A Europe free of AIDS, TB and viral hepatitis - and no one left behind

Webinar Report:

Standards of CARE: HIV, VH, and TB – Good Practices and Ensuring Prevention & Care for People on the move

16 February 2023

EU Civil Society Forum – Thematic Network on HIV, TB, viral Hepatitis and STIs

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Contents

Introduction by the EU Civil Society Forum on HIV, TB and Hep (CSF) Coordination team 1

Introduction by the European Commission 2

Artur Furtado, DG SANTE 2

Hanna Abraha, DG SANTE 2

HIV, VH, STIs, TB European action plans: Objectives and targets for the European countries . 3

Stela Bivol, WHO Europe **3**

Current Standards of Care, challenges in implementation 5

Standards of Care audits and good practices: Jürgen Rockstroh, University Hospital Bonn AöR 5

Standards and gaps in harm reduction services: Marios Atzemis, Positive Voice 6

Good practices in implementation and cross-border healthcare 7

Milosz Parczewski, Pomeranian Medical University & European AIDS Clinical Society 7

Magdalena Ankiersztejn-Bartczak, Foundation for Social Education & European AIDS Treatment Group 8

Yevgenia Kononchuk, Eurasian Harm Reduction Association 8

Paul Sommerfeld, TB Europe Coalition 9

Introduction by the EU Civil Society Forum on HIV, TB and Hep (CSF) Coordination team

Ann Isabelle von Lingen
European AIDS Treatment Group

Since its creation in 2005, the EU Civil Society Forum on HIV/AIDS (hereafter CSF) and since 2017, the EU CSF on HIV/AIDS, TB and viral hepatitis has been instrumental in providing and sharing critical information and evidence, in undertaking joint actions, and creating synergies between its members.

These activities have advanced policies and interventions improving the health and well-being of communities that are most affected by HIV, viral hepatitis, and tuberculosis. Click here for more information.

With the European Health Policy Platform Thematic Network on HIV/TB/VH/STIs, the CSF aims to raise awareness of outstanding challenges and nurture solution-oriented collaboration among stakeholders beyond the CSF membership (see here). This webinar is part of a series of two. Today, the session will focus on **Standards of Care: HIV, VH, and TB – Good Practices and Ensuring Prevention & Care for People on the move.** On 16 March, the second session will tackle issues and good practices in addressing **Stigma and Discrimination** (more details will be shared soon). In February and March, the CSF/Thematic network will be drafting a statement which will be based on discussion and information shared during the two webinars. By early April, the draft will be shared for input from CSF members, Thematic Network members and interested stakeholders so to have a final document to submit by 10 April to the European Commission. The result of the Joint Statement will publicly be presented on 19 April at the EU Health Policy Platform annual meeting and then further disseminated at relevant policy events at national and European levels.

Please find here the presentation.

Introduction by the European Commission

Artur Furtado

Head of Unit, Disease Prevention and Health Promotion, DG SANTE B.4

On behalf of DG SANTE, Furtado welcomes the discussions and exchanges on good practices that are held in this webinar to improve the work in this area and to help Member States to ensure prevention and care for people on the move.

Furtado informs about the establishment of a new Commission Expert Group on Public Health, set up in December 2022. The first meeting was held on 3 February 2023. The Group brings together the public health experts from all EU Member States, Norway and Iceland and it advises the European Commission on major policy developments and the transfer of best practices, related to major public health challenges (non-communicable and communicable diseases).

Currently, the Group is working on cancer, vaccinations, and mental health. Priorities will evolve as the agenda is regularly updated. The next meeting will take place this Spring. If the Public Health Expert Group validates certain areas as priority area of work, then the Commission will open a call for proposals for best practices.

Hanna Abraha

Policy Officer, Disease prevention and Health promotion, DG SANTE

Abraha provides a brief overview of the Commission actions and initiatives in relation to HIV/AIDS, viral hepatitis and tuberculosis. For many years now, the European Commission has worked jointly with Member States by supporting various actions and policies on HIV/AIDS, Tuberculosis and Hepatitis through different policy instruments. One of them is the 2016 Commission Communication

with the title of *Next Steps for Sustainable European future*. With this Communication, the EU Commission committed to helping member states in reaching the United Nations Sustainable Development Goals on health and more specifically focused on ending HIV/AIDS, Tuberculosis and reducing Hepatitis.

