ELPA
European Liver Patients' Association

LIVER–CVD LINK

MASLD: THE MISSING PIECE IN CARDIOVASCULAR PREVENTION

Protecting millions by **recognising a critical risk factor**

Cardiovascular disease (CVD) is Europe's leading cause of death. Yet one highly prevalent condition remains largely unaddressed in prevention guidelines: **Metabolic dysfunction-associated steatotic liver disease (MASLD)**. Strongly linked to diabetes, metabolic syndrome, obesity, dyslipidemia and hypertension, MASLD significantly increases the risk of heart attacks, stroke, and heart failure. Including MASLD in cardiovascular strategies will improve early detection, risk assessment, and long-term outcomes.

HOW MASLD INCREASES CARDIOVASCULAR RISK

Insulin Resistance
Disrupts metabolism and raises blood sugar, increasing vascular strain.

Chronic Inflammation
Ongoing liver-related inflammation spreads systemically, damaging blood vessels.

Oxidative Stress
Cell damage from reactive oxygen species contributes to artery plaque formation.

Endothelial Dysfunction
Blood vessels become stiff and reactive, raising blood pressure and clot risk.

Liver Fibrosis
The amount of liver scarring predicts future heart events and all-cause mortality.

Dyslipidemia
Altered lipid metabolism produces atherogenic apoB-containing lipoproteins, a major driver of atherosclerotic cardiovascular disease.

HIDDEN PREVALENCE

25–30%
of European adults have MASLD

70%+ in those with type 2 diabetes

90%+ in those with obesity

RISK MAGNIFIER

MASLD + T2DM = 4X
higher risk of cardiovascular events

Cardiovascular disease is the **leading cause of death** in MASLD patients.

EARLY CLUES IN THE LIVER

The liver shows cardiovascular risk before symptoms appear

Simple liver tests can identify high-risk individuals years before their first heart event.

MISSED BY CURRENT TOOLS

Risk calculators like SCORE-2 don't include MASLD.

But it can be detected using existing non-invasive tests (e.g., FIB-4).

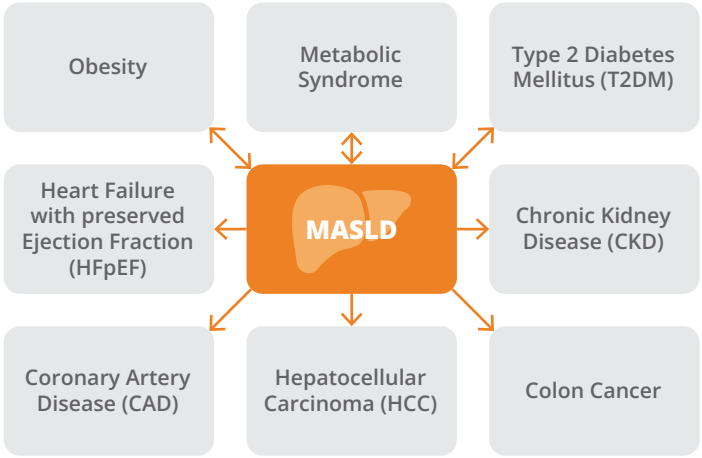
PROPOSED SOLUTION

Including MASLD in cardiovascular prevention policy means **earlier detection, better outcomes, and lower cost.**

INTRODUCTION

Cardiovascular disease (CVD) is the primary cause of mortality in Western society. Several risk factors have been described to calculate the risk for individual subjects, and risk tables like the SCORE-2 are being used to initiate cardiovascular risk management in patients.

However, one important risk factor is not included in these guidelines, namely metabolic dysfunction steatotic liver disease (MASLD). This condition is characterised by the presence of at least 5% liver fat in combination with a cardiometabolic condition like obesity, diabetes, hypertension or dyslipidemia[1]. MASLD has been associated with an increased risk of atherosclerotic cardiovascular disease (ASCVD), heart failure and stroke[2].



