



Swiss Hepatitis Strategy 2014 – 2030

Time to Act Now!
Process Paper – A Living Document

July 2015

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0. Foreword

Viral hepatitis B and C are chronic infections prevalent in Switzerland with increasing, potentially deadly consequences hitting the national health care system. These silent diseases often progress with few symptoms, even during advanced stages of disease, causing individual, social and economic harm. However, despite the availability of highly efficient prevention and treatment measures, public awareness, detection and treatment of viral hepatitis remain suboptimal in our country. The viral time bomb, as the epidemic has been described by the World Health Organization WHO, keeps ticking.

Driven by the concerns over the growing public health burden, over 70 personalities from the medical field, the economy, peer group and patient associations, funding agencies and politics followed the invitation of the Swiss Experts in Viral Hepatitis (SEVHep) to contribute to the elaboration and implementation of a comprehensive strategy to combat chronic viral hepatitis in Switzerland. They are all offering their expertise on a voluntary basis, which allows keeping the financial expenditures low and covered by unrestricted funds. The Swiss Association for the Study of the Liver, the Swiss Society for Gastroenterology, the Swiss Society for Infectiology, the Positive Council Switzerland and the Global Health Programme of the Graduate Institute of International and Development Studies joined SEVHep to lead this bottom-up approach. A patronage committee of half a dozen Swiss celebrities supports the initiative as well.

So far the milestones of this Swiss Hepatitis Strategy process were the development of a strategy vision, the launch of six working groups defining the needs and measures in their given fields of action and the setting up of an overall time plan. The paper is considered as a "living document" and everybody involved in this initiative is kindly invited to share his or her suggestions about it. Its purpose is to serve as a guideline for the implementation of the strategy and it is expected to evolve as we go.

This process paper is the result of the enormous efforts and a vast amount of time invested by the network members, their institutions and the patronage committee supporting this strategy. In the name of the project board and the project management I would like to express my sincere gratitude to all of these highly committed people and organizations.

We are on a promising way to achieve our vision of a hepatitis-free Switzerland!

Philip Bruggmann
SEVHep Chairman

1. Introduction

In Switzerland, 60'000 to 80'000 people live with hepatitis C (HCV), 20'000 to 30'000 with hepatitis B (HBV). Over half of the affected individuals are unaware of their infection. Viral hepatitis is the main cause for liver cancer and liver transplantations. Switzerland has signed the World Health Organization (WHO) resolution on hepatitis¹, which was passed by the World Health Assembly in 2014. It urges member states to develop national strategies according to the epidemiological situation to prevent, diagnose and treat viral hepatitis. Furthermore, due to a revolution in the development of drugs, HCV has become a curable disease. For HBV a vaccine is available. The main barriers stopping prevention, diagnosis and treatment of viral hepatitis are: lack of awareness of the disease in the general population, among decision makers in politics and among health care providers; the fact that the health care system is not yet ready to test and treat; the existing stigma attached to this chronic disease and finally the fact, that viral hepatitis often affects vulnerable social groups that are difficult to reach. With 80'000 to 110'000 people living with chronic hepatitis in Switzerland and with most infections having occurred before the early 1990s, Switzerland is very likely to face an increase in the number of severe liver disease cases in the next ten to twenty years.

In an initiative started by Swiss Experts in Viral Hepatitis (SEVHep)², and joined by the Swiss Association for the Study of the Liver (SASL), the Swiss Society for Gastroenterology (SGGSSG), the Swiss Society for Infectiology (SGINF), the Positive Council and the Global Health Programme (GHP) of the Graduate Institute of International and Development Studies, over 70 personalities decided that it is time to act now in order to reduce the harmful impacts of viral hepatitis in the future. A patronage committee of half a dozen Swiss celebrities supports the initiative as well. The "Governmental Learning Spiral" (GLS), a multidimensional approach that is designed to enhance collective learning in complex political environments, was chosen as the underpinning method of the project.

This document is the first tangible outcome of this initiative and the result of many months of voluntary work by the network members. It is composed by eight chapters starting with describing the Status Quo of viral hepatitis worldwide and in Switzerland (Chapter two) as well as explaining the reasons why it is necessary to act now (Chapter three). A fourth Chapter describes the GLS method and Chapter five gives an overview of the projects structure such as its organization, finances, meetings and timeline.

Based on the bottom-up approach the applied structure is an open and flexible one: The core body are the over 70 network members. They are engaged in six working groups, each group covering one or two fields of actions. A liaison person for each group together with one representative of the initiating organizations serves as project board. These bodies are supported in their activities by a small project management that oversees the operative work and is responsible for planning, organising, overseeing finances, dealing with communication as well as evaluating the process. The later will be described in Chapter six.

A first result of the project process is the development of the vision and aims of the Swiss Hepatitis Strategy that will be presented in Chapter seven. The

vision targets the elimination of viral hepatitis in Switzerland till 2030. In order to turn this vision into reality, three aims must be achieved:

1. Reducing the socio-economic impact of viral hepatitis on the individual, the community and the whole population;
2. Reducing the transmission of HBV and HCV;
3. Reducing morbidity and mortality caused by viral hepatitis.

In Chapter eight, the seven fields of action of the strategy are described, as well as the first results, activities and needs of the Working Groups (WG). Four fields of action and their affiliating working groups have a specific self-contained course of action: Prevention & Awareness (WG1), Surveillance & Screening (WG 2), Access to Treatment (WG 3) and Pricing (WG 5a). Furthermore, there are three fields of action that have a cross-sectional function related to each of the self-contained activities above. These are: High-Risk Groups (WG 4), Financing (WG 5b) and Politics & Policies (WG 6). Envisioned activities reach from the development of communication material, a screening and surveillance programme and treatment guidelines to the evaluation of pricing schemes, analyses of cost-effectiveness of activities and the collection of epidemiological data for different social groups.

This Process Paper is a „living“ document, which will be further developed until completion. It serves as a guideline for the activities for all participants involved and it keeps the network member, potential sponsors and other supporters and interested parties informed about its progress and first results.

2. Status Quo

HBV and HCV are a serious global threat. It is now responsible for 1.44 million deaths every year, compared with 1.46 caused by HIV/AIDS and 1.17 by malaria.³ Worldwide, approximately 500 million people currently live with viral hepatitis, an estimate of 23 million in Europe alone.⁴ In Switzerland approximately 60'000 to 80'000 people are infected with HCV and 20'000 to 30'000 with HBV. HCV is the predominant cause for liver transplantations and if comprehensive measures against the epidemic are not introduced immediately, potentially fatal consequences will increase. They include cirrhosis, liver failure and hepatocellular cancer.⁵ The highest number of patients with cirrhosis and liver cancer will be reached between 2020 and 2025. It is widely assumed that the majority of HBV or HCV infected people are not aware of their illness because these infections produce almost no symptoms before the secondary diseases break out.⁶

Despite these numbers, until recently, viral hepatitis received very little attention from the general public, policy makers, patients and health care professionals. The lack of political focus was often explained by the "class stigma" attached to hepatitis diseases. High-risk groups for acquiring and spreading the disease are injecting drug users, children of infected mothers, professional sex workers, prison inmates, migrant populations and men having sex with men. These people have little political clout. For a long time the low level of awareness remained a significant barrier to efficiently respond to this growing epidemic.⁷

According to the Euro Hepatitis Index Report 2012, which measures effectiveness of prevention, screening and treatment instruments, Switzerland is only ranked 12th. In the specific area of case finding and screening it is ranked 17th.⁸ Prevalence of infections is estimated to be approximately 0,3 % for HBV and approx. 0,7 to 1 % for HCV. The costs incurred by HCV alone amount to an estimate of over 100 million Swiss francs for medical expenditures per year. In view of the ageing infected population and the increasing numbers of advanced illnesses among risk groups, these numbers are likely to further deteriorate.⁹

In 2014 a revolution in HCV treatment became reality with the extent of Direct Acting Antiviral (DAA) therapy development and interferon-free treatments.¹⁰ In 25 years, the field of viral hepatitis advanced from discovery of the virus to the beginning of the curative era for viral infection.¹¹ While HBV has been an avoidable disease by way of vaccination and those infected have been treatable to end the progression, HCV is from now on a curable and preventable disease too. The downside of these developments is that the cost for HCV treatments is considered to be unreasonably high with prices between CHF 60'000 and CHF 130'000 for a typical person's total cure.¹²

Concerned by such high pricing rates, the Federal Office of Public Health (FOPH) introduced a so-called "limitatio" that defines the medical conditions, under which the new hepatitis drugs are covered by the mandatory health care insurance.¹³ A measure that doctors and patient organizations alike criticised and refused to accept.¹⁴ As a result of these pricing and treatment regulations, viral hepatitis received an increasing amount of attention from the media and led to fierce debates among health officials, the pharmaceutical industry and the general public.

