

THE ROMANIAN HEPATITIS ACTION PAPER

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LIST OF ABBREVIATIONS AND ACRONYMS

ALT	Alanine Aminotransferase
AFP	Alpha-fetoprotein
CT	Computed Tomography
DG SANCO	Directorate-General for Health and Consumers
EASL	European Association for the Study of the Liver
ECDC	European Centre for Disease Prevention and Control
ELPA	European Liver Patients Association
EORTC	European Organisation for Research and Treatment of Cancer
FNAUSS	National Sole Social Health Insurance Fund, Romania
HBV	Hepatitis B Virus
HCC	Hepatocellular Carcinoma
HCV	Hepatitis C Virus
HDV	Hepatitis Delta Virus
IDU	Intravenous Drug Users
MSM	Men Who Have Sex with Men
SVR	Sustained Virologic Response
WHO	World Health Organisation
Genotype	The genetic constitution of an organism or a group of organisms

I. ROMANIA: CURRENT SITUATION

1. Overview

Romania is among other European countries which lack specific detection, prevention and treatment policies on viral hepatitis. The efforts of the government to address the problem have been rather inconsistent and unsystematic. Generally speaking, the Government considers hepatitis B and C a public health issue only on a declarative level, in reality the steps undertaken for this are still insufficient¹. In practice, the National Sole Social Health Insurance Fund (FNAUSS) provides funding only for treatment of patients with moderate and advanced fibrosis (F2-F4).

Viral hepatitis create serious challenges for the Romanian society, which imposes the need for determined actions to include more effective therapeutic regimens, to improve access to treatment of patients and to implement effective protection and detection policies, which will eventually diminish the transmission rate and limit the potential channels of infection. In Romania there is a group of experts meeting at least once a year in order to draft proposals for updating or changing current therapeutic protocols. Also, the Gastroenterology Commission has been active towards the implementation of a National Program for Viral Hepatitis, which has been presented to the Government on various occasions.

As in other European states, the average age of the patients with hepatitis C in Romania is around 50 years (almost 70% of them are between 40 and 60 years old)². Thus, these diseases can be considered a socially significant phenomenon as they affect primarily still employed or at least active people.

The negative effects of the disease concern also the status of the patients in the social realm as they suffer from stigmatisation. As a result, they are pressed to conceal their health condition when using medical services thus increasing the risk of spreading the disease to others. The hepatitis burden is further experienced at the occupational level as patients are often discriminated by employers and co-workers.

The current situation could be improved significantly if the government will have the political willpower to undertake concrete steps to ensure mechanisms for early detection and treatment of hepatitis. More importantly, however, it is crucial to recognize the need for collaboration with the non-governmental sector in order to effectively promote and implement protection and prevention policies through awareness and screening campaigns. To achieve this goal, it is necessary to analyse the existing data, identify the lacks and areas of improvement, familiarize with good examples from other countries regarding how to tackle these needs and finally, turn the conclusions into concrete policies.

¹ Viral Hepatitis Global Policy, 2010, pg. 139

² Mircea Grigorescu, "HCV Genotype 1 is Almost Exclusively Present in Romanian Patients with Chronic Hepatitis C"; Journal of Gastrointestinal Liver Diseases, March 2009 Vol. 18 No 1, 45-50.

The following analysis is mainly based on the data provided by the extensive comparative research developed by the Health Consumer Powerhouse and funded by the European Liver Patients' Association "The Euro Hepatitis Care Index". This assessment concentrates on four main areas: prevention, detection, treatment and surveillance and has been done by analysing the existing data for the purpose of identifying the weaknesses as compared to other European countries. The analysis is also based on a literature review and a survey amongst the leading specialists in the field of gastroenterology and infectious diseases. Based on the results ELPA organised face to face interviews with leading Romanian experts, whose opinions and experience have been incorporated in this document.

Epidemiology

Hepatitis B (HBV)

The HBV prevalence in Romania is 5.6% (*according to ECDC 2010*) and the predominant HBV genotypes are A and D³. Biopsies for HBV show that co-infection for HBV + HDV is found at 17-20% of HBV patients. Patients with HBV are primarily treated with Entecavir or Adefovir. In the past, patients were mainly treated with Lamivudin and those who showed resistance to treatment with Lamivudin were treated with double dose (1mg) of Encatevir which was reimbursed by health insurances. Access to innovative treatment (Tenofovir and Telbivudin) is not available. The costs for laboratory tests of HBV patients (such as HBsAG and viral load detection) are very high. Since the introduction of the mandatory HBV vaccination for children, the incidence for HBV has decreased from 30% to 3%.

