Meeting Report

International Roundtable Summit on Funding for Elimination of Viral Hepatitis

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In collaboration with
United States Centers for Disease Control and Prevention
and World Health Organization
International Roundtable Summit
On Funding for Elimination of Viral Hepatitis

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Organized by ZeShan Foundation

In collaboration with
United States Centers for Disease Control and Prevention
and World Health Organization

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About ZeShan Foundation
ZeShan Foundation is a privately funded foundation established by the Chen family in 2004. Aiming to be a catalyst, ZeShan identifies the needs in communities and society by tackling their root causes through a comprehensive approach.
Website: www.zeshanfoundation.org ; www.EndHEP2030.org
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EXECUTIVE SUMMARY

Introduction

In June 2016, ZeShan Foundation, in collaboration with the United States Centers for Disease Control and Prevention (US CDC) and the World Health Organization (WHO), convened a meeting in Hong Kong to articulate the critical needs and gaps in resources to support the achievement of the 2030 global viral hepatitis elimination goals endorsed by the World Health Assembly (WHA) in May 2016.

The meeting was designed to stimulate critical thinking and discussion around the establishment of an international funding mechanism to support the implementation of the Global Health Sector Strategy on Viral Hepatitis (“WHO Global Hepatitis Strategy”) and Regional Action Plans by fostering strategic partnerships, building collaborations for analysis of strategic information, supporting national planning, program implementation and evaluation, increasing public awareness, improving access to quality treatment, and spurring innovations of prevention technologies.
Participants included thought leaders from a diverse array of sectors, including philanthropy, government, international NGOs, and public health bodies. In preparation for the meeting, the Organizing Committee, comprised of representatives from the US CDC, the WHO, and ZeShan Foundation, developed and circulated *Viral Hepatitis and Gaps in Response and Funding: A Backgrounder* ("Backgrounder"), which laid out the epidemiological burden of viral hepatitis globally, available prevention and treatment interventions, and introduced the WHA-endorsed elimination targets.

### A. Making the Case

The time to act on viral hepatitis is now. With the WHA May 2016 endorsement of 2030 elimination targets for viral hepatitis, it is mission critical to launch a catalytic hepatitis fund to support countries’ achievement of these elimination targets. The viral hepatitis burden has never been greater or more deadly. There are an estimated 1.45 million deaths per year due to viral hepatitis, making it the seventh leading cause of death globally. About 240 million people are infected with chronic hepatitis B, of which 25% will die of hepatitis-B related causes, and another 70-130 million with chronic hepatitis C. The Asia-Pacific region bears the largest burden of disease, with 63% of viral hepatitis-related deaths globally occurring in the region.

However, highly effective prevention and treatment tools exist in the form of childhood vaccinations for hepatitis B that prevent 95% of infections, treatment for hepatitis B that can reverse liver scarring and the risk of cancer, and combination direct-acting antivirals (DAA) regimens that yield a >90% cure rate for hepatitis C. For the first time hepatitis has been included in the Sustainable Development Goals, recognizing the virus’s impact on population health and development, and the WHO Global Hepatitis Strategy makes explicit the targets for elimination. Achieving these targets will require direct financing by national health systems through a variety of innovative financing mechanisms. However, to achieve these targets in the next 14 years, outside catalytic funding is critical.

### B. Rallying the Stakeholders

In June 2016 ZeShan Foundation, in collaboration with the US CDC and the WHO, convened a meeting in Hong Kong to articulate the critical needs and gaps in resources to support the achievement of the 2030 viral hepatitis elimination goals. The meeting stimulated critical thinking and discussion around the establishment of an international funding mechanism to support the implementation of the WHO Global Hepatitis Strategy and Regional Action Plans by fostering strategic partnerships and building collaborations. Participants included thought leaders from a diverse array of sectors, including philanthropy, government, international NGOs, and public health bodies. The agenda and full participant list can be found in Appendix 1 and 2. The Organizing Committee drafted and circulated to participants the Backgrounder and *A Dedicated Fund for the Elimination of Viral Hepatitis: Initial Concept for Discussion* ("Working Draft Concept Paper") included as Appendix 3 and 4.

### C. Mobilizing Resources

US$50-100 million was set as the target amount needed to launch the fund. The funding was positioned as catalytic – to accelerate action on viral hepatitis and leverage additional monies. To that end, the following vision and mission of the proposed entity were presented and endorsed by meeting participants.

**Vision:** A world where viral hepatitis has been eliminated as a major public health threat by 2030

**Mission:** To catalyze actions to engage, prepare, and assist low and middle income countries to reach the targets for eliminating viral hepatitis as a public health threat

The fund will be a grant-making organization to be governed by a Board of Directors and staffed by a small Executive Team. It is explicit in its intention to create a stream-lined organization that will focus on funding proposals that are evaluated to be catalytic. The intention is not to fund countries’ response to viral hepatitis wholesale, but rather to identify projects that can accelerate action and bring about transformative change in global responses to viral hepatitis.

### D. Pinpointing Barriers to Action

The meeting generated a list of barriers to action on viral hepatitis that the proposed fund will need to address head on.

**Currently there is no global funding mechanism available for hepatitis-related activities.**

While the Global Fund to Fight AIDS, Tuberculosis and Malaria ("the Global Fund") has recently allowed countries to include hepatitis C-related activities within HIV programs, there is no other funding for hepatitis-related activities on a global scale. This is perhaps the most glaring barrier and the direct impetus for the proposed fund.

**Low public awareness of viral hepatitis and its links to liver cirrhosis and cancer,** even in the Western Pacific region which carries a disproportionate burden of disease, was identified as a major challenge to catalyzing action on viral hepatitis. A major task for the global hepatitis movement is to get the message out about viral hepatitis to governments and to populations. A prominent gap was articulated as “making the case for investment in viral hepatitis” through a strategic communication campaign.
The need for **simplification** emerged as a major theme. This included the need for simplification of diagnostics, specifically in point-of-care (POC) testing, to ensure greater access to testing. Greater incentives are needed for companies to accelerate simpler, faster and less expensive diagnostics. Direct-acting antiviral regimens have already simplified treatment and testing algorithms but participants hope for further simplification if pan-genotypic treatment becomes available. Finally, simplification of service delivery models was articulated as an important area, with possible task shifting away from specialists to primary care physicians as a key feature. Operational research to identify optimal service delivery models for hepatitis and define what a “comprehensive hepatitis program” might look like are urgently needed.

**Imprecise and dated burden of disease data** were also noted as barriers to action, particularly when health ministries do not have an accurate and up-to-date picture of the epidemiology of hepatitis B and C in their own countries, nor have the resources or adequate technical expertise to conduct sero-surveys and other targeted epidemiological studies to better characterize the burden of disease within their populations. Without such data, it is difficult for ministries of health to effectively advocate for dedicated hepatitis resources from ministries of finance and national leaders.

**National costed action plans for viral hepatitis** were deemed a necessary first step for countries to move forward in their response. Some countries in the region, such as Mongolia and Vietnam, already have such a plan while others, like China, are still in the process of development. The WHO, US CDC, and Center for Disease Analysis (CDA) have worked with some countries in the region to provide inputs into such costed plans, and more such collaboration will be essential. Alternative ways of framing cost arguments based on national priorities, such as loss of productivity due to viral hepatitis, impact on life expectancy, cost of inaction, affordability versus cost effectiveness, were also suggested.

**Among donors and global health institutions, there is a move away from disease-specific funds.** The fund will need to align with this very appropriate trend, by ensuring that any grant-making should require projects to make health system strengthening and sustainability key components of their aims.

### E. Formulating a Strategy
Based on the barriers identified above, the following recommendations emerged.

1. Develop three distinct strategic communication campaigns to raise awareness and make the case for action on viral hepatitis among (a) potential institutional and private donors to generate funds; (b) country governments, with a particular focus on ministries of finance, to mobilize allocation of funds from existing health budgets and mobilize new monies; (c) national populations, to increase testing and linkage to preventative and curative care.

2. Promote a "simplification" agenda to (a) incentivize companies to accelerate simpler, faster, and less expensive diagnostics; (b) ensure that once a pan-genotypic treatment regimen becomes available, it will be made accessible and affordable as quickly as possible; (c) identify service delivery models for hepatitis care appropriate to low and middle income settings.

3. Invest in generating more accurate snapshots of the epidemic to better characterize the burden of disease within countries and regions and among key populations, in order to arm ministries of health with the data needed to effectively advocate for dedicated hepatitis resources from ministries of finance and national leaders.

4. Identify innovative financing mechanisms appropriate for preventative and curative care, recognizing that funding approaches will have to differ depending on the disease burden, health insurance system, and for hepatitis C treatment as compared to the monitoring of hepatitis B and cancer prevention. Options to be explored include tax-based financing, out-of-pocket approaches, and health insurance.

5. Support countries to develop national costed plans that are crafted in response to specific national priorities, recognizing that one size will not fit all.

### F. Calling for Action
Given the severity of the epidemic and the momentum building around the elimination agenda, this effort should be recognized and embraced as urgent and inherently risky. The proposed entity should be seen as an emerging organization managing an emerging fund, with the expectation and acceptance that things will get clarified along the way. The goal of the fund is to catalyze action in countries on viral hepatitis and leverage additional funding.