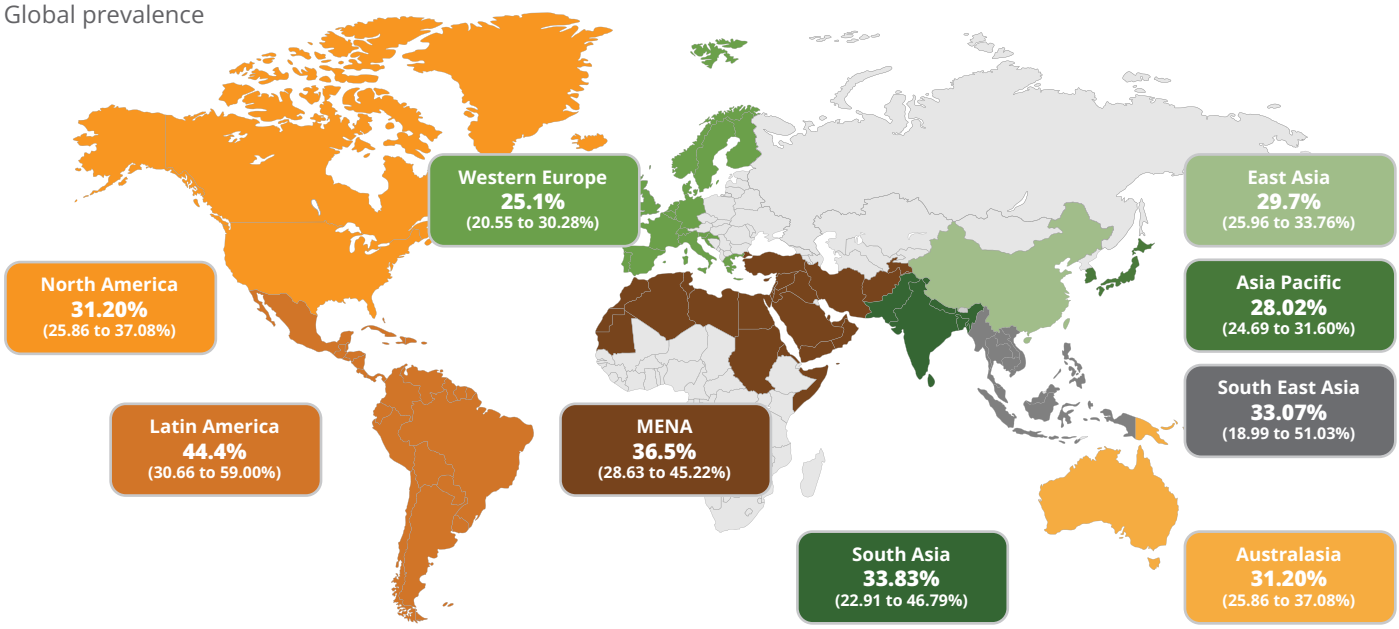
PEOPLE WITH MASLD AND TYPE 2 DIABETES FACE A 4X HIGHER RISK OF CARDIOVASCULAR DISEASE

- Increased risk of cirrhosis, liver failure, HCC
- **77%** increased risk of cardiovascular morbidity compared to controls
- **1,5-2x** increased risk of developing T2DM
- **2x** increased risk of chronic kidney disease (CKD)
- **2-3x** increase in the occurrence of adenomatous polyps in colon
- Increased risk of colorectal cancer

MASLD increases the risk conferred by the cardiometabolic condition. Since MASLD is highly prevalent, the most recent estimations suggest that 30% of the world's population may have MASLD[3]. This condition has a huge impact on the total cardiovascular burden for health care.

EPIDEMIOLOGY OF MASLD

Global prevalence



Pooled Prevalence of MASLD:
30.05% (95% confidence interval: 27.88 to 32.32%)

Younossi ZM, Golabi P, Paik J, Henry Let al Hepatology 2022

In this paper, we highlight the importance of including MASLD identification in cardiovascular guidelines to prevent events and decrease cardiovascular morbidity and mortality. For this purpose, we encourage following the current recommendations to screen for MASLD as advocated by the European Associations involved (European Association for the Study of the Liver (EASL), The European Association for the Study of Diabetes (EASD), The European Association for the Study of Obesity (EASO)).

1 EASL Clinical Practice Guidelines on MASLD (2024). *European Association for the Study of the Liver.* https://easl.eu/publication/easl-clinical-practice-guidelines-on-masld-2024
2 A. Mantovani et al. Lancet Gastroeneterol Hepatol 2021; 6: 903-913
3 Younossi ZM et al. (2023). Nonalcoholic fatty liver disease: A global public health perspective. https://www.nature.com/articles/s41575-022-00698-4

BACKGROUND & PURPOSE

Metabolic dysfunction-associated steatotic liver disease (MASLD) is a chronic liver condition characterised by the accumulation of fat in the liver not caused by alcohol.

MASLD is part of a wider spectrum of metabolic disorders and is closely associated with insulin resistance, obesity, type 2 diabetes, hypertension and dyslipidemia. It progresses silently in many individuals but can lead to liver inflammation, fibrosis, cirrhosis, and even liver cancer.

Importantly, MASLD is also a strong, independent risk factor for cardiovascular disease (CVD), which is the leading cause of death among MASLD patients.