Hepatitis C (HCV)

Unfortunately there is no reliable data regarding the number of HCV infected people in Romania due to the lack of harmonized efforts to identify transmission channels and infection rate. A harmonised and systematic surveillance system is also missing in Romania, which should be an essential part in a modern health care system. However, sociological and epidemiologic research reflects a prevalence rate of 3.24% ⁴ (according to the study conducted by Conf. Dr. Liana Gheorghe, Clinical Institute Fundeni) and 5.4% (according to the Extension at the ARSF Epidemiological Study 2008-2009, <http://www.balkanhep.eu/Romania.htm>), which ranks Romania at the top of table in comparison with other European countries. It was estimated that there were approximately 600,000 infected Romanians, out of which 80-90% suffering from chronic HCV and needing antiviral treatment. In Romania, 99% of the patients with HCV have genotype 1b (^{4,5}), which would indicate extremely high prevalence of infection through blood transfusion in

³ Extension to ARSF epidemiological study, 2008-2009. Available at: <http://www.balkanhep.eu/Romania.htm>

⁴ Study by Conf. Dr. Liana Gheorghe, National Institute Fundeni,, <http://www.ncbi.nlm.nih.gov/pubmed/21188327>

⁵ Mircea Grigorescu, "HCV Genotype 1 is almost exclusively present in Romanian patients with Chronic Hepatitis C" ; Journal of Gastrointestinal Liver Diseases, March 2009 Vol.18 No 1, 45-50.

the past 3-4 decades. It is estimated that only 10 % out of the infected patients are detected.

Out of the detected patients, most have received double therapy (PegInterferon + Ribavirin) with an average of 50 % SVR. This means that at least half 17,000-30,000 patients who need access to modern triple therapy, otherwise being condemned to develop cirrhosis and liver cancer (HCC). Also, according to a study published in 2011 (*Pascu O, Gheorghe L, Voiculescu M, Ceausu E, Mateescu B. „How severe is chronic hepatitis with HCV genotype 1b? A study of 1.220 cases on the waiting list for antiviral therapy in Romania”*- <http://www.ncbi.nlm.nih.gov/pubmed/21451798>), in Romania the HCV infection manifests more severe forms and as such it is highly necessary to start treatment much earlier, in order to prevent complications like cirrhosis and HCC.

Detection

The general detection rate in Romania, in comparison to many other EU countries, is very low. Overall, most patients were detected by accident during blood testing or hospitalization for treatment of various diseases. Even more so, the asymptomatic progression of hepatitis until later stages poses additional obstacles in identifying infected persons.

The difficulty in detecting hepatitis cases is due to the lack of specific measures for early diagnostics. To begin with, testing for HBV/HCV is neither compulsory, nor available for free to all people, but only to some groups (*see footnote 5*). Free anonymous hepatitis testing and counselling are not easily accessible. Both annual screening for infectious diseases to IDU and HCV antibody testing for HIV-infected persons are being provided but in an unsystematic manner. In 2008, the screening of the health status of the population included only transaminases, which may or may not be an indicator for hepatitis. Patients with normal ALT were not tested for viral hepatitis although more than 20 % of cirrhotic patients have normal ALT (Zeuzem et al.). Also, hepatitis C testing within high risk groups is not available. The only positive development in this regard is the fact that ALT determination is routinely prescribed to all chronic patients before they start treatment⁶.

Prevention

Perhaps the most important middle and long-term measure for managing disease with social impact like viral hepatitis is to adopt systemic and targeted prevention policies. The purpose of investing in programs for raising awareness and ensuring wide access to information is to educate the citizens about the potential dangers of being infected with viral hepatitis and the impact of the disease on the quality of life. Another goal is to facilitate patients' decision making process by providing accurate information on screening possibilities and what are the next steps after being diagnosed with hepatitis.

⁶ Viral Hepatitis Global Policy, 2010, p. 139

Successful prevention policies are usually the result of the productive collaboration between the main healthcare stakeholders, namely government officials, patient organisations and other community representatives as well as the pharmaceutical industry. In the last years authorities have started to involve patient organisations more in their decision making processes. There have been consultative meetings and medical conferences where patient organisations and authorities could meet. Nevertheless, the acknowledgement of the importance of patient organisations activities by the authorities needs to be strengthened and most importantly translated into action. Also, the Government has not taken any measures against the stigmatisation and discrimination against persons infected with HCV and HBV⁷.