The Organizing Committee concluded the meeting by setting out the following next steps: documentation of the two-day meeting and participant comments in the form of a Meeting Report; further development of the Working Draft Concept Paper to a more definitive statement of the mission of the organization; initiating steps to build the organization with the goal of a soft launch by World Hepatitis Day, July 28, 2017. Participants were invited to remain engaged in the development of the organization. The meeting concluded with a dinner hosted by Mr. Roy Chen, Director of ZeShan Foundation, and featuring the remarks of keynote speaker Dr. Shin Young-soo, WHO Regional Director for the Western Pacific, who underscored the urgency for the establishment of such a fund.
Dr. Gottfried Hirnschall of the WHO was appointed as chairperson for the first day of the Summit meeting. He spoke of the growing momentum around hepatitis elimination, which was evidenced by the endorsement by WHO Member States of the first ever global hepatitis strategy and targets in May 2016. He applauded the convening of this group of diverse stakeholders, recognized the long-standing collaboration between the US CDC, the WHO, and ZeShan Foundation as an inspirational example. She closed by announcing ZeShan Foundation’s commitment to becoming a seed donor to the proposed entity and expressed the hope that the summit yield an actionable agenda.

Immediately following the successful conclusion of the Summit, the Organizing Committee set to work on transitioning to a steering committee with an expanded membership for the purpose of establishing the Hepatitis Elimination Partnership 2030 (HEP2030). Among the priority tasks were to develop terms of reference for the HEP2030 Steering Committee (completed on September 29, 2016) and identify additional individuals to serve on the Steering Committee. (The HEP2030 Steering Committee was officially constituted and became operational on October 1, 2016). The inaugural conference call of the HEP2030 Steering Committee took place on October 6, 2016.

The Steering Committee is tasked with creating the HEP2030 entity by developing a governance structure; developing operating principles and operational procedures; developing a resource mobilization plan; and nominating and selecting board members and executive team members for the operationalization of HEP2030. The target date for a functioning Board of Directors and Executive Team is the World Hepatitis Day, July 28, 2017.

It was also agreed that it should be explored to register HEP2030 in Hong Kong as a 501(c)(3)-type charity organization under section 88 of Hong Kong’s Inland Revenue Ordinance. Furthermore, a number of related domain names have been registered by ZeShan Foundation for future use: www.HEP2030.org, www.EndHEP2030.org, www.EndHEP2030.com, www.EndHEP2030.net, with www.EndHEP2030.org being the primary domain. Also created was www.facebook.com/EndHEP2030. The Working Draft Concept Paper would be refined and combined with the Backgrounder into a brochure for the entity as well as a Donor’s Toolkit on giving to the elimination of viral hepatitis.
Overview of Global Viral Hepatitis
Dr. John Ward, US CDC

Dr. Ward provided an overview of the global hepatitis burden. Viral hepatitis is caused by infection with one of five viral agents. Hepatitis A virus and hepatitis E virus are spread via the fecal-oral route in situations with poor hygiene and by contaminated food and water; these infections typically cause acute or immediate disease after infection and the mortality is low for most infected persons. Hepatitis B virus (HBV), hepatitis D virus, which requires HBV to reproduce, and hepatitis C virus (HCV) are blood borne pathogens. All three viruses are readily spread by direct contact with the blood of an infected person in healthcare settings, through injection drug use, and also to a variable extent during sexual contact, at the time of birth, and following other exposures. Worldwide, most HBV-infected persons were exposed to HBV at the time of birth to an HBV-infected mother or in early childhood. HBV and HCV frequently persist as chronic infections which cause liver inflammation, progressive liver damage leading to severe liver scarring known as cirrhosis, and liver cancer; HCV can also cause a number of extra-hepatitis diseases. If left undiagnosed and untreated, 25% of persons living with HBV infection and 20%-40% of HCV-infected persons are at risk of death from these infections.

Together, HBV and HCV contribute an estimated 1.4 million deaths from viral hepatitis annually. Worldwide, approximately 240 million people have chronic HBV infection and 70-130 million have chronic HCV infection. Most countries in Africa and Asia have high rates of HBV infection; over 90 million persons in China are living with HBV infection. Two thirds of all HCV-infected persons live in four regions: East Asia (including China), South Asia (including Pakistan and India), Southeast Asia (including Thailand) and North Africa (including Egypt). Although China and India have relatively low HCV prevalence rates, they account for approximately 15 million and 7 million HCV-infected persons respectively. Mongolia and Vietnam are examples of countries with high rates of both HBV and HCV infections.

To prevent transmission of HBV and HCV, and reduce the large burden of disease and mortality, the WHO recommends specific interventions. The cornerstone of prevention is hepatitis B vaccination. With the introduction of vaccination, the prevalence of hepatitis B has fallen among vaccinated children. However, birth dose coverage remains low and mother-to-child transmission of HBV continues. Improvements in infection control in healthcare settings, harm reduction among injection drug users, and safer sexual practices also reduce HBV and HCV transmission. Testing, care and treatment can control HBV infection and cure HCV infection. Effective treatment dramatically reduces the risk of severe disease, mortality and transmission. However, most persons infected with HBV and HCV remain undiagnosed, not in care and untreated. Additional epidemiological data, public health planning, and capacity building will be required for countries in Asia and other regions to improve hepatitis B vaccination, and HBV and HCV testing, care and treatment, which are needed to reduce and eventually eliminate HBV and HCV transmission and disease as public health threats.

Discussion
Participants began an animated discussion around the reasons why the extent of the hepatitis burden remains unknown in many settings. The following reasons were articulated:

- Surveillance and surveys are time- and resource-intensive and are therefore often out of date. Strategies are needed to find ways to characterize hepatitis epidemiology as efficiently as possible.
- Cost of test kits is a major impediment to testing and, by extension, treatment. The cost of test kits varies greatly, and in some countries where drug costs are covered by the government, the cost of diagnostics still falls on the individual.
- The issue of variable quality of test kits was elaborated in a discussion of a US CDC evaluation of test kits, which suggested a 300-fold variation in quality and significant presence of counterfeit products on the market in many countries.
- Historical inaction by governments and global health institutions in hepatitis were due to lack of data, lack of platform, lack of media coverage, and lack of civil society organizing.

Participants discussed what could be learned from the Global Fund both in terms of what to emulate and what to avoid. There was consensus among those who have experience interacting with the Global Fund that the proposed entity should be significantly more modest in scale, with the focus on catalyzing resources and action by national governments rather than underwriting countries’ hepatitis responses.

Participants called for the articulation of a public health case for a proactive response to viral hepatitis that quantifies the cost of inaction in terms that matter to national governments. “Elimination” as a concept was heralded as energizing and participants urged the future entity to frame the issue in these terms, citing the elimination goal as an opportunity to seize upon.
WHO Global Hepatitis Strategy and Regional Action Plans
Dr. Gottfried Hirnschall and Dr. Stefan Wiktor, WHO

In May 2016, the WHA, the governing board of the WHO, endorsed the first ever global hepatitis strategy, which proposes ambitious prevention and treatment targets with the ultimate goal of eliminating hepatitis as a public health threat by 2030 (defined as a 90% reduction in incidence of chronic hepatitis B and C infections and a 65% reduction in hepatitis-related mortality). These goals are to be achieved by scaling up hepatitis B vaccination including birth dose, assuring safe healthcare practices including sterile injections in healthcare settings and among people who inject drugs, and testing and treating those with chronic hepatitis B and C infections. The strategy has five strategic directions which are aligned with the principles of Universal Health Coverage. Achieving the goals of the strategy will require dramatic increases in financial resources and commitment.

Discussion
Participants agreed that national costed plans should be a critical advocacy tool to push forward government action on viral hepatitis, and made the important observation that the power resides most often in ministries of finance rather than ministries of health. It was noted that engaging ministries of finance in such costing exercises was critical, and that it was useful to frame action on hepatitis as a short-term investment in population health that would have a positive return on investment in the medium term and an end-date with the elimination of viral hepatitis.

In discussing the role of the proposed fund, two important points were made: 1) the hepatitis field is not yet crowded and the proposed entity has an opportunity to create significant impact if it moves quickly; 2) participants articulated a tension between the creation of a vertical response to yet another disease and the call for universal health access and integration of disease-specific programs into health systems. Participants expressed that these need not be at odds, as the proposed fund could seek proposals that demonstrated health systems level impact and integration within health services and systems.

WHO Western Pacific Regional Action Plan
Dr. Ying-Ru Jacqueline Lo, WHO Regional Office for the Western Pacific (WPRO)

Viral hepatitis is the seventh leading cause of mortality globally, responsible for 1.45 million deaths in 2013. One quarter of the world’s population live in the Western Pacific, but the region bears 40% of the world’s deaths caused by hepatitis. Hepatitis kills more than 1,500 people every day in the region.

WPRO’s work has been impressive: over 7 million deaths have been averted as a result of hepatitis B vaccination programs from 1999 to 2014. WPRO is now working toward a region free from new hepatitis infections, and where people living with chronic hepatitis have access to care and effective treatment.

The Regional Action Plan for Viral Hepatitis in the Western Pacific 2016-2020 was approved by 37 WHO Member States and Areas at the 66th session of the WHO Regional Committee in 2015. It provides a systematic approach to five priority areas for action by countries to reduce the impact of viral hepatitis, with a focus on chronic hepatitis B beyond immunization and hepatitis C. The Action Plan is an important step toward eliminating viral hepatitis as a public health threat by 2030, and sets clear milestones and targets for the Western Pacific.

• Know it: Breaking the silence - through knowing the risks of infection, knowing the true scale of the devastating epidemics, and reducing the stigma associated with hepatitis.
• Treat it: Ensuring treatment success - through improving diagnosis, access to effective treatment, and care for hepatitis patients.
• Prevent it: Stopping transmission - through implementing successful newborn and infant vaccination programs.

Discussion
It was recognized that success in Asia will have a global impact given the burden of disease in the region. Participants raised the question here, and throughout the meeting, “Should the proposed fund be global in scope or focus its efforts on Asia?”