The connection stems from shared mechanisms such as chronic inflammation, oxidative stress, and metabolic imbalance. Given its high prevalence and its cardiovascular implications, MASLD deserves greater recognition in public health strategies focused on non-communicable diseases. However, due to a lack of knowledge and the fact that liver health has not yet been incorporated in cardiovascular clinical guidelines, health care providers do not take liver health into account when evaluating individual risk profiles.

The proposed Roadmap by the European Alliance for Cardiovascular Health (EACH)[4] outlines key priority areas such as early detection, health literacy, multi-sectoral collaboration, digital innovation, and integrated chronic care. These goals align directly with the rationale and urge to include and rank MASLD as a risk factor for cardiovascular disease in the EU Cardiovascular Health Plan. Liver health screening can reinforce these pillars by facilitating earlier recognition of people at highest cardiovascular risk, targeted prevention, and holistic management of cardiometabolic diseases.

This paper provides a concise scientific overview of the evidence linking MASLD and cardiovascular outcomes and recommends pragmatic steps to include MASLD in European policy, supporting the broader ambitions of the EACH roadmap.

BURDEN OF MASLD IN EUROPE

MASLD is a clinical condition associated with many cardiometabolic disorders, ranging from simple liver fat accumulation to inflammation leading to fibrosis and ultimately liver cirrhosis. During this evolution, the risk for cardiovascular complications rises steadily, and in fact, cardiovascular complications are the first presentations of MASLD[5].

It has been estimated that MASLD affects 25–30% of the adult population in Europe[6]. The prevalence exceeds 70% among patients with type 2 diabetes and over 90% among those with obesity[7]. Many of these individuals are already undergoing cardiovascular and metabolic assessments. Still, liver health as a significant contributor to cardiovascular risk remains largely overlooked—identification of MASLD among these patients is of clinical relevance. For example, patients with type 2 diabetes mellitus (T2DM) are known to have a 2-fold increased risk of CVD. When MASLD is present, especially the inflammatory component leading to liver fibrosis, the risk of CVD is 4-fold increased in T2DM, placing these subjects at an extremely high risk[8].

The clinical consequence should be that more stringent treatment targets for individual cardiovascular risk factors should be used in this population. So far, cardiovascular management guidelines do not include this recommendation (EASD, EAS, ESC guidelines).

MASLD significantly raises the risk of cardiovascular events—by up to 65% in some cohorts[9]. Furthermore, MASLD contributes to chronic kidney disease (CKD), worsens glycemic control in diabetes, and increases the demand for healthcare services.

Economically, MASLD imposes a burden exceeding €35 billion annually in Europe[10]. Delayed diagnosis leads to high costs associated with advanced liver disease and cardiovascular complications.

4 European Alliance for Cardiovascular Health (EACH), A European Cardiovascular Health Plan: The Roadmap, 2025 https://www.cardiovascular-alliance.eu/wp-content/uploads/2025/04/EACH-A-EUROPEAN-CARDIOVASCULAR-HEALTH-PLAN-THE-ROADMAP_FINAL_WEB.pdf accessed July 1, 2025

5 NWS Chew et al, Circulation 2025; 151: 09-119
6 Zhou et al, Eur J Gastroenterol 2018: 30: 631-636
7 Targher G, Byrne CD. (2021). *MAFLD and risk of cardiovascular disease.* Lancet. https://doi.org/10.1016/S2468-1253(20)30234-3
8 Francque S et al. (2021). *A clinical overview of MASLD.* Journal of Hepatology. https://doi.org/10.1016/j.jhep.2020.11.038
9 H Park et al https://doi.org/10.1038/s41598-024-56085-3 / Chew et al 2025
10 Tapper EB, Lok AS. (2021). Cost-effectiveness of non-invasive fibrosis testing. J Hepatol. https://doi.org/10.1016/j.jhep.2020.10.017

SCIENTIFIC LINK WITH CARDIOVASCULAR DISEASE

While MASLD and CVD share several common risk factors and biological pathways, it is increasingly evident that MASLD itself is not just a coexisting condition—it is a driver of cardiovascular risk. In other words, addressing cardiovascular disease alone will not automatically reduce the burden of MASLD. Instead, MASLD must be detected and managed proactively to reduce downstream cardiovascular complications.

Recent studies suggest that liver fibrosis in MASLD is one of the most powerful predictors of future cardiovascular events, both atherosclerotic vascular disease and heart failure[11] and overall mortality[12]. As such, early intervention in MASLD can serve as a vital entry point for preventing CVD and other metabolic complications.