3. Why Act Now

In early 2014, the sixty-seventh World Health Assembly restated its recognition of viral hepatitis as a global public health problem and the need for governments and populations to take action to prevent, diagnose and treat viral hepatitis. It called upon the WHO to develop and implement a comprehensive global strategy to support these efforts, and expressed concern over the slow pace of implementation. It urged member states to develop and implement coordinated multi-sectoral national strategies for preventing, diagnosing, and treating viral hepatitis based on the local epidemiological context.¹⁵ This WHO declaration was signed by Switzerland, promising to develop comprehensive measures for national coordination to combat viral hepatitis and limit its consequences. The individual, economical and social burden of viral hepatitis is expected to continuously worsen in Switzerland if efforts to increase awareness, detection and treatment of those in need are not coordinated nationally.¹⁶ The current detection strategy of viral hepatitis with risk-based testing has not been effective.

However, instead of moving ahead and realising these declarations, heated debates emerged about drug pricing policies of the pharmaceutical industry on the one hand and selection criteria introduced by the FOPH that determine patients' eligibility for health insurance coverage on the other. During this stand-off, SEVHep recognized the urgency to act and tried to achieve conciliation and initiated a process to develop and implement a Swiss Hepatitis Strategy in early 2014. This conviction of having to act was shared by SASL, SGGSSG, SGINF, the GHP of the Graduate Institute of International and Development Studies and the Positive Council Switzerland, which joined SEVHep in leading this initiative.

In January 2014 these organizations invited thirty-five personalities with national and international backgrounds and reflecting all major state-of-the-art perspectives related to HBV and HCV, including representatives of patient advocacy groups, to a first kick-off meeting held in Berne. Despite their different and sometimes contradicting points of view, a common understanding emerged among the participants, that there is an urgent need and a political momentum to take action and launch a coordinated strategy to combat and eradicate viral hepatitis in Switzerland. This perception was reinforced by the commitment of the participants to voluntarily engage in a network that actively supports the strategy development and implementation.

The initiative received support from the federal authorities in form of two letters, one from the Federal Councillor Alain Berset and the other from the FOPH Director-General Pascal Strupler, who stated that they "appreciated [this] initiative and the steps taken so far towards improving the health of the Swiss population in the field of chronic viral hepatitis" and that they "welcomed the well functioning information exchange between the FOPH and the representatives of the initiative that allows a mutual alignment of activities and coordination of possible upcoming steps". Recently a patronage committee was formed that supports the initiative as well.

4. Method

The development and implementation of a Swiss Hepatitis Strategy is a complex matter and in many ways unknown territory. The points of view related to the issue are numerous, multi-dimensional and contradicting. Nobody knows it all and the task cannot be delegated to a single political authority or a single expert alone. In relation to HBV and HCV more than thirty distinctive perspectives were identified that need to be reflected in such a strategy. To prevent that the process paper itself does not degenerate into a “standalone” document without any practical relevance, its development and implementation has to be handled as an integrative and overlapping process where the ones who develop are also the ones who implement.

An approach that allows such a multidimensional and collaborative bottom-up process is the “Governmental Learning Spiral” (GLS).¹⁷ This method is a theory-based and practice-approved approach designed to initiate collective learning to develop sustainable knowledge in political settings. It is based on the understanding that political knowledge is by nature contextual, has a short half-life and therefore needs to be reviewed on an on-going basis. The later requests an ongoing monitoring and evaluation of the process.

An important effect of the GLS is that it enhances a sense of social belonging among the involved actors, which leads to the alignment of different viewpoints as well as the creation of social networks. By doing so, a broader audience gets involved, which in turn evokes feedback loops that lead to the continuous improvement of the strategy process as a whole. The involved actors give their expertise for free. Their return of investment is new first-hand insight from the other participants as well as the opportunity to influence the process as a whole. Another advantage of this knowledge-based approach is that it keeps the project cost low and protects it from financial interests..

The process of GLS is designed and led by an impartial “knowledge broker”. In close collaboration with the project initiator he or she defines the relevant content perspectives and selects and briefs the so-called “knowledge holders” that represent the respective point of views. Besides this knowledge-based selection, the participants as a group have to have sufficient institutional and political weight to create the political momentum needed for the implementation of a strategy. The knowledge broker introduces the project members to the method and supports them on organizational and content-related issues during the entire process.¹⁸

5. Organization, Finances, Meetings and Timeline

Since its beginnings, the initiative passed through a range of different organizational phases and it is likely that this institutionalization process will continue towards a more differentiated and legally formalized structure. The form and speed of this process will depend on the different necessities required during the future development of the project. It is important to stay lean and financially independent. This keeps the budget low and allows covering it by unrestricted funds, as it has been the case so far. The contributors who support the initiative are listed at the SEVHep website.¹⁹ Up to now, all funding was used to finance meeting infrastructures as well as honorariums.

The Swiss Hepatitis Strategy project was initiated by SEVHep. In fall 2013, a Project Management was set up comprised by two Co-Project Leaders and an assistant. In February 2015 a communication and fundraising employee complemented the team.²⁰ At the the *First Swiss Hepatitis Strategy Meeting* held in January 2014, SASL, SGGSSG, SGINF, GHP and Positive Council as well as 35 selected personalities joined SEVHep in its effort. The purpose of the event was to work out a first inventory of corner stones that need to be considered when developing a comprehensive hepatitis strategy. Based on these findings a "Concept Paper" was drafted describing a roadmap on how to develop and implement a Swiss Hepatitis Strategy.

Over time the group of people grew into a network of more than 70 individuals. At the *Second Swiss Hepatitis Strategy Meeting* in September 2014 the network members become operationally active and committed to engage in one of six working groups, each led by a liaison person. A patient representative is present in each working group too. The groups are responsible for one or two allocated field of action derived from the corner stones developed in the first meeting.

To coordinate the overall process a Project Board was created, comprising one representative from SEVHep, SASL, SGGSSG, SGINF, GHP and the Positive Council, as well as the liaison persons. It is supported in its activities by the Project Management. The board has no legal status and its constitution and resolution depends on the will of its members. Decisions are made by majority rule. The SEVHep Chair currently heads this body as "primus inter pares" and can cast the deciding vote. SEVHep is entitled to sign all legal contracts related to the project and is responsible for representing the body towards third parties. From the beginning it was foreseen that additional stakeholders, whose expertise is considered complementary, could supplement this body. It is a clear goal of the Project Board to involve those directly affected, patients and persons at high risk and therefore especially vulnerable in all steps of the process and that their voices are heard.

The Project Board oversees the Project Management, which is in charge of the operational tasks such as setting up and running a project office, developing and implementing the project structure and timeline as well as supporting the network and its working groups in their activities. The Project Management is collecting and giving access to strategy related national and international experiences. It is responsible for the fundraising, budgeting, accountability and communication. (For an overview of the current project structure see Figure 2)

At the *Third Swiss Hepatitis Strategy Meeting* held in December 2014 the network members entered into the planning phase of the project, pursuing a comprehensive overview of all field related activities across the six Working Groups. At the *Fourth Swiss Hepatitis Strategy Meeting* in March 2015 concrete implementation steps were worked out and coordinated (see Figure 1), with a special emphasize of the first six-month implementation phase (see Figure 3). Decisions were made regarding what field related activities will be taken first, in collaboration with whom and what resources will be used. Furthermore, it was decided to develop a monitoring and evaluation instrument to survey the process as well as a communication and fundraising concept, ready to be applied for the second twelve-month implementation phase in 2016. Regularly held Swiss Hepatitis Strategy Meetings would be held at the crossing points to review the project progress, the evaluation results, and to discuss the upcoming implementation steps. To facilitate communication among the network members a Dropbox account was setup, which allows instant exchange of project relevant information's and documents.

6. Monitoring and Evaluation

A key feature of the GLS process, referred to as the feedback loop, is a custom-made monitoring and evaluation system (M&E). Learning in political environments can only take place when project-related activities and attitudes are comprehensively measured, critically analysed and meaningfully fed back to the involved stakeholders on an ongoing basis. Such an evidence-based approach allows continuous reviewing and improving the strategy process in regard to implementation progress, budget decisions, project management, and accountability. To prevent an over-engineering of the M&E system, it needs to be kept simple and pragmatic. Its application and performance should be subject to regular review too.

The proposed approach is designed to be broad in scope and long-term oriented. To secure ownership and to mark the way forward accurately, indicators are developed along the seven fields of action by the members of the six working groups. The existing field-related activities serve as a base. Approximately 40 statements directed towards the project vision and aims shall be derived from them. They are written in English and no longer than 20 words each. If necessary, statements can be added or omitted later on. A scale of five indexes from 0/strongly disagree to 5/strongly agree and the option of "no answer" allow the measurement of attitudes towards and the intensity of acceptance or rejection of the given statements (see Likert scale²¹).

Based on these statements, a questionnaire is created. Its completion takes between 10 and 15 minutes. The transformation of the collected data into charts and graphs takes half a day. The sample includes the network members (n=70). It may be extended to other targeted individuals later on. The design of this longitudinal study foresees its repetition every six months over a timeframe of 15 years, starting in January 2016 and ending in December 2030. The compilation of each poll shall be recorded on a scorecard that gives an overview about the progress of the project over time.