Then, Europe's Beating Cancer Plan, which seeks to help improve prevention, early detection, diagnosis and treatment and quality of life for cancer patients and survivors. The plan specifically points to the need to address Hepatitis B and C, to prevent cancers caused by these infectious diseases, most notably liver cancer.

The Commission awarded funding to five ongoing projects on HIV, Tuberculosis and Hepatitis, under the 2021 EU4Health Programme. These projects seek to provide an expanded access to community-based healthcare and services for hard-to-reach populations, including migrant populations as well as people who use drugs. These projects will last between 24 to 36 months, and it will be very interesting to follow up on their outcomes.

HIV, VH, STIs, TB European action plans: Objectives and targets for the European countries

Stela Bivol
Unit Lead, Joint Infectious Diseases Unit, WHO Europe

In 2022, the Regional Committee endorsed the Regional Action Plans for Ending AIDS and the Epidemics of Viral Hepatitis and Sexually Transmitted Infections 2022–2030 and the Tuberculosis Action Plan for the WHO European Region 2023–2030.
In the WHO European region, hepatitis B and C represent the highest burden with 14 million people infected with hepatitis B virus and 13 million with hepatitis C. Liver cancer is one of the key unfavourable outcomes with almost 90,000 deaths registered across the WHO European region. We are generally familiar with testing for HIV, but we do not always hear about testing and treatment progress for hepatitis B and C. While we have seen an increase in the proportion of people diagnosed and doubled figure in people getting treatment, with a 20% increase in treatment of hepatitis C. The actual levels of diagnostics and treatments are still very low: 19% for hepatitis B and 24% for hepatitis C have been diagnosed, whereas the treatment is less than 10%.

The WHO European region is off-track with the HIV targets: the number of estimated new infections has increased, whereas the previous target was less than 40,000 cases, we, in fact, see an increase in the number of new HIV infections of 170,000. The target for the number of deaths has not been achieved, as the number of deaths due to HIV is still around 40,000. Also, the targets for the 90 90 90[1] have not been met, with the European region being well below the target. The TB/HIV co-infection is rising with 12% HIV prevalence among new TB cases. According to the 2021 WHO European region report on HIV diagnosis, we see the same persisting challenges over the last ten years: a large number of undiagnosed number of people and late diagnosis, especially in the Eastern part of the European region, and increases in late diagnosis, being more prevalent among men. During the COVID-19 pandemic, the gap between the estimated new infections and the actual new HIV diagnosis has widened in 2021, and we are not doing enough to bridge this gap and bring it back to the pre-COVID-19 years.

[1] For more information, please click on the link: https://www.unaids.org/en/resources/909090

The number of TB and HIV co-infections is increasing, and the treatment outcomes are not improving, and they are on the worsening side. There is still much work to be done regarding TB preventive treatment among people living with HIV. The burden of TB is lower compared to viral hepatitis and HIV, yet it accounts for about 70,000 estimated new cases of drug-resistant TB and 29,000 of number of people with TB-HIV co-infection. The WHO European region is doing better in terms of reaching the targets for new diagnosis, but it has not reached the target of decrease in the disease for the region. The region is also experiencing an increase in TB related deaths – partly resulting from the COVID-19 pandemic; the recovery is much slower in WHO European region than in other parts of the globe. It is similar for the gap between the number of diagnoses reported with TB, where we are seeing some improvement in the treatment outcomes for drug-resistant TB and this is a breakthrough, probably related to the introduction of oral regimens for new treatments.

We are not on track, but we can do it through a renewed political focus and by resetting the agenda. There are innovative options for prevention, screening, diagnosis, and medicines and new service delivery approaches, so if we do everything right, we can achieve our targets. The Regional Action Plans for ending AIDS and the Epidemics of Viral Hepatitis and Sexually Transmitted Infections 2022–2030 have been adopted at 72nd Regional Committee in Tel Aviv on September 14, 2022. The vision and goals are a cross-cutting and shared strategic direction to create a unified vision of HIV, viral hepatitis and STIs within universal health agenda and health systems approach. Then there are the three action plans and vision and goals for HIV, viral hepatitis and STIs that are aligned with the SDGs:

1. Seventy-second Regional Committee for Europe: Tel Aviv, 12–14 September 2022: background document: Tuberculosis Action Plan for the WHO European Region 2023–2030 https://apps.who.int/iris/handle/10665/361921
2. Seventy-second Regional Committee for Europe: Tel Aviv, 12–14 September 2022: Regional action plans for ending AIDS and the epidemics of viral hepatitis and sexually transmitted infections 2022–2030 https://apps.who.int/iris/handle/10665/361524
3. Seventy-second Regional Committee for Europe: Tel Aviv, 12–14 September 2022: Tuberculosis action plan for the WHO European Region 2023–2030 https://apps.who.int/iris/handle/10665/361367

The targets may be very ambitious, but we are expected to be aligned in decreasing by 2025 and to drastically decrease HIV-related deaths by 2030. Similar is the Action Plan for TB by reducing TB deaths by 75% by 2025, with the baseline being 26% in 2020; reduce TB incidence by 50% by 2025 and improve the MDR treatment to 80%. The TB Action Plan for WHO European region follows the structure of the NTB strategy. Under the first pillar, people are now placed to make sure that we focus on the importance of equity and leaving no one behind by providing specific activities for service delivery, but also for key and vulnerable populations, including migrants, refugees, and mobile populations, and the other two pillars, bold policies, supportive systems and intensified research and innovation. In each of these areas, the focus is placed on providing better services, multi-disease care and diagnostics, reaching key populations, engaging communities, the importance of doing track-approach across the plans, re-focus of testing, urgent treatment scale-up, and rebound prevention by using a diversity of platforms.

Please find here the presentation.

A Europe free of AIDS, TB and viral hepatitis - and no one left behind

Current Standards of Care, challenges in implementation

Standards of Care audits and good practices:

Jürgen Rockstroh
University Hospital Bonn AöR, Medical Clinic and Polyclinic, Outpatient Clinic for Infectiology & Immunology and European AIDS Clinical Society

One cannot talk about standards of care and good clinical practices without mentioning the BHIVA standards of care, developed since 2009 for people living with HIV. The standards are designed to provide a reference point against which to benchmark the quality of HIV care in the context of the changing needs of patients of the current financial pressure. Recently, they have been asked to include sections on prevention, stigma and well-being.

Why do we need standards or audits beyond 2023?

The clinical demands and HIV care are changing, we must face an ageing population with over half of the individuals we are taking care of being over 50 years old, a first generation of HIV nurses and physicians are retiring, new medical staff is starting without history of HIV disease development, and there is need for broader education with increased migration refugee flow with changing needs. Management of new treatment strategies based on long-acting regimens are revolutionising HIV care. Audits support reimbursement strategies and national health guidance. Audits create evidence for what is needed in times of unforeseen events such as COVID-19 pandemic and other pandemics, which are sure to come.

The European AIDS Clinical Society (EACS), has worked on standards of care since 2014, starting with a consensus paper reflecting on the strong disparities between various regions in Europe and trying to develop a standard which could be implemented everywhere, some of the good examples of audits from the BHIVA Association were implemented. Viral hepatitis was discussed at one of the multi-stakeholders' meetings in Bucharest, in 2019. Viral hepatitis is commonly found in the population of individuals living with HIV as the transmission pathways are very similar. The idea was to look at hepatitis screening, prevention management of people living with HIV, and the benchmark are the guidelines, EACS issues every year. The structure was a policy survey and a case note review but also addressing issues around individual cases, concentrating on patients who are recently diagnosed with HIV and then those with HBV or HCV co-infection. The various recommendations from the guidelines for screening different viral hepatitis is vaccination. If you are not immune, vaccination is the prevention tool to not get infected with hepatitis B; for those who have Hepatitis B to look at screen for Delta infection, and then for those who have chronic hepatitis liver disease to also integrate screening for hepatitis cell carcinoma. Five countries were selected Georgia, Romania, Poland, Germany, and Spain with up to five centres participating.

The policy survey results pointed to huge differences depending on which country, was being analysed despite the recommendation from the guidelines for hepatitis A, B, and C. The vaccination rates vary substantially, depending on the possibility of achieving reimbursement for vaccination in the respective countries. Delta screening did not work well in any of the countries that participated in the survey. Whereas the guidelines recommend everyone with chronic hepatitis B should receive the other screen, this was only reached in a few centres, and some centres did not screen at all. In the first audit, the lowest reporting country only screened around 30% of the individuals, whereas the number increased

in the subsequent survey in 2022. This represents the best example of what an audit can deliver, namely improve care and be sure that guidelines are followed in practice.