11 Francque SM et al. Non-alcoholic fatty liver disease and cardiovascular risk: Pathophysiological mechanisms and implications. J Hepatol (2016), http://dx.doi.org/10.1016/j.jhep.2016.04.005
12 H Park et al https://doi.org/10.1038/s41598-024-56085-3 and NWS Chew et al, Circulation 2025; 151: 09-119

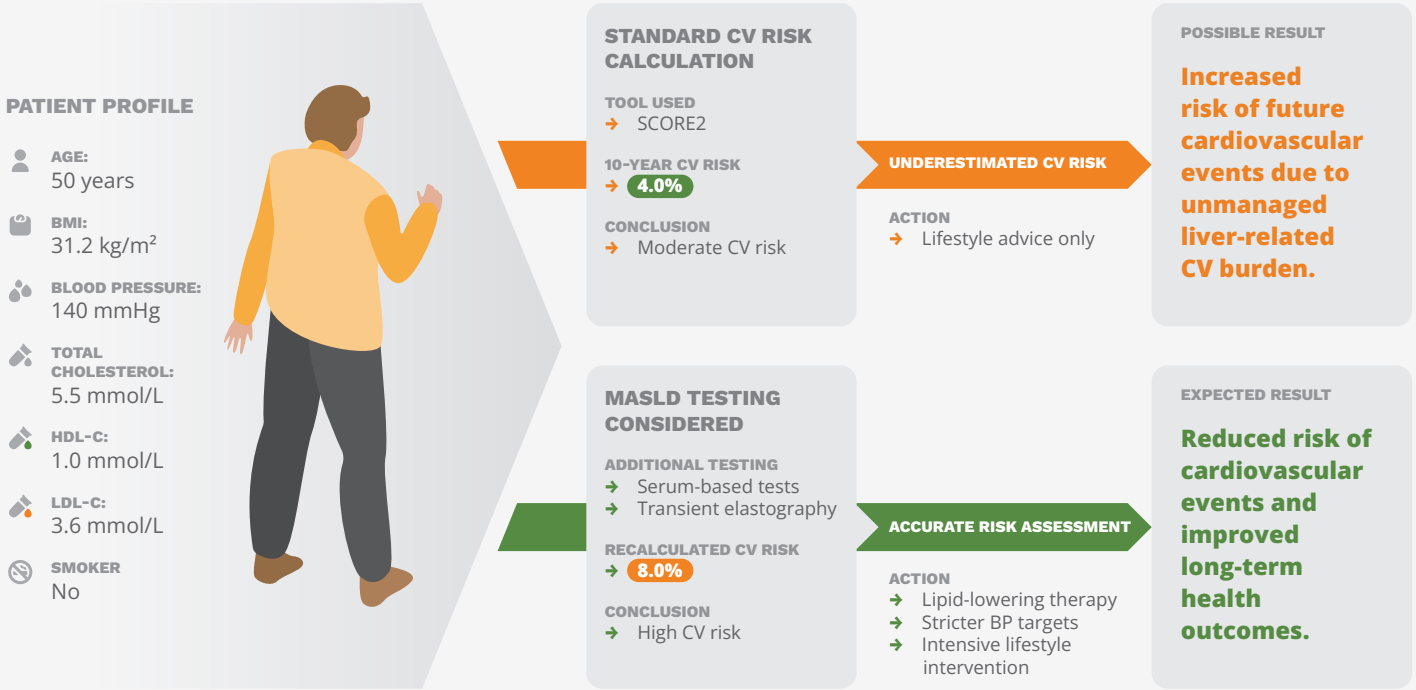
When too much fat builds up in the liver, it can damage how the liver's energy-producing cells (mitochondria) function. The consequence is that the liver will secrete cytokines that will damage the blood vessels ultimately leading to vascular dysfunction and plaque generation.

The amount of scarring in the liver (fibrosis) is the most reliable predictor of heart-related and overall mortality in MASLD patients, surpassing basic liver enzyme levels. The initiator fibrosis generation is the accumulation of intrahepatic fat (steatosis).

EXAMPLE OF CLINICAL CASE UNDERLINING THE IMPORTANCE OF EARLY MASLD IDENTIFICATION:

A 50-year-old patient with a systolic blood pressure of 140, a total cholesterol of 5.5 mmol/L, High-Density Lipoprotein Cholesterol (HDL-C) of 1,0 mmol/L, Low-Density Lipoprotein Cholesterol (LDL-C) of 3,6 mmol/L, a non-smoker, the current guidelines using the SCORE2 engine show a 10-year risk of fatal and non-fatal CVD events of 4,0%. This means that this patient would not be eligible for pharmacological intervention, and lifestyle recommendations would be sufficient. However, if additional testing was done and, for example, an indication existed to evaluate for MASLD, because this patient has obesity with a Body Mass Index (BMI) of 31,2 Kg/m2, the overall conclusion could be very different. Serum-based testing followed by vibration-controlled transient elastography suggests that this patient not only has significant liver steatosis (MASLD) but also liver fibrosis. This information leads to a twice-elevated CV risk (8,0%), putting this patient in a high cardiovascular (CV) risk group mandating implementation of more strict CV risk management. Lipid-lowering medication should be started with for example an LDL-C target of 1,8 mmol/L. In addition, blood pressure targets should be taken into account. Of course, this would be paralleled by intensive lifestyle intervention.