A user-friendly and cost-effective tool to execute such a study is SurveyMonkey.²² Although the design and execution of this kind of web-based survey is very lean and time-efficient, the analysis and discussion about its impact should be as detailed and rigorous as possible. It should include all network members and, if advised, other project-related individuals. A first test of the survey will be conducted in October 2015 and the results will be discussed at the *Fifth Swiss Hepatitis Meeting* in December 2015.

7. Vision and Aims

Since the beginning of the initiative the content of the strategy vision and aims were regularly discussed by the network members and the project board. To date the following wording was agreed upon: *The Vision of the Swiss Hepatitis Strategy is the elimination of viral hepatitis in Switzerland within the next fifteen years.*²³ This shall be achieved by preventing new hepatitis infections, optimising treatments, and lowering the morbidity and mortality associated with viral hepatitis. By doing so, the individual, medical and socio-economic consequences of the hepatitis epidemic shall be limited with patient-friendly, cost-efficient and implementable measures.

Based on this vision, the three following aims were derived:

1. *Reducing the socio economic impact of viral hepatitis on the individual, the community and the general population*

The growing morbidity and mortality of viral hepatitis is accompanied by major public health, social and economic burdens. Hepatitis C is associated with stigma and discrimination. Raising awareness, detection rates and targeted treatment uptake as well as price reductions of hepatitis medications e.g. by volume related pricing could lower these burdens.

2. *Reducing transmission of HBV and HCV*

It is estimated that less than 50% of those infected with the virus are tested and therefore aware of the disease and the potential to transmit it to others. Relevantly improving detection as well as treatment rates and prevention in the population groups most affected by on-going transmission and efficiently finding and treating undetected infections causing progressive disease in the general population must therefore be a primary goal of the strategy. Hepatitis B transmissions can be reduced by a maximal coverage of vaccination in the general population. The targeted value for new infection rates should be the reduction by 30% in 5 years and by 90% in 15 years.

3. *Reducing morbidity and mortality caused by viral hepatitis*

Among infected individuals, hepatitis related morbidity and mortality continues to grow. Successful treatment can prevent disease progression and death, and availability should be made a priority for those most at risk and most likely to need treatment. The systemic character of hepatitis C infection, not only causing liver related morbidity and mortality, should be taken into account. With the availability of highly efficient and safe hepatitis C medication, a feasible test-and-treat approach should be envisaged. To achieve this, the cost of medication must be lowered concomitant with cancellation of prescribing restrictions. A broad planned detection strategy accompanied by an awareness campaign for health professionals, high-risk groups and the general population must be implemented.

The targeted values are:

- Hepatitis C chronic infections will be reduced by 30% within 5 years and eliminated in 15 years

- Hepatitis B chronic infections will be reduced by 20% within 5 years, and by 80% within 15 years
- Liver transplantations due to viral hepatitis induced end stage liver disease will be reduced by 30% within 5 years and reduced to zero by 2030
- Liver cancer due to viral hepatitis will be reduced by 30% in 5 years and eliminated within 15 years

This vision and aims reflect the result of numerous debates among the members of the project network so far. Depending the process progress they might be questioned and readjusted. However, upon this point it is important that these statements are considered as the relevant guidelines, according to which future activities shall be aligned.

8. Fields of Action

Goals, Related Activities, Priorities, Responsibilities and Resources

In the Fourth Swiss Hepatitis Strategy Meeting the six Working Groups (WG) defined the goals of each field of action, determined the related activities and priorities, allocated the respective responsibilities and assessed resources for their implementation. The systematic compilation of these field related activities made evident that they serve different purposes: On the one hand, the working groups dealing with Prevention & Awareness (WG 1), Surveillance & Screening (WG 2), Access to Treatment (WG 3) and Pricing (WG 5a) provide a specific self-contained course of action. On the other hand, the working groups in charge for High-Risk Groups (WG 4), Financing (WG 5b) and Politics & Policies (WG 6) do have a cross-sectional function related to each of the self-contained activities above. The strategy can therefore be presented in a two-dimensional matrix, with four self-contained activities on the horizontal axes and three cross-sectional activities on the vertical axes (see Figure 3).

The forthcoming description of the goals, activities, priorities, responsibilities and resources for each Working Group reflect the very nature of the different field of action and are therefore rather inconsistent and heterogeneous. Depending the course of action of the strategy project they may also alter, what in itself will result in further changes of related activities. To obtain more detailed information's about the activities of the Working Groups at any given time see the "One pager Documents of the Working Groups" (Annexe ?) as well as documents posted in the Dropbox. Access to the Dropbox can be requested at the Project Management.

In the following presentation the self-contained activities will be presented first, followed by the cross-sectional activities:

8.1. Self-contained Activities

8.1.1. Working Group 1: Prevention & Awareness

Goals:

Raising awareness by informing the general population and risk groups without creating unnecessary anxieties or fear, and reducing stigma by informing the general population, health care providers and risk groups.

This will be done by first providing the general population with the necessary knowledge about viral hepatitis infections, in order to promote prevention, targeted testing, follow-up, treatment and reduction of aggravating risk factors, and second, providing people at increased risk, people affected by hepatitis, health care providers and professionals, who are in contact with infected individuals with the necessary knowledge about viral hepatitis infections, in order to promote prevention, targeted testing, follow-up, treatment and reduction of aggravating risk factors.

Activities and Priorities:

- In the first six months, surveys and data research (best practice examples) have to be conducted in order to learn what people, health care

providers and affected people already know about viral hepatitis. Collected best practice examples and existing material will allow drafting a prevention and awareness strategy more rapidly and precisely.

- In the second half of the first year, key messages for all target groups have to be developed. As a second priority and in accordance with Working Group 3 (access to treatment), educational material for health care providers and other professionals will be developed.
- In the second year, prevention and communication material will be developed and distributed.
- In the third year, the prevention and awareness campaign is continued, evaluated and further developed according to need.

Responsibilities:

Members of Working Group 1 during the first year: Establishing an extended project group under the lead of an institution or a federal department. Needs clarification.

Resources:

CHF 60'000 – 80'000 for surveys and data research. 30 days of human resources (or the equivalent in financial means). CHF 23'000 to 25'000 for the second half of first year. CHF 250'000 or more for campaign and communication material. Human resources have to be determined (work load for members of WG).

8.1.2. Working Group 2: Surveillance & Screening

Goals:

Firstly, we aim to select screening and surveillance tools based on the analysis of their advantages and drawbacks and on the available data in literature. Since the prevalence of viral hepatitis is inhomogeneous (it occurs more frequently in particular age groups), our second aim will be to define the most adequate population to be offered screening and surveillance. And the third to develop a model for a screening and surveillance strategy including diagnostic tests that will allow identifying infected patients and patients with the disease. Furthermore, we will test feasibility of a screening and surveillance programme on a small scale, which will act training ground for the development of a national screening and surveillance strategy on a significantly larger scale.

Activities and Priorities:

1. First we plan to summarize the utility of various diagnostic tests, such as serology, PCR or liver elastography to screen, based on currently available data, and to follow up patients with chronic viral hepatitis. The main evaluation criteria of these tests include performance accuracy, feasibility, acceptance in the target population, costs and tangible results of testing and surveillance.
2. Secondly, summarizing and reviewing epidemiological data available for the situation in Switzerland will allow identifying the characteristics of the population in which a strategy of screening and surveillance will likely be successful. Not only advantages, but also possible adverse effects of screening will be evaluated.
3. The third aim will be achieved by defining a model and a roadmap for a strategy. In previous discussions and work we identified two possible scenarios including a forward strategy, i.e. the initial identification of infected patients (HCV positive serology and PCR), followed by surveillance of the disease (advanced liver fibrosis), and a backward strategy, starting with screening for the disease first and identifying the infected later.

The aims 1-3 represent the priorities for the activities that need to be developed by September or October 2015. The progress of the group will be monitored and discussed in virtual (Skype/GoToMeeting) and face-to-face meetings (Cercle de la Grande Société, Berne).

4. The fourth step will be assessing feasibility and results on a small scale. To achieve this we consider applying one selected screening and surveillance strategy over a short time period and in a small test population in early 2016. At the end of the preliminary experimental phase, results will be analysed according to previously determined criteria of success. This approach will allow to correct inefficient processes and to improve the general performance of the strategy.
5. Lastly, the strategy will be ready for implementation on a national scale in 2017-2018 and coordinated with the other fields of action.

Responsibilities:

1. Selecting screening and surveillance tools: Pierre Deltenre and Pietro Vernazza
2. Identifying the population for screening and surveillance: Christoph Hatz and Andri Rauch
3. Developing of a model for a screening and surveillance strategy: Vernazza and De Gottardi
4. Strategy project on a small scale: Christoph Niederhauser, Gila Stump and Harry Witzthum
5. Implementation of a national screening strategy: All

Resources:

For the activities scheduled for 2015 the costs are limited to the expenses of the meetings. The costs of the preliminary experimental phase and of the national implementation of the screening and surveillance strategy in 2016 will greatly vary according to the type of selected diagnostic methods and can therefore not be estimated at this point of time.

