



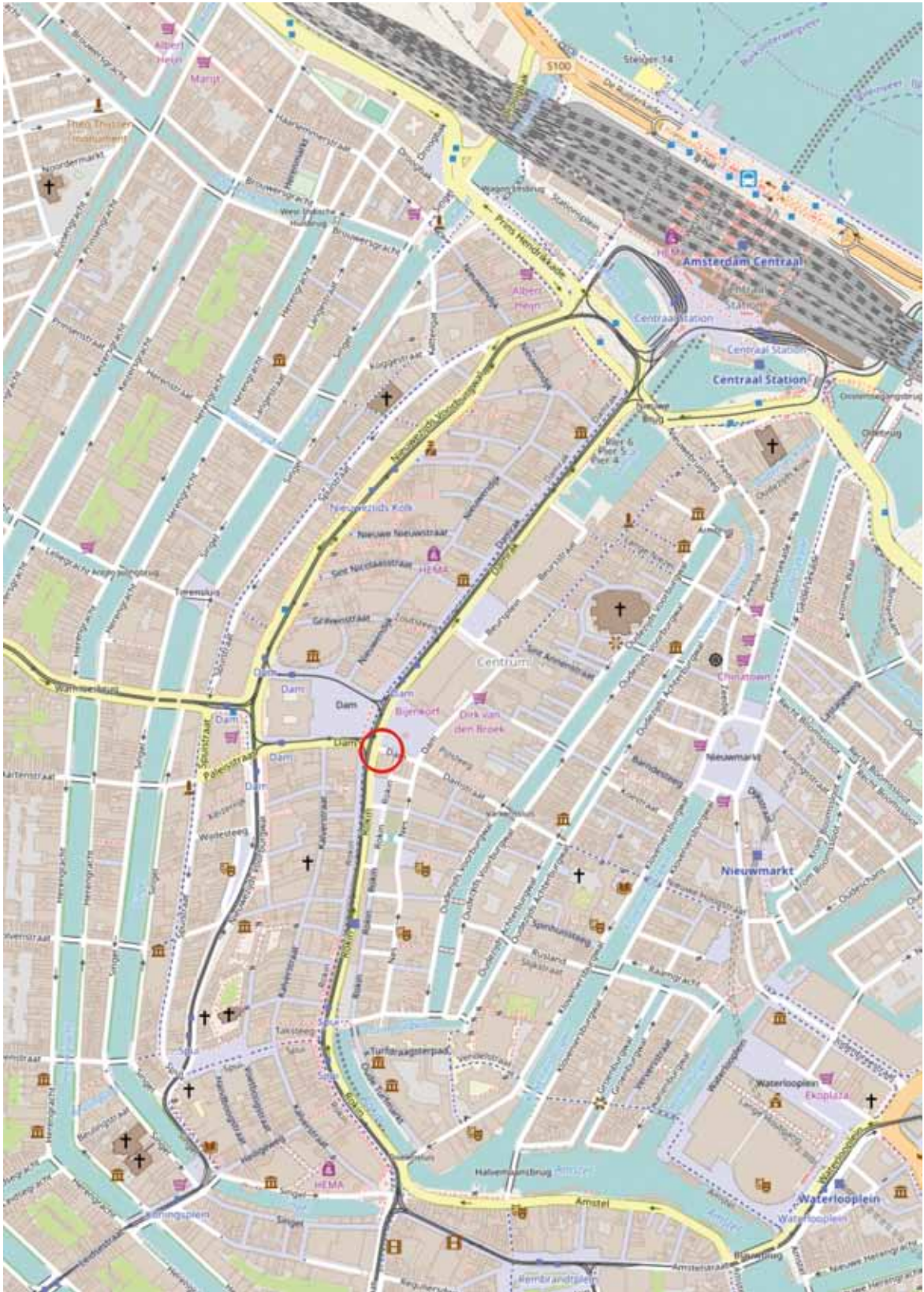
HEPATITIS-C

Community Summit

Amsterdam 18/19 April 2017

BRIDGING THE GAP BETWEEN
RESEARCH, HARM REDUCTION, TREATMENT
AND PEOPLE LIVING WITH HEPATITIS C

Programme



Welcome to the HEPATITIS-C Community Summit from 18-19 April in Amsterdam!

BRIDGING THE GAP BETWEEN RESEARCH, HARM REDUCTION, TREATMENT AND PEOPLE LIVING WITH HEPATITIS C

On behalf of Correlation Network/Organising Committee, it is our pleasure to welcome you to the Hepatitis-C Community Summit. In the next two days a great number of excellent plenary speeches and abstracts will be presented.

