom, Uzbekistan.

2 Action plan for the health sector response to viral hepatitis in the WHO European Region, September 2016

3 Razavi H et al, Lancet Gastroenterology and Hepatology, March 2017

Addressing the challenge

Since the 1990s, the public health focus on viral hepatitis has progressively increased and major policy developments have followed.

In May 2014, the World Health Assembly approved Resolution 67.6 to improve the prevention, diagnosis and treatment of viral hepatitis and to promote the involvement of civil society in all aspects of preventing, diagnosing and treating viral hepatitis.[4] It calls on governments to develop and implement comprehensive national strategies and asks the WHO to assist them. It asks the WHO to examine the feasibility of eliminating hepatitis C (and B) with a view to setting targets. The work of the World Hepatitis Alliance (WHA) was central to achieving this Resolution, calling on the WHO and the World Health Assembly to implement a global strategy to control and prevent viral hepatitis.

February 2016 marked another key milestone with the first ever high-level European Policy Summit on the elimination of the Hepatitis C, with the participation of the European Commissioner for Health and Food Safety, Vytenis Andriukaitis and other key policy-makers and stakeholders from the liver community.

The Summit raised awareness of HCV among EU and national policy-makers, set out the current situation in Europe and ensured an understanding of the possibility of effectively eliminating HCV in Europe. The Summit provided policy-makers with a political vision and tangible goal (elimination), as well as a framework for action.[5] During the Summit, the HCV Elimination Manifesto[6] was launched. The Manifesto sets out high-level policy asks to enable the elimination of HCV in Europe by 2030. The Manifesto has been endorsed by EU and national policy-makers, as well as the broader liver community. The Manifesto is intended to complement the WHO Global Health Sector Strategy (GHSS), which approaches elimination from a global perspective.

On 28 May 2016, in line with the United Nations 17 Sustainable Development Goals (SDGs), the World Health Assembly endorsed three global health sector strategies that had been developed by the World Health Organization. The strategies cover HIV, viral hepatitis, and sexually transmitted infections (STIs) and run from 2016-2021.

The WHO GHSS on viral hepatitis for 2016-2021 set out a clear vision of a world where viral hepatitis transmission is stopped and everyone has access to safe, affordable and effective prevention, treatment and care.[7] Through this plan, 194 WHO member states committed to eliminating viral hepatitis by 2030, reducing new infections by 90% and mortality by 65% through prevention and treatment interventions including: immunisation against hepatitis B, prevention of mother-to-child transmission of hepatitis B, blood and injection safety, prevention of transmission of HBV and HCV among people who inject drugs through harm reduction services and testing and treatment.

The 2016 WHO Action plan for the health sector response to viral hepatitis in the WHO European Region[8] adapted the Global Health Sector Strategy on Viral Hepatitis 2016–2021 to the political, economic and epidemiological contexts of the European Region. The WHO Action Plan is aligned with the 2030 Agenda for Sustainable Development and the European policy for health and well-being. The Plan addresses all five hepatitis viruses with a particular focus on HBV and HCV. Its main goal is the elimination of viral hepatitis as a public health threat in the European Region by 2030 through the reduction of transmission, morbidity and mortality due to viral hepatitis and its complications, and by ensuring equitable access to comprehensive prevention, and recommended testing, care and treatment services for all.

In June 2017, the European Parliament adopted a resolution on the EU response to HIV/AIDS, Tuberculosis and Hepatitis C.[9] In this non-legislative resolution, the European Parliament called on the Commission and EU member states to develop a comprehensive EU Policy Framework addressing HIV/AIDS, tuberculosis and viral hepatitis. It also called on the Commission, under the direction of the European Centre for Disease Prevention and Control (ECDC), to launch a multidisciplinary plan, in coordination with member states, which will standardise screening, testing and treatment protocols, and which will eradicate hepatitis C by 2030.

A key role in the adoption of this resolution has been played by the ACHIEVE coalition (Associations Collaborating on Hepatitis to Immunize and Eliminate the Viruses in Europe). The members of the coalition include patients, clinicians and researchers, collaborating to advance the fight against hepatitis in line with the WHO Global Health Sector Strategy, the WHO Europe Action Plan and the UN SDGs.[10]

4 http://www.wpro.who.int/hepatitis/wha67_r6-en.pdf

5 To access the presentations, click on the following link http://www.hcvbrusselssummit.eu/material/summit-documents

6 Document included in the Annexes.

7 http://apps.who.int/iris/bitstream/10665/246177/1/WHO-HIV-2016.06-eng.pdf?ua=1

8 http://www.euro.who.int/__data/assets/pdf_file/0008/315917/66wd10e_HepatitisActionPlan_160555.pdf?ua=1

9 http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-%2f%2fEP%2f%2fTEXT%2bMOTION%2bB8-2017-0436%2b0%2bDOC%2bXML%2bV0%2f%2fEN&language=EN

10 Members include: The European Liver Patients' Association (ELPA), the Viral Hepatitis Prevention Board, Hepatitis B and C Public Policy Association, EASL International Liver Foundation, European Aids Treatment Group (EATG), Correlation Network, the World Hepatitis Alliance

Implementing the Elimination Manifesto

In collaboration with leading experts in the field, the Hepatitis B&C Public Policy Association has developed concrete policy recommendations and actions to be taken at national level to implement the Elimination Manifesto and to contribute to the elimination of HCV by 2030. Working to implement these policy recommendations will enable policy-makers to make a positive contribution to the elimination of HCV in their country and demonstrate that they are taking a leadership role in this cause.

This document includes an overview of the seven policy asks of the Elimination Manifesto and the related policy recommendations for policy-makers. The main part of the document provides the environmental context for each Manifesto ask, the policy recommendations for policy-makers and suggested actions they can implement to work towards achieving the recommendations. The document has been developed in collaboration with HCV experts.[11]

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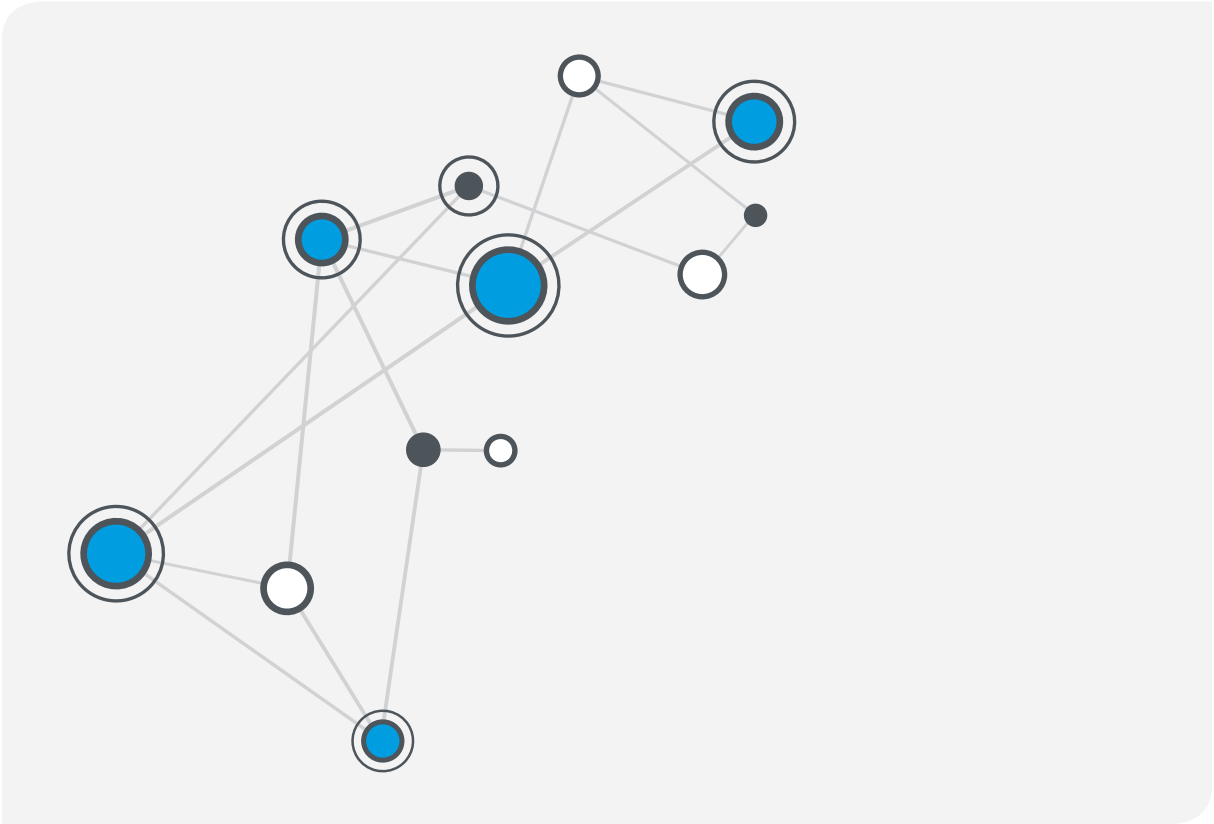


EXECUTIVE SUMMARY

The following is a summary of the policy asks of the HCV Elimination Manifesto and the specific recommendations for implementation.