8.1.3. Working Group 3: Access to Treatment

Goals:

Goal 1:

- a. Facilitating access to care, overcoming the limitation
- b. Synchronized systems (no loss to follow-up between different institutions)

Goal 2:

- a. Integration of primary care physicians (family physicians) and representatives of special institutions, (e.g. prisons, institutions dealing with migrants, Opioid Substitution Treatment (OST) and other drug rehabilitation programs and further institutions of importance) into the treatment plan
- b. Integration of up to date treatment recommendation from national and international bodies

Goal 3:

- a. To start, maintain and successfully achieve treatment goal
- b. To achieve a sustained treatment success (prevent re-infections, reduce co-morbidities (e.g. alcohol, overweight etc.)

Activities and Priorities

Derived from three levels: system/provider/patient:

1. a) Seeking dialogue with health authorities, health care insurances and the industry
1. b) Conducting an assessment of the current care continuum with its strengths and weaknesses, in order to define clinical pathways and the coordination of care and to develop supportive tools
2. a) Identifying and discussing barriers and needs with all before-mentioned players and subsequently developing tools for comprehensive patient assessment
2. b) Regularly updating treatment recommendations
3. a/b) Identifying needs and barriers and developing patient support accordingly

(Activities for health care providers should be coordinated with Working Group 1: Prevention and Awareness, Working Group 2: Surveillance and Screening, Working Group 4: High Risk Groups, and Working Group 5: Financing and Pricing)

Responsibilities:

1. Actively participating in "round table" discussions with FOPH in March. Contacting main health care providers is only possible, when the entire strategy including screening, pricing etc. is well established and is being presented as a coordinated effort in close collaboration with Working Groups 1, 2 and 4.
2. Treatment recommendations will be updated continuously. Two members of the Working Group (Beat Müllhaupt and Jan Fehr) are part of the writing committee and David Semela and Francesco Negro are

part of the review committee of the treatment recommendations published by SASL/SGG and SSI.

3. The already existing "ready4therapy" programme could serve as point of departure to address the specific needs of hepatitis C patients.²⁴ Two members of the "ready4therapy" (Jan Fehr and Dunja Nicca) are participating in our Working Group.

Resources:

Resources (financial and human): Will be determined in a next WG3 meeting/telephone conference.

8.1.4. Working Group 5a: Pricing

Goals:

- Conducting a health technology assessment
- Determine pricing and cost effectiveness of treatment
- Setting up free and anonymous screening and vaccination

Activities and Priorities:

- In a first activity, pricing schemes of selected countries will be reviewed. Options for Switzerland will be selected. In doing so, ethical considerations have to be taken into account. The aim is to develop a value-based pricing scheme for patient subgroups. This activity will address the costs and benefits of treatment in patient subgroups and the effects of wider implications on the costs and prices.
- In a second activity, the different options will be discussed with key stakeholders. Based on these findings, an activity plan will be drafted. Starting early 2016, an activity plan will be executed.

Responsibilities:

Members of Working Group 5

Resources:

Time and human resources of group members

8.2. Cross-sectional Activities

8.2.1. Working Group 4: High-Risk Groups

Goals:

1. High-risk groups get tested and are treated for viral hepatitis
2. Barriers to treatment are known and addressed. Those subgroups most at risk are identified
3. Health care providers know about the vulnerability of high-risk groups and act accordingly
4. Activities for high-risk groups are included on all levels of the strategy

Activities and Priorities:

1. Obtaining relevant epidemiological data among the risk groups, men who have sex with men (MSM), people who use drugs (PWUD), Prison population, migrants and sex workers.
2. Identifying and prioritizing sub-groups among high-risk groups that are most at risk.
3. Barriers to treatment are known and addressed.
4. Health care providers will be made aware of vulnerability of high-risk groups and will be instructed how to act.
5. In close cooperation with these four Fields of Actions strategies to inform, test and treat people at increased risk are implemented.
6. High-risk groups get tested and are treated for viral hepatitis.
7. Collaborating with other Working Groups to ensure that the different activities are closely monitored and made sure, that high-risk groups are incorporated in all activities according to the need and relevance.

Activities and Priorities:

- MSM: First Priority, if confirmed, no further action will be taken except further monitoring and interventions on behaviour among the most exposed MSM subgroup
- PWUD: First Priority, rapid increase of treatment rates is needed and possible in this population
- Prisons: Second Priority, needs political commitment
- Migrants: Second Priority, needs intensive political actions to obtain commitment for treatments
- Sex workers: Second Priority, needs intensive political actions to obtain commitment for treatments

Responsibilities:

- MSM: Claude Scheidegger, Andreas Lehner, Pietro Vernazza, Hansruedi Völkle
- PWUD: Philip Bruggmann, Peter Menzi, Claude Scheidegger
- Prisons: Bidisha Chatterjee, Marcel Ruf, Claude Scheidegger
- Migrants: Sandra Hollinger, Serge Houmard
- Sex workers: Andreas Lehner, Claude Scheidegger, Hansruedi Völkle

Resources:

- MSM: none
- PWUD: CHF 10'000-20'000
- Prisons: CHF 10'000-20'000
- Migrants: CHF 10'000-20'000
- Sex workers: CHF 10'000-20'000

8.2.2. Working Group 5b: Financing

Goals:

1. Finding ways of financing the development and implementation of the Hepatitis Strategy
2. Studying various options for pricing for the treatment and evaluating its cost-effectiveness

Activities and Priorities:

The development and implementation of the national hepatitis strategy is costly.

- In a first activity, financial needs for the different action fields and the three cross-sectional functions have to be assessed.
- A fundraising concept will be developed in collaboration with the project management.
- Possible funding sources are to be evaluated.
- Factsheets and documents illustrating the need for a national strategy are developed.

Responsibilities and resources will be defined at a later stage.

8.2.3. Working Group 6: Politics and Policies

Goals:

1. Key persons in politics and public health system are identified
2. Tools to address key persons are developed
3. A strategy to influence policies is established and implemented on national and cantonal levels

Activities and Priorities:

Lobbying activities are crucial for a successful development and implementation of a national hepatitis strategy.

- In a first activity, key persons who are most likely to assist the WG in convincing politicians and key figures in public health of the necessity of a hepatitis strategy for Switzerland will be identified.
- Factsheets and communication material targeting politicians and decision makers will be developed and continuously updated.
- Based on the evaluation of other successfully implemented strategies in the public health sectors, a strategy will be developed to promote the strategy on a political level and hence influence health policies.
- Politics and Policies will work closely with all four fields of action to support them in their activities.

Responsibilities and resources will be defined at a later stage.

ANNEX

Annex 1: One Pager Documents of the Working Groups

Working Group 1 – Prevention & Awareness

A. Main Purpose of the Field of Action

Working group 1 defined two overall goals, which should be achieved with the planned activities:

1. Raising awareness by informing the general population and risk groups in a way, that we do not create unnecessary anxieties or fear.
2. Reducing stigma by informing the general population, health care providers and risk groups.

Goals:

To provide the general population with the necessary knowledge about hepatitis infections, in order to promote prevention, targeted testing, follow-up, reduction of aggravating risk factors and treatment. As a second priority the awareness and education campaign targets as well high-risk groups, people affected by hepatitis, health care providers and professionals, who have contact with infected persons.

Activities for health care providers should be coordinated with working group 3 (Access to Treatment).

Activities for high-risk groups should be coordinated with working group 4 (High-Risk Groups)

B. Concrete Activities

WG1 defined five fields of action:

1. Awareness and Education Campaign;
2. Reduction of Stigmatization;
3. Education of Health Care Professionals,
4. Networks to Promote Awareness/Prevention,
5. Lobbying and Advocacy

Within this field of actions, we prioritized the following activities:

1. Survey among the general population on knowledge about hepatitis

It is unknown, what the general population knows about hepatitis infections, transmission, prevention, immunization, diagnostics and treatment. To formulate the right messages we have to know, what knowledge is already available, how affected individuals are perceived (stigma) and what the needs are. Therefore, a survey in the general population should be conducted.

II. Finding best practice examples

We do not have to invent everything from the start. We can build on already existing examples, which proved to be working. Therefore, we should study best practice examples and identify the lessons learnt. We can use also the experience made with HIV.

III. Identification of existing programmes

In order to use possible synergies, existing programmes should be approached for collaboration (eg. "MiGes – migration and health", HIV-STI programme, addiction strategy, vaccination programmes) as well as existing materials, where the key messages can be included.

IV. Understanding the dimension of stigma

Is stigma a problem? To what extent? Is it a barrier to treatment? How do risk groups, eg. the community of migrants perceive hepatitis? Is it one of the taboo issues? Are migrants ready to do a test without having a fear of their community feedbacks? In order to create the right messages, we should understand the stigma better. A survey among patients should be conducted.