The point was raised that in WHO’s Global Burden of Disease group, chronic and acute hepatitis are treated individually instead of together, thus underestimating the true burden of disease due to viral hepatitis. For advocacy purposes, there needs to be better aggregating of the numbers across chronic and acute hepatitis.
Participants discussed the importance of advocacy and the use of costing exercises as an advocacy and fundraising tool. Detailed discussion of the framing of costing exercise ensued. The following views were expressed:

- Cost effectiveness should be framed as “how much money will Country X save if it acts versus if it does not act”
- Australia was cited as an example where a “cost of doing nothing” scenario was presented at the policy level and was incredibly powerful in mobilizing action on HCV treatment.
- Costing exercise of the “status quo” scenario should include: costs that patients and insurance companies spend on suboptimal treatments today, and costs related to liver disease and end-of-life care. However, others responded that in many of these settings “end-of-life care” was not a major expense to be costed because people just die a slow and painful death without much medical care.
- The framing of the investment case needs to be tailored for different countries, and should consider the national development priorities of each country and frame the argument within those broader terms. Possible framing includes the impact of action on life expectancy, and the impact of inaction on the loss of productivity and quality of life.
- Participants from WPRO responded that disease burden and economic analyses conducted by the WHO, the US CDC and CDA are used to improve or inform national action plans; several examples were cited:
  » China: For every RMB1 (US$0.68) spent on HBV, a RMB1.7 (US$ 1.16) return on investment to society was generated.
  » Mongolia: In a country of 3 million people with an HCV prevalence of 7%, the cost of those infections to society is US$1.5 billion over 15 years. With government subsidization of HCV treatment, the return to investment would be 1:4.5.
- Others noted that such analyses, which are ongoing in many countries, take years to do and are out of date already by the time they are completed.
- The question of the advantage of approaching ministries of finance to request independent financing for hepatitis versus funding hepatitis within a basket of other non-communicable diseases was raised.
- Participants also suggested that it is important to recognize that, while treatment is often cost-saving, the government still needs to pay in the short term and benefits are accrued much later (thus less incentives politically as those decision makers will no longer be in office). Therefore, political advocacy is one of the key barriers to overcome.

Advocacy emerged as a major topic of discussion, including the need for advocacy to governments writ large; advocacy to the ministries of finance to support the funding of a hepatitis response; and advocacy to the general population through celebrities and WHO goodwill ambassadors. Participants acknowledged that this was an area where more work needs to be done and the proposed entity could play a role.

Making the Case for Action and the Need for Resources
— How Data Analytics Informs Formulation of Public Health Policy and Determines Resource Allocation
Dr. Homie Razavi, Center for Disease Analysis

National strategies for the elimination of hepatitis by 2030 will require an understanding of the disease burden both today and in the future as the population ages. In addition, informed decision making requires a good understanding of the impact of different intervention strategies and the associated costs. Data analytics has been helpful in developing common definitions across countries, forecasting disease burden under different scenarios, estimating the required number of screened and treated to achieve a reduction in mortality, and calculating the economic impact of different strategies.

In the last eight years, considerable advances have been made in developing national and regional estimates which combine traditional literature searches with country interviews. In addition, flexible modeling has enabled countries to run what-if scenarios to help develop cost-effective national strategies and plan their healthcare spending. Dr. Razavi provided a review of the current available tools, activities underway, and their impact on health policy and resource allocation.

Discussion
Participants asked for clarifications and made suggestions for inputs into the modeling, including:

- Possibility of including the gain in productivity due to treatment into the model, which is currently not captured.
- Possibility for regularly updating cost of treatment as prices for DAA regimens fall. Could there be a mechanism by which TREAT Asia who tracks prices provides up-to-date pricing information to CDA to compile such updates?
- Could the benefit of increased life expectancy be incorporated into the model?
There followed a robust discussion around barriers to cheaper, more reliable, and more accessible diagnostics, the relationship to the development of pan-genotypic regimens, and whether the proposed entity could have a role to play in this area. Discussion points included:

- Broad recognition that there is a need to champion a focus on diagnostics. (US CDC was convening a meeting on this topic in September 2016.)
- The need for simplification of diagnostics and the role of the WHO in pre-qualifying POC diagnostics, such as the GeneXpert.
- One component of simplification is the use of biomarkers like aspartate aminotransferase-to-platelet ratio index (APRI) and fibrosis-4 (FIB-4). However, physicians are still hesitant to accept these.
- Companies lack incentives to improve testing technologies, including POC tests. Could donors play a role in funding research on better POC diagnostics?
- There was some discussion about the need for genotyping in settings like Mongolia and Vietnam, where the epidemics are quite homogenous (i.e. 98% genotype 1B in Mongolia; 97% genotype 1 or 6 in Vietnam).

Responses by Australian and Taiwan Governments Regarding Viral Hepatitis Elimination

Dr. Stephen Locarnini, Victorian Infectious Diseases Reference Laboratory and Coalition for the Eradication of Viral Hepatitis in Asia Pacific

Australia was the first country to have a public health strategy for hepatitis C and launched the National Hepatitis C Strategy in 2000. It is now in its fourth update, with key guiding principles including: human rights, access and equality, health promotion, prevention, harm reduction, commitment to evidence-based policy, partnerships with key stakeholders and meaningful involvement of the affected communities. Equally important, the Strategy is funded; so implementation has been robust. Targets and indicators have been included in the latest Strategy and evaluation will be an important activity for stakeholders. The National Hepatitis B Strategy, in contrast, has not been funded or implemented.

Taiwan was one of the first countries to implement a national hepatitis policy (1982) and subsequently has invested significantly in primary prevention (hepatitis B vaccination) and chemoprevention (hepatitis B therapies) programs. The key success there has been government commitment. This presentation highlighted the importance of strategies and partnerships, including the commitment of governments to initiate policy development, introduce the necessary laws and regulations, and drive broad public health programs. The performances of Taiwan and Australia were measured against the Four Axes of the WHO Global Hepatitis Framework, toward the goal of elimination.

Discussion

Dr. Mark Jacobs explained that in Australia there is a system by which community champions and clinicians for HIV have access to the Minister of Health. This model was adapted for HCV and meant that these voices from communities and clinicians were at the negotiating table with the government and pharmaceutical industry, so communities and clinicians could advocate for their needs effectively. Few other countries have such a mechanism.

Participants noted that with the current rapid rate of hepatitis C treatment uptake in Australia (~16,000 people in two months), it was possible that Australia would be able to eliminate HCV in less than five years. However, both Taiwan and Australia are high income countries and the question was raised how applicable these lessons are to other lower income countries in the region, and how to advocate for the inclusion of diagnostics and treatment in universal health care in settings where that exists.

Finally, the issue of decentralization of services to family doctors who coordinated with specialists through phone, fax, and email, was heralded as an important learning point. An important operational research question is “what are the barriers to decentralization”, particularly in high burden countries like China with very complicated healthcare system.

Critical Needs and Gaps: Challenges to Achieving the Global Elimination Goals

Mr. Charles Gore, World Hepatitis Alliance

The WHO Global Hepatitis Strategy has a set of impact and service coverage targets, which modeling suggests will bring about elimination. However, there are some critical barriers to achieving these targets. Leadership and political will are uneven and in most countries lacking. There is inadequate data to prioritize action and to monitor the effectiveness of interventions. Coverage of prevention programs is inadequate, the vast majority of people living with viral hepatitis do not know their status, and few have access to care and treatment, partly but not only...
because of the cost of diagnostics and medicines. Very few countries have taken a public health approach to hepatitis, meaning that health systems needs and integration approaches have not been adequately addressed. There is also insufficient attention focused on stigma, discrimination and other structural barriers that hinder equitable access to services. Finally, a lack of dedicated funding is a major barrier and underlies many of the others.

Discussion
A discussion on the actual status of drug registration ensued with the following facts laid out:

Two and a half years post approval, only 16 countries have approved drugs for a DAA regimen, of which only four are in the region. Harvoni, a new medication used to treat hepatitis C, has only been registered in six to eight countries, with Mongolia the only country licensed outside of India in the region. There is very slow progress in registering generics. Without access to medications at an affordable price, it is challenging to achieve progress in treatment and toward elimination. Further complicating the issue is the different registrational status of tenofovir disoproxil fumarate (TDF) for HIV versus HBV in some countries.

The discussion then moved to the question of service provision models and what integration, decentralization, and task shifting means for hepatitis. A mapping or scoping paper on how drugs are prescribed and delivered in different settings to different populations was identified as a possible useful exercise to identify optimal service delivery models, and what a “hepatitis program” entails began to become more concrete. Participants were quick to note that standalone programs with protected workforce and resources, as were set up for HIV and tuberculosis, are probably counterproductive at this point in time and that “optimal models” should articulate their integration within the greater health system.

There followed a robust discussion about the relationship of testing and treatment, with some participants expressing hesitation on promoting widespread testing campaigns in the absence of accessible treatment, and others noting that testing and diagnosing is useful in and of itself, as it allows individuals to take preventative measure to slow down the progression of disease and prevent onward transmission.

Overview of the Concept for a Dedicated Fund
Mr. Wangsheng Li, ZeShan Foundation

As momentum is building, it is high time to consider a partnership funding mechanism to support international efforts to implement the WHO Global Hepatitis Strategy and Regional Action Plans by fostering strategic partnerships, building collaborations for analysis of strategic information, supporting national planning, program implementation and evaluation, increasing public awareness, improving access to quality treatment, and spurring innovations of prevention technologies.