We are facing exciting opportunities. With the new medicines now available an opportunity exists to completely eradicate hepatitis C. However, it will require pharmaceutical companies, governments, doctors, and health purchasers to come together to ensure these medicines are quickly available to all. Also a crucial factor for success will be the involvement of people living with hepatitis C.

The implementation of harm reduction and low threshold community based services, providing access to testing and treatment as well as effective prevention interventions will be critical to ensure the treatment of high risk groups such as people who inject drugs, men having sex with men and immigrants.

This summit aims to create an opportunity for a variety of stakeholders to come together and bridge the gap that exists between what is our current reality and what can be our reality, a world where hepatitis C is eradicated.



Organising Committee

Correlation Network – Hepatitis C Initiative
European Aids Treatment Group (EATG)
European African Treatment Advocates Network (EATAN)
European Network of People Who Use Drugs (EURONPUD)
European Liver Patient Association (ELPA)
International Doctors for Healthier Drug Policy (IDHDP)
AFEW International
Alliance for Public Health, Ukraine
Prometheus Association, Greece



Sponsors

The organising committee would like to extend a special thanks to the sponsors of the Hepatitis-C Community Summit



The Correlation Hepatitis C and Drug Use Initiative was funded by the EC Commission DPIP programme and received an unrestricted grant by Gilead Ltd and financial support by Abbvie Biochemicals Sarl

Venues



Koninklijke Industriële Groote Club

Dam 27
1012 JS Amsterdam

Venue Abbvie Lunch Session

Eggertzaal
Eggertstraat 8,
1012 NN Amsterdam

Hospitality Desk

The hospitality Desk will be located on the Ground Floor at the Reception near the entrance. Here you can register for parallel sessions if you haven't done so, pick up your name-tag and ask any questions on the conference itself

Emergency contact

For any logistical issues or questions, please contact
Natacha Berbers, +31657345785

WIFI code

Free wireless information is available at the venue using the login-codes below
Network: Koninklijke IGC
Password: amsterdam1012

Programme

Tuesday, 18.04.2017

13.30 - 14.30	Coffee and registration
14.30 - 15.00	<p>Opening and welcome: Location: Central Hall Chair: Eberhard Schatz, Correlation Network</p> <p>Welcome word: - Stephen Malloy, European Network of People Who Use Drugs - Denis Onyango, European African Treatment Advocates Network</p> <p>Welcome address and EASL recommendations on the treatment of HCV Frank Tacke, European Association of the Study of the Liver</p> <p>Hepatitis C policy and care needs involving of all – turn the page Graham Foster, Queen Mary University of London A1</p>
15.00 - 16.00	<p>Plenary speeches: Location: Central Hall</p> <p>From data collection to recommendation Philippa Easterbrook– Global Hepatitis Programme, World Health Organisation A2</p> <p>From recommendation to practice: Access to testing and treatment in Europe Mojca Maticic - Clinic for Infectious Diseases and Febrile Illnesses, University Medical Centre Ljubljana A3</p> <p>From peer to research Magdalena Harris, London School of Hygiene and Tropical Medicine A4</p> <p>From patient to advocate Anton Basenko, Alliance for Public Health, Kiev A5</p>
16.00 -16.30	Coffee break

16.30 - 17.15	<p>Round table discussion: Location: Central Hall</p> <p>Moderator: Chris Ford, IDHDP</p> <p>Experiences to treat risk groups in a barrier-free, low threshold setting</p> <p>With the complete eradication of hepatitis C now possible with new treatments, we need to think how best to get these medicines to all the people who need them. This round table discussion will look at 3 experiences of providing testing and treatment of hepatitis C from within a community based setting from Scotland, France and Austria. Following the brief presentations there will be an open discussion to examine opportunities for more barrier free treatment making testing and treatment available and accessible to all. Delegates are welcome to talk about their own experiences.</p> <p>Speakers: John Dillon, University of Dundee, Scotland Vo Tran, GAIA, Paris Hans Haltmayer, Suchthilfe, Vienna</p>
17.15 - 18.15	<p>Round table discussion: Location: Central Hall</p> <p>Moderator: Ricardo Bapista Leite, Member of National Parliament, Portugal, Head of Public Health, Católica University of Portugal</p> <p>A politician interviews experts from different areas: Elimination – can we make it?</p> <p>Speakers: Jason Grebely, The Kirby Institute, UNSW Sydney, from a research perspective Daniel Simões, EATG, from a community perspective Céline Grillon, Médecins du Monde, from an advocacy perspective Maka Gogi, HR network Georgia, experiences on elimination in Georgia</p>
18.15 - 19.00	<p>Reception</p>