V. Creation of key messages and communication strategy

Based on the results of the surveys above (activities I and IV), key messages have to be developed to address target groups. It will be important to stress the benefits of knowing one's own hepatitis status. Positive messages have to be formulated and transmitted. Messages should be simple to understand and – if possible – they should be available in different languages. The messages will be included in a detailed communication strategy.

VI. Improving the knowledge of health care professionals

Health care professionals, like general practitioners, nurses, medical staff in prisons and so on, as well as social workers in specific settings should have enough knowledge on hepatitis to react accordingly. Eg. know-how and awareness of general practitioners is crucial, so that the right individuals get tested, investigated and follow-uped appropriately, informed correctly and eventually treated for hepatitis at right the moment with the right drugs. Professionals should also be aware of the cultural and social norms and their differences in order to pass culturally appropriated messages and to make sure of their acceptance by migrant communities. (Learnings from the HIV-field may be adoptable). To reach this goal, training programs should be developed for doctors and nurses, as well as other professionals. In Collaboraton with Working Group 3 (Access to treatment)

VII. Production of information material on- and offline

Development of information material in print, of a website/social media targeting general population, high-risk Groups (in coordination with working

group 4) as well as experts, incl. the development of a risk assessment tool similar to the one in the HIV-Campaign.

VIII. Evaluation and further development of activities

Activities in coordination with other working groups:

IX. Lobbying and Advocacy Campaign (Working Group 6; Politics and Policies)

C. – E. Aligning and Sequencing Activities, Resources to implement, Responsibilities

	Activity	Responsible	Resources (in CHF / HR)
	Period 01. – 06.15		
1.	Survey of knowledge in the general population and high-risk groups, including questions about stigma and analysis of already existing findings.	Project Group "Prevention & Awareness"*** Mandating a university for applied Science or sim. institution and/or omnibus survey (eg. GFS)	40-50'000
2.	Finding best practice examples of prevention and awareness campaigns. Literature check.	Project Group "Prevention & Awareness"	HR 7 days
3.	Identification of existing programmes, which should be approached for collaboration (MiGes, Suchtstrategie) as well as existing materials, where the key message can be included.	Representatives of the federal department in working group 1 (BAG, Infodrog, BFM)	HR 3 days
4.	Stigma survey: Understanding the dimension of stigma: Is stigma a problem for individuals living with hepatitis? To what extent? Is it a barrier to treatment?	Project Group "Prevention & Awareness" Mandating a university for applied Science or sim. institution	20-30'000
	Period 07. – 12.15		
5.	Creation of key messages and drafting a communication's strategy with involvement of individuals from target groups (high-risk groups) including staff (doctors or physicians or other specialists)	Project Group "Prevention & Awareness": With the help of a communication's agency	8'000
6.	Health Care Professionals: Improving knowledge of health care professionals: Production of information material, development of	Project Group "Prevention & Awareness", with schools of health professions (Fachhochschulen) and medical societies (gastroenterology and hepatology, general	In Cooperation with group 3, Access to Treatment (Lead)

	training courses in accordance with Working Group 3 (Access to treatment)	medicine, FMH)	HR / 15'000
	Period 01. – 12.16		
7.	Production of information material (online and offline), integration in existing material	Project Group "Prevention & Awareness": Mandating a communication's agency	250'000 To be discussed: if the survey's results show, that a wider campaign for the general population is necessary (TV Ads etc.), the amount will be substantially higher.
	Period 01.17 – 12.18		
8.	Evaluation of campaign and other activities Distribution of material Continuing with communication's activities	Project Group "Prevention & Awareness"	

**Project Group "Prevention & Awareness": working group 1 or an extended version of working group 1 functions as project leader and coordinator of all prevention and awareness activities. It has to be defined, which organisation/institution will take the lead. A communication's agency is mandated to execute activities and structure the process (similar to the HIV/AIDS-campaign LOVE LIFE).

Working Group 1 P&A/January 31, 2015

Working Group 2 – Screening and Surveillance

A) Main aims of the field of action „Screening and surveillance“

The purposes of this group are summarized in five main domains. Firstly we aim at selecting screening and surveillance tools based on the analysis of their advantages and drawbacks and on the available data in the literature. Since the prevalence of viral hepatitis is inhomogeneous (it occurs more frequently in particular age groups), our second aim will consist in defining the most adequate population to be offered screening and surveillance. The third move will be the development of a model for a strategy of screening and surveillance including the diagnostic tests that will allow identifying patients with the infection and patients with the disease. Furthermore, we will test feasibility of a screening and surveillance program at a small scale, which will represent a training field for the development of a national screening and surveillance strategy to be implemented on a significantly larger scale.

B) Concrete activities

In the context of our *first* purpose we are analyzing various diagnostic tests, such as serology, PCR or liver elastography to screen and to follow up patients with chronic viral hepatitis. The main evaluation criteria of these tests include performance accuracy, feasibility, acceptance in the target population, costs and concrete consequences of testing and surveillance.

Second, analyzing epidemiological data available for the situation in Switzerland will allow identifying the characteristics of the population in which a strategy of screening and surveillance will likely be successful. Not only advantages, but also possible adverse effects of screening will be evaluated.

The *third* aim will be achieved by defining a model and a roadmap for a strategy. In previous discussions and work we identified two possible scenarios including a forward strategy, i.e. the initial identification of patients with the infection (HCV positive serology and PCR), followed by surveillance for the disease (advanced liver fibrosis), and a backward strategy, starting with screening for the disease first and identification of the infection later.

The *fourth* step will consist in assessing feasibility and results on a small scale. To this aim we consider the application of one selected strategy of screening and surveillance over a short time period and in a small test population. At the end of the preliminary experimental approach, results will be analyzed according to previously determined criteria of success. This approach will allow to correct inefficient processes and to improve the general performance of the strategy.

Lastly, the strategy will be ready for implementation on a national scale and will be coordinated together with the other field of action.

C) Priorities and time schedule

The aims 1-3 represent the priorities for the activities of the group to be developed until september-october 2015. The progress of the group will be monitored and discussed in virtual (Skype/GoToMeeting) and concrete meetings (Cercle de la Grande Soci  t  , Berne).

This preparatory work will serve as a basis for a small-scale experiment to test the feasibility and efficiency of this strategy in early 2016. In the same year, the results of this experimental work will be analyzed and integrated into a project for a national strategy of screening and surveillance that will be launched in 2017-2018.

D) Resources

This group includes experts in various fields related to screening and surveillance in viral hepatitis, so that currently an excellent know-how is available. All team members are providing their contribution on a voluntary basis, therefore an efficient use of resources, in particular time, is particularly important. For the activities scheduled in 2015 the costs are limited to the expenses of the meetings, which are very limited if we can use social media and meet in Berne. The costs of the preliminary experimental part and of the national implementation of the screening and surveillance strategy in 2016 will deeply vary according to the type of diagnostic methods that will be selected and cannot be evaluated at this time point.

E) Responsibilities

The responsibilities for each priority point are distributed according to the expertise and availability of the members of the group, who, in turn, will coordinate the moves of each single aim.

ACTIVITY	RESPONSIBILITY
selection of screening and surveillance tools	Pierre Deltenre and Pietro Vernazza
identification of the population for screening and surveillance	Christoph Hatz and Andri Rauch
development of a model for a strategy of screening and surveillance	Pietro Vernazza and Andrea De Gottardi
strategy project at a small scale	Christoph Niederhauser, Gila Stump, Harry Wituthum
implementation of a national screening strategy	All

A. Main Purpose of the Field of Action

We propose the following comprehensive treatment approach:

1. System readiness/preparedness
 - a. Facilitating access to care, overcoming the limitation
 - b. Synchronized systems (no loss to f'up between different institutions)
2. Provider readiness/preparedness
 - a. Integration of primary care physicians (family physicians) and representatives of special institutions (e.g. prisons, opioid substitution treatment (OST) and other drug rehabilitation programs) into the treatment plan
 - b. integration of up to date treatment recommendation from national and international bodies
3. Patient readiness/preparedness
 - a. To start, maintain and successfully achieve treatment goal
 - b. To achieve a sustained treatment success (prevent re-infections, reduce co-morbidities (e.g. alcohol, overweight etc.).

Activities for health care providers should be coordinated with working group 1 (prevention and awareness), working group 2 (surveillance and screening) and working group 4 (high-risk groups), working group 6 (Financing and Pricing)

B. Concrete Activities (derived from three levels: system/provider/patient)

1. a) Seek dialogue with health authorities, health care insurances, industry
- c. b) An assessment of the current care continuum with strengths and weaknesses will be conducted, in order to define clinical pathways, coordination of care and to develop supportive tools
2. a) Identify and discuss barriers and needs with mentioned players. In a next step development of tools for comprehensive patient assessment.
- d. b) Work on regular update of treatment recommendations
3. a/b) Assessment of needs and barriers and derived from that development of patient-support.