The Global Hepatitis Strategy was recognized as being catalytic and motivational in and of itself. The central question articulated was “How viable is a dedicated fund for the elimination of viral hepatitis in the context of the Global Hepatitis Strategy?”. The envisioned dedicated fund would aim to leverage resources and cultivate synergies through innovative public and private partnerships.

Mr. Li shared the genesis and evolution of the discussion to date, outlined key characteristics of the envisioned fund, and invited participants to contribute their thoughts on the plan.

The initial scope of the fund was proposed at US$50-100 million, with a minimal pledge of US$50 million for launching. Five possible options for the administration of such a fund were presented: 1) a standalone registered non-profit; 2) a program within an existing fund; 3) an affiliation with an existing fund but with an independent board and governance structure; 4) a part of a charitable trust with an independent board of governors; 5) a fund under a donor-advised fund with an independent board of governors. Mr. Li presented a limited lifespan of 20 years as an important feature of such a fund for potential donors and for recipients of funds. World Hepatitis Day, July 28, 2017, was proposed as a target date for launch.

Discussion
There was uniform and resounding enthusiasm for the idea of such a fund. There was recognition that given its limited scope, the fund would need to be catalytic and focused on innovation. There was broad agreement that given a $50-100 million initial budget, the proposed fund should be very clearly different from the Global Fund – it should catalyze national responses and provide seed funding, but should not be seen as a source of funding for national programs or aspects like purchase of commodities. One suggestion was to consider the fund as “prize money” for innovative ideas that will be funded ex post based on achievement.
It was recognized that the WHO Global Hepatitis Programme team has very limited capacity due to small size of the team (only five to six staff) and limited resources. While the implementation of the WHO Global Hepatitis Strategy requires capacity and staffing at the headquarters and regional offices to support countries, such resources are currently unavailable.

Once again the theme of advocacy, making the case, and awareness-building was discussed. Participants acknowledged that those gathered in the room represent the converted, those who believe that responding to viral hepatitis is a strategic investment in population health with a sure win in the not-too-distant future. But the question is why others outside the room have not recognized this. Some participants suggested that the fund could invest in global and country level public relations campaigns, so as to convince high prevalence countries to take ownership of hepatitis treatment at minimum and liver cancer prevention more broadly; others noted that the global health community has not yet made a compelling enough case and suggested rethinking communication strategies, such as comparing viral hepatitis elimination messaging to “cancer prevention” messages; still others clearly stated that in their view the fund needed to do be “advocacy-plus”, and that resources should be made available to provide technical capacity to national governments to develop national costed plans with identification of resources for their implementation. A desire to fund demonstration projects was also strongly articulated by some participants, while others raised the possibility of the fund being positioned to build capacity. Finally, the idea of the fund having a role as a “rapid response strike force” to combat misinformation around adverse events was also raised.

The question of donors was raised, with discussion around which type of donors would be acceptable and asked to contribute. For example, would pharmaceutical contributions be accepted? Could development banks be engaged? How about international development / aid programs under the auspices of national governments?

Elimination of Viral Hepatitis: How Governments Respond—Case Examples of Vietnam and Mongolia
Dr. Nick Walsh, WPRO

The presentation briefly reviewed the viral hepatitis situation and response, including gaps and challenges in the response, in Vietnam and Mongolia. Dr. Walsh began by describing WPRO’s three-pronged approach to supporting countries, including working with countries to develop national action plans, providing technical assistance for the development of disease burden and economic analyses, and increasing treatment access. The presentation then delineated key issues facing both countries in understanding key economic considerations, the financing requirements for elimination, and how these could be met.

He used a recent joint mission of the US CDC, National Cancer Institute and the WHO to Vietnam as an example. The March 2016 mission sought to promote alignment between national policy and regional and global initiatives, and found early adoption of a comprehensive National Action Plan. It identified data linkages between already existing sources of data as a key area for further work, particularly around liver cancer and its relationship to viral hepatitis epidemiology and programing, but also noted that specification of individual hepatitis viruses within notifiable disease systems was already in development. The mission delved into financing, including health insurance reimbursement, of diagnostics, and of care and treatment. It found that a disease burden modeling and investment case was already underway, with inputs expected from a planned representative sero-survey for HBV and HCV in 2017. As in many other countries, the mission urged that separate preventive and curative sectors within the Ministry of Health work together to plan and implement, in order to ensure a care continuum and maximize opportunities for cost efficiencies. Finally, the mission found widespread prescription of ineffectual, expensive treatments and highlighted the need for patient education around the availability of curative treatment for hepatitis C.

A successful collaboration with Mongolia was also detailed, including WHO-US CDC joint engagement with the Ministry of Health and Sports since 2014, which included support for the development of a new National Hepatitis Program aligned with the WHO, disease burden modeling, including intervention scenarios with economic and financial analyses, and promoting access to medicines and improving quality of care. By late 2015, the Cabinet and Parliament approved the elimination agenda. For hepatitis C, combination DAA became available in late November 2015, with close to 3,000 people treated since then; however, insurance coverage
remains pending. Hepatitis B treatment is already included in the National Health Insurance, with 50-98% of the cost covered depending on the drug cost (originator versus generic). With national endorsement of an elimination strategy and availability of drugs, implementation will take center stage. Decentralization to primary care physicians will be necessary to reach elimination targets, requiring intensive effort to train the healthcare workforce.

**Discussion**

The distinction between high burden and high prevalence countries was identified as a key issue that requires some consideration, and the WHO headquarters is developing a framework that takes this question into account. It may be that initiatives in small populations (Mongolia) can achieve elimination faster. But this will have more limited impact on global targets. Which one is more important for such a fund?

Mongolia, with its small population, of which 50% is concentrated in the capital, was suggested as a “laboratory for innovation” and a setting where the government has already endorsed a national strategy for elimination and is working to identify an optimal approach to funding treatment through insurance schemes. There is an “early detection of liver cancer” policy in Mongolia through population-based testing for HBV and HCV for all those aged 45-65. But implementation is decentralized and uneven, and collation of data is suboptimal. Could Mongolia’s “early detection of liver cancer” approach be studied and assessed for relevance in larger population settings?

In response to the impressive high reported coverage rate of the hepatitis B birth dose in Vietnam, it was pointed out that the timeliness of the birth dose (within 24 hours of birth) is critical for its efficacy but that there is very low awareness of this point among healthcare workers and parents. While this is a technical issue, it was presented as another area of need for awareness and public education messaging.

**SUMMIT DAY TWO**

Dr. Ray Yip of bgC3 was appointed as chairperson for the second day of the Summit meeting. Dr. Yip summarized the discussion of the previous day by noting that, while a strong investment case is already obvious to everyone in the room, the biggest challenge is to convince others outside the room, including, importantly, potential donors. He noted that the agenda for this day was to discuss how to best utilize the funds once they were raised, but reminded participants that the first step was to articulate a more compelling case.

**Innovative Financing into Hepatitis B and C Prevention and Treatment in LMICs**

*Prof. Dr. Pierre Van Damme, Viral Hepatitis Prevention Board*

Recent scientific breakthroughs in the treatment for hepatitis C, together with the WHO Global Hepatitis Strategy, call for new approaches to finding innovative funding mechanisms to scale up treatment of viral hepatitis, and supporting health systems in delivering it in low and middle income countries (LMICs). In 2015, the Viral Hepatitis Prevention Board initiate a project to explore a range of these mechanisms, their feasibility for deployment in the area of prevention and treatment of hepatitis B and C in LMICs, and insights from funders herein. A round table with experts was organized, and a survey of over 250 organizations involved in (innovative) financing and/or health care was conducted. The project results were documented in a report titled *Innovative financing into hepatitis B and C prevention and treatment in LMICs* (www.vhp.org). Key findings include:

1. Affordability, rather than cost-effectiveness, is more a key consideration for countries.
2. There is a need to lower prices and raise volumes of drugs – but which action should come first is an open question.
3. There is a need to simplify and optimize the cost of other elements in the spectrum of care, such as diagnostic tests.
4. Financing should include not only commodity procurement, but also the identification or building of infrastructure for delivering hepatitis services across the spectrum of care.

The report concludes that a number of innovative financing mechanisms offer considerable promise. Examples of financing mechanisms include the creation of new funds, financial protection of individuals through health savings accounts or micro-health insurance, social impact investments, mechanisms to enhance affordability, performance-based mechanisms, and crowdsourcing for small contributions. However, focusing on only one single financing mechanism is unlikely to be feasible. Optimal conditions for setting up new financing mechanisms will require political support for a viral hepatitis national plan, and competence in selecting the mechanisms, which are best adapted to country-specific challenges and meet the needs of all the stages of the therapy cycle.

Discussion

Following Dr. Van Damme’s presentation there was a discussion around microfinance as an approach to financing. A heated debate ensued between those who believed that should be a viable option to be explored, and those who felt the approach was fundamentally flawed by excusing the state from its obligations and placing the burden of health on individuals and their families. A public-private partnership providing credit for HCV treatment in Mongolia was described. The credit card-based system offers loans at low interest rates (compared to commercial lending rates) over a three-year term without requiring a collateral. The loans are accepted by all health sector companies to cover all treatment and related costs. An alternative to this temporary approach, which was acknowledged as plausible in the specific context of Mongolia, would be a universal health insurance system that builds solidarity between those who are ill and those who are not.

The different approaches to financing for hepatitis B versus hepatitis C was also highlighted. Hepatitis B is already covered in the Mongolian and Vietnamese insurance plans. For hepatitis C, governments must identify innovative financing mechanisms quickly, so as to provide a large amount of investment over a short timeframe to get over the hump that is treatment/cure. This is an important point to understand when discussing these issues with countries – while cost effectiveness can be used to convince donors, countries are motivated by affordability.