EACS is working with ECDC to define standards of care throughout Europe, to implement potential auditable outcomes and to develop an audit tool which can be used in the various participating countries. The project will include annual workshops conferences, advisory group meetings, the development of standards of care modules, audits, which shall be formed preferably after the development of the audit tool, and then support the implementation of standards and assess the implementation of those standards.

There is a great variation in the quality of care delivered across clinics in Europe that needs to be addressed, few surveyed countries so far have standards of care and the levels of performance monitoring vary. BHIVA standards and audit track record are well developed. They present a good example to encourage similar efforts and strategies in Europe. The goal is to have a consensus on the European standard of HIV care across the European region. The same goal needs to be applied to viral hepatitis and TB to support implementation of standards of care across the European region. Raising standards of care, will help reduce the observed inequities in the standards of care and support European countries on measures to be taken to reach the sustainable development goals.

Please find here the presentation.

Standards and gaps in harm reduction services

Marios Atzemis
Positive Voice, Greece

Greece has been a kind of experimental lab for the past 12 years due to severe austerity measures. These had a direct negative impact on harm reduction services, which lay fertile ground for an HIV outbreak among people who inject drugs from 2011 until 2013. I am one of the recorded incidents and one of the survivors of this kind of outbreak. Since then, a lot of progress has been made but many challenges remain. Since the COVID-19 outbreak, the disruption of services negatively affected vulnerable populations who became even more vulnerable. We now have some new harm reduction services that are essential to people who use drugs living in the streets, for example a drug consumption room, a new dropping center, and intensified street work with technical equipment and distribution.

From a community perspective, we still see major gaps that need to be addressed for undocumented migrants who use drugs or are vulnerable to HIV and viral hepatitis or are HIV positive. Without legally recognised documents, they cannot access a series of frontline services, for instance shelters, Opioid substitution treatment (OST) units, HIV clinics or care for hepatitis. One of the main difficulties is linking them to any kind of healthcare. Some doctors are going out of their way to provide them with needed medication and to connect them to HIV clinics. They are usually able to provide them medication for a short period of time while their asylum or temporary asylum request is processed. The process can take long. It often happens that people are linked to HIV clinics and are then very abruptly disconnected.

Recent data collected by epidemiologists show that the mortality rates of HIV-positive drug users are skyrocketing. In a country with free opioid substitution treatment, without waiting lists, with free medication for HIV, with free medication for hepatitis C, people are dying and are left alone. The answer is quite simple: there is an enormous gap between the most vulnerable members of this

community and the frontline services that link people to care. Grassroots organisations, like Positive Voice, that practice peer-led harm reduction services are not adequately supported. We need more peer navigation projects. We speak the same language and share the same lived experiences; we have privileged access to drug scenes that seem harder to reach to anyone else. We are the communities, and we strongly suggest that HIV and Hep C must be the priorities of the European Commission, HIV clinics need to be adequately supported. Civil society organisations (CSOs) must be immediately supported to implement their projects, peer education support and linkage to care with proper funding. All of the above is the negative impact of the absence of CSOs that have directly affected communities from the design and implementation of the services addressed to them.

Good practices in implementation and cross-border healthcare

Access to quality care/prevention for displaced persons

Milosz Parczewski
Pomeranian Medical University, District Hospital, Infectious Diseases and Hepatology Clinic, Szczecin, Poland, and European AIDS Clinical Society

Firstly, when we look at access to quality care and prevention of HIV, Hepatitis, TB and STIs field, we have to take a look into the maintenance of high antiretroviral treatment efficacy for displaced people and how they respond to the differences in characteristics, especially higher number of women and people of childbearing potential diagnosis as early as possible; expand vaccination program, try to maintain the access to oral TB drugs and take a brief look into HIV drug susceptibility.