Programme

Wednesday, 19.04.2017				
09.30 - 11.00	<p>Plenary session: Location: Central Hall Chairs: Magdalena Harris, LSHTM, George Kalamitsis, Prometheus Association</p> <p>Engaging Migrants - barriers to testing and treatment Mesfin Ali, Embrace UK Community Support Centre, London A6</p> <p>Thirty years of harm reduction in the Netherlands - HCV elimination ahead? Esther Croes, Trimbos Institute, Utrecht A7</p> <p>Hepatitis in prison settings Heino Stöver, University of Applied Science, Frankfurt A8</p> <p>Access in EECA countries - Natalia Kravchenko, Alliance for Public Health, Kiev A9</p>			
11.00 - 11.30	Coffee break			
11.30 - 13.00	<p>Abstract driven sessions overview:</p> <table border="1"> <tr> <td> <p>Parallel session 1 Location: Damzaal Chair: John-Peter Kools</p> <p>The treatment cascade</p> <p>Good practices from a diversity of countries on how HCV testing, outreach and treatment is organised in harm reduction settings</p> <p>A10 - A11 - A12 - A13</p> </td> <td> <p>Parallel session 2 Location: Bibliotheek Chair: Sebastian Saville</p> <p>Reach your crowd</p> <p>Innovative tools and methods for HCV awareness and information</p> <p>A14 - A15 - A16 - A17</p> </td> <td> <p>Parallel session 3 Location: Bestuurskamer Chair: Denis Onyango and Julia del Campo</p> <p>Workshop</p> <p>On the move – Infectious diseases in migrant populations</p> <p>A18</p> </td> </tr> </table>	<p>Parallel session 1 Location: Damzaal Chair: John-Peter Kools</p> <p>The treatment cascade</p> <p>Good practices from a diversity of countries on how HCV testing, outreach and treatment is organised in harm reduction settings</p> <p>A10 - A11 - A12 - A13</p>	<p>Parallel session 2 Location: Bibliotheek Chair: Sebastian Saville</p> <p>Reach your crowd</p> <p>Innovative tools and methods for HCV awareness and information</p> <p>A14 - A15 - A16 - A17</p>	<p>Parallel session 3 Location: Bestuurskamer Chair: Denis Onyango and Julia del Campo</p> <p>Workshop</p> <p>On the move – Infectious diseases in migrant populations</p> <p>A18</p>
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13.00 - 14.30	<p>Lunch Lunch will be served in the hall of the venue, vegetarian options are available.</p>			
13.00 - 14.30	<p>Lunch time session: Location: Eggertzaal</p> <p>Path to Zero: Fresh thinking on the road to eliminating Hepatitis C</p> <p>This session will bring together representatives from around the world to explore actionable ways to raise awareness of, finance initiatives to and put knowledge into practice to help eliminate HCV. The session will have a specific focus on the 'Path to Zero', a program developed by the Economist Intelligence Unit (EIU) and sponsored by AbbVie which aims to enhance awareness of and initiate a global dialogue around innovative solutions toward eliminating the disease. It will feature a panel discussion with ground-breaking innovators, or 'HCV Change Makers', to present case studies and explore new strategies to affect real change. The EIU will moderate the session, which is sponsored by AbbVie.</p> <p>*Lunch will be provided. pre-registration required, max. participants 40 persons</p>			