	Policy asks	Specific recommendations
1	Make hepatitis C and its elimination in Europe an explicit and adequately resourced public health priority, to be pursued using appropriate means at all levels – through collaboration between individual citizens, civil society organisations, researchers, the private sector, local and national governments, European Union institutions – including the Commission, ECDC, EMCDDA, the WHO Regional Office for Europe and other relevant regional bodies.	– Ensure that there is a national plan or strategy for HCV that clearly states elimination by 2030 is the goal and addresses all aspects including awareness, prevention, diagnosis and treatment – Ensure that there is adequate monitoring of the implementation of the plan that specifically tracks progress towards elimination by 2030 – Ensure that the plan is fully funded through national and EU funding
2	Ensure that patients, civil society groups and other relevant stakeholders are directly involved in developing and implementing hepatitis C elimination strategies, with existing best practice examples and guidelines serving as the basis for people-centred health system-based strategies that emphasise tailored implementation at the local level.	– Ensure that all relevant stakeholders are included in the development of the national elimination strategy – Ensure best practice examples in HCV are collated and recognised during the development of the national elimination strategy – Ensure strategies to improve health systems are people-centred, in line with WHO and OECD calls
3	Make the development of integrated care pathways a core component of hepatitis C elimination strategies, taking into account the specific health system barriers and other challenges related to the management of hepatitis C infection.	– Ensure that the challenges of managing hepatitis C infection are understood by the Ministry of Health and other policy-makers and that integrated care pathways are recognised as being part of the solution – Ensure that primary care professionals consider HCV as a priority – Ensure the need for integrated care pathways is reflected in national elimination strategies and provision is made for this to happen in practice – Ensure care pathways are integrated, are easily accessible and include all necessary specialists working together to deliver optimal management and care to patients

4	Pay particular attention to the links between hepatitis C and social marginalisation, and for all hepatitis C elimination-related activities to be consistent with fundamental human rights principles including non-discrimination, equality, participation and the right to health.	– Ensure that there is an understanding amongst policy-makers of the key barriers (e.g., discrimination and legal barriers) to accessing prevention, diagnosis and treatment for stigmatised groups and that hepatitis is included in anti-discrimination legislation – Ensure that the challenges faced in identifying and treating socially-marginalised groups are addressed in national elimination strategies – Ensure that national elimination strategies include provisions and adequate funding so that all hepatitis C patients have equal access to treatment
5	Strengthen efforts to harmonise and improve the surveillance of hepatitis C across the European Union, to inform and evaluate hepatitis C elimination strategies.	– Ensure that the core requirements of effective surveillance systems are determined and communicated to key decision-makers – Ensure that national decision-makers collaborate with colleagues in other countries to harmonise surveillance systems – Ensure that measures to harmonise surveillance systems across the EU are in place
6	Introduce a European Hepatitis Awareness Week (the week of World Hepatitis Day) to hold intensive, coordinated awareness-raising and educational activities across Europe.	– Ensure support at national level for an official European Hepatitis Awareness Week – Ensure that the country actively participates in European Hepatitis Awareness Week – Ensure that there are coordinated, country-wide initiatives to mark European Awareness Week
7	Review progress on achieving the objectives and goals set out in this manifesto on a regular basis and promote the manifesto at all relevant opportunities.	– Ensure that the calls of the Elimination Manifesto are shared widely – Ensure that progress on the implementation of the Elimination Manifesto is measured

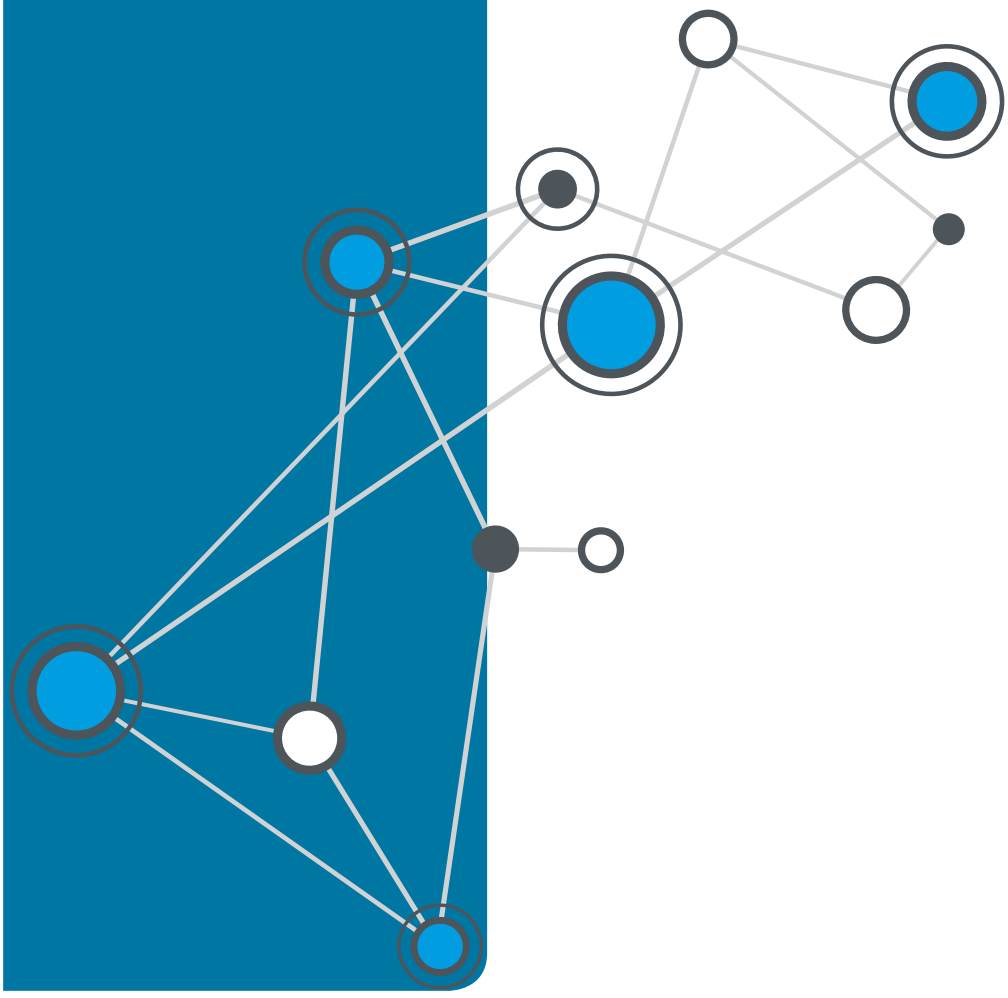
European Policy Guidelines

RECOMMENDATIONS

FIRST Manifesto ask

1

Make hepatitis C and its elimination in Europe an explicit and adequately resourced public health priority, to be pursued using appropriate means at all levels – through collaboration between individual citizens, civil society organisations, researchers, healthcare professionals, the private sector, local and national governments, European Union institutions – including the Commission, European Centre for Disease Prevention and Control (ECDC), European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the WHO Regional Office for Europe and other relevant regional bodies.



I Environmental context for ask

Many countries are making significant progress in their fight against HCV and this is demonstrated by the increasing access to treatments and the publication of national strategies and elimination plans. However, there are no national plans or strategies in place in most countries and where they have been adopted, there is often a lack of adequate funding to ensure their implementation. Funding deficiencies are in evidence at a treatment level but also more broadly, for example for education in relation to HCV and its prevention.

II Policy recommendations for national policy-makers

1. Ensure that there is a national plan or strategy for HCV that clearly states elimination by 2030 is the goal and addresses all aspects including awareness, prevention, diagnosis and treatment
2. Ensure that there is adequate monitoring of the implementation of the plan that specifically tracks progress towards elimination by 2030
3. Ensure that the plan is fully funded through national and EU funding

III Actions for policy-makers

1 Ensure that there is a national plan or strategy for HCV that clearly states elimination by 2030 is the goal, by for example:

a. Holding a parliamentary debate on the elimination of HCV, bringing together a cross-party group of parliamentary champions for HCV with the intention of meeting on a regular basis
b. Contacting the Minister of Health to ask about the plans to meet the goal of elimination and the targets set out and agreed by the Government in the WHO GHSS and the WHO European Action Plan
c. Writing an opinion piece for a leading national newspaper setting out the need to meet the WHO goal and targets and calling for a national plan to achieve this
d. Asking the Minister of Health to call for an EU Joint Action on HCV, including its elimination

2 Ensure that there is adequate monitoring of the implementation of the plan that specifically tracks progress towards elimination by 2030, by for example:

a. Contacting the head of the national surveillance agency to ask when and how often the agency will be producing the data required by the WHO GHSS monitoring and evaluation framework to track progress towards elimination
b. Asking a parliamentary question about the resources available for HCV monitoring and whether they are adequate to track elimination progress
c. Contacting the Minister of Health asking for a commitment to monitor progress towards elimination in line with the government's international obligations