This case illustrates how including MASLD in the algorithms will lead to improved CV risk management. Eventually, this approach will help to decrease CV burden for society.



PATIENT UNMET NEEDS AND GAPS IN POLICY AND SCREENING PRACTICE

Despite clear evidence of its connection to cardiovascular outcomes, MASLD is not currently included in the European Commission's cardiovascular or non-communicable disease plans. This omission contributes to:

- Missed opportunities for early diagnosis.
- Fragmented care for patients with overlapping chronic diseases.
- Inefficient use of routine diagnostic tools already in practice.
- Lack of awareness and knowledge among health care providers.
- Lack of awareness and knowledge in the general population.
- Lack of collaboration between primary and secondary health providers implementing specific patient care paths, including liver health assessment.
- Liver health assessment not being recommended in current cardiovascular risk guidelines.
- Insufficient scientific information demonstrating that targeting improved liver health will decrease cardiovascular risk.
- Until recently, a lack of specific, efficient interventions improving liver health.
- Stigma associated with liver disease which can discourage patients from seeking care.

STRATEGIC PRIORITIES FOR INTEGRATION

Primary care plays a central role in the early detection and management of MASLD and its cardiovascular complications. Strengthening collaboration at this level is essential to raise awareness of risk factors, screening tools, and referral pathways. Educating general practitioners on the link between MASLD, cardiovascular disease, and metabolic disorders is key to closing the diagnostic gap.

Until recently, MASLD had no approved pharmacological treatments and was largely addressed through lifestyle change. This makes it an ideal target for prevention and health literacy efforts. At the same time, new treatments such as resmetirom, semaglutide, and lanifibranor are emerging and will shift clinical practice. Providers must be prepared to identify and manage patients at highest risk.

In this context, MASLD highlights the value of early health education, cross-sector cooperation, and integrated screening. Liver risk assessment can be seamlessly incorporated into existing cardiovascular and diabetes prevention programs using tools already available in primary care.

PREVENTION & EARLY DETECTION

Routine metabolic check-ups already include tests (e.g., ALT, AST) that can support simple liver fibrosis scoring tools like FIB-4 and MAF-5. Early detection of MASLD enables timely lifestyle interventions that prevent progression to cirrhosis and reduce CVD events.

MULTIMORBIDITY & INTEGRATED CARE

MASLD coexists with diabetes, obesity, and cardiovascular disease. Integrating MASLD into NCD care pathways fosters more holistic treatment plans and improves long-term outcomes. This aligns with EACH's focus on care coordination for chronic conditions.

COST-EFFECTIVE SCREENING

Health economic analyses show that non-invasive testing for MASLD is affordable and scalable, with an ICER of €70,000–90,000 per QALY[13].

13 Tapper EB, Lok AS. (2021). Cost-effectiveness of non-invasive fibrosis testing. J Hepatol. https://doi.org/10.1016/j.jhep.2020.10.017

ALIGNMENT WITH THE EACH ROADMAP

The EACH Roadmap emphasises:

- **EARLY AND INTEGRATED PREVENTION.**
- **DIGITAL TOOLS FOR CHRONIC CARE.**
- **CROSS-SECTOR COLLABORATION.**

Incorporating MASLD screening directly supports these goals. For example, digital health systems can automate FIB-4 scores from routine bloodwork, and integrated teams can manage MASLD within existing CVD clinics.