Considering other specific prevention policies present in other European countries, Romania proves to have done only little to prevent the spread of hepatitis. In 2008, the Ministry of Health conducted a public screening campaign which included the liver enzymes. As a consequence, many hepatitis patients have been identified. Unfortunately the Government stopped the screening program, so nowadays there are only some screening campaigns supported by patients' organisations and funded by pharmaceutical companies. It is strongly recommended that the Government engages in systematic screening and awareness campaigns again.

Post-exposure immunization for hepatitis B is available to everyone but is not free for "non-occupational exposure" (Reference: Euro Hepatitis Index). In terms of reducing hepatitis incidence in prisons, there is only free available condom distribution in some prisons. HBV vaccination payment is not provided by the Government for anyone except for children. A positive step regarding prevention is the universal HBV vaccination of more than 90% of the infants born after 1995 and the universal HBV screening before birth for pregnant women⁸, which is free. Nevertheless many pregnant women do not get to do it. HCV testing for pregnant women is not paid by the Government. Fortunately there is a free mandatory screening for dialysis patients.

Last but not least, there is a surveillance system for acute hepatitis but not for chronic hepatitis.

In 2004, the Romanian government implemented a short-term free screening policy for several diseases, including hepatitis. As a result, a number of HBV/HCV patients were discovered. Despite the success of this initiative, it did not lead to any systematic effort in the direction of implementing sustainable prevention policies or to establish a robust surveillance system. Moreover, the lack of funding and the lack of a strategic approach are among the biggest obstacles.

⁷ Euro Hepatitis Care Index, 2012

⁸ Viral Hepatitis Global Policy, 2010, p. 139

Treatment

According to recent data, approximately 40,000 patients have received various therapeutic regimens for HCV infection (between 2002 – 2012)⁹. Based on the effectiveness of the treatment and the adherence of patients (*Liana Gheorghe, Speranta Iacob, Mircea Grigorescu, Ioan Sporea, Roxana Sirli, Dana Damian, Cristian Gheorghe, Razvan Iacob, High Sustained Virological Response Rate to Combination Therapy in Genotype 1 Patients with Histologically Mild Hepatitis C; Journal of Gastrointestinal Liver Diseases, martie 2009 Vol. 18 No 1*), it was estimated that half of the treated patients achieved sustained virologic response (SVR), which is the medical description for being cured.

As far as treatment funding is concerned, there is no special support for patients with hepatitis. Currently only the double therapies (PegInterferon and Ribavirin) are available in Romania, as the main constraint to the implementation of triple therapies is the limited funding capacity of the Government. HCV genotyping is not a current practice for chronic patients. Moreover, patients with viral hepatitis in Romania do not enjoy timely access to new improved drugs with less side effects and better treatment results. There are no hepatitis specialist nurses. Furthermore, there is no national registry for hepatocellular carcinoma (HCC). In the context of correlation between hepatitis and HCC, the development of such registry could provide additional data to support the need for vaccination strategies for HBV, screening and treatment of HBV and HCV infections. The lack of effective treatment policies is further reinforced by the fact that Romania demonstrates only partial compliance with the guidelines of EASL on HBV/HCV.¹⁰

As far as human capacities are concerned, Romania has only a limitation of physicians who are experts of hepatitis and can offer proper treatment. It is strongly recommended to improve trainings for doctors to increase expertise in hepatitis.

II. ROMANIA: FACING THE HEPATITIS CHALLENGE AND LEARNING FROM BEST PRACTISE EXAMPLES

As the Euro Hepatitis Care Index clearly indicates¹¹, Romania currently faces a number of challenges which need to be addressed in a systematic manner rather than in a problem-solving approach.

In brief, the main identified issues are:

- lack of systematic detection measures of infected persons;

⁹ Treatment costs have been covered by the National Health Insurance Fund and pharmaceutical companies, who provided a 75% reduction from the price of Ribavirin. Without this reduction, the price of PegInterferon + Ribavirin would rise by 45%.

¹⁰ Health Consumer Power House, 2012, “Euro Hepatitis Care Index”.

¹¹ Health Consumer Power House, 2012, “Euro Hepatitis Care Index”.

- lack of funding for testing without a referral from the family or specialist physician;
- lack of availability of new therapeutic regimens;
- lack of a national HCC registry;
- lack of nurses specialised in the management of the hepatitis disease;
- lack of an efficient national viral hepatitis surveillance system

To fight an epidemic of the complexity of hepatitis C, the action of the medical system alone is not enough. Taking into consideration the size and diversity of the groups exposed to an infection risk, the active participation of different governmental and non-governmental actors in this field, including from outside the health care system, becomes vital and coordination and harmonised actions are critical. A targeted specific national strategy will help identify and build a hierarchy of the current main problems, coordinate all involved actors and set a standardized information management system. A national strategy creates the premises for a harmonized action of all those involved in the fight against viral hepatitis B and C.