Deconstructing the Working Draft Concept Paper

Dr. Nicole Smith, US CDC

This presentation focused on the proposed framework for a dedicated fund as outlined in the Working Draft Concept Paper (Appendix 4). Dr. Smith shared additional background and contextual information drawing on the observations and experiences of other global health partnerships. Dr. Smith guided participants through each aspect of the Working Draft Concept Paper and elicited comments and reactions.

Discussion

Participants framed the discussion around the creation of an entity with two components:
1. In order to convince donors that they should contribute their resources to this effort, the story of the business case needs to be sharpened
2. In order to attract donations, a strong entity needs to be created, which donors believe will be well-managed and well-directed and are thus willing to place their funds into.

Members of the Organizing Committee reminded participants and each other of the themes that emerged from the previous day’s discussion: the desire for this entity to provide catalytic funding in the initial scale of $100 million, to be invested in demonstration projects, support capacity building within countries, and promote innovation.

Participants were asked whether the list of areas presented was comprehensive, and whether there were areas they thought the fund should not work in. Three additional areas for potential funding were elaborated: modeling, pan-genotypic treatment, and implementation science research on service delivery models.

There ensued a discussion on the word “entity” – carefully chosen by the Organizing Committee to indicate that the organizational structure of the proposed fund is still an open question. Should it be a free-standing entity or hosted within an existing organization? Could it be hosted by the US CDC, the WHO, or UNITAID? If created within an existing organization, there will be overheads; if created as a free-standing organization, there will be other costs. There was agreement that there needs to be a clear governance structure and independence of governance.

Continuing with semantics, participants discussed the definition of the word “catalytic”. Some returned to the root of the word “catalyst” in chemistry, as in a substance that increases the rate of chemical reaction; an outside force that makes
things happen more quickly than they otherwise would have. For example, the fund could be catalytic in that it sends a message to other funding organizations to reconsider their position on funding viral hepatitis. The fund should both catalyze action in countries, and catalyze additional funding.

The metaphor of “building the plane while flying it” was put forth: Given the urgency of the epidemic and the momentum building around the elimination agenda, the present effort should be recognized and embraced as inherently risky – the entity should be seen as an emerging organization managing an emerging fund, with the expectation and acceptance that things will get figured out along the way. Even with very little money, the entity could start by playing a convening role for “learning communities”. Such communities would carry out a combination of peer education and technical assistance, as well as help articulate the case for supporting elimination of viral hepatitis – so that over a short period of time, the entity could already begin to enhance practice and identify bright spots, and through this process make the case for how to build the fund.

Work needs to be done to refine the message for different audiences: Are we preventing cancer; are we saving lives; or are we augmenting countries’ economic development? Should the fund consider outside help in articulating the message that is most likely to catalyze action?

The session ended with a central question: How could such a fund help catalyze elimination? It was noted that the elimination agenda does not need billions of dollars of new money – what it needs are small, strategic investments to drive decision making and bring costs down. How should the entity identify these strategic investments?

Breakout Sessions on Framework for a Dedicated Fund

Participants were divided into two groups, with one group assigned to “Articulating the need for global support” and the second to “Identifying potential financing mechanisms”. The two groups then switched the topics in the second round of breakout sessions. The following is a summary of the discussions. It should be noted that at this early stage, the intention of these sessions was to brainstorm an array of ideas rather than to reach conclusions, let alone consensus.

Building on the discussion of the previous day, the mandate of the proposed fund was articulated as “funding maximally catalytic projects” by seeking to leverage resources with minimal investments; to maximize partnership opportunities, including in-kind investments; and to identify projects that have the potential to maximize impact, scalability, and replicability by engaging governments as well as affected populations and civil society.

Participants did not think it was beneficial at this early stage to limit the types of funders to be approached. Family foundations, industry, governments, as well as crowdsourcing small donations from high burden countries were all presented as possible sources of funding worth investigating.

Participants brainstormed a laundry-list of types of activities that could be funded. Support for countries to develop national costed plans was at the top of the list, as were projects that could advance the “simplification” agenda.

The need for a strong governance structure and documentation were highlighted. There was much discussion on how much capacity for technical assistance such a
Doing Small Things to Help with the Big Picture
Dr. Lillian Lou, The John C. Martin Foundation

The John C. Martin Foundation is a private, not-for-profit foundation registered in 2014 in the US. Because of the background and experience of its founder and staff, the foundation is dedicated to scientific, medical and health-related programs targeting endemic diseases in under-served regions of the world. Special attention is paid to diseases caused by chronic viral infection, such as HIV/AIDS and viral hepatitis. Believing that knowledge is fundamental to driving positive action, the foundation mainly focuses on supporting access to current information on disease progression, prevention of transmission, patient care, and epidemiology of viral infection. Categories of potential and supported programs include in-country forums that allow knowledge-sharing between international/regional experts and local healthcare professionals, disease surveillance and epidemiological analysis, and observational studies to evaluate implementation plans. Priorities are given to projects that would be self-sustainable once started and benefit the local community with long-lasting impact.

Building a “Culture of Health” in the US: Philanthropy as Catalyst for Change
Dr. Paul Kuehnert, Robert Wood Johnson Foundation

The philanthropic sector is a key partner in collaborative efforts to improve population health at the community, national, and international levels. Key examples from RWJF’s history of over 40 years were provided to illustrate how the foundation has catalyzed systems and policy changes in US public health. The foundation’s current strategic focus on building a national “culture of health” is based on this history, and is intended to be catalytic for engaging multiple sectors of society in improving population health, well-being, and equity. How the foundation is implementing this strategy through its Culture of Health Action Framework was discussed.
Mobilizing Global Health Action: The Role and Challenge of Catalytic Philanthropy
Dr. Ray Yip, bgC3

Dr. Yip pointed out that to a large extent, philanthropy is viewed as a source of financial support for those with great needs that are not met by the public sector or the market. In essence, it is a relief effort and can be characterized as “direct philanthropy”.

For important public issues, shifting policy – including policies that affect funding – can also be the role of philanthropy and characterized as “catalytic philanthropy”. In fact, he suggested one can argue that philanthropy has a unique and useful role in shifting policy. One of the key reasons is that philanthropy represents the interests of those who are under-served, not the interests of private sectors. In many cases where there is an important role for the private sector to play, such as making a medical solution accessible to those who cannot afford it, philanthropy can broker the public and private discussion, which otherwise would be difficult due to regulatory constraints. For the same reason, philanthropy can also facilitate the coordination of private companies to work toward a common goal, something that would otherwise be hard to do due to laws against collusion.

One major contribution of catalytic philanthropy is to fund the demonstration and test of the feasibility of a specific program, so that if it is proven to be cost-effective, governments have data to support its adoption. Generating evidence-based analysis for policy input is a role that philanthropy should play more often. When a sound policy is adopted by the government, the coverage of and sustainable funding for the health program will be achieved. Philanthropic organizations should invest more and work together in such catalytic efforts to advocate changes for the better.

One of the challenges Dr. Yip observed is that few people in the philanthropic world disagree with the advocacy role as defined for catalytic philanthropy. However, few organizations are willing to put together a competent team to define the strategy that can achieve the policy goal. Such skills and talents are not the same as those needed to manage direct giving and projects. In essence, catalytic philanthropy is not the same business model as direct philanthropy; instead, it calls for a different set of talents to mobilize policy.

Discussion
The inherent riskiness of “catalytic philanthropy” as compared to “direct philanthropy” was discussed by participants, with the acknowledgement that while “catalytic philanthropy” has a greater risk of failure, it also has the potential for greater results. The Summit itself was held up as an example of catalytic philanthropy – bringing together a diverse group of stakeholders to set in motion the creation of a new entity to address a global health challenge.

Panelists were asked how their institutions’ interests in viral hepatitis and the proposed fund could be piqued. Two panelists noted that it would likely be challenging for their respective institutions to support an endeavor focusing on one disease area. For example, it is unlikely that the Bill and Melinda Gates Foundation would create a new division focused on viral hepatitis; instead, the fund could identify approaches that build on the work at the foundation, for example, a focus on diagnostics that could build on the malaria and HIV diagnostic platforms. The foundation has already invested in. For the RWJF, with its strategic focus on building a “culture of health”, the entity would need to communicate how work on a specific disease could address broader issues of public health, such as equity, engaging with the most vulnerable populations, and strengthening health systems.

It was also acknowledged that different approaches would need to be taken when making a case to established foundations, versus new donors who are “cultivated” to invest in health for the first time. Asian donors, including high-net-worth individuals and family foundations, were identified as important targets for fundraising efforts given the high disease burden in Asia, with participants noting that it is incumbent upon the proposed entity to make a strong business case for philanthropists in Asia. However, panelists urged participants to also consider established US foundations by assessing how the viral hepatitis issue could be packaged for different institutional priorities – such as culture of health, equity and resiliency, and health system strengthening. Finally, the value of in-kind support, such as strategic communication support, was also acknowledged.

Dr. Shin concluded the session by sharing his own experience in advocating for viral hepatitis elimination in the region. He noted the serious perception problem among government officials and the general population, with persistently low awareness of the viruses, their link to cancer, and the existing tools for prevention and cure. Therefore, strategic communication to transmit this knowledge to governments and the general public, including by engaging the media, needs to be a priority. Dr. Shin also mentioned that the Asia Pacific region is home to an increasing number of middle income countries which are not accessing the low pricing for drugs and diagnostics. He suggested that more effective action is needed in this area, potentially with the WHO at the helm of such efforts. For instance, guaranteeing procurement of massive volumes of drugs and diagnostics, potentially through bulk purchasing across countries, should make it possible for companies to agree to lower prices.
Concluding remarks were made by members of the Organizing Committee. It was agreed that the meeting solidified a clear mandate for action on viral hepatitis and that there was a strong sense of urgency to act on this problem. A recurring theme was that powerful interventions exist to prevent and treat hepatitis B and C, the issue now is how to quickly get these interventions to populations who need them through sustainable public health approaches that strengthen health systems. The need for simplification – of diagnostics, treatment and service delivery models – was clearly articulated and posited as one strategic angle that the proposed entity could develop. Strategic communication to governments and general populations to raise awareness of the disease burden and available interventions was another area of potential focus.