C. Prioritisation of the activities (derived from three levels: system/provider/patient)

1. Active participation in 'round table' discussion with FOPH in March. *
2. Treatment recommendations will be updated continuously. Two members of the working group (BM, JF) are part of the writing committee and (DS, FN) are part of the review committee of the treatment recommendation published by SASL/SGG and SSI (see: www.sasl.ch, www.sasl.ch or www.sginf.ch)
3. The already existing "ready4therapy" (www.ready4therapy.ch) program could serve as point of departure to address the specific needs of hepatitis C patients. Two members of the "ready4therapy" are (JF, DN) are participating of our working group

*Contacting main health care providers is only possible, when the entire strategy including screening, pricing etc. is established and has to be performed as a coordinated effort in close collaboration with working group 1, 2 and 4.

D. Resources (financial/human)

Will be defined in a next WG3 meeting/telefonconference

Working Group 4 – High-risk Groups

MSM

Hypothesis (purpose)	Viral hepatitis is not considered to be a major issue in Swiss HIV non-infected MSM so far (Schmidt et al, BMC Public Health 2014)
Priority	1 (if confirmed, no further action will be taken except further monitoring and interventions on behaviour among the most exposed MSM subgroup)
Action	Submit Article Schmidt et al to a series of opinion leaders and ask for comment – don't forget to check and treat HIV infected MSM for viral hepatitis
Expected resources	none
Responsibilities	Claude Scheidegger, Andreas Lehner, <u>Pietro Vernazza</u> , Hansruedi Völkle

PWUD

Hypothesis (purpose)	Prevalence rates of viral hepatitis among Swiss PWUD are expected to be well-known (Cominetti et al, IUMSP 2014), i.e. very high
Priority	1 (rapid increase of treatment rates is needed and possible in this population)
Action	To confirm obtain recent data from a series of opioid maintenance institutions as well as drug injections facilities (injections rooms) including a) anti-HCV prevalence, b) RNA prevalence among anti-HCV positive, c) fibrosis stages (assessed by non-invasive tests) – don't forget HBV vaccination campaigns
Expected resources	CHF 10'000-20'000
Responsibilities	Philip Bruggmann, <u>Peter Menzi</u> , Claude Scheidegger

Prisons

Hypothesis (purpose)	Prevalence rates of viral hepatitis among prison inmates are considerably higher than in the general population, this subpopulation will be an easy-to-treat group in the near future (taken into account a duration of treatment of 8-12 weeks and 95-100% treatment success rates)
Priority	2 (needs political commitment)
Action	obtain recent data from a series prisons including a) anti-HCV prevalence, b) RNA prevalence among anti-HCV positive, c) fibrosis stages (assessed by non-invasive tests) – don't forget HBV vaccination campaigns

Expected resources CHF 10'000-20'000
Responsibilities Bidisha Chatterjee, Marcel Ruf, Claude Scheidegger

Migrants

Hypothesis (purpose) Prevalence rates of viral hepatitis among migrants are considerably higher than in the general population, the political commitment to treat this subpopulation will be difficult to obtain in the near future (even taken into account a duration of treatment of 8-12 weeks and 95-100% treatment success rates)

Priority **2** (needs intensive political actions to obtain commitment for treatments)

Action obtain recent data from a series of various migrant groups of interest (refugees, asylum seekers, migrant workers from countries with high hepatitis prevalence) including a) anti-HCV prevalence, b) RNA prevalence among anti-HCV positive, c) fibrosis stages (assessed by non-invasive tests) – don't forget HBV vaccination campaigns

expected resources CHF 10'000-20'000
Responsibilities Sandra Hollinger, Serge Houmard

Sex workers

Hypothesis (purpose) Prevalence rates of viral hepatitis among sex workers might be considerably higher than in the general population, the political commitment to treat this subpopulation will be difficult to obtain in the near future (even taken into account a duration of treatment of 8-12 weeks and 95-100% treatment success rates)

Priority **2** (needs intensive political actions to obtain commitment for treatments)

Action obtain recent data from a series of sex worker groups including a) anti-HCV prevalence, b) RNA prevalence among anti-HCV positive, c) fibrosis stages (assessed by non-invasive tests) – don't forget HBV vaccination campaigns

Expected resources CHF 10'000-20'000
Responsibilities Andreas Lehner, Claude Scheidegger, Hansruedi Völkle

Working Group 5 – Financing and Pricing

The working group 5 – „Financing and Pricing“ is looking at how the Swiss Hepatitis Strategy development and implementation can be financed and is studying various options for pricing the treatment and evaluating its cost effectiveness. In pursuing these goals the working group will be engaged in three major activities:

Activity 1: Sponsoring of the strategy development and implementation

In order to assess the overall financial needs the working group contacts the other working groups to find out their prospective needs and their own plans for rising the support needed. At the same time a concept for approaching potential sponsors and listing them will be developed and discussed with key stakeholders. We attempt to professionalize communication and sponsoring.

Activity 2: Assuring outcome research

We will evaluate the cooperation with the Swiss cohort study with the aim to supply the scientific community with a deeper knowledge on outcome for the kind of intervention chosen. This activity has to be coordinated with working group 3 (Access to treatment). A further goal of this outcome research is to support cost effectiveness claims and sustain financial support for the intervention.

Activity 3: Development of value-based pricing scheme

We propose to develop a value-based pricing scheme for patient subgroups and seek the guidance with WG3 in order to properly define subgroups. This activity should address the costs and benefits of treatment in patient subgroups and effects of wider indications on the costs and prices. Since limitations for treatment access currently exist, ethical and economic considerations on these limitations will be formulated. The situation in other countries will be reflected.

Working Group 6 – Politics and Policies

Blueprint for an operational strategic approach (27.1.2015)

It is proposed to follow the strategic approach as outlined below:

1. Group 6 will produce periodically briefing notes and strategic summary documents about outputs of groups 1-5, which are submitted to the *Project Board*.
2. The *Project Board* amends the proposals as deemed necessary.
3. The *Project Board* shares the proposals as deemed adequate with the BAG for information purposes only.
4. If the BAG recommends amendments, the *Project Board* will submit these for further discussion to all members of the concerned working group through the liaison person, which will make modifications as deemed acceptable.
5. The *Project Board* distributes the document to all members of the *Swiss Hepatitis Strategy* in order to finalize it.
6. The *Project Board* shares the document(s) with interested parties and/or with the public as deemed necessary.

Group 6 will produce a comprehensive strategic document when sufficient outputs are available. The strategic paper is to follow the same stepwise clearing approach as mentioned above. It may be necessary to produce several subsequent strategic documents according to operational developments.

The *Project Board* decides together with all members of the *Swiss Hepatitis Strategy* on how to best implement the strategy.

Schweizerische Initiative zur Reduzierung der gesundheitlichen Folgen der viralen Hepatitis

Virushepatitis, eine Entzündung der Leber durch Infektion mit einem Hepatitisvirus (meist Hepatitis B oder Hepatitis C Virus) ist in der Schweiz häufig, potenziell tödlich und wird weitgehend unterschätzt. Mehr als 70'000 Personen sind chronisch infiziert und können demzufolge Leberzirrhose oder Leberkrebs entwickeln. Die Kosten für medizinische Ausgaben pro Jahr für die Hepatitis C alleine werden auf über 100 Millionen Franken veranschlagt. Die Weltgesundheitsorganisation (WHO) vergleicht die Hepatitis-Epidemie mit einer weltweiten "viralen Zeitbombe".

Eine Schweizerische Hepatitis-Strategie

Die Schweiz wurde im Euro Hepatitis Index Report nur im unteren Mittelfeld klassiert. Eine nationale Strategie ist demzufolge notwendig. Eine Kick-off -Meeting fand in Bern am 16. Januar 2014 statt und verfasste eine erste umfassende Bestandsaufnahme um die Eckpfeiler einer Schweizer Hepatitis-Strategie zu entwickeln. Die 35 Teilnehmer des Kick-off-Meetings und etwa fünfzig weitere interessierte Personen arbeiten zurzeit gemeinsam daran (Mitgliederliste auf Anfrage erhältlich).

Ziele:

- Die Übertragung von Hepatitis B (HBV) und C (HCV) zu reduzieren.
- Reduzierung der von HBV und HCV verursachten gesundheitlichen Folgen und Mortalität.
- Reduzierung der sozio-ökonomischen Folgen von HBV und HCV auf individueller, gemeinschaftlicher und Bevölkerungs-Ebene.

Project Board:

Schweizerische Expertengruppe für Virale Hepatitis (SEVHep), Schweizerische Gesellschaft für Infektiologie (SGI), Schweizerische Gesellschaft für Gastroenterologie (SGG), the Swiss Association for the Study of the Liver (SASL), und das Global Health Program (GHP) des Graduate Institute of International and Developments Studies in Genf.

Das Board ist offen und bei Bedarf können zusätzlich Interessenten oder Organisationen mit willkommener Expertise teilnehmen.

Das Swiss Hepatitis Strategy Board hat keinen legalen Status und kann jederzeit von ihren Mitgliedern aufgelöst werden.