A comprehensive strategy for tackling these issues should comprise a number of priorities that include at least the following: education and awareness initiatives to increase the education and awareness about viral hepatitis, testing and treatment measures to fight liver diseases, implementing a surveillance, prevention and treatment for high risk groups.

In this respect, Romania could further benefit from adopting good practice examples that can be easily implemented through appropriate administrative measure and political will. Good practices in this respect are provided by France and Scotland, where the implementation of national hepatitis strategies has led to significant improvements in the detection, prevention and surveillance of hepatitis. This has also had a positive impact on the quality of life of patients with hepatitis and also on the health services system and the health budget.

France

France has developed its current “National Plan for Fighting Hepatitis B and C 2009-2012” following two other triannual action plans (1999-2002 and 2002-2005).

The first plan was meant to increase the detection rate of infected persons and that did increase by 20% a year. The intention was to strengthen the efforts to prevent the transmission of the virus, increasing the awareness, consolidating a surveillance system and centralizing the projects in the field of hepatitis C. As a result, an epidemiological surveillance and treatment system was created, made up of 26 regional centres and also a network of regional services made up of the family and specialist physicians, as well as multidisciplinary networks for the interaction with groups with high risk of infection.

The objectives and measures put forward in the second national plan aimed at decreasing the transmission rate of HCV and HBV. Among other positive measures, the plan made HBV/HCV testing for medical staff compulsory and implemented preventive measures with respect to detecting hepatitis infected persons.

The **National Plan of Fight against Hepatitis B and C 2009-2012** stipulated that detection measures were a top level priority. Acknowledging the fact that detection of HCV carriers is essential in preventing transmission, the new strategy was based on five priority axes:

1. Reducing the transmission of HBV and HCV through:
 - a. continuing the national communication campaigns;
 - b. increasing safety in the activity of the service providers involved in percutaneous operations (medical services, as well as cosmetic and tattoo services, etc.);
2. Increasing the detection rate of people infected with HCV from 57% to 80% by simplifying access, setting and communication of the results of the tests;
3. Increasing the access to and the quality of the treatment and care through:
 - a. optimisation of the medical practices and the coordination among health care service providers;
 - b. coordination between family physicians, treating physicians, other specialist physicians (especially psychiatrists) and social services providers;
 - c. coordination outside the medical practice networks, especially with the patient and professional associations in the relationship between community and the health care system
 - d. improvement of the medical staff training;
 - e. use of non-invasive methods for estimating liver fibrosis;
4. Complementary measures for imprisoned persons that are infected or exposed to the risk of infection;
5. Improvement of epidemiological knowledge, medical practices and identifying training needs.

Scotland

With a prevalence of hepatitis C of about 1% of the population, whilst most people infected being IDUs, Scotland has developed over the past seven years 3 triennial action plans against the epidemic:

1. Hepatitis C Action Plan - **Phase I 2006 – 2008**
2. Hepatitis C Action Plan - **Phase II 2008 – 2011**

3. The Sexual Health and Blood Borne Virus Framework 2011 - 2015¹²

The priority aim was to prevent the spreading of HCV with special attention to young. The two Hepatitis C Action Plans concerned six major areas of development, namely:

1. Coordination of services;
2. Prevention;
3. Detection;
4. Treatment and support;
5. Education, training, and awareness-raising;
6. Surveillance and monitoring

Phase I focused on building institutional mechanisms, training medical professionals and patients and gathering data for the implementation of the appropriate actions in Phase II. The institutional framework was centrally coordinated by an Action Plan Coordination Group, assisted by three working groups specialised in (i) prevention, (ii) testing, treatment, care, and support and (iii) education, training, and awareness-raising. At the local level, care management networks were established which consisted of healthcare providers, social service providers and NGOs. In addition, coordinators for HCV activities had to be appointed at the local level. These coordinators were to report to the central groups with respect to the status of its implementation. Furthermore, communication activities were conducted for the purpose of informing, educating and raising awareness among professionals and patients and their relatives. Last, but not least, a research was conducted among infected persons to identify specific needs.

Phase II of the Hepatitis C Action Plan (2008-2011) paid special attention to vulnerable groups at risk of HCV infection, particularly young people and new drug users. Children in schools and centres for juvenile offenders were taught how to avoid the virus. After these measures awareness campaigns were planned, in order to improve detection, treatment, care and support had been implemented to meet the increase in the demand for services. Another priority was the development of an integrated information system for HCV to support the specialists in Hepatitis C case management. In addition, laboratory services were bound to collect personal information about tested patients so that they can be contacted if they gave up treatment and care services.