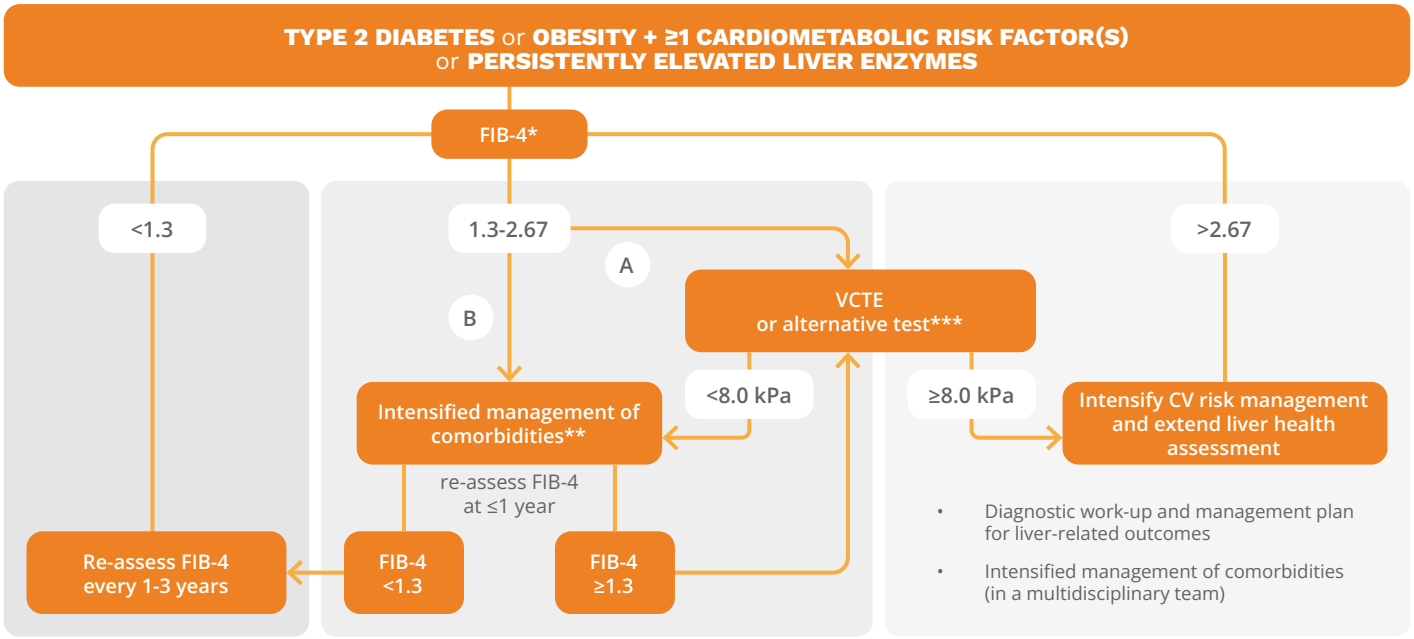
MASLD workup following current guidelines endorsed by EASL, EASD and EASO:

TARGET POPULATIONS:

Cardiometabolic risk factors in the definition of MASLD.

Metabolic risk factor	Adult criteria
Overweight or Obesity	Body mass index ≥25 kg/m² (≥23 kg/m² in people of Asian ethnicity) Waist circumference ≥94 cm in men and ≥80 cm in women (Europeans) ≥90 cm in men and ≥80 cm in women (South Asians and Chinese) ≥85 cm in men and ≥90 cm in women (Japanese)
Dysglycaemia or type 2 diabetes	**Prediabetes:** HbA_{1c} 39-47 mmol/mol (5.7-6.4%) or fasting plasma glucose 5.6-6.9 mmol/L (100-125 mg/dl) or 2-h plasma glucose during OGTT 7.8-11 mmol/L (140-199 mg/dl) or **Type 2 diabetes:** HbA_{1c} 248 mmol/mol (26.5%) or fasting plasma glucose 27.0 mmol/L (2126 mg/dl) or 2-h plasma glucose during OGTT ≥11.1 mmol/L (2200 mg/dl) or **Treatment for type 2 diabetes**
Plasma triglycerides	≥1.7 mmol/L (≥150 mg/dl) or lipid-lowering treatment
HDL-cholesterol	≤1.0 mmol/L (≤39 mg/dl) in men and ≤1.3 mmol/L (≤50 mg/dl) in women or lipid-lowering treatment
Blood pressure	≥130/85 mmHg or treatment for hypertension

HbA1c, glycated haemoglobin; HDL, high-density lipoprotein; OGTT, oral glucose tolerance test.



*FIB-4 thresholds valid for age ≤65 years (for age >65 years: lower FIB-4 cut-off is 2.0)
**e.g. lifestyle intervention, treatment of comorbidities (e.g. GLP1RA), bariatric procedures
***e.g. MRE, SWE, ELF, with adapted thresholds

A and B are options, depending on medical history, clinical context and local resources

(Figure adapted from EASL guideline)

KEY RECOMMENDATIONS

- Officially recognise MASLD as a cardiometabolic risk factor within EU policy.
- Include MASLD in routine workup in cardiometabolic conditions like T2DM, overweight/obesity, and hypertension.
- Integrate liver fibrosis scoring (FIB-4, MAF-5) into cardiovascular and diabetes screening guidelines and promote the use of other noninvasive tests, such as vibration-controlled transient elastography.
- Support research on MASLD-CVD pathways and fund real-world pilots under Horizon Europe.
- Train healthcare providers on MASLD's role in heart and metabolic health.
- Facilitate collaboration between primary and secondary care providers to improve the identification of subjects at the highest risk.
- Promote cardiovascular intervention studies in MASLD patients evaluating efficacy of different approaches.
- Stimulate long-term studies to understand better the natural course of cardiovascular complications in MASLD populations.
- Support health literacy and awareness among the general public.