Over the last year, Poland has received more than 3000 migrants into the system of HIV care with 16 effective centres, the number of people treated has reached 15,000. Most migrants were receiving TLD, and it was working very well, the viral logical efficacy threshold of 90% was reached in the incoming population. Unfortunately, TLD is unavailable as it was available only for a short period of time as there is a major issue with licensing. From the perspective of quality of care, the quality was maintained but sometimes from single-tablet regimen there was necessity to switch to multiple drug regimen. From the standards of care perspective, the first challenge was variable availability of single-drug regimens in Europe and the frequent need for antiretroviral treatment change. Secondly, change in the predominant transmission route: majority of the people who come are female, and almost 10% reported previous tuberculosis infection. This poses a significant challenge and the need to respond by working on maintenance of gynaecological and obstetric care, especially relating to language barrier, sensitivity, and fear of stigma in this population.

Additionally, 54% of new diagnoses in the European region are diagnosed late and present increased numbers of multidrug resistant TB and remain undiagnosed in all Central European populations. Another challenge is related to the expansion of targeted, including home-based testing services, non-disclosure of MSM status for the fear of stigma. In Poland, we've been struggling to access the oral TB drugs; theoretically, it is there, but practical implementation of oral TB treatment is sub-optimal and quite difficult. Obviously, hepatitis co-infection represents a major issue for refugees coming from Syria and Turkey, where a significant proportion are people co-infected with hepatitis. Access to HCV treatment is only offered within the national framework and vaccination for Hep B is infrequent, with very small numbers of migrant populations being vaccinated across Europe.

Please find here the presentation.

Magdalena Ankiersztejn-Bartczak
Foundation for Social Education (Poland) and European AIDS Treatment Group

The Foundation for Social Education (FES) offers support for HIV and other STIs. It works on prevention, testing, and advocacy work and support for people living with HIV, people who use drugs. It provides harm reduction services. In Poland, besides the wave of refugees from Ukraine, there is also a humanitarian crisis of migrants coming through Belarus. Since the outbreak of the war in Ukraine, FES started cooperating with several international organisations. We are supporting people living with HIV and people who use drugs. We try to link with HIV clinics and opioid substitution treatment by providing information on our website. We try to adapt our services. We have dedicated support for people from Ukraine, we have psychologists, social workers, lawyers and educators. Since the beginning, we received financial support. However, funding is ending while needs have not gone away. We will try to help as much as possible. All information on our social media is translated into Ukrainian to help people to find support also in Poland. Through our mobile harm reduction service, we offer needle exchange equipment and testing for HIV, hepatitis and syphilis to all migrants.

To continue providing these services, we need to shift from thinking that this is just a temporary situation and start thinking about long-term support for different organisations working in the field. We must find ways to help organisations on the ground that are supporting migrants and without funding, Polish NGOs do not have the possibility to continue to do their work.

Please find here the presentation.

Yevgenia Kononchuk
Eurasian Harm Reduction Association

Since the full-scale Russian aggression on Ukraine, the estimated number of people who use drugs who have moved is more than 27,000, given that the estimated number of people who use drugs in Ukraine is more than 300,000, the numbers in all EU countries could be much higher. Unfortunately, people who use drugs from Ukraine, who have moved, experienced a number of difficulties, like all other Ukrainians, but have also experienced specific difficulties. Since the beginning of the Russian invasion of Ukraine, a wide range of international, European, and national stakeholders have mobilised resources to coordinate their response to the humanitarian crisis in the field of drugs, EU agencies (ECDC, EMCDDA), and international organisations (WHO, Eurasian Harm Reduction Association, and other international civil society organizations). International organisations, national government institutions and NGOs in EU countries and Ukraine quickly established platforms to coordinate actions and facilitate contacts between stakeholders.

Successful practices have been formed in response to the need of people and people who use drugs. Firstly, mobilisation needs assessment and monitoring, NGOs have collected contacts and information about available services in different EU countries and have created unique information online, offline centres for patients who need that information. Secondly, lowering the threshold for receiving opioid agonist therapy (OAT) or other treatment for drug use disorders in line with the European Council directive, most EU countries have eased the legal condition for accessing free drug use services. Following, raising awareness of displaced Ukrainian about the availability of such services; across EU

countries, information was produced to offer materials in Ukrainian and Russian, and online with the creation of the European Test Finder platform. Lastly, established communication with Ukrainian NGOs and national health authorities, for example the Ukrainian Public Health Center, who communicated directly with European partners to facilitate enrollment and ensure that the patients from Ukraine have all the necessary medical documentation. Overall, these services were very helpful and well-received in almost all countries.