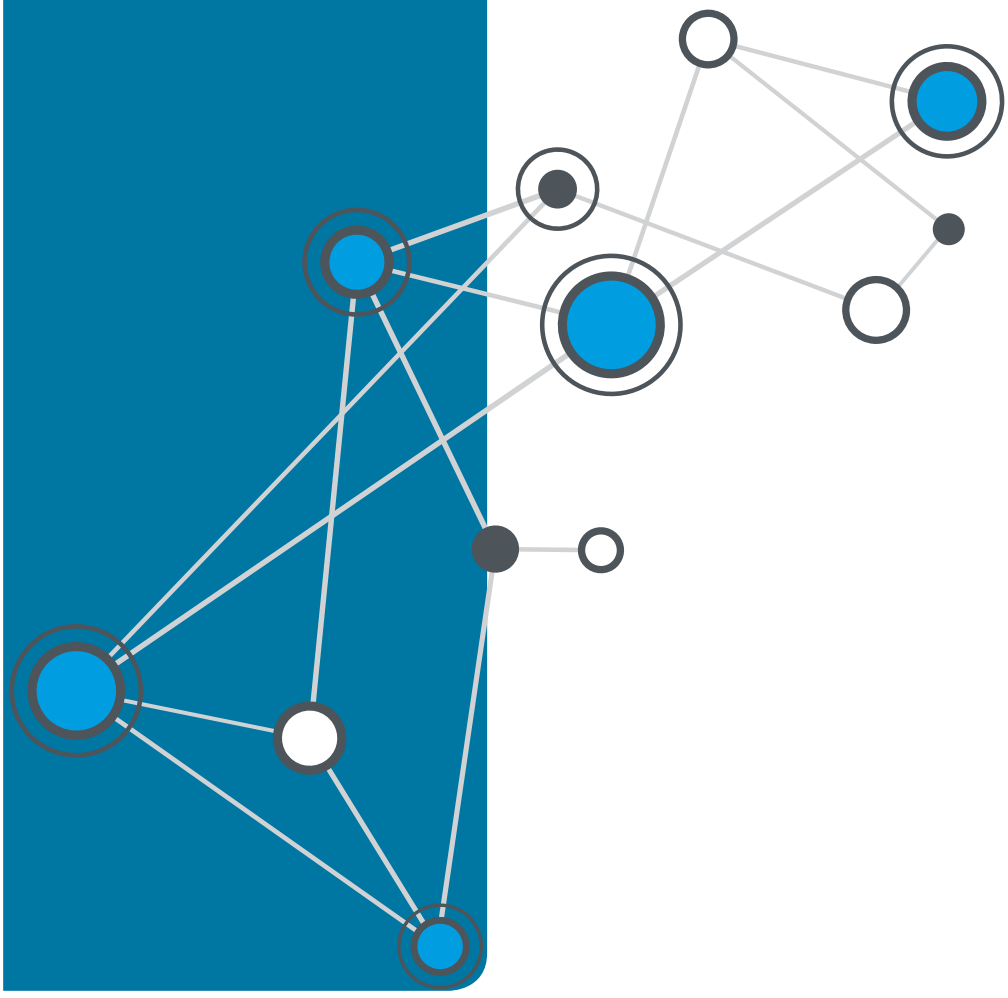
3 Ensure that the plan is fully funded, by for example:

a. Asking a parliamentary question about the availability of funding
b. Lobbying members of the budget committee or equivalent for a specific funding line for HCV
c. Brokering a meeting between the Minister of Health or relevant national/regional agency and the pharmaceutical industry to ensure that patients have access to treatments and all stakeholders collaborate to identify undiagnosed patients

SECOND Manifesto ask

2

Ensure that patients, civil society groups, healthcare professionals and other relevant stakeholders are directly involved in developing and implementing hepatitis C elimination strategies, with existing best practice examples and guidelines serving as the basis for people-centred health system-based strategies that emphasise tailored implementation at the local level.



I Environmental context for ask

Civil society – in particular patient organisations and groups representing those who are most affected and at risk of infection – are crucial in the HCV community as they represent the link between science, politics and real-life experience. They are able to bring the views of patients and those who are involved in diagnosing, treating and managing HCV, and an understanding of what concrete changes are needed. Given the societal aspect that hepatitis has, it is important that civil society has a key role if we want to achieve elimination.

II Policy recommendations for national policy-makers

1. Ensure that all relevant stakeholders are included in the development of the national elimination strategy
2. Ensure best practice examples in HCV are collated and recognised during the development of the national elimination strategy
3. Ensure strategies to improve health systems are people-centred, in line with WHO and OECD calls

III Actions for policy-makers

1 Ensure that all relevant stakeholders are included in the development of the national plan, by for example:

a. Calling on the Minister of Health to convene a meeting of all relevant stakeholders to seek their views on the key elements of a national elimination strategy for HCV
b. Hosting a meeting with all relevant stakeholders to gather input on the content of a national elimination strategy and to present best practice examples from other countries
c. Participating in a press conference with key relevant stakeholders, setting out the need for a national elimination strategy and the key elements to be included and calling on the Minister of Health to continue to consult with all relevant stakeholders

2 Ensure best practice examples in HCV are collated and recognised during the development of the national elimination strategy, by for example:

a. Asking a parliamentary question on the process to develop a national elimination strategy and how the government plans to build on existing best practice
b. Calling on key stakeholders to provide best practice examples that can be used during the development of a national elimination strategy
c. Inviting representatives from countries demonstrating best practice in HCV elimination to participate in a meeting in the Parliament, potentially inviting representatives of the Ministry of Health

3 Ensure strategies to improve health systems are people-centred, by for example:

a. Asking a parliamentary question about how the Ministry of Health intends to structure the national elimination strategy, putting patients at the centre
b. Asking ministries of health who will be involved in changes to health systems and calling for civil society to be included in process
c. Holding a parliamentary evidence session to understand what the HCV community needs from a national elimination strategy (e.g., where testing would be most convenient, where treatment should take place) and communicating the outcomes to the Minister of Health

THIRD Manifesto ask

3

Make the development of integrated care pathways a core component of hepatitis C elimination strategies, taking into account the specific health system barriers and other challenges related to the management of hepatitis C infection.

I Environmental context for ask

HCV is a complex disease from both a clinical and social perspective, with no standard care pathway. Healthcare professionals, and in particular primary care professionals, are key to the implementation and functioning of integrated care pathways. Unfortunately, across Europe the level of awareness about HCV among healthcare professionals is not homogenous and, in some countries, is not satisfactory.

Consideration should be given to the planning and provision of comprehensive harm reduction services and other prevention tools, routine screening, diagnosis, referral pathways and comprehensive support to enable prisoners, people with a history of taking drugs, migrants and other vulnerable or under-served groups to access high quality care. Integrated or closely linked, easily accessible services are required that make it easier for vulnerable people to access high-quality treatment, care and support.

II Policy Recommendations for national policy-makers

1. Ensure that the challenges of managing hepatitis C infection are understood by the Ministry of Health and other policy-makers and that integrated care pathways are recognised as being part of the solution
2. Ensure that primary care professionals consider HCV as a priority
3. Ensure the need for integrated care pathways is reflected in national elimination strategies and provision is made for this to happen in practice
4. Ensure care pathways are integrated, are easily accessible and include all necessary specialists working together to deliver optimal management and care to patients

III Actions for policy-makers

1 Ensure that the challenges of managing hepatitis C infection are understood by the Ministry of Health and other policy-makers and that integrated care pathways are recognised as being part of the solution, by for example:

a. Brokering a meeting between the Ministry of Health, leading policy-makers and key stakeholders to explain the key challenges in managing hepatitis C infection – including regulatory and legal barriers that restrict access to treatment – and to present potential solutions, including the need for integrated care pathways
b. Asking the Ministry of Health what programmes are in place / plans to develop programmes to facilitate and encourage integrated care pathways
c. Lobbying the Ministry of Health to address the national barriers currently restricting and complicating access to optimal diagnosis, treatment and management of HCV

2 Ensure that primary care professionals consider HCV as a priority, by for example:

a. Asking the Ministry of Health to ensure increased education for primary care physicians and other professionals to inform them about HCV and the risk factors
b. Convening a meeting between the HCV community and the relevant educational and training establishments to understand how an HCV module can be included within standard medical academic training
c. Asking the professional bodies to provide the possibility to attend refresher training sessions on the topic, to provide updates on treatment options available and to improve referrals to specialists

3 Ensure the need for integrated care pathways is reflected in national elimination strategies and provision is made for this to happen in practice, by for example:

a. Asking the Ministry of Health to provide clear guidance on what healthcare workers need to do to ensure the creation of an integrated care pathway, including effective communication between services and effective clinical networks
b. Convening a meeting with leading healthcare professionals to understand the challenges to establishing integrated care pathways
c. Calling on the HCV community to develop key principles to establishing integrated care pathways, e.g., creating multi-disciplinary centres of expertise

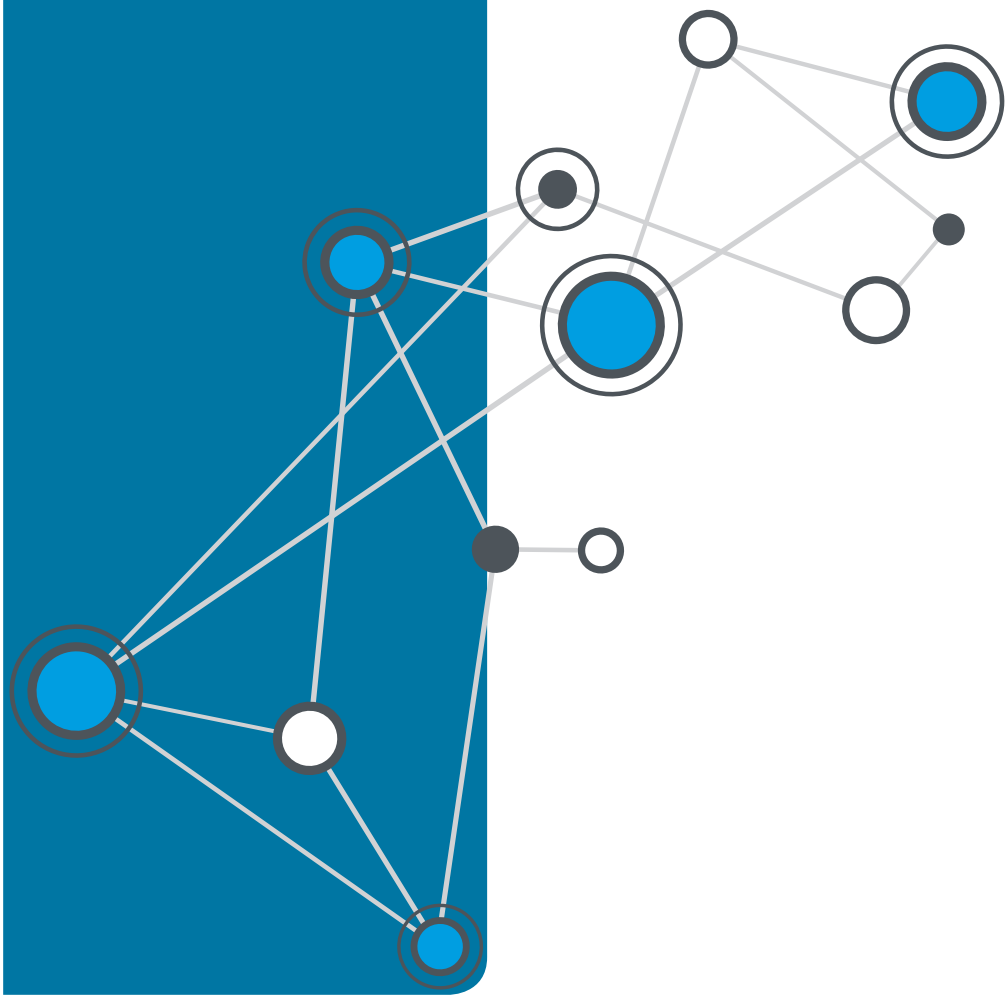
4 Ensure care pathways are integrated, are easily accessible and include all necessary specialists working together to deliver optimal management and care to patients, by for example:

a. Asking a Parliamentary question on what concrete actions are being taken to establish integrated care pathways and what funding is being provided
b. Asking leading policy-makers to join lobbying efforts to request specific funding from the budget committee or equivalent for multi-disciplinary HCV centres of expertise
c. Writing a thought leadership piece to raise awareness about the need for integrated care pathways, effective communication between services, and effective clinical networks

FOURTH Manifesto ask

4

Pay particular attention to the links between hepatitis C and social marginalisation, and for all hepatitis C elimination-related activities to be consistent with fundamental human rights principles including non-discrimination, equality, participation and the right to health.



I Environmental context for ask

Some population groups have specific profiles in terms of incidence and prevalence. Some groups are more vulnerable than others such as people who inject drugs and their needs vary. Some groups need intensified prevention, testing and treatment services, while others are more vulnerable to hepatitis because of their poor access to appropriate healthcare or because they are marginalised or stigmatised and need access to care and other services, including employment, without discrimination. If we want to reach elimination, we need to approach the problem in a comprehensive manner without any exclusions.

II Policy Recommendations for national policy-makers

1. Ensure that there is an understanding amongst policy-makers of the key barriers (e.g., discrimination and legal barriers) to accessing prevention, diagnosis and treatment for stigmatised groups and that hepatitis is included in anti-discrimination legislation
2. Ensure that the challenges faced in identifying and treating socially-marginalised groups are addressed in national elimination strategies
3. Ensure that national elimination strategies include provisions and adequate funding so that all hepatitis C patients have equal access to treatment

III Actions for policy-makers

1 Ensure that there is an understanding amongst policy-makers of the key barriers (e.g., discrimination and legal barriers) to accessing prevention, diagnosis and treatment for stigmatised groups and that hepatitis is included in anti-discrimination legislation, by for example:

a. Facilitating a meeting between leading policy-makers and the affected communities to identify key barriers to accessing prevention, diagnosis and treatment for stigmatised groups, e.g., people who use drugs; the homeless; migrants; prisoners
b. Asking the Minister of Health what provisions are being put in place to address the specific needs of stigmatised groups with hepatitis C, in line with the principles of fundamental human rights to ensure no-one is left behind
c. Asking leading policy-makers / Ministry of Health to host specific roundtable meetings for each target group to identify what could be done to remove the barriers being faced and to ensure each of these groups has equal access to prevention advice, diagnosis and treatment

2 Ensure that the challenges faced in identifying and treating socially-marginalised groups are addressed in national elimination strategies, by for example:

a. Lobbying with leading policy-makers to ask the Ministry of Health to address the specific needs of working with socially-marginalised groups at risk of HCV
b. Brokering a meeting between the Ministry of Health and key stakeholders, including representatives of socially-marginalised groups, to agree concrete actions needed to work with groups at risk of HCV
c. Asking the Ministry of Health to establish programmes to support engagement with socially-marginalised groups and those at risk from HCV infection – these programmes could include working with peers to provide education and support

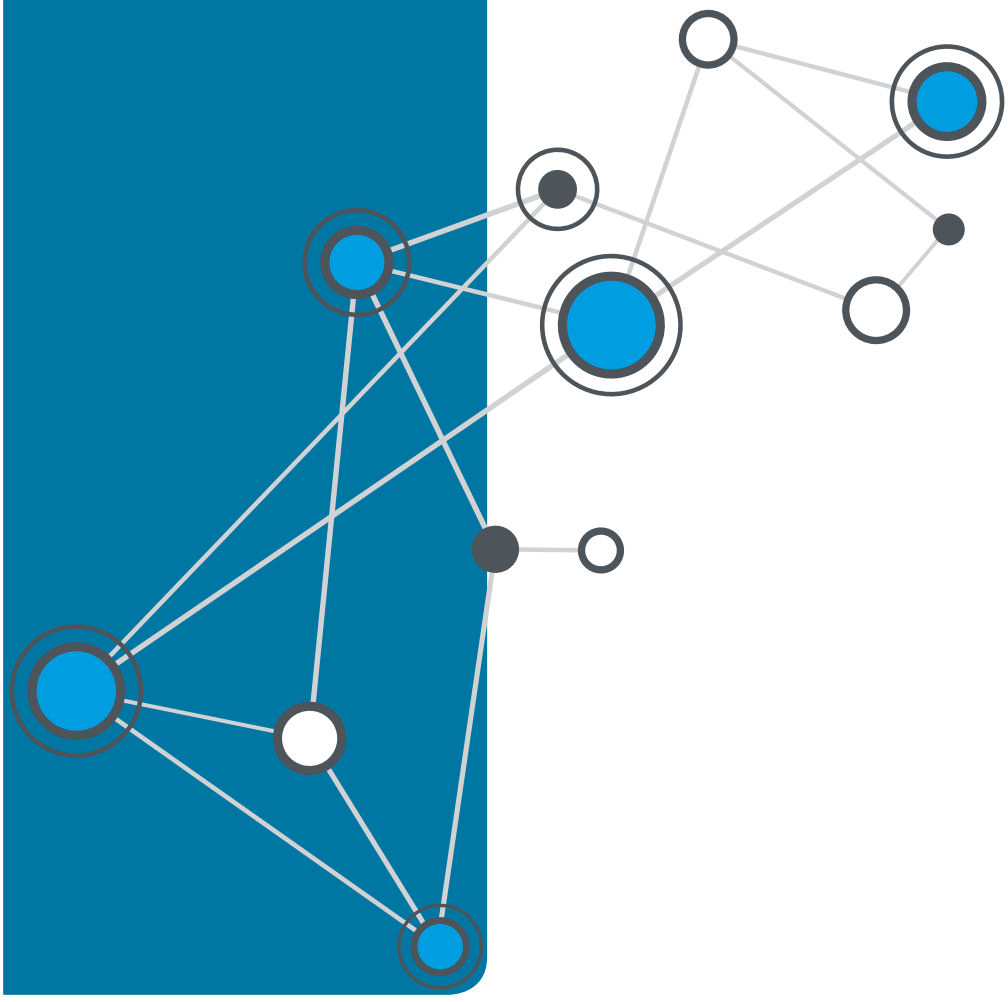
3 Ensure that national elimination strategies include provisions and adequate funding so that all hepatitis C patients have equal access to treatment:

a. Asking a parliamentary question about the availability of funding specifically to address the challenges in identifying, treating and managing socially-marginalised HCV patients
b. Calling on the Ministry of Health to provide adequate funding to enable an increase in capacity within existing treatment centres
c. Convening a meeting with key stakeholders to determine how treatment guidelines can be amended so that all patients diagnosed with hepatitis C have equal access to treatment and are provided with adequate information about available treatment options

FIFTH Manifesto ask

5

Strengthen efforts to harmonise and improve the surveillance of hepatitis C across the European Union, to inform and evaluate hepatitis C elimination strategies.



I Environmental context for ask

Surveillance is at the base of any effort to control and eliminate a disease, including HCV. To achieve concrete policy change and implementation, information systems based on surveillance and programme data are fundamental but unfortunately many countries still lack data.

II Policy Recommendations for national policy-makers

1. Ensure that the core requirements of effective surveillance systems are determined and communicated to key decision-makers
2. Ensure that national decision-makers collaborate with colleagues in other countries to harmonise surveillance systems
3. Ensure that measures to harmonise surveillance systems across the EU are in place

III Actions for policy-makers

1 Ensure that the core requirements of effective surveillance systems are determined and communicated to key decision-makers, by for example:

a. Writing to the head of the national surveillance agency to ask what measures are being put in place to align national surveillance systems with other countries.
b. Meeting the head of the national surveillance agency to understand potential areas for improvement in the surveillance of hepatitis C and understand why current systems are not harmonised
c. Hosting a meeting between the Ministry of Health, the head of the national surveillance agency and HCV experts to determine the challenges in aligning surveillance systems across the EU and to discuss potential solutions, including the core requirements of effective surveillance systems / methodologies

2 Ensure that national decision-makers collaborate with colleagues in other countries to harmonise surveillance systems, by for example:

a. Calling on the Ministry of Health / head of the national surveillance agency to convene a meeting with other countries with whom it may be possible and / or most beneficial to harmonise surveillance systems / methodologies, taking into account the positive impact such harmonisation would bring at a national level
b. Contacting the European Centre for Disease Prevention and Control (ECDC), setting out the need for improved harmonisation of national surveillance system and asking leading policy-makers in other countries to support this. Harmonisation should build on work done by the ECDC European Network for Hepatitis B and C Surveillance
c. Brokering a series of multi-lateral meetings with member state representatives to develop approaches to harmonise surveillance systems / methodologies across the EU