CALL TO ACTION

We urge the European Commission, Member States, and the medical and patient communities to:

INCLUDE MASLD IN THE EUROPEAN CARDIOVASCULAR HEALTH PLAN.

ALIGN LIVER HEALTH POLICIES WITH EXISTING NCD AND CVD STRATEGIES.

EMPOWER MULTIDISCIPLINARY, PATIENT-CENTRED APPROACHES TO CARE.

FORMALISE PATIENT ENGAGEMENT IN CARDIOVASCULAR POLICY DEVELOPMENT, MONITORING, AND EVALUATION.

ACRONYMS

CVD : Cardiovascular disease
MASLD : Metabolic dysfunction steatotic liver disease
T2DM : Type 2 diabetes mellitus
ASCVD : Atherosclerotic cardiovascular disease
CKD : Chronic kidney disease
EASL : The European Association for the Study of the Liver
EASD : The European Association for the Study of Diabetes
EASO : The European Association for the Study of Obesity
EACH : The European Alliance for Cardiovascular Health
HDL-C : High-Density Lipoprotein Cholesterol
LDL-C : Low-Density Lipoprotein Cholesterol
BMI : Body Mass Index
CV : Cardiovascular
NCDs : Noncommunicable diseases
ICER per QALY : Incremental cost-effectiveness ratio per quality-adjusted life year

CONTRIBUTING AUTHORS AND AFFILIATIONS

Diederick E. Grobbee[1,2] , Sven Francque[3], A.G. (Onno) Holleboom[4], Christophe Moreno[5], Vlad Ratziu[6], Manuel Romero-Gómez[7], Jörn M. Schattenberg[8,9], Marko Korenjak[11], Beatrice Credi[11], Milan Mishkovikj[11], Veronika Všetičkova[11], Manuel Castro Cabezas[2,10,12]

1. Julius Center for Health Sciences and Primary Care, University Medical Center Utrecht, Utrecht, The Netherlands, ORCID: 0000-0002-4692-479X **2.** Julius Clinical, Zeist, The Netherlands **3.** Division of Gastroenterology and Hepatology, University Hospital Antwerp, Antwerp, Belgium, ORCID: 0000-0002-7527-4714 **4.** Department of Vascular Medicine and Internal Medicine, Amsterdam University Medical Centre, Amsterdam, the Netherlands, ORCID: 0000-0002-2911-2917 **5.** Department of Gastroenterology, Hepatopancreatology and Digestive Oncology, CUB Hôpital Erasme, Université Libre de Bruxelles, Brussels, Belgium, ORCID: 0009-0001-5305-2483 **6.** Sorbonne Université, ICAN Institute for Metabolism and Nutrition, Hospital Pitié-Salpêtrière, Paris, France, ORCID: 0000-0002-3051-0111 **7.** UCM Digestive Diseases and SeLiver Group, Virgen del Rocio University Hospital, Institute of Biomedicine of Seville (HUVR/CSIC/US), University of Seville, Seville, Spain, ORCID: 0000-0001-8494-8947 **8.** Department of Internal Medicine II, Saarland University Medical Centre, Homburg, Germany **9.** Saarland University, Saarbrücken, Germany, ORCID: 0000-0002-4224-4703 **10.** Department of Internal Medicine, Franciscus Gasthuis & Vlietland, Rotterdam, Rotterdam, the Netherlands, ORCID: 0009-0009-5164-2082 **11.** European Liver Patients' Association - ELPA **12.** Department of Endocrinology, Erasmus University Medical Centre, Rotterdam, the Netherlands

CONTACT

Manuel Castro Cabezas, MD, PhD
Internist-endocrinologist/vascular specialist

FRANCISCUS GASTHUIS & VLIETLAND

Department of Internal Medicine, Centre of Endocrinology, Diabetes and Vascular Medicine

Department of Internal Medicine, Erasmus MC, Rotterdam

Kleiweg 500, 3045 PM, Rotterdam, the Netherlands

m.castrocabezas@franciscus.nl

+31 10 461 6760

Marko Korenjak
ELPA President

EUROPEAN LIVER PATIENTS' ASSOCIATION - ELPA

Bastion Tower, Place du Champ de Mars 5
1050 Brussels, Belgium

office@elpa.eu

0032 478 155 224

In addition to its **policy and advocacy work**, ELPA continues to collaborate with scientific bodies and experts, **ensuring the patients' voice is represented in several research projects**.