The US CDC and the WHO were acknowledged for their strong technical leadership globally. ZeShan Foundation was recognized for its catalytic leadership for envisioning and organizing the meeting and bringing together a knowledgeable, invested, diverse set of participants. Participants were thanked for their active participation, and invited to stay engaged as next steps are developed.

Several immediate next steps were identified. These included naming the entity and beginning to consider entity branding; registration of the organization in a geographic location and online; creation of an investment case with potential donors as the target audience, and the development of a tiered donor strategy; a decision on where to house the proposed fund; refinement of the Working Draft Concept Paper based on feedback from meeting participants; and the development of terms of reference for Steering Committee members to be invited. Potential opportunities for engagement with key stakeholders and potential donors are events scheduled in proximity to the Grantmakers in Health forum in Washington DC in November 2016 and the World Hepatitis Summit in Brazil in November 2017.

Immediately following the successful conclusion of the Summit, the Organizing Committee set to work on transitioning to a steering committee with an expanded membership for the purpose of establishing the Hepatitis Elimination Partnership 2030 (HEP2030). Among the priority tasks were to develop terms of reference for the HEP2030 Steering Committee (completed on September 29, 2016) and identify additional individuals to serve on the Steering Committee. (The HEP2030 Steering Committee was officially constituted and became operational on October 1, 2016). The inaugural conference call of the HEP2030 Steering Committee took place on October 6, 2016.

The Steering Committee is tasked with creating the HEP2030 entity by developing a governance structure; developing operating principles; developing operational procedures; developing a resource mobilization plan; and nominating and selecting board members and executive team members for the operationalization of HEP2030. The target date for a functioning Board of Directors and Executive Team is the World Hepatitis Day, July 28, 2017.

It was also agreed that it should be explored to register HEP2030 in Hong Kong as a 501(c)(3)-type charity organization under section 88 of Hong Kong’s Inland Revenue Ordinance. Furthermore, a number of related domain names have been registered by ZeShan Foundation for future use:

- www.HEP2030.org
- www.EndHEP2030.org
- www.EndHEP2030.com
- www.EndHEP2030.net

www.EndHEP2030.org will be the primary domain. Also created was www.facebook.com/EndHEP2030. The Working Draft Concept Paper would be refined and combined with the Backgrounder into a brochure for the entity as well as a Donor’s Toolkit on giving to the elimination of viral hepatitis.
APPENDIXES

1. Summit Agenda
2. Participants Roster
3. Viral Hepatitis and Gaps in Response and Funding: A Backgrounder
4. A Dedicated Fund for the Elimination of Viral Hepatitis: Initial Concept for Discussion
5. Photo Album
6. WPRO Infographics
7. WPRO Public Awareness Poster
8. Glasgow Declaration on Hepatitis

1. SUMMIT AGENDA

Day One  Monday June 20
Chair: Dr. Gottfried HIRNSCHALL

<table>
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<tr>
<th>Time</th>
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| 9:00 am | Welcome and Opening Remarks  
Ms. Annie CHEN, ZeShan Foundation |
| 9:30 am | Overview of Global Viral Hepatitis  
Dr. John WARD, US CDC |
| 9:50 am | WHO Global Hepatitis Strategy and Regional Action Plans  
Dr. Gottfried HIRNSCHALL and Dr. Stefan WIKTOR, WHO |
| 10:10 am | WHO Western Pacific Region Action Plan  
Dr. Ying-Ru Jacqueline LO, WPRO  
Plenary Discussion |
| 11 - 11:30 am | Coffee Break |
| 11:30 am | Making the Case for Action and the Need for Resources  
How data analytics informs formulation of public health policy and determines resource allocation  
Dr. Homie RAZAVI, Center for Disease Analysis  
Plenary Discussion |
| 12:15 pm | Responses by Australian and Taiwan Governments Regarding Viral Hepatitis Elimination  
Dr. Stephen LOCARNINI, Victorian Infectious Diseases Reference Laboratory and CEVHAP  
Plenary Discussion |
| 1 pm | Lunch |
| 2:30 pm | Critical Needs and Gaps: Challenges to Achieving the Global Elimination Goals  
Mr. Charles GORE, World Hepatitis Alliance |
| 3 pm | Overview of the Concept for a Dedicated Fund  
Mr. Wangsheng LI, ZeShan Foundation  
Plenary Discussion |
| 4 - 4:30 pm | Coffee Break |
| 4:30 pm | Elimination of Viral Hepatitis: How Governments Respond  
Case examples of Vietnam and Mongolia  
Dr. Nick WALSH, WPRO |
| 5:30 - 6 pm | Summary of Day One discussions  
Dr. Kathrine MEYERS, Aaron Diamond AIDS Research Center |
| 6:45 pm | Dinner |
Day Two  Tuesday June 21  
Chair: Dr. Ray YIP

9:00 am  Innovative Financing into Hepatitis B and C Prevention and Treatment in LMICs  
Prof. Dr. Pierre VAN DAMME, Viral Hepatitis Prevention Board

9:30 am  Deconstructing the Working Draft Position Paper  
Dr. Nicole SMITH, US CDC

Plenary Discussion

10:20 am  Coffee Break

10:50 am  Breakout Sessions on Framework for a Dedicated Fund  
#1 Articulating the need for global support
• Priorities for direct support [WHO/global, regional, national/sub-national - target countries]
• What activities to support [planning, implementation, capacity building, evaluation, monitoring, technical assistance]
• Resource targets [public and private, levers, innovative models]

#2 Identifying potential financing mechanisms
• Whether to have centralized or decentralized approach
• Alternative models for governance
• How to manage and how to assure accountability

12:40 pm  Report back on breakout sessions and follow-up discussion

1 pm  Lunch

2:30 pm  Breakout Sessions on Framework for a Dedicated Fund (continued)  
#1: Articulating the need for global support  
#2: Identifying potential financing mechanisms

3:30 pm  Report back on breakout session discussions

4:00 pm  Coffee Break

4:30 pm  Panel Discussion: Philanthropy as Catalyst in Public Health  
Panelists: Dr Paul KUEHNERT, RWJF; Dr. Lillian LOU, The John C. Martin Foundation; Dr. Ray YIP, bgC3  
Chair: Dr. SHIN Young-soo, WPRO  
Moderator: Dr. Gottfried HIRNSCHALL, WHO

5:45 pm  Closing Remarks and Next Steps  
Mr. Wangsheng LI, ZeShan Foundation

6:00 pm  Group Photo

6:15 pm  Cocktail Reception

7:00 pm  Summit Dinner  
Hosted by Mr. Roy CHEN, ZeShan Foundation  
Keynote speaker: Dr. SHIN Young-soo, WPRO

2. PARTICIPANTS ROSTER

(in alphabetical order of surname)

Dr. Marc BULTERYS  Medical Officer, US CDC
Mr. Edmond CHAN  Past President, Rotary Club of Channel Islands, Rotary District 3450 (Hong Kong/Macao/Mongolia/Guangdong)
Dr. Henry LY CHAN  Head of Division of Gastroenterology & Hepatology, The Chinese University of Hong Kong
Dr. Pw-lin CHAN  Advisor, Hepatitis/HIV/STI, WHO China
Ms. Yan CHAN  Program Director, ZeShan Foundation
Ms. Annie CHEN  Director, ZeShan Foundation
Mr. Roy CHEN  Director, ZeShan Foundation
Dr. Isaac CHIKWANHA  Deputy Program Manager, Médecins Sans Frontières
Mr. Brian DAVIES  Head of East Asia, Médecins Sans Frontières Access Campaign
Dr. DUAN Zhongping  Chairman, Chinese Society of Hepatology
Dr. Jean-Louis EXCLER  Head of Clinical Development & Regulatory, International Vaccine Institute
Mr. Charles GORE  President, World Hepatitis Alliance
Dr. Gottfried HIRNSCHALL  Director, HIV/AIDS Department and Global Hepatitis Programme, WHO
Prof. HOU Jinlin  Professor, Nanfang Hospital Southern Medical University
Dr. Mark JACOBS  Director, Division of Communicable Diseases, WPRO
Dr. Youngmee JEE  Director, Center for Immunology and Pathology, Korea CDC
Mr. KHWAIRAKPAM Giten  Manager, Community and Policy, TREAT Asia, amfAR
Dr. Paul KUEHNERT  Assistant Vice President, Program, Robert Wood Johnson Foundation
Mr. Wangsheng LI  President, ZeShan Foundation
Ms. Lily LIU  Country Director, Marie Stopes International China
Dr. Ying-Ru Jacqueline LO  Coordinator HIV, Hepatitis and STI, WPRO
Prof. Stephen LOCARNINI  Divisional Head of Research & Molecular Development, Victorian Infectious Diseases Reference Laboratory
Dr. Lillian LOU  Director, The John C. Martin Foundation, Ltd.
Dr. Kathrine MEYERS  Social Scientist & Director of China AIDS Initiative, Aaron Diamond AIDS Research Center
VIRAL HEPATITIS

Viral hepatitis and its consequences have an impact across populations from young to old, and across the health sector from maternal and child health, to communicable diseases as well as non-communicable diseases. Transmission can occur at birth or at any time during life. The resultant liver diseases progress into adulthood, resulting in severe liver damage (cirrhosis) and liver cancer, and increasing the severity of diabetes, kidney disease and other conditions. Vaccination prevents both infants and adults from acquiring hepatitis B infection; effective infection prevention and control measures and blood screening stop hepatitis B and C transmission. Treatment can control hepatitis B and cure hepatitis C infection, reducing the risk of severe disease and death for those fortunate enough to be diagnosed and treated before the onset of liver disease and cancer.