3 Ensure that measures to harmonise surveillance systems across the EU are in place, by for example:

a. Calling on the Minister of Health to develop policies to enable the establishment or the strengthening of HCV national patient registries that can be harmonised across the EU and can be used to collect comparable data
b. Asking the Minster of Health and head of the national surveillance agency what processes are being considered to enable countries to share data effectively and widely across the EU and what measures the Minister is taking to facilitate that
c. Lobbying the Minister of Health and head of the national surveillance agency to involve civil society stakeholders in all initiatives to harmonise surveillance systems
d. Advocating for a legal framework on data collection at European level for the implementation of patient registries across Europe

SIXTH Manifesto ask

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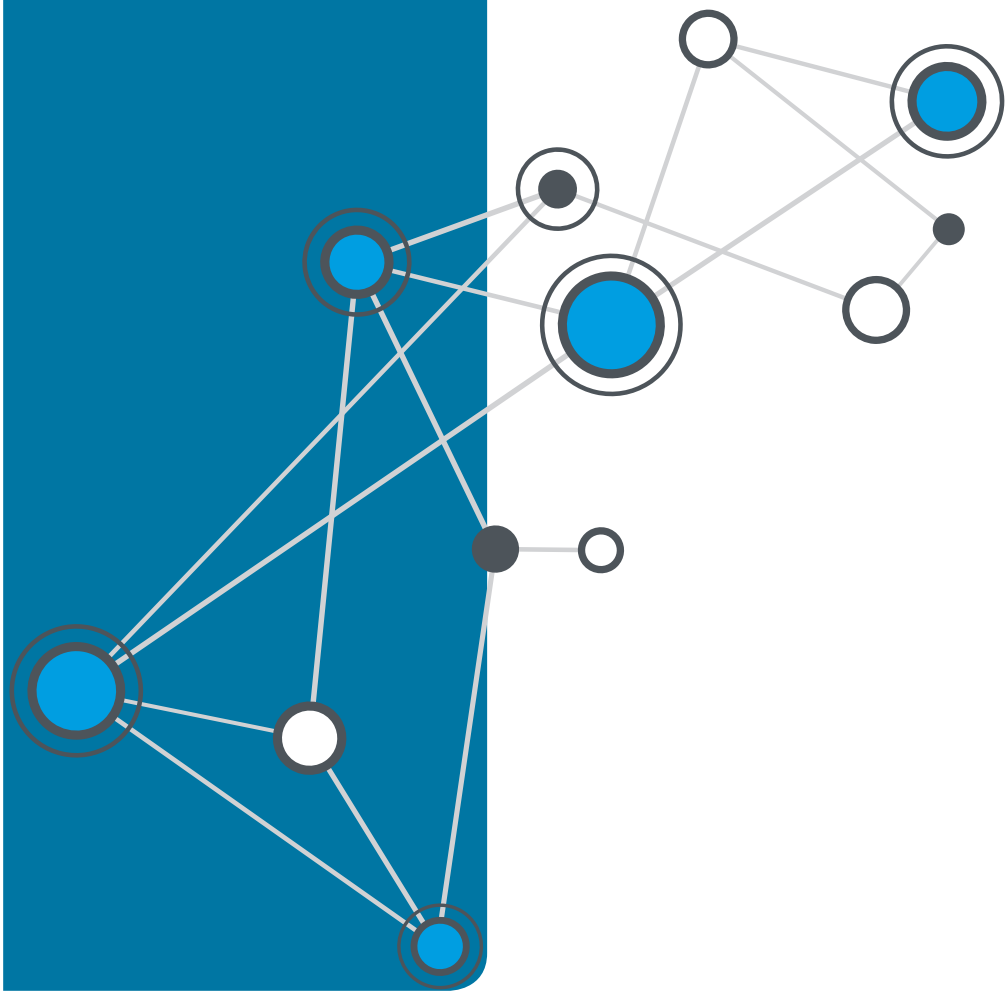
Introduce a European Hepatitis Awareness Week (the week of World Hepatitis Day taking place on 28 July) to hold intensive, coordinated awareness-raising and educational activities across Europe.



I Environmental context for ask

Awareness is key for the elimination of HCV and more engagement is needed to eliminate the disease. It is challenging to identify undiagnosed patients, partly due to the disease often being asymptomatic. There is also a stigma attached to being diagnosed with HCV, which makes diagnosis and treatment more challenging. An official awareness week would provide the necessary framework for national policy-makers and stakeholders to promote targeted initiatives.

II Policy Recommendations for national policy-makers

1. Ensure support at national level for an official European Hepatitis Awareness Week
2. Ensure that the country actively participates in European Hepatitis Awareness Week
3. Ensure that there are coordinated, country-wide initiatives to mark European Awareness Week

III Actions for policy-makers

1 Ensure support at national level for an official European Hepatitis Awareness Week, by for example:

a. Calling on other policy-makers and the Minister of Health to support the call for an official European Hepatitis Awareness Week
b. Hosting a Parliamentary event (e.g., photo exhibition) to raise awareness of the need for an official European Hepatitis Awareness Week
c. Hosting a roundtable meeting to plan activities during the Awareness Week, with input from the WHA on the theme and coordination of events around the country

2 Ensure that the country actively participates in European Hepatitis Awareness Week, by for example:

a. Hosting a Parliamentary event (e.g., photo exhibition) to raise awareness of European Hepatitis Awareness Week and the key national policy recommendations
b. Writing an editorial about the challenges in hepatitis, encompassing the calls of the Elimination Manifesto
c. Securing a series of interviews with national media, to raise awareness of the challenges in hepatitis and the calls of the Elimination Manifesto

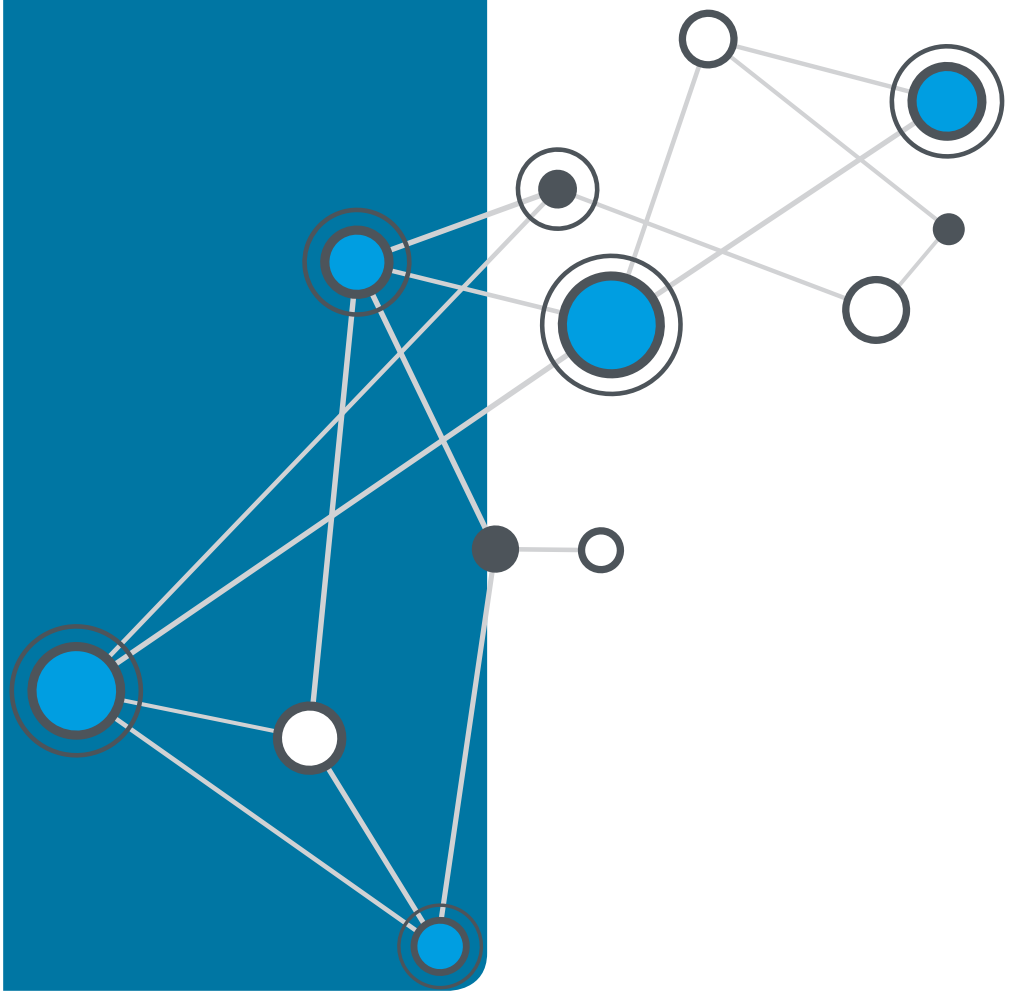
3 Ensure that there are coordinated, country-wide initiatives to mark European Awareness Week, by for example:

a. Asking a parliamentary question to the Minister of Health, to determine what national initiatives are planned to mark European Hepatitis Awareness Week and to include hepatitis in other relevant national disease / health events
b. Calling on the Ministry of Health to provide national funding for a focused, pan-EU awareness campaign during the week of World Hepatitis Day, intended to identify the undiagnosed and aiming to address the stigma attached to having HCV
c. Engaging civil society stakeholders as well as scientific and professional societies throughout the process

SEVENTH Manifesto ask

7

In line with the WHO GHSS, review progress on achieving the objectives and goals set out in this Manifesto on a regular basis and promote the Manifesto at all relevant opportunities.