Eine „Project Task Force“ koordiniert den gesamten Prozess. Sechs verschiedene Arbeitsgruppen erarbeiten zurzeit die notwendigen Grundlagen und die strategischen Grundpfeiler:

1. *Prävention und Aufklärung*
2. *Überwachung und Screening*
3. *Zugang zur Behandlung*
4. *Risiko-Gruppen*
5. *Finanzierung und Preispolitik*
6. *Politik und strategische Aspekte*

Zeitplan

Die Implementierung der Strategie wird voraussichtlich 2015 beginnen und bis 2018 dauern.

Annex 2: Figures and Tables

Figure 1: Timeline Activities of Working Groups

Timeline Swiss Hepatitis Strategy

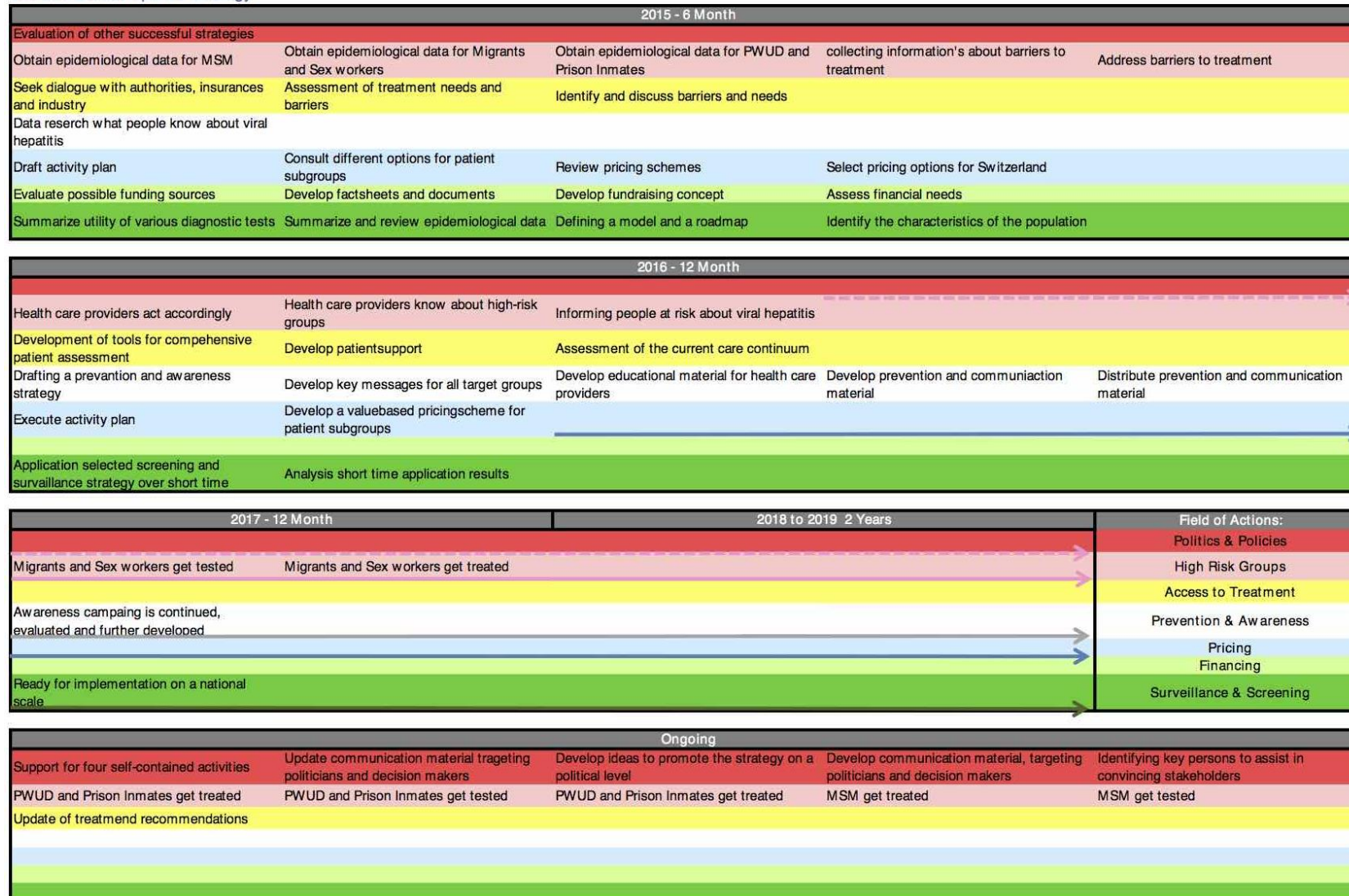


Figure 2: Swiss Hepatitis Strategy: Project Structure

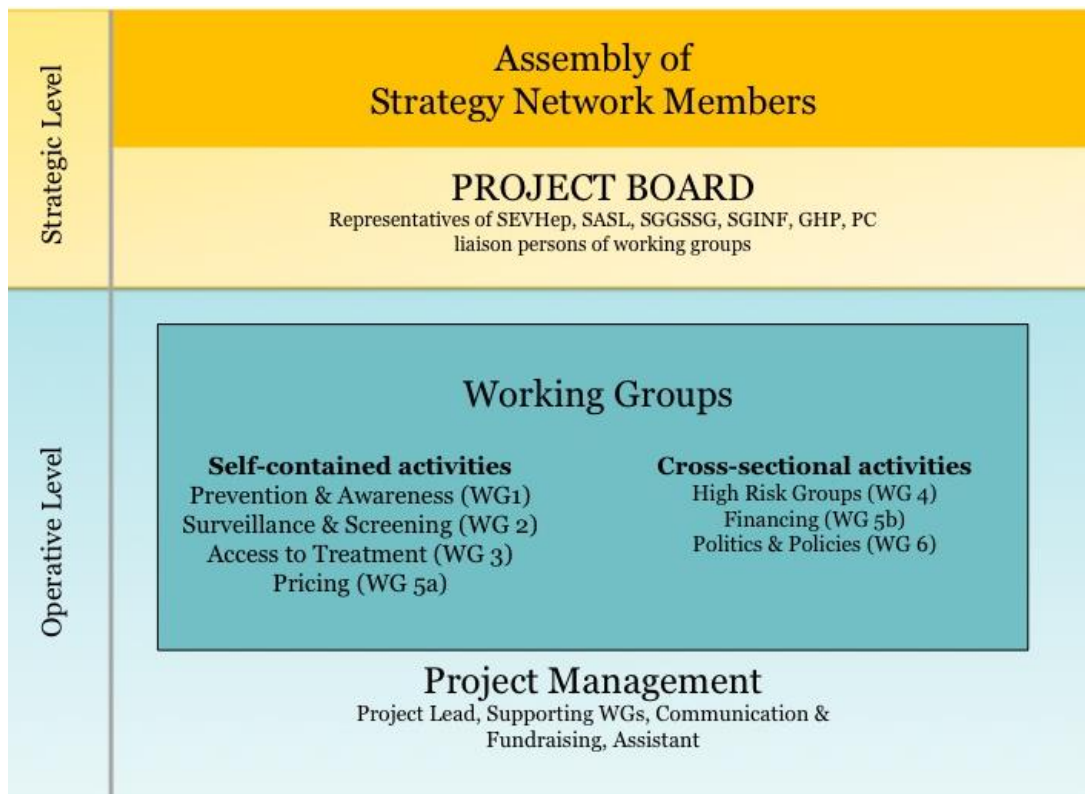


Figure 3: Matrix of the 7 Field of Actions

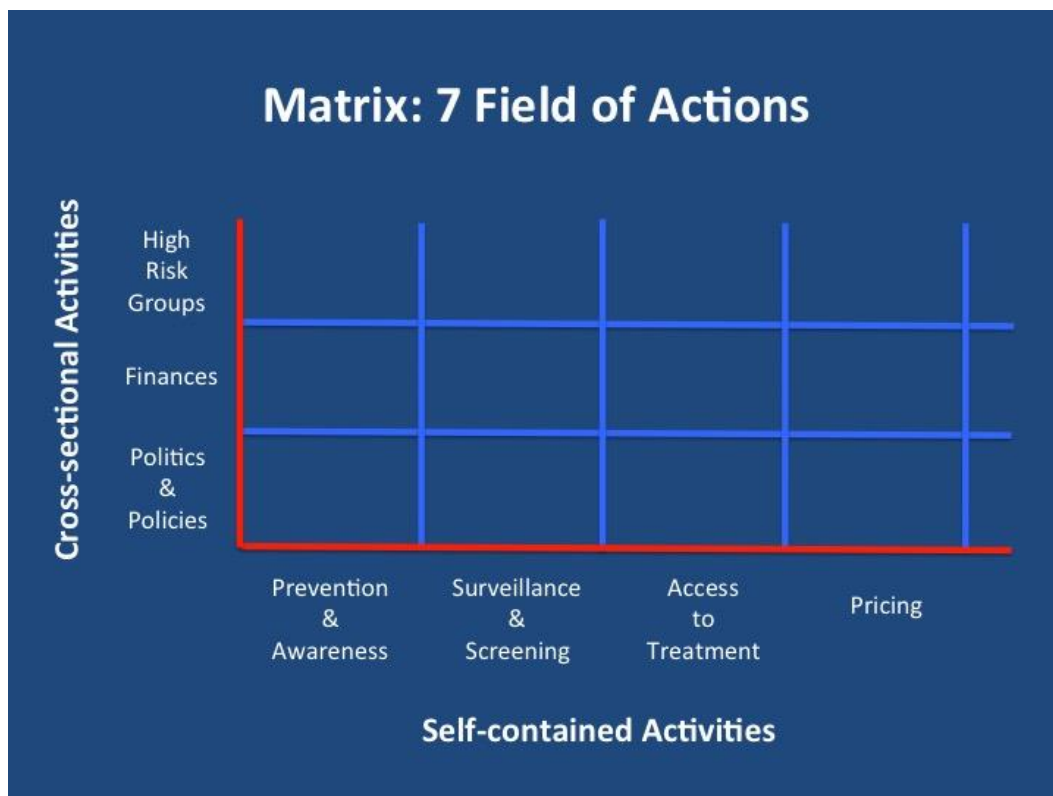
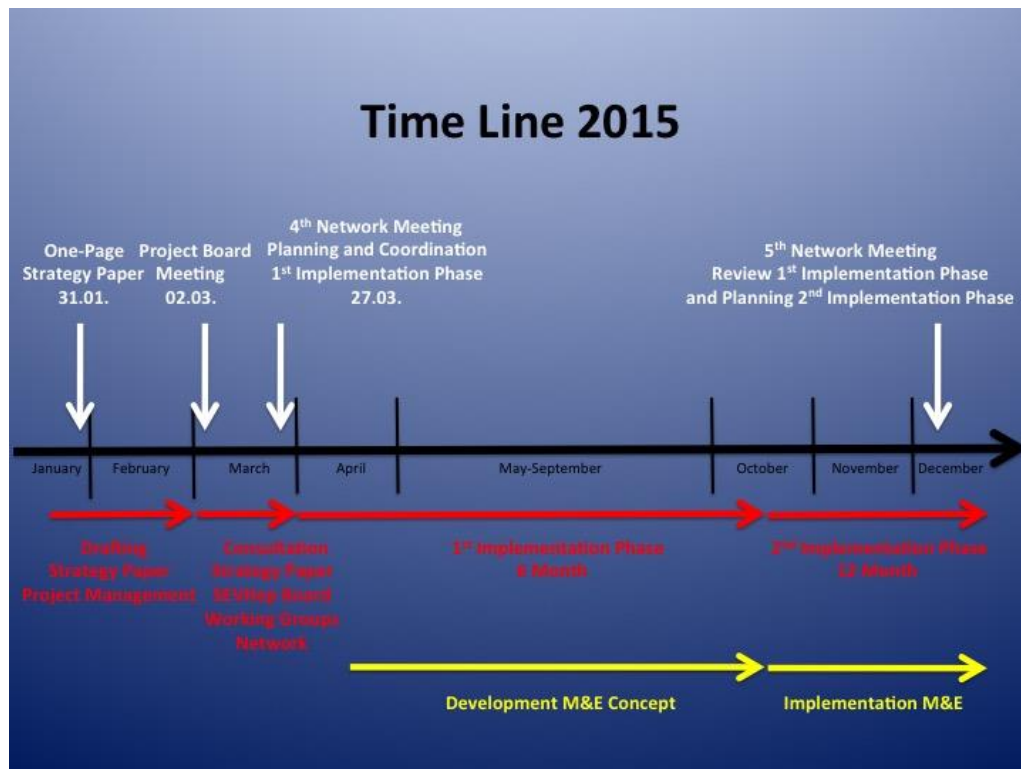


Figure 4: Timeline Strategy Process 2015



Annex 3: Abbreviations

DAA Direct-Acting Antivirals
FOPH Federal Office of Public Health
GHP Global Health Program
GLS Governmental Learning Spiral
HBV Hepatitis B Virus
HCV Hepatitis C Virus
MSM Men having Sex with Men
PWUD Persons Who Use Drugs
SASL Swiss Association for the Study of the Liver
SEVHep Swiss Experts in Viral Hepatitis
SGGSSG Swiss Society for Gastroenterology
SGINF Swiss Society for Infectiology
WG Working Group
WHO World Health Organization

Annex 4: References and Notes

- ¹ See http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R6-en.pdf
- ² Since 20 years SEVHep is a registered Swiss association with the primary goal "to bring experts from the most relevant national and international societies together to establish consensus statements for the diagnosis, epidemiology, pathogenesis, therapy and prevention of all forms of viral hepatitis and to spread this information to health care professionals, patients and the general public". For further information's see <http://www.hepatitis-schweiz.ch>
- ³ Call to Action to Scale up Global Hepatitis Response. Global Partners Meeting on Hepatitis – Convened by WHO in March 2014 in Geneva. See http://www.who.int/hiv/mediacentre/news/hep_calltoaction_new.pdf
- ⁴ Bjornberg, A. and Cebolla, B.: Euro Hepatitis Index 2012 Report. Health Consumer Powerhouse AB, 2012. This publication is available on the Internet at: <http://www.hep-index.eu>
- ⁵ Fretz, R., Negro, F., Bruggmann, P., Lavanchy, D. De Gottardi, A., Pache, I., Masserey Spicher, V., Cerny, A.: Hepatitis B and C in Switzerland. Healthcare provider initiated testing for chronic hepatitis B and C infection. In: Swiss Medical Weekly. Current opinion. <http://www.smw.ch>
- ⁶ Francesco N.: Der Kampf gegen Hepatitis B und C: ein Notfall für die öffentliche Gesundheit in der Schweiz. Schweizerische Ärztezeitung | Bulletin des médecins suisses | Bollettino dei medici svizzeri | 2013, pp. 27-28.