Worldwide, approximately 240 million people have chronic hepatitis B virus (HBV) infection and 70-130 million have chronic hepatitis C virus (HCV) infection. Hepatitis B will contribute to death in around 25% of those infected, usually through liver failure or cancer in late midlife. Vaccination at birth prevents infection in over 95% of cases, while treatment reverses liver scarring and the risk of cancer. Long term hepatitis C infection causes progressive scarring of the liver and ultimately can result in liver failure (cirrhosis) or liver cancer and multiple other conditions.

As of 2013, viral hepatitis is the seventh highest cause of mortality globally and the second highest cause related to infectious diseases. It is responsible for an estimated 1.4 million deaths (2015 WHO) per year from acute infection and hepatitis-related cirrhosis and liver cancer, a toll comparable to that of HIV and tuberculosis. Of those deaths, approximately 47% are attributable to HBV, 48% to HCV and the remainder to hepatitis A and hepatitis E. About 2.9 million people living with HIV are coinfected with HCV and 2.6 million with HBV. The Asia-Pacific is particularly affected by viral hepatitis, contributing 63% of all deaths due to hepatitis globally.

To prevent transmission of viral hepatitis and to reduce the large burden of disease and mortality, the WHO recommends...
specific interventions. A cornerstone of viral hepatitis prevention is hepatitis B vaccination. Hepatitis B vaccination is safe, inexpensive and, when delivered effectively, prevents transmission among infants and adults in > 90% of cases. Viral hepatitis testing enables individuals to be aware of their diagnosis and seek care and treatment. Hepatitis B antiviral treatment, which is oral and well tolerated, reverses liver disease and can reduce liver cancer risk by 50%. Hepatitis C antiviral treatment, which is oral and of limited duration (around three months), has a near 100% cure rate, reducing the risk of death from liver disease and other causes.

While hepatitis B vaccination programs have been highly successful in reducing hepatitis B transmission in many countries, access to birth dose is more limited, resulting in children continuing to become infected with HBV. Testing and treatment are not available to the vast majority of people living with viral hepatitis around the world.

In May 2016, at the World Health Assembly, countries of the world agreed to implement a Global Health Sector Strategy on Viral Hepatitis 2016-2021 to eliminate viral hepatitis as a public health threat. This includes reducing new hepatitis infections by 2030 and reducing mortality from hepatitis by 65% through the implementation of five core viral hepatitis interventions. Regionally, countries of the Western Pacific (37 countries and areas with 1.8 billion people in total) agreed in October 2015 to implement a Regional Action Plan for Viral Hepatitis to systematically address hepatitis disease and deaths by improving prevention, diagnosis and treatment for patients as well as building and improving national health systems’ responses to hepatitis in Asia.

However, many countries with a large hepatitis burden are low or middle income, and viral hepatitis often affects the poorest of society. These factors not only mean poor access to hepatitis prevention, diagnosis, and treatment for people living with hepatitis, but that national health systems do not have the capacity nor technical know-how to address hepatitis epidemics effectively. As a consequence, viral hepatitis and related liver disease continue to destroy lives and impose a burden on health systems in many countries.

A DEDICATED FUND

Despite the high impact of viral hepatitis and related diseases and the availability of very effective public health tools, there is currently no dedicated funding initiative to support high burden low and middle income countries (LMICs) to achieve hepatitis elimination.

Here, we propose a hepatitis fund to catalyze action to achieve hepatitis elimination, particularly for the worst-affected countries and communities where, despite national commitment, the national health systems cannot adequately or effectively address hepatitis epidemics.

This proposed entity will be supported by public and private donors, and has been conceived to specifically support activities to achieve viral hepatitis goals and milestones agreed through the structures of the United Nations World Health Assembly and Regional Committees.

This entity would work to fill the gaps in activity funding, when national health sectors are unable to support appropriate or adequate hepatitis-related public health interventions.

Supported activities would not replace national health sector responsibility, but would catalyze actions to engage, prepare, and assist LMICs to reach goals for eliminating viral hepatitis as a public health threat. These actions would build indigenous capacity and achieve sustainable outcomes for health sectors.

Supported activities would engage a range of sectors, including governments, civil society, affected communities, technical partners, professional and non-professional community alliances, as well as other stakeholders.

RATIONALE, ESPECIALLY AT THIS TIME

Many other disease categories have dedicated funds to support public health goals, with a focus on high burden LMICs – such as Gavi, the Vaccine Alliance for vaccination, the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as a number of other funding initiatives with broader mandates.

We think there is now a strong case for supporting countries to address viral hepatitis for the reasons listed below. We are focusing on hepatitis B and C, as these two viruses are responsible for over 90% of viral hepatitis related diseases and deaths.

1. Nations have now, in May 2016, signed a global agreement to eliminate viral hepatitis as a public health threat by 2030, with interim 2020 targets to spur immediate action. This shows both global and national commitment.
2. Some regions (the Western Pacific, the Americas) have taken the extra step of endorsing regional action plans to specifically outline the steps to support such a goal.

3. Hepatitis B vaccine is cheap, safe and effective, and hepatitis B vaccination programs have been very successful in reducing mother-to-child and early horizontal transmission:
   a. For example in the Western Pacific, the prevalence of chronic hepatitis B among five year olds is now <1%, resulting in 7 million averted deaths and 37 million averted infections in that region alone.
   b. Despite this progress, in a number of countries, infant hepatitis B vaccine coverage continues to be too low, resulting in unnecessary and harmful transmission to infants and children.

4. The vast majority of people living with hepatitis B and C remain undiagnosed, unaware of their infection.

5. Hepatitis B treatment is oral, once daily, affordable in most countries (as low as $7/month), reverses liver disease, and can reduce the risk of liver cancer by 50%:
   a. Yet even in high income countries, <5% of people living with chronic hepatitis B are currently treated, and in most LMICs this figures falls to <1%.

6. New hepatitis C treatment is oral, averages around 12 weeks in duration, and results in complete cure in nearly 100% of people.
   a. The price of these medicines has fallen from US$84,000 to US$750 per 12-week curative treatment duration in some countries in the past two years, and is very likely to fall much further.
   b. Worldwide, it is estimated that only 900,000 of 70 million individuals were treated for HCV in 2015.

CONCLUSION
The case to now develop a dedicated fund to catalyze actions to eliminate hepatitis is supported by: the high national, regional, and global disease burden; availability of highly effective prevention and treatment tools; global and regional agreements on hepatitis elimination; and lack of sufficient funding to achieve this elimination goal.

Principal author: Dr. Nick Walsh (Viral Hepatitis Focal Point, WPRO), with contribution from members of the Organizing Committee

3. WHO South East Asia and Western Pacific regions combined.
4. GBD 2013 Mortality and Cause of Death Collaborators. “Global Burden of Disease Study 2013”.
**GUIDING PRINCIPLES**

What should be the guiding principles that direct the manner in which the entity functions?

*Ideas for potential options:*

<table>
<thead>
<tr>
<th>Operating Principle</th>
<th>Achieved through these Objectives</th>
</tr>
</thead>
</table>
| **Catalytic, leveraging, aligned** | • Through strategic investments, pilot how best to introduce or augment interventions to overcome regional, national, or local barriers that hinder hepatitis-program implementation.  
  • Complement and build on programs with activities that are aligned with partner countries’ strategies, local epidemiological context, and capacity; and harmonized across implementing entities. |
| **Integration and health system strengthening** | • Support efforts that use local systems and build on existing programmatic efforts to advance hepatitis surveillance, prevention and treatment.  
  • Promote capacity by strengthening health systems to support hepatitis action with measurable impact; core concepts of service delivery should be applied, including high quality, simplification, decentralization, and task-sharing. |
| **Country ownership and adequate financing** | • Ensure partner countries develop their own action plans, align with global or regional strategies, assume responsibility for improving their domestic institutions, provide an enabling environment for action, and have plans for sustaining these activities.  
  • Ensure adequate resourcing by setting realistic targets, acknowledging the real costs of program or project management, and determining how to finance operational costs. |
| **Managing for results through mutual accountability** | • Ensure partner countries and donors both assume accountability for producing – and measuring – results (e.g., changes in policies, programs, outputs, and outcomes), including acting to improve on such feedback. |
| **Governance and transparency** | • Ensure strong leadership and an efficient, effective organizational structure; incorporate representation of stakeholders; apply standards for the selection of partners; establish systems for managing conflicts of interest; and ensure basic elements of transparency regarding funding and governance decisions. |

**BREADTH OF FOCUS FOR THE ENTITY**

To what extent should the entity support a specialized set of activities/actions or provide a broader level of support? And, if there should be a focus on particular activities/actions, should those be in areas for which there are relatively few other initiatives (e.g., surveillance, testing, care, and treatment versus routine childhood vaccination, blood safety, or infection control)?

**Assistance to build capacity to meet specific needs essential to the elimination of viral hepatitis as a public health threat**

Priority areas for action, current or potential barriers, and examples of catalytic projects to overcome these barriers to achieve elimination goals are listed in table below.