I Environmental context for ask

To implement an effective elimination strategy, a systematic review needs to be run to assess progress and establish or correct actions to be taken. The systematic review should be accompanied by the constant promotion of the Elimination Manifesto, to enlarge the endorsement base and provide legitimacy to the elimination effort.

II Policy Recommendations for national policy-makers

1. Ensure that the calls of the Elimination Manifesto are shared widely
2. Ensure that progress on the implementation of the Elimination Manifesto is measured

III Actions for policy-makers

1 Ensure that the calls of the Elimination Manifesto are shared widely, by for example:

a. Signing the Manifesto on the website and calling on other policy-makers to sign the Manifesto
b. Hosting a national roundtable meeting to communicate the Elimination Manifesto to other policy-makers
c. Supporting the organisation of a biennial Summit on Hepatitis C to present the status of hepatitis in their country and the policy asks of the Elimination Manifesto

2 Ensure that progress on the implementation of the Elimination Manifesto is measured:

a. Asking the Minister of Health for a status overview of national measures to address HCV, to be used as a benchmark to measure progress
b. Calling on the Minster of Health to produce an annual report that tracks the elimination of hepatitis C in their country, in line with the WHO framework on Monitoring and Evaluation.

Hepatitis B and C Public Policy Association

EASL European Association for the Study of the Liver | ENDORSED EVENT

ELPA

EATG European AIDS Treatment Group

International Centre for Migration, Health and Development

Correlation European Network Social Inclusion & Health

World Hepatitis Alliance

VHPB

ANNEX 1
HCV Elimination Manifesto

Hepatitis C Elimination in Europe

"Our vision for a Hepatitis C-free Europe"

We, the signatories of this declaration, gathered in Brussels on the occasion of the first European Union HCV Policy Summit, on 17 February 2016, are committed to the elimination of hepatitis C in Europe.

- **Hepatitis C is a life-threatening disease; it affects millions of people across Europe and has a significant morbidity and premature death burden1;**
- **Today, scientific breakthroughs give us the unique opportunity to eliminate hepatitis C in Europe, averting a significant toll in terms of deaths and societal and economic costs;**
- **The specific challenges of hepatitis C require holistic, people-centred, health system-wide approaches to disease awareness, prevention and integrated care, with all stakeholders combining their diverse skills and resources in a unified response.**

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

1. Make hepatitis C and its elimination in Europe an explicit and adequately resourced public health priority, to be pursued using appropriate means at all levels – through collaboration between individual citizens, civil society organisations, researchers, the private sector, local and national governments, European Union institutions – including the Commission, ECDC, EMCDDA, the WHO Regional Office for Europe and other relevant regional bodies;
2. Ensure that patients, civil society groups and other relevant stakeholders are directly involved in developing and implementing hepatitis C elimination strategies, with existing best practice examples and guidelines serving as the basis for people-centred health system-based strategies that emphasise tailored implementation at the local level;
3. Make the development of integrated care pathways a core component of hepatitis C elimination strategies, taking into account the specific health system barriers and other challenges related to the management of hepatitis C infection;
4. Pay particular attention to the links between hepatitis C and social marginalisation, and for all hepatitis C elimination-related activities to be consistent with fundamental human rights principles including non-discrimination, equality, participation and the right to health;
5. Strengthen efforts to harmonise and improve the surveillance of hepatitis C across the European Union, to inform and evaluate hepatitis C elimination strategies;
6. Introduce a European Hepatitis Awareness Week (the week of World Hepatitis Day) to hold intensive, coordinated awareness-raising and educational activities across Europe;
7. Review progress on achieving the objectives and goals set out in this manifesto on a regular basis and promote the manifesto at all relevant opportunities.

TO NOTE

In developing this Manifesto, the following documents were taken into consideration:

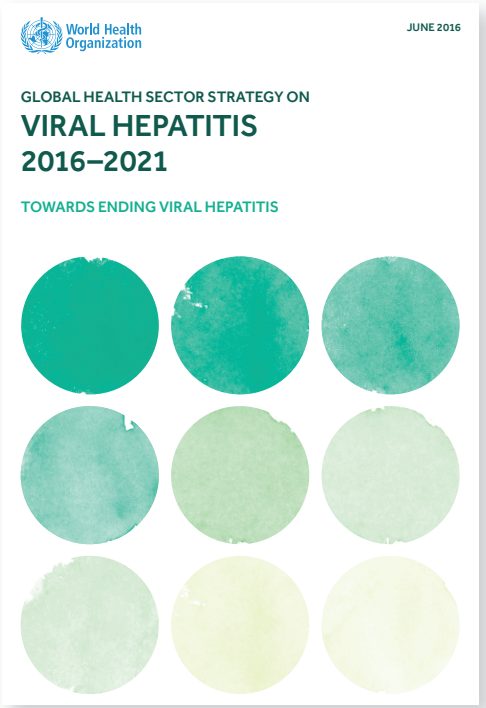
- World Hepatitis Summit, 2-4 September 2015, Glasgow - www.worldhepatitissummit.com
- Glasgow Declaration on Viral Hepatitis, September 2015 www.worldhepatitisalliance.org/sites/default/files/resources/documents/WHS2015 Glasgow Declaration on Viral Hepatitis.pdf
- World Health Assembly, Resolution 67.6 on Hepatitis, 24 May 2014 – apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R6-en.pdf
- WHO, Prevention and Control of Viral Hepatitis Infection: Framework for Global Action, 2012 – www.who.int/hiv/pub/hepatitis/Framework/en
- World Health Assembly, Resolution 63.18 on Viral Hepatitis, 21 May 2010 – apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R18-en.pdf
- Hepatitis B and C Public Policy Association, High Level Meeting "Economic crisis and healthcare – ensuring access to public health services: the case of hepatitis B and C", 3-4 June 2014 – www.hepsummit2012.org
- Hepatitis B and C Public Policy Association, Summit Conference on Hepatitis B and C in Mediterranean and Balkan Countries, 5-7 September 2012 – www.hepsummit2012.org
- Hepatitis B and C Public Policy Association, Summit Conference on Viral Hepatitis, 14-15 October 2010, Brussels www.hepbcppa.org/2010-summit-conference

REFERENCES

1. The WHO estimates that there are 14 million people affected by hepatitis C across WHO European Region and various accounts report some 6 million living in the European Union alone
2. In line with the goals of the draft WHO Global Health Sector Strategy 2016-2021, November 2015 www.who.int/reproductivehealth/Hepatitis-global-strategy_Nov2015.pdf?ua=1

ANNEX 2
WHO Global Health Sector Strategy on Viral Hepatitis 2016-2021

www.who.int/hepatitis/strategy2016-2021/ghss-hep/en/



ANNEX 3
WHO Hepatitis C Fact Sheet[12] Hepatitis C

Fact Sheet

Updated April 2017

Key facts

- Hepatitis C is a liver disease caused by the hepatitis C virus: the virus can cause both acute and chronic hepatitis, ranging in severity from a mild illness lasting a few weeks to a serious, lifelong illness.
- The hepatitis C virus is a bloodborne virus and the most common modes of infection are through exposure to small quantities of blood. This may happen through injection drug use, unsafe injection practices, unsafe health care, and the transfusion of unscreened blood and blood products.
- Globally, an estimated 71 million people have chronic hepatitis C infection.
- A significant number of those who are chronically infected will develop cirrhosis or liver cancer.
- Approximately 399 000 people die each year from hepatitis C, mostly from cirrhosis and hepatocellular carcinoma.
- Antiviral medicines can cure more than 95% of persons with hepatitis C infection, thereby reducing the risk of death from liver cancer and cirrhosis, but access to diagnosis and treatment is low.
- There is currently no vaccine for hepatitis C; however research in this area is ongoing.

Hepatitis C virus (HCV) causes both acute and chronic infection. Acute HCV infection is usually asymptomatic, and is only very rarely (if ever) associated with life-threatening disease. About 15–45% of infected persons spontaneously clear the virus within 6 months of infection without any treatment.

The remaining 55–85% of persons will develop chronic HCV infection. Of those with chronic HCV infection, the risk of cirrhosis of the liver is between 15–30% within 20 years.

12 http://www.who.int/mediacentre/factsheets/fs164/en/

Geographical distribution

Hepatitis C is found worldwide. The most affected regions are WHO Eastern Mediterranean and European Regions, with the prevalence of 2.3% and 1.5% respectively. Prevalence of HCV infection in other WHO regions varies from 0.5% to 1.0%. Depending on the country, hepatitis C virus infection can be concentrated in certain populations (for example, among people who inject drugs) and/or in general populations. There are multiple strains (or genotypes) of the HCV virus and their distribution varies by region.

Transmission

The hepatitis C virus is a bloodborne virus. It is most commonly transmitted through:

- injecting drug use through the sharing of injection equipment;
- the reuse or inadequate sterilization of medical equipment, especially syringes and needles in healthcare settings; and
- the transfusion of unscreened blood and blood products.

HCV can also be transmitted sexually and can be passed from an infected mother to her baby; however these modes of transmission are much less common.

Hepatitis C is not spread through breast milk, food, water or by casual contact such as hugging, kissing and sharing food or drinks with an infected person. Estimates obtained from modelling suggest that worldwide, in 2015, there were 1.75 million new HCV infections (globally, 23.7 new HCV infections per 100 000 people).

Symptoms

The incubation period for hepatitis C is 2 weeks to 6 months. Following initial infection, approximately 80% of people do not exhibit any symptoms. Those who are acutely symptomatic may exhibit fever, fatigue, decreased appetite, nausea, vomiting, abdominal pain, dark urine, grey-coloured faeces, joint pain and jaundice (yellowing of skin and the whites of the eyes).