¹² Information in this section comes from the following bibliographic sources:

- Hepatitis C Action Plan for Scotland Phase I: September 2006 – August 2008, Scottish Executive, Edinburgh 2006;
- Hepatitis C Action Plan for Scotland Phase II: May 2008 – March 2011, The Scottish Government, Edinburgh 2008
- Scotland's Action Plan for Hepatitis C Phase 1 September 2006 – August 2008: First Year Progress Report, Health Protection Scotland, December 2007;
- Scotland's Action Plan for Hepatitis C Phase II May 2008 – March 2011: First Year Progress Report, Health Protection Scotland, May 2009;
- Sexual Health and Blood Borne Virus Framework for Scotland: 2011 - 2015, The Scottish Government, Edinburgh 2011.

The positive results obtained by Scotland during the first six years of implementation of the coordinated systematic measures led to a 30% increase in the annual rate of detection, doubled the number of treated patients, increased the intervention, monitoring, evaluation, and adjustment capacity and also created management networks for exchange of best practices.

The currently applicable strategic document on HCV in Scotland is “The Sexual Health and Blood Borne Virus Framework 2011 – 2015”, which combines the measures to combat hepatitis B, C, HIV/AIDS and other sexually transmitted diseases. The next HCV objectives relate mainly to (i) preventing transmission of HCV, (ii) detecting infected individuals, and (iii) providing treatment, care, and support to infected people.

III. ROMANIA: KEY RECOMMENDATIONS

1. Form a Task Force

For maximal efficiency it is essential that a task group is established, to be led by a skillful person who will be able to allocate responsibilities and observe the progress of the development of a national strategy. The task force should include representatives from various fields such as physicians, epidemiologists, economists, patient representatives, public health officials and any other stakeholders who have the capacity and expertise to contribute to the overall project which involves consideration of disease management, financial limitations and social fairness. Moreover, it is important that international organisations, such as the World Health Organisation and the World Hepatitis Alliance are also involved and informed about the work of the task group.

It is therefore important that the group meets regularly and strictly follows the rules and procedures in accordance with the set deadlines. The work of the task force needs to be regularly evaluated in the context of a dynamic social and political environment and also according to the latest developments in the European Union countries. This can be achieved by organising round-table discussions and workshops with EU experts to receive competent advice and feedback on the possible challenges and good practices.

2. Implement a Surveillance System

Another important step towards a targeted approach against viral hepatitis threat and for preventing its transmission is the implementation of a robust and systematic surveillance system. The purpose of this is to effectively assess the hepatitis situation in Romania in terms of disease prevalence, incidence, morbidity and mortality. Such an instrument needs to include the development of a registry for diagnosed patients, whose records should be available and accessible by other specialists to ensure that the therapy will not be compromised by other treatments that patients undergo.

Moreover, the development of a cohesive surveillance system will also have to monitor the treatment success of patients and the adverse reactions that occur during the course of treatment. Besides providing useful information to the Government based on scientific evidence, such database will diminish the administrative burden and facilitate the process of enrolling non-responders or relapsed patients for treatment under new therapeutic regimens.

Last but not least, this surveillance system will keep a record of the ways in which diagnosed patients have been infected, which will also point out the necessary actions for conducting an effective prevention policy.

Ultimately, this comprehensive tool will provide the basis for a timely and regular cost-benefit analysis of the social burden of hepatitis but also the social and economic effectiveness of certain health policies.

3. Establish Prevention Policy

i. Improve Access to Screening

It is the common conviction that screening is crucial to limiting the spread of viral hepatitis and ensuring that timely treatment is conducted for the purpose of optimizing the chances for recovery of patients. The starting point for the development of an effective prevention system is to understand the key role of family doctors in screening. Family doctors have regular contact with patients, therefore are in the best position to inform patients regarding the importance of screening. Moreover, involving patients at this level of healthcare will minimize the costs involved in current process upon which family doctors refer patients to infectious diseases doctors or gastroenterologists.

Among the current obstacles to involving family doctors in the screening process are an insufficient medical training and skills with respect to liver diseases. This may result in:

- the inability of family doctors to suspect a viral hepatitis diagnosis and refer patients to the specialist physician
- the lack of comprehensive screening process which includes consecutive tests before confirming the need for treatment.

Another problem is that family doctors cannot prescribe hepatitis tests for free. They can prescribe these if they have reasons to suspect these are necessary, but the patients will then have to pay for the tests.