MEMBER OF:

ENDORSEMENTS AND SUPPORT

The MASLD position paper has gained wide recognition and strong backing across different sectors. It is supported not only by patient organizations but also by leading voices in science, academia, research, policy, and Members of the European Parliament (MEPs).

This broad coalition of stakeholders reflects the urgency of including MASLD in cardiovascular prevention strategies and demonstrates a shared commitment to advancing awareness, prevention, and equitable care.

SUPPORTED BY THE SCIENTIFIC COMMUNITY

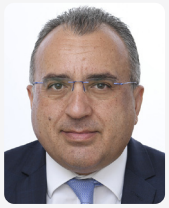
EASL Endorsed

EASL, the European Association for the Study of the Liver, founded in 1966, is a medical association dedicated to pursuing excellence in liver research, to the clinical practice of liver disorders, and to providing education to all those interested in hepatology. As of 2024, EASL serves 6,800 members from 112 countries.

MEMBERS OF THE EUROPEAN PARLIAMENT, OR SUBSTITUTES OF THE COMMITTEE ON PUBLIC HEALTH – SANT ENDORSING THIS CALL TO ACTION:

TOMISLAV SOKOL,

Croatia, Group of the European People's Party (Christian Democrats)



MICHALIS HADJIPANTELA,

Cyprus, Group of the European People's Party (Christian Democrats)

SIRPA PIETIKÄINEN,

Finland, Group of the European People's Party (Christian Democrats)

ANDRÁS TIVADAR KULJA,

Hungary, Group of the European People's Party (Christian Democrats)

IRENA JOVEVA,

Slovenia,
Renew Europe Group

SEBASTIAN EVERDING,

Germany, The Left group in the European Parliament - GUE/NGL

VYTENIS POVILAS ANDRIUKAITIS,

Lithuania, Group of the Progressive Alliance of Socialists and Democrats in the European Parliament

ELPA MEMBERS

ALBANIA
- Albanian Association "Patients with hepatitis"

BELGIUM
- Vlaams Hepatitis Contactpunt - VHC

BOSNIA & HERZEGOVINA
- The Chronic Viral Hepatitis Patients Association - B18

CROATIA
- HUHIV - Croatian Association for HIV and viral hepatitis

CYPRUS
- Cyprus Liver Patients Association - Promitheas

DENMARK
- Leverforeningen

EGYPT
- Association of Liver Patients' Care – ALPC

FINLAND
- The Finnish Kidney and Liver Association

FRANCE
- Fédération SOS hépatites & Maladies du foie,
- Fédération des Déficients et Transplantés Hépatiques - TRANSHÉPATE

GEORGIA
- Hepatitis C Cured Patient Association

HUNGARY
- Hungarian Association of Chronic Hepatitis Patients - VIMOR

IRELAND
- Hepatitis C Partnership

ISRAEL
- Israeli Association For The Health Of the Liver - Hetz

ITALY
- Italian Association for Research on Primary Sclerosing Cholangitis - AIRCS

KAZAKHSTAN
- Anti Hepatits C Organisation - AGEP C

MONTENEGRO
- 4Life

NORTH MACEDONIA
- Association for health education, prevention and better treatment - HEPTA,
- Hepar Centar - Bitola

NORWAY
- proLAR

POLAND
- Star of Hope Foundation

PORTUGAL
- SOS Hépatites Portugal

ROMANIA
- Patients with hepatic impairment Association of Romania - APAH-RO

RUSSIA
- Humanitarian Action,
- United Against Hepatitis

SERBIA
- Association for helping patients with chronic viral hepatitis - HRONOS

SLOVAKIA
- HEP HELP KLUB, Šanca pre pečeň,
- Slovak Coalition of People with Obesity and Overweight - SKLON

SLOVENIA
- Association - SLOVENIJA HEP

SPAIN
- Catalan Association of Liver Patients - ASSCAT,
- Catalan Federation of Rare Diseases - FECAMM,
- National Federation of Liver Patients and Transplanted - FNETH,
- Spanish Association for Lysosomal Acid Lipase Deficiency - AELALD

SWEDEN
- Riksföreningen Hepatit C – RHC

TURKEY
- Living with Hepatitis Association - HEPYAŞAM

UNITED KINGDOM
- British Liver Trust,
- Hep C Positive,
- Liver4Life

SUPPORT FROM OTHER PATIENT COMMUNITIES