Screening and diagnosis

Due to the fact that acute HCV infection is usually asymptomatic, few people are diagnosed during the acute phase. In those people who go on to develop chronic HCV infection, the infection is also often undiagnosed because the infection remains asymptomatic until decades after infection when symptoms develop secondary to serious liver damage.

HCV infection is diagnosed in 2 steps:

1. Screening for anti-HCV antibodies with a serological test identifies people who have been infected with the virus.
2. If the test is positive for anti-HCV antibodies, a nucleic acid test for HCV ribonucleic acid (RNA) is needed to confirm chronic infection because about 15–45% of people infected with HCV spontaneously clear the infection by a strong immune response without the need for treatment. Although no longer infected, they will still test positive for anti-HCV antibodies.

After a person has been diagnosed with chronic hepatitis C infection, they should have an assessment of the degree of liver damage (fibrosis and cirrhosis). This can be done by liver biopsy or through a variety of non-invasive tests.

In addition, these people should have a laboratory test to identify the genotype of the hepatitis C strain. There are 6 genotypes of the HCV and they respond differently to treatment. Furthermore, it is possible for a person to be infected with more than 1 genotype. The degree of liver damage and virus genotype are used to guide treatment decisions and management of the disease.

Getting tested

Early diagnosis can prevent health problems that may result from infection and prevent transmission of the virus. WHO recommends screening for people who may be at increased risk of infection.

Populations at increased risk of HCV infection include:

- people who inject drugs;
- people who use intranasal drugs;
- recipients of infected blood products or invasive procedures in health-care facilities with inadequate infection control practices;
- children born to mothers infected with HCV;
- people with sexual partners who are HCV-infected;
- people with HIV infection;
- prisoners or previously incarcerated persons; and
- people who have had tattoos or piercings.

About 2.3 million people of the estimated 36.7 million living with HIV globally have serological evidence of past or present HCV infection. Conversely, among all HIV-infected persons, the prevalence of anti-HCV was 6.2%. Liver diseases represent a major cause of morbidity and mortality among persons living with HIV.

Treatment

Hepatitis C does not always require treatment as the immune response in some people will clear the infection, and some people with chronic infection do not develop liver damage. When treatment is necessary, the goal of hepatitis C treatment is cure. The cure rate depends on several factors including the strain of the virus and the type of treatment given.

The standard of care for hepatitis C is changing rapidly. Sofosbuvir, daclatasvir and the sofosbuvir/ledipasvir combination are part of the preferred regimens in the WHO guidelines, and can achieve cure rates above 95%. These medicines are much more effective, safer and better-tolerated than the older therapies. Therapy with DAAs can cure most persons with HCV infection and treatment is shorter (usually 12 weeks). Meanwhile, there remains a limited role for pegylated interferon and ribavirin in certain scenarios where currently data are limited in supporting DAA-only therapies. Although the production cost of DAAs is low, these medicines remain very expensive in many high- and middle-income countries. Prices have dropped dramatically in some countries (primarily low-income) due to the introduction of generic versions of these medicines.

Access to HCV treatment is improving, but remains limited. In 2015, of the 71 million persons living with HCV infection globally, 20% (14 million) knew their diagnosis. 7.4% of those diagnosed (1.1 million) were started on treatment in 2015. Much needs to be done to ensure that these advances lead to greater access to treatment globally.

Prevention

Primary prevention

There is no vaccine for hepatitis C, therefore prevention of HCV infection depends upon reducing the risk of exposure to the virus in health-care settings and in higher risk populations, for example, people who inject drugs, and through sexual contact.

The following list provides a limited example of primary prevention interventions recommended by WHO:

- hand hygiene: including surgical hand preparation, hand washing and use of gloves;
- safe and appropriate use of health care injections;
- safe handling and disposal of sharps and waste;
- provision of comprehensive harm-reduction services to people who inject drugs including sterile injecting equipment;
- testing of donated blood for hepatitis B and C (as well as HIV and syphilis);
- training of health personnel; and
- promotion of correct and consistent use of condoms.

Secondary and tertiary prevention

For people infected with the hepatitis C virus, WHO recommends:

- education and counselling on options for care and treatment;
- immunization with the hepatitis A and B vaccines to prevent coinfection from these hepatitis viruses and to protect their liver;
- early and appropriate medical management including antiviral therapy if appropriate; and
- regular monitoring for early diagnosis of chronic liver disease.

Screening, care and treatment of persons with hepatitis C infection

In April 2016, WHO updated its "Guidelines for the screening, care and treatment of persons with chronic hepatitis C". These guidelines complement existing WHO guidance on the prevention of transmission of bloodborne viruses, including HCV. They are intended for policy-makers, government officials, and others working in low- and middle-income countries who are developing programmes for the screening, care and treatment of people with HCV infection. These guidelines will help expand of treatment services to patients with HCV infection, as they provide key recommendations in these areas and discuss considerations for implementation.

Guidelines for the screening, care and treatment of persons with chronic hepatitis C

www.who.int/entity/hepatitis/publications/hepatitis-c-guidelines-2016/en/index.html

Access to HCV treatment is improving, but remains limited. In 2015, of the 71 million persons living with HCV infection globally, 20% (14 million) knew their diagnosis. Worldwide, 7% of those diagnosed (1.1 million) were started on treatment in 2015. Of those started on treatment in 2015, about half received DAAs. Globally, over the years, the cumulative number of those placed on treatment reached 5.4 million persons in 2015. Most of the patients treated before 2015 received older treatments, primarily interferon-based therapies.

Summary of key recommendations

Recommendations on screening for HCV infection

1. Screening to identify persons with HCV infection

It is recommended that HCV serology testing be offered to individuals who are part of a population with high HCV prevalence or who have a history of HCV risk exposure/ behaviour.

2. When to confirm the diagnosis of chronic HCV infection

It is suggested that following a positive HCV virus serological test another test (NAT for the detection of HCV RNA) be performed to diagnose chronic infection. NAT for HCV RNA should also be performed to assess whether to start treatment for hepatitis C.

Recommendations on care of people infected with HCV

3. Screening for alcohol use and counselling to reduce moderate and high levels of alcohol intake

An alcohol intake assessment is recommended for all persons with HCV virus infection followed by the offer of a behavioural alcohol reduction intervention for persons with moderate-to-high alcohol intake.

4. Assessing degree of liver fibrosis and cirrhosis

In resource-limited settings, the aminotransferase/platelet ratio index (APRI) or FIB4 tests should be used for the assessment of hepatic fibrosis rather than other non-invasive tests that require more resources such as elastography or fibrotest.

Recommendations on hepatitis C treatment

5. Assessing for HCV treatment

All adults and children with chronic HCV infection should be assessed for antiviral treatment

6. Treatment with direct-acting antivirals (DAAs)

WHO recommends that all patients with hepatitis C be treated with DAA-based regimens, except for a few specific groups of people in whom interferon-based regimens can still be used (as an alternative regimen for patients with genotype 5 or 6 infection and those with genotype 3 HCV infection who also have cirrhosis).

7. Telaprevir and boceprevir should no longer be used

These 2 first-generation DAAs, which are administered with pegylated interferon and ribavirin, were recommended in the 2014 guidelines. Evidence now shows that they result in more frequent adverse effects and less frequent cures compared with newer DAA-based regimens. Thus, these 2 medicines are no longer recommended by WHO.

8. WHO recommends preferred and alternative DAA regimens based on genotype and cirrhosis status

The Guideline Development Group reviewed all the available data (over 200 studies) to determine which regimens were most effective and safest to treat each of the 6 different genotypes.

WHO response

In May 2016, The World Health Assembly adopted the first "Global Health Sector Strategy on Viral Hepatitis, 2016-2021". The strategy highlights the critical role of Universal Health Coverage and the targets of the strategy are aligned with those of the Sustainable Development Goals. The strategy has a vision of eliminating viral hepatitis as a public health problem and this is encapsulated in the global targets of reducing new viral hepatitis infections by 90% and reducing deaths due to viral hepatitis by 65% by 2030. Actions to be taken by countries and WHO Secretariat to reach these targets are outlined in the strategy.

WHO is working in the following areas to support countries in moving towards achieving the global hepatitis goals under the Sustainable Development Agenda 2030:

- raising awareness, promoting partnerships and mobilizing resources;
- formulating evidence-based policy and data for action;
- preventing transmission; and
- scaling up screening, care and treatment services.

WHO also organizes World Hepatitis Day on 28 July every year to increase awareness and understanding of viral hepatitis.