Therefore, the first necessary step is to provide family doctors with better information regarding to liver diseases, to ensure that this entering point of patients in the health system (family doctors) efficiently identifies hepatitis cases and risks as well. Also it is

important to discuss the possibility to extend the responsibilities of family doctors to include prescription of ALT together with serologic markers for hepatitis (such as antibody tests) for free. Last but not least, it is important to minimize the administrative work by simplifying and synchronizing the paperwork to meet the needs of both GPs and specialist doctors.

Undeniably the most efficient way to address the lack of systematic screening is through the implementation of regulations by the Government, which are to be strictly observed. It is also important however to ensure that innovative programs are introduced in order to stimulate medical students.

A crucial element for a successful screening program, especially for HBV, is post-screening. To ensure that patients who have been vaccinated for HBV are still protected with time is a necessary precondition for a long-term sustainable screening strategy.

Unavoidably the main concern when implementing an improved screening program is the available funding. Therefore, the main focus must be put on high risk groups who are at risk of getting infected due to their work or their lifestyle.

ii. Cirrhotic patients

According to a research conducted by Conf. Dr Liana Gheorghe, in Romania there are approximately 2000 new cases of cirrhosis annually. Testing chronic patients for HCC is a frequent practice, yet not a law. Screening of cirrhotic patients is performed usually at stage 3 of fibrosis. In some places, screening for HCC is performed at F4 but this is not a generalized practice. Screening methods include ultrasound, AFP and CT.

As far as surveillance/ monitoring is concerned, there is no single HCC registry. A good start in this direction is the initiative of some hospitals in Timisoara, Bucharest and Cluj to develop an HCC registry based on their clinical practice. It is necessary to extend such efforts further to a national level, in order to have reliable statistical data showing the impact and magnitude of the problem.

iii. Groups with high risk of being infected and/or spreading hepatitis

The biggest risk group is the cohort of patients between 40 and 60 years old, or the so-called “decretei generation”, who were born during 1963-1982. The higher number of infected patients at this age is due to unsafe sterilization and transfusion practices in those times. Before 1995 blood transfusions were a major problem in Romania due to lacking safety measures (actually the implementation of safety measures started in 1992, but only from 1995 can we speak of a good safety level). Another main risk group with respect to HCV/HBV includes medical workers who are exposed daily to nosocomial infections. Therefore it is recommended to offer them regularly tests for free and implement needle stick injury safety measures.

Procedures such as tattooing, piercing and manicure/ pedicure may also provide the conditions for fast disease dissemination due to exposure to blood. In this respect, an extremely important requirement is to ensure the use of sterile syringes and instruments. It is highly necessary on the one hand to have more frequent and thorough controls of safety measures and on the other hand more active education campaigns about the rights and obligations of both studios and customers.

Another group vulnerable to the hepatitis threat is the Roma population, of which a vast majority is affected by poor sanitary conditions, poverty and limited education levels.

Similarly, homeless people lacking health insurance and living in poor environments, as well as sex workers are at high risk of being infected themselves or infecting others.

It is unclear to what extent hepatitis is spread among MSM groups as gay people hardly proclaim their sexual orientation and therefore they are difficult to be monitored. It is also important to mention other people with high risk situations, although to a lesser extent, such as prisoners, partners to people with HBV/HCV, immigrants from high prevalence countries, IDUs', people with mental disorders and also people who are institutionalized (for example orphans in care centers), and also the staff working in such institutions.

It is therefore essential to prioritize the high risk groups and include them in the screening and post-screening programs. In this respect a surveillance system will facilitate the identification of the main risk groups to be targeted through systematic screening and awareness-raising actions. It is also vital to identify other possible risk groups which have not been addressed so far, namely adolescents (16-18 years old), university students and IT companies (where the majority of employees are at the age of 40 and as such fall under the abovementioned risk group).

iv. Patients who are at risk to develop cancer

Among the most vulnerable and patients in need for help are those who are at a later stage of HBV/HCV infection and are therefore at risk to develop liver cancer. People who have the highest risk are those with chronic HBV/HCV infection or with cirrhosis, alcohol-users and those with co-infection of HBV+HCV. As such, these patients need to receive immediate care and fast access to the latest treatment therapies, to ensure higher chances of survival. Early detection of HCC in the early stage of cancer via Ultrasound is crucial (when nodules are smaller than 3cm. in diameter, according to the EASL Guidelines for HCC).