- ⁷ National Institute for Health and Clinical Excellence 2012. See also: Hepatitis B and C: ways to promote and offer testing to people at risk of infection, at: <http://publications.nice.org.uk/hepatitis-b-and-c-ways-to-promote-and-offer-testing-to-people-at-increased-risk-of-infection-ph43>
- ⁸ See <http://www.hep-index.eu>
- ⁹ Francesco N.: Der Kampf gegen Hepatitis B und C: ein Notfall für die öffentliche Gesundheit in der Schweiz. Schweizerische Ärztezeitung | Bulletin des médecins suisses | Bollettino dei medici svizzeri | 2013, pp. 27-28.
- ¹⁰ Afdhal, N.H., Zeuzem, S., Schooley, R.T., et al.: The new paradigm of hepatitis C therapy: integration of oral therapies into best practices. In: Journal of Viral Hepatitis, 2013; 20(11): pp. 745-760
- ¹¹ See 10.1002/hep.27377
- ¹² See for example the discussions in the New York Times at http://www.nytimes.com/2014/08/03/upshot/is-a-1000-pill-really-too-much.html?_r=0&abt=0002&abg=1
- ¹³ See Grundversicherung der Obligatorische Krankenpflegeversicherung (OKP): [http://www.pharmasuisse.org/DE/dienstleistungen/berufspolitik/seiten/obligatorische-krankenpflegeversicherung-\(okp\).aspx](http://www.pharmasuisse.org/DE/dienstleistungen/berufspolitik/seiten/obligatorische-krankenpflegeversicherung-(okp).aspx)
- ¹⁴ See Medienmitteilung des Positivrats: Manifest zu Chronischer Hepatitis C: http://www.positivrat.ch/cms/images/PDF/Medienmitteilung_Manifest.pdf
- ¹⁵ See Sixty-seventh World Health Assembly, WHA67.6, Agenda item 12.3, held in May 2014

¹⁶ Razavi H et al. The present and future disease burden of hepatitis C virus (HCV) infection with today's treatment paradigm. *JvH* 2014, 21; 34-59

¹⁷ Blindenbacher, R. (in collaboration with Bidjan Nashat): *The Black Box of Governmental Learning. The Learning Spiral - A Concept to Organize Learning in Governments.* (World Bank Press) Washington DC 2010. This publication is available for free online at:
<https://openknowledge.worldbank.org/handle/10986/2474>

¹⁸ As "Knowledge Broker" acts in the project Dr. Raoul Blindenbacher from the Blindenbacher Borer Consulting Ltd.

¹⁹ For SEVHep's sponsors and supporters see:
<http://www.viralhepatitis.ch/en/node/925>

²⁰ The Co-Project Leaders are Dr. Philip Bruggmann, SEVHep Chair, and Dr. Raoul Blindenbacher, Blindenbacher Borer Consulting Ltd. The project assistant is Nimoll Pek (20%) and the communication and fundraising employee is Bettina Maeschli (20%).

²¹ Likert, R. (1932). A technique for the measurement of attitudes. *Archives of Psychology*, 22 140, 55.

²² See <https://de.surveymonkey.com/home>

²³ Under elimination is understood the reduction of the incidence of infection to zero in Switzerland as a result of deliberate efforts, but requires the presence of continued measures to prevent re-establishment of transmission (e.g. measles, poliomyelitis).

²⁴ See <http://www.ready4therapy.ch>