ANNEX 4

Table 1 Viraemic hepatitis C virus epidemiology for EU countries in 2015

2015	viraemic infections	viraemic prevalence (%)	total diagnosed *†	newly diagnosed* †	trated †	cured †	new infections
Austria	21 100 (6000-30 300)	0,25% (0,07-0,35)	7000 (33,2%)	600 (8,6%)	2 000 (9,5%)	1 810 (8,6%)	590 (120-890%)
Belgium	64300 (23 000-75 700)	0,57% (0,21-0,67)	28 300 (44,0%)	2 300 (8,1%)	1 300 (2,0%)	1 280 (2,0%)	540 (70-700%)
Bulgaria	92 200 (48 400-117 000)	1,29% (0,69-1,65)	17 760 (19,3%)	1 200 (6,8%)	720 (0,8%)	440 (0,5%)	1 460 (905-1 814%)
Croatia	26 100 (16 600-28 300)	0,60% (0,39-0,67)	6 350 (24,3%)	150 (2,4%)	150 (0,6%)	90 (0,3%)	191 (158-220%)
Cyprus	6 200 (4 400-7 400)	0,53% (0,38-0,62)	620 (10,0%)	60 (9,7%)	46 (0,7%)	29 (0,5%)	52 (44-65%)
Czech Republic	42 900 (21 900-48 500)	0,40% (0,21-0,46)	13 300 (31,0%)	800 (6%)	880 (2,0%)	480 (1,1%)	1 200 (470-1 400%)
Denmark	19 500 (14 300-19 700)	0,34% (0,25-0,35)	12 300 (63,1%)	700 (5,7%)	630 (3,2%)	540 (2,8%)	350 (270-350%)
Estonia	18 100 (11 700-19 900)	1,42% (0,92-1,56)	9 100 (50,3%)	190 (2,1%)	450 (2,5%)	410 (2,3%)	210 (160-250%)
Finland	22 600 (16 200-26 200)	0,40% (0,29-0,46)	17 500 (77,4%)	930 (5,3%)	300 (1,3%)	220 (1,0%)	650 (500-250%)
France	190 000 (92 600-222 000)	0,29% (0,14-0,34)	140 800 (74,1%)	9 000 (6,4%)	19 400 (10,2%)	17 500 (9,2%)	5 500 (3 600-5 880%)
Germany	204 800 (90 100-313 400)	0,25% (0,11-0,39)	117 300 (57,3%)	5 000 (4,3%)	23 200 (11,3%)	20 870 (10,2%)	5 600 (3 660-9 170%)
Greece	130 800 (82 100-169 400)	1,14% (0,71-1,47)	37 600 (28,7%)	4 000 (10,6%)	2 100 (1,6%)	1 610 (1,2%)	3 400 (1 920-4 790%)
Hungary	52 300 (28 600-55 500)	0,53% (0,29-0,56)	25 100 (48,0%)	2 100 (8,4%)	1 200 (2,3%)	660 (1,3%)	2 200 (1 710-2 730%)
Ireland	29 500 (20 100-42 500)	0,62% (0,42-0,289)	11 900 (40,3%)	820 (6,9%)	840 (2,9%)	800 (2,7%)	650 (430-1 030%)
Italy	699 900 (452 400-927 000)	1,11% (0,74-1,59)	294 800 (42,1%)	30 400 (10,3%)	30 700 (4,4%)	27 660 (4,0%)	5 874 (4 948-8 528%)
Latvia	43 200 (25 000-49 900)	2,21% (1,43-2,55)	19 400 (44,9%)	1 300 (6,7%)	910 (2,1%)	560 (1,3%)	2 000 (1 340-2 550%)
Lithuania	32 700 (19 800-38 700)	1,09% (0,66-1,30)	4 100 (12,5%)	500 (12,2%)	930 (2,8%)	830 (2,5%)	1 100 (670-1 430%)
Luxembourg	5 200 (3 300-5 800)	0,92% (0,57-1,01)	2 800 (53,8%)	100 (3,6%)	189 (3,6%)	140 (2,7%)	150 (95-225%)
Malta	1 200 (1 000-1 900)	0,29% (0,24-0,44)	1 100 (91,7%)	20 (1,8%)	12 (1,0%)	4 (0,3%)	26 (25-40%)
Netherlands	16 400 (5 200-25 500)	0,11% (0,03-0,15)	9 800 (59,8%)	650 (6,6%)	2 000 (12,2%)	1 800 (11,0%)	590 (230-950%)
Poland	184 100 (136 100-224 300)	0,48% (0,35-0,58)	33 000 (17,9%)	4 000 (12,1%)	4 000 (2,2%)	2 980 (1,6%)	4 900 (3 380-6 380%)
Portugal	89 200 (73 900-120 100)	0,83% (0,69-1,12)	30 700 (34,4%)	1 300 (4,2%)	5 300 (6,0%)	4 830 (5,4%)	570 (510-850%)
Romania	546 700 (397 000-566 000)	2,54% (1,85-2,63)	87 900 (16,1%)	7 500 (8,5%)	3 400 (0,6%)	2 700 (0,5%)	11 000 (9 730-12 180%)
Slovakia	32 900 (19 800-37 400)	0,60% (0,36-0,68)	3 100 (9,4%)	270 (8,7%)	350 (1,1%)	190 (0,6%)	730 (430-950%)
Slovenia	6 300 (4 400-7 200)	0,30% (0,21-0,35)	3 300 (52,4%)	170 (5,2%)	150 (2,4%)	140 (2,2%)	130 (110-150%)
Spain	387 900 (201 500-619 800)	0,84% (0,44-1,34)	131 700 (34,0%)	5 500 (4,2%)	38 000 (9,8%)	35 790 (9,2%)	2 600 (1 366- 3556%)
Sweden	37 700 (27 900-43 400)	0,39% (0,29-0,45)	31 900 (84,6%)	1 500 (4,7%)	2 300 (6,1%)	2 070 (5,5%)	1 600 (1 330-1870%)
UK	187 700 (91 100-210 700)	0,29% (0,14-0,33)	72 300 (38,5%)	7 700 (10,7%)	9 000 (4,8%)	6 800 (3,6%)	5 200 (3 030-5 620%)
EU	3 238 000 (2 106 000-3 795 000)	0,64% (0,41-0,74)	1 180 000 (36,7%)	88 800 (7,5%)	150 000 (4,6%)	133 000 (4,1%)	57 9000 (43 900-67 300%)

Razavi H et al, Lancet Gastroenterology and Hepatology, March 2017

Data are n (95% uncertainty interval), % (95% uncertainty interval), or n (%). *Viraemic diagnosed cases only.
† Total viraemic infections is the denominator. ‡ Total diagnosed cases is the denominator. EU=Europen Union.

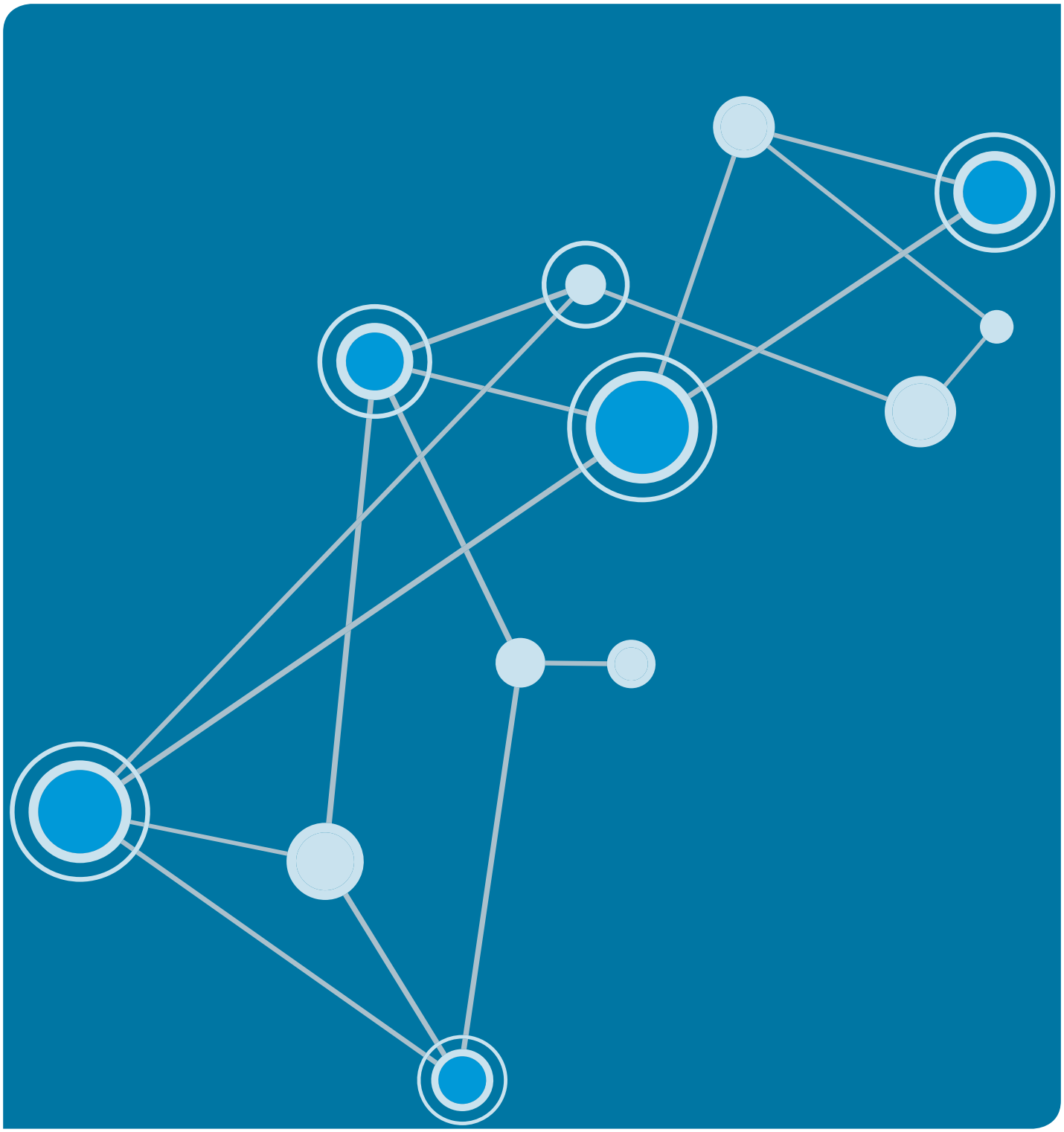
ANNEX 5
Presentations and podcast of the 1st HCV Policy Summit

The following link will direct you to the EU HCV Policy Summit presentations presented on 17 February 2016 in Brussels

www.hcvbrusselssummit.eu/images/documents/slide-deck/HCVPolicySummit-MasterSlide-Deck_20160217.pdf

The following link will direct you to the podcast of the event where you can listen to all the interventions listed above

www.hcvbrusselssummit.eu/material/summit-podcast



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