<table>
<thead>
<tr>
<th>Operating Principle</th>
<th>Barrier</th>
<th>Examples of Funding Activity</th>
</tr>
</thead>
</table>
| **Advocacy and awareness** | Limited awareness of viral hepatitis | • Develop general-public and provider education campaigns  
  • Build knowledge and awareness in affected populations to increase demand for testing and treatment  
  • Implement an anti-stigma and discrimination campaign |
| **Policy and planning** | Hepatitis activities not planned or coordinated | • Develop multisectoral national hepatitis task force  
  • Conduct assessment of status of capacity to implement hepatitis services at various levels of the health system  
  • Support stakeholder consultations for national planning  
  • Build capacity in regulatory and procurement systems to meet demand for testing and treatment  
  • Engage key actors and affected communities to reduce policy barriers to effective prevention and treatment interventions |
<table>
<thead>
<tr>
<th>Operating Principle</th>
<th>Barrier</th>
<th>Examples of Funding Activity</th>
</tr>
</thead>
</table>
| **Data & surveillance** | Lack of data for action and lack of confidence in hepatitis surveillance data | • Analyze public health surveillance and other strategic information  
• Conduct hepatitis semi-surveys nationally and among specific at-risk populations  
• Revise disease reporting systems to collect viral hepatitis data  |
| Prevention of transmission | Low birth-dose coverage for hepatitis B vaccination | • Assess birth-dose coverage and barriers  
• Pilot test alternative strategies to increase birth-dose coverage or coverage of catch-up programs for at risk individuals  |
| | Need for better methods to prevent mother-to-child transmission of hepatitis B | • Pilot test acceptability of antenatal testing  
• Evaluate effectiveness of antivirals to prevent transmission  |
| | High rates of unnecessary injections | • Develop locally effective strategies to reduce unnecessary injections  
• Carry out novel interventions to reduce unnecessary injections  |
| | Transmission still occurring in people who inject drugs (PWID) or vulnerable populations | • Increase participation of PWID in harm reduction and other prevention activities  |
| **Testing** | Uncertain quality of testing | • Identify, evaluate, and promote use of quality diagnostics  
• Evaluate performance of serologic tests to develop national testing algorithm  |
| | Lack of unified national testing strategies | • Support development of quality management systems for laboratories  
• Support the evaluation of point-of-care tests and use of dried blood spots to inform the development of a unified national testing strategy  |
| | Low coverage of testing among groups that are difficult to reach | • Develop comprehensive testing policies  
• Introduce testing services where persons at risk receive care (e.g., primary care, pre-natal care, harm reduction centers, prisons, homeless shelters)  
• Develop hepatitis case finding and linkage to care models tailored to meet local needs  |
| **Treatment** | Lack of human capacity to deliver hepatitis services | • Train healthcare workers (including in the private sector) in using novel, replicable methods  |
| | Poor linkage to care | • Evaluate strategies to retain persons in care to fully benefit from completed treatments  |
| | Lack of integration of services | • Introduce hepatitis treatment in harm reduction clinics  
• Evaluate effectiveness of nurse-led treatment and models of shared care  |
| | Substandard quality of services leading to poor treatment outcomes | • Implement novel models to increase the quality of hepatitis care and treatment in the private sector  
• Introduce quality improvement interventions  |
| | Quality of treatment program is unclear | • Support the development of quality indicators and reporting/measuring of these hepatitis program data  |
| | Lack of access to medicines | • Support novel approaches to secure less expensive hepatitis medicines |
PRIORITIZING GEOGRAPHIC REGIONS AND/OR LEVELS OF PROPOSED PROJECTS

To what extent should the fund be oriented toward achieving health impact at the regional, national and/or sub-national levels? And, should priority be given to countries or communities that have low(er) resources? If resources should be considered, what should the indicator(s) be?

Ideas for potential options:

• Level of impact to be achieved
  » Regional  Regions with large population and large burden of disease (e.g., Western Pacific region; Objective: WHO reaches regional goals; Note: baseline data are not available in all countries)
  » National  Countries with high prevalence of infection (e.g., Mongolia; Objective: Reduce impact on national-level mortality)
  » Sub-National  Countries with key populations with high prevalence of infection and/or are underserved (provinces, ethnic minorities, PWID, the incarcerated) (e.g., Ukraine; Objective: Assist community to achieve targets)
• Economic need
  » All LMICs eligible

CRITERIA FOR PRIORITIZING PROJECTS:

What criteria should be considered when assessing which projects should receive support?

Ideas for potential options:

• Quality of the proposal / project plan
• Level of impact on the number of new cases, ill persons, and/or deaths
• Demonstrated commitment
  » Degree of governmental commitment
  » Status of country plan (under development, drafted, or implemented)
  » Availability of complementary local resources
  » Engagement of endorsement by health sector (including permission of ministries of health for subnational level projects)
  » Engagement of affected communities
• Ability to monitor results
• Scalability and/or ability to generalize elsewhere (e.g., setting, population, country)
• Sustainability
• Level of innovation [could include research/development efforts to meet critical needs (e.g., developing new lab tests), or programmatic approaches (e.g., promoting new care models)]
• Project duration and/or timeline

ELIGIBLE APPLICANTS

Will the fund consider applications from a range of different actors or will it prioritize submissions from specific types of applicants? If so, which ones?

Ideas for potential options:

• National and sub-national governmental agencies
• International and national non-governmental organizations
• International agencies

FUNDING APPROACH:

How should resources be provided?

Ideas for potential options:

• Grants provided to above-mentioned organizations in line with project priorities

Principal author: Dr. Nicole Smith (Associate Director, Policy Office, Division of Viral Hepatitis, US CDC), with contribution from members of the Organizing Committee
5. PHOTO ALBUM

Welcome Remarks

Ms Annie Chen of ZeShan Foundation opens the Summit

Co-chairs

Dr. Gottfried Hirnschall of WHO

Mr. Charles Gore of World Hepatitis Alliance

Prof. Dr. Pierre Van Damme of Viral Hepatitis Prevention Board

Dr. Ray Yip of bgC3

Speakers

Dr. John Ward of US CDC

Dr. Stefan Wiktor of WHO

Prof. Stephen Locarnini of Victorian Infectious Disease Reference Laboratory

Dr. Nicole Smith of US CDC

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Breakout Sessions on Framework for a Dedicated Fund

(From left) Dr. John Ward, and Dr. Homie Razavi of Center for Disease Analysis

Panel Discussion: Philanthropy as Catalyst in Public Health

Chair: Dr. Shin Young-soo of WPRO

Moderator: Dr. Gottfried Hirnschall
Cocktail Reception

(From left) Dr. Nicole Smith and Mr. Charles Gore

Cocktail Reception

(From left) Dr. John Ward, and Mr. Roy Chen of ZeShan Foundation

Cocktail Reception

(From left) Dr. Nick Walsh of WPRO, and Dr. Stefan Wiktor

Summit Dinner

(From left) Ms. Meredith Potts of F.I.R.E Projects; Ms. Annie Chen; Dr. Munkhjargal Ayurzana of F.I.R.E Projects; Mr. Edmond Chan of Rotary Club of Channel Islands

Summit Dinner

Host: Mr. Roy Chen
6. WPRO INFOGRAPHICS

**HEPATITIS**
**KNOW IT. TREAT IT. PREVENT IT.**

- **THE SITUATION TODAY**
  - 40% of the world’s deaths from hepatitis
  - 50% of all hepatitis B-related deaths worldwide
  - 20% of people living with hepatitis C
  - 60% of all liver cancer cases

- **PROGRESS IN THE REGION**
  - 7 million deaths averted as a result of regional hepatitis B immunization programs from 1998 to 2011

- **TOWARDS A BETTER TOMORROW**
  - The Regional Action Plan for Viral Hepatitis in the Western Pacific, 2014 – 2020, provides a systematic approach to stopping viral hepatitis transmission and allowing people living with viral hepatitis to have access to safe, affordable, and effective care and treatment.

*Keynote speaker: Dr. Shin Young-soo*

*(From left) Mr. Wangsheng Li of ZeShan Foundation, and Dr. Paul Kuehnert*
7. WPRO PUBLIC AWARENESS POSTER

TREAT HEPATITIS
Stop Liver Cancer

1500 people die every day from hepatitis in the Western Pacific.

They don’t need to die.

Antiviral treatment for hepatitis can:

- PREVENT liver failure
- HEAL liver scarring
- PREVENT liver cancer

Action is needed:

- Enable rapid approval of new hepatitis medicines
- Provide public financing for hepatitis care and treatment

TREAT HEPATITIS AND SAVE LIVES

www.wpro.who.int/hepatitis

Glasgow Declaration on Viral Hepatitis

4 September 2015

Today we commit to set targets towards the elimination of hepatitis as a global health threat.

Because there are 400 million people living with hepatitis B or hepatitis C infection with no country/region unaffected,

Because there is a lack of global awareness and most persons with hepatitis remain undiagnosed,

Because 1.4 million people die every year from complications of viral hepatitis yet most of these deaths can be prevented,

Because there are highly effective measures to prevent new hepatitis B and C infections and highly effective treatments that can suppress hepatitis B virus replication and cure hepatitis C infection,

Because universal access to prevention, diagnosis, care and treatment is a human right and promoting access to and affordability of these services is the responsibility of all stakeholders,

The participants of the inaugural World Hepatitis Summit believe it is possible and essential to set as a goal the elimination of both hepatitis B and C as public health concerns. We therefore call upon governments in all jurisdictions to develop and implement comprehensive, funded national hepatitis plans and programmes in partnership with all stakeholders and in line with the World Health Assembly Resolution 67.6 and, in collaboration with the World Health Organization, to define and agree on realistic yet aspirational global targets for prevention, testing, diagnosis, care and treatment.