4. Expand Public Awareness

An important milestone in terms of prevention is the public awareness on the disease, its transmission channels and the prevention methods. Apart from the conventional methods of communication which include campaigns in the media or in public places, it is important to integrate tools for systematic provision of information to people. Specific consideration should be paid to people in distant regions and small villages who are in

unfavorable socio-economic situation and therefore, are more vulnerable due to limited access to information and treatment.

Among the good practices in this direction comprise active media campaigning (TV, radio, social media, leaflets). It is also highly recommended that family doctors are trained to inform patients about the importance of screening and protection. Another way to inform people, especially the younger generation, is by organising educational meetings, coordinated by specialists and community representatives, in order to inform students in secondary and high schools of the dangers associated with HCV/ HBV infections.

5. Improve Access to Treatment Policy

To clearly define the scope of action of the national hepatitis strategy in terms of treatment of HBV and HCV in a context of budget restraints, it is crucial to update the hepatitis treatment protocol. Modern personalized medicine requires a flexible treatment regime that approaches individual hepatitis cases according to their individual need. In order to optimize the treatment, there are several issues that are needed: the availability of financial resources, the practical implementation of updated guidelines on treatment as well as the introduction of additional training programs for physicians to ensure that the most appropriate therapy will be decided, with their respective beneficial effects and also side effects (which would also lower the costs due to stopping the treatment).

Therefore, the main two issues to be considered when discussing access to HBV and HCV treatment are the severity of the disease before treatment admission and also the success of the chosen therapeutic regimen within a certain period of time to avoid side effects. Hence, there is an overall consensus that standard therapy for HCV treatment (PegInterferon + Ribavirin) ought to be preferred as an initial therapy before triple therapy is prescribed. More specifically, physicians should observe the decline of viral load to determine the success of the standard therapy and make a decision if triple therapy is indicated.

Yet, there are cases of severe disease progression when access to triple therapy for HCV (Pegylated interferon + Ribavirin + Protease inhibitors) or other therapies that shall be tested and approved by the EMA is absolutely crucial. So far, triple therapy is practically still not available in Romania (Telaprevir and Boceprevir have been approved by the government but is not included in the list of medicines that are reimbursed). Overall, the pharmaceutical industry has sponsored some hospitals to offer triple therapy. It is therefore recommended that at least 8 hospitals be able to provide the triple therapy, which should be implemented for non- or partial responders and to relapsed and naïve patients depending on the stage of fibrosis.

Also, access to treatment in Romania depends on the still unsettled issue of how to define hepatitis – as an infectious or a chronic disease. Currently the Ministry of Health provides reimbursement for chronic but not infectious diseases. Therefore, it could be more useful to underline the chronic nature of the hepatitis disease, as there are very few patients who

are caught in the acute phase of the disease, whilst more than 80% of patients develop chronic HCV infection.

Regarding HBV, it is strongly recommended for patients to have access to all latest nucleotide and nucleoside analogs.

6. Improve the Healthcare System

In order to improve the healthcare system it is crucial to first explore the good practices and working models throughout Europe. It is therefore necessary to gather a team of experts who can provide an adequate advice on the European healthcare models and adapt them according to the particular circumstances in Romania.

For this purpose, the political will is of utmost importance, as well as flexible debates on the legislative basis. It is important to consider the opinion of medical specialists, legal experts, economists and other relevant parties when shaping the legislature. In other words, a systematic review of the existing practices and their comparison to other best practice examples will improve the healthcare system in Romania and help save substantial amounts of money.

The communication and active collaboration between the different medical centers treating hepatitis is essential for the exchange of good practice examples and consultation on the best application of certain therapeutic regimens.

The result of such targeted approach should be the establishment of guidelines on more efficient and cost-effective screening and treatment. All legal barriers need to be removed so that timely and effective treatment can be implemented.

The preparation of guidelines by leading medical experts will provide clear and unified criteria for implementing treatments. The guidelines should also consider the cost evaluation of the different treatment options.

7. Create Training Opportunities

It is quite obvious that one of the main components of a successful strategy for fighting hepatitis is the provision of sustainable training opportunities for doctors from any medical specialty who are involved in the care of hepatitis patients. This training should focus on screening promotion, programs for medical training of graduates, education on the latest developments in the field of treatment and prevention. Other training options include the possibility of leading specialists to present their practical experience and insights to younger students or medical experts. The training of medical specialists, especially regarding the triple therapy for HCV, should extend beyond doctors who directly treat hepatitis patients (gastroenterologists and infectious diseases doctors) and should further include dermatologists and internal medicine doctors. An important part of

the training of specialists to apply therapies is the introduction of a certification system of medical centers where patients are referred to for treatment.