Many difficulties appeared when providing services to drug users for refugees from Ukraine, among them language barrier and ensuring continuity of care. From an administrative point of view, most EU countries have some minimum legal requirements to ensure access to OAT programs, ART, and other necessary assistance; concerns about stigmatisation and protection of children's rights; lack of gender-sensitive services. Moreover, most Ukrainians and people who use drugs are, in many cases, patients in transit to other countries which has created particular challenges for service providers to ensure compliance and treatment continuation. Lastly, difficulties for European doctors in providing displaced populations with OAT drugs and different nomenclature and forms of drugs.

What can be learned from these experiences to improve access to drug use services and ensure that they are properly addressed? First of all, we need flexibility and fast actions from international donors to support Ukrainian people in the country and abroad. Secondly, emergency harm reduction packages should include access to medical care, housing, social care, and employment. Flexibility of national programs for people who use drugs and people living with HIV as their needs are unpredictable and could be much larger than national programs' capacity. Following, OST access as the need is unpredictable and could be much greater than national program capacity. Specialised shelters/support to key populations and integrated approaches to respond to the needs of diverse and changing population flows in a culturally sensitive manner.

Most harm reduction programmes in EU countries have their own challenges and are not ideally suited for refugees and for displaced people. However, over the last year, we have gained experience, and we need change, not only for temporarily displaced people in Europe, but also for European citizens.

Please find here the presentation.

Paul Sommerfeld

TB Europe Coalition

Over the last year, three good practices have been developed in terms of provision of TB care. The first is the development of a standardised package for TB Care provided by CSOs. Civil society tends to be underutilised but they represent a major resource that could be used and is not used enough for practical activity and the main background reason is the lack of funding and particularly of sustained funding. Developing a standardised package of care can provide CSOs with a clear idea of what they can and should be providing, but most importantly the healthcare services know what they are contracting to receive. This makes it possible to move away from the uncertainty of long-term financing of grants and donations which hopefully will lead to good sustainable funding and greater activity by civil society in TB Care. This is already happening in two countries in Eastern Europe and Central Asia, nine countries are currently looking at it, but it would also be relevant in Western European countries.

Secondly, *OneImpact* – a digital platform – is now being used by TB services and a number of countries and is especially effective in Ukraine. Despite the war and Russian invasion, TB services continue to work effectively in Ukraine. OneImpact is used in Ukraine by a TB survivor-led organisation, TB People of Ukraine. Over the last year, they have received 1800 requests relating to treatment problems,

discrimination, money difficulties, rights violations. The organisation was able to assess these issues individually and used them as evidence in advocating for change to legislation and procedures within Ukraine. This digital platform could be an effective tool that could be used across western Europe.

Thirdly, hand-held X-ray equipment, enhanced by AI, is a new technology that can be used by CSOs in the field. It links an important new diagnostic tool for TB with the ability of CSOs to reach out to the community, effective examples in Romania and Azerbaijan. Of course, reading the results remains a prerogative of medically qualified personnel and local arrangements for that need to be made.

Regarding achieving treatment continuity for refugees with TB, WHO Europe managed to set up a system where Ukrainian national TB programme receives requests from doctors who are meeting with refugees in other European countries and helps them to be linked to the original doctor in Ukraine, who was originally providing treatment for that individual and so that that helps to ensure mutual understanding and the organisation of continuing treatment.

Currently, what is not being a good practice is the problem of access to new TB drugs across western Europe. This is an exciting time for action against tuberculosis as new drugs and new diagnostic tools are becoming available, but in Western Europe, because the incidence of TB is low, the market for TB drug is small and producers are reluctant to incur the high costs of licensing. Certain drugs are not available in Europe because they are not licensed for use either in the European Union or United Kingdom. For example, child formulations of the regular TB drugs are available elsewhere in the world for the past 10 years and Rifapentine which is important for treating latent TB and a component in the first regimen WHO has ever approved for a short 4-month regimen is simply not available because of its high price.

We encourage the use by authorities of purchasing health services of the *Standardised Package for TB Care by CSOs* which we have developed together with a Moldovan NGO, PAS, and with active engagement of WHO Europe. Introduce *OneImpact* to local TB-NGOs and TB services and use of Enhance TB action by using CSOs with Hand-held X-ray equipment. We are willing to collaborate to find a way to make drugs available for diseases with only a small market in the West.

Please find here the presentation.