Training opportunities need to be provided to patients as well, due to the poor understanding of the treatment benefits and challenges. During such trainings, doctors should have the responsibility to inform patients about the specific nature of the therapy, its administration and the management of adverse reactions.

In order to optimize the impact of the training sessions of medical specialists, it is important to compare the local experience to the international practices. A committee of experts needs to be created, to assess the applicability of the international regulations to the national context (socio-economic situation, educational background, religious beliefs).

The best way to achieve this goal is by organising workshops to exchange expertise and train young doctors on screening activities and treatment advancements. The ultimate goal is to prepare a report (through a collaboration of doctors and patients' organisations) with proposals on how to improve the screening and prevention measures.

8. Improve the Collaboration with Patients' Organisations

It is unfortunately not acknowledged by everybody that patient representatives of patients, that is national and international patients' organisations are a key driving force in the evolution towards more accessible and quality treatment. It is absolutely crucial to unite the efforts of hepatitis patients' organisations and doctors for the purpose of optimizing the impact on government policies. A strong hepatitis patients' organisation to support the work of a physicians' organisation through advice, insights and common projects and ideas will lead to a more efficient approach of liver conditions' related issues.

In this respect, it is important to extend the efforts of the national hepatitis patients' organisations in approaching more actively medical specialists who are in a daily contact with patients and therefore, could direct them to the hepatitis patients' organisations for advice, help and feedback. One possible action is to provide leaflets in hospitals, public and private medical centers, laboratories, where both physicians and patients can receive information. To improve the discussion channels between hepatitis patients' representatives and specialists, it is necessary to consider the possibility for annual conferences for the purpose of exchanging information and experience.

The efforts of the local hepatitis patients' organisations and medical specialists need to be combined with the leverage of international organisations such as ELPA, EASL, EU Directorates, e.g. ECDC or DG SANCO as well as WHO. The purpose of this is both practical and symbolic – on the one hand, to raise awareness among Romanian government officials of the scale of the problem and its importance at the international scene; on the other hand, to affirm the decisiveness of the international community regarding the provision of treatment for those who need it.

IV. ROMANIA: FOLLOW-UP ACTIONS

As shown above, in order to effectively address the numerous problems that patients with hepatitis face in Romania, it is crucial to take consecutive steps towards the development of a comprehensive strategy, and the French and Scottish good practices examples can be adapted for the Romanian strategy.

A first step towards achieving this goal would be organising round-table gathering policy makers, medical experts, financial experts, patient organisations and foreign public health experts. The purpose of this is to present publicly the findings of the current report and raise awareness among policy-makers regarding the magnitude and severity of the hepatitis threat. The goal is to recognize at this level the need for concrete actions for a national strategy.

Once the Government announces its support for such actions, a task force needs to be formed, which can be an expert panel or a steering committee. It can include also medical experts, public health experts, financial experts, legal professionals and patient representatives, and shall be responsible for preparing and presenting the national strategy within the established time frame.

Before creating the national hepatitis strategy, this group needs to revise the existing good practices and identify the current legal constraints in Romanian legislature that may become obstacles in the process of implementing good practices. Also it needs to identify the challenges that doctors and patients face, based on the findings of this report along with other sources of information. Afterwards, a cost-benefit analysis needs to be conducted to assess the effectiveness and financial burden of each case scenario. Subsequently there is the need to draft a cost-benefits analysis, for assessing the effectiveness and financial burden. After reaching an agreement within this group's members regarding the best options for prevention, screening and treatment, the national strategic plan against viral hepatitis in Romania must be drafted.

This strategic plan can incorporate the abovementioned recommendations, namely the need for developing a comprehensive detection, prevention, treatment policies along with a surveillance system to monitor and assess the flow of patients according to various relevant criteria. The plan should further search for ways to improve the collaboration between different specialist doctors, reinforce the need for training and best-practice exchange and emphasize the need for collaboration with patients' organisations.

The plan will serve as a main guideline and have a compulsory rather than optional nature. Therefore, it is crucial to consider the implementation of monitoring mechanisms to ensure the efficacy of the actions. However, for the purpose of maintaining the credibility of the national plan, it is important to also include mechanisms for revising and updating the plan with the latest developments and good practices, for the purpose of optimizing efficiency and minimizing the costs of prevention, screening and treatment policies.

V. CONCLUSIONS

The authors of this paper believe that now it is high time to develop a comprehensive and coordinated strategy for the care of all patients with viral hepatitis in Romania. We affirm that, if implemented in good faith, the above recommendations (supported by leading physicians around Romania) will considerably improve the situation and care of these patients and also the level of public healthcare in the short and long-term.

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