13.00 - 14.30	<p>Lunch time session: Location: Dameszaal Chair: Anke van Dam, AFEW</p> <p>AIDS 2018 How to give Hep C and harm reduction a better profile at AIDS2018! Brainstorm session on topics, speakers and other preparations for the international AIDS conference in Amsterdam next year.</p> <p>*Lunch will be provided. pre-registration required, max. participants 12 persons</p>			
14.30 - 16.00	<p>Abstract driven sessions overview:</p> <table border="1" data-bbox="339 824 1391 1137"> <tr> <td data-bbox="339 824 691 1137"> <p>Parallel session 4 Location: Damzaal Chair: Katrin Schiffer</p> <p>Peer work as a key role in all phases of the process - prevention, testing and access to care</p> <p>A19 - A20 - A21 - A22</p> </td> <td data-bbox="699 824 1050 1137"> <p>Parallel session 5 Location: Bibliotheek Chair: Achim Kautz</p> <p>Best practice examples in different areas of HCV counseling, screening and monitoring</p> <p>A23 - A24 - A25 - A26</p> </td> <td data-bbox="1058 824 1391 1137"> <p>Parallel session 6 Location: Bestuurskamer Chair: Ludmila Maistat</p> <p>Availability and pricing examples of effective advocacy for affordable DAA's</p> <p>A27 - A28 - A29 - A30 - A31 - A32</p> </td> </tr> </table>	<p>Parallel session 4 Location: Damzaal Chair: Katrin Schiffer</p> <p>Peer work as a key role in all phases of the process - prevention, testing and access to care</p> <p>A19 - A20 - A21 - A22</p>	<p>Parallel session 5 Location: Bibliotheek Chair: Achim Kautz</p> <p>Best practice examples in different areas of HCV counseling, screening and monitoring</p> <p>A23 - A24 - A25 - A26</p>	<p>Parallel session 6 Location: Bestuurskamer Chair: Ludmila Maistat</p> <p>Availability and pricing examples of effective advocacy for affordable DAA's</p> <p>A27 - A28 - A29 - A30 - A31 - A32</p>
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16.00 -16.30	<p>Coffee break</p>			
16.30 - 17.30	<p>Plenary session: Location: Central Hall Chair: Marko Korenjak, ELPA</p> <p>The 2016 Hep-CORE Report: Monitoring European policy responses to viral hepatitis Jeff Lazarus, Rigshospitalet, University of Copenhagen, and ELPA members from 5 countries A33</p> <p>Community Declaration Presented by Magda Ferreira, peer worker at GAT, Lisbon</p>			
18.00 - 20.00	<p>Final Networking Session, reception: Location: Central Hall</p> <p>WRAP UP video conference, prepared by Igor Kouzmenko, Drug User News, Kiev</p> <p>Julian Hows, GNP+ - What can we learn from the HIV/AIDS movement?</p> <p>Khalid Tinasti, Global Commission on Drugs, presents the work of the Commission on Hepatitis and introduces the VIDEO message of Professor Michel Kazatchkine, former Executive director of the Global Fund to fight AIDS, tuberculosis and malaria</p> <p>Ricardo Baptiste Leite, Member of National Parliament, Portugal presents Hepatitis C: Policy in Action!</p>			

Abstract: per presentation and session

A1 Hepatitis C policy and care needs involving of all – turn the page

Graham Foster, Queen Mary University of London, London

Chronic hepatitis C infection has wreaked havoc among those who use drugs. For far too long therapy has involved unpleasant, poorly effective medicines that have been unpopular with patients and their doctors. The last two years has seen a transformation in treatment options and we now have tablet only therapies that are side effect free and cure over 90% of those who are infected. Clinical trials have demonstrated their efficacy in those who are actively using drugs and many countries are now beginning major public health campaigns to treat all who are infected with HCV and eliminate this virus from our planet. However among the optimism and hope brought by the new drugs is the ever present menace of discrimination and 'selection of the worthy' - in some American states drug users are denied access to opiate substitution therapy and needle exchange but when they die from their drug overdoses the American medical system springs into life to harvest their organs to transplant into others, who can then undergo treatment for the hepatitis C that is inevitably transmitted with the new organ. To maximise the benefits from the opportunities offered by the new drugs will require a commitment to evidence based treatment for all.

A2 From data collection to recommendation

Philippa Easterbrook– Global Hepatitis Programme, World Health Organisation

A core function of WHO Global Hepatitis Programme is the provision of evidence-based guidance in hepatitis prevention, care and treatment particularly for low and middle income countries. Key recent care and treatment guidelines include for hepatitis C in 2016, and hepatitis B in 2015, and most recently testing for viral hepatitis in 2017. The presentation will summarise the key new WHO recommendations and how these relate to higher risk populations, as well as the WHO guidelines process: (i.e. how we decide on the topics, review and rate the quality of evidence, and formulate recommendations based not just on the evidence but on considering cost, cost-effectiveness, feasibility and acceptability). The critical role of civil society in the guidelines process will be highlighted.

A3 From recommendation to practice: Access to testing and treatment in Europe

Mojca Maticic - Clinic for Infectious Diseases and Febrile Illnesses, University Medical Centre Ljubljana, Ljubljana

Hepatitis C virus (HCV) infection is the leading cause of cirrhosis, end-stage liver disease and hepatocellular carcinoma. To date, among the estimated 130-150 million of infected worldwide, 75% have not yet been tested for HCV infection and only 3-5% have received HCV treatment. In European region people who inject drugs (PWID) represent the majority of infected and the proportion of those who were tested and treated for HCV varies among countries. The first recommendations on the management of HCV infection set up by the international expert societies in the late nineties were restrictive to HCV treatment in PWID due to several barriers, which over the years proved to be unjustified. In recent years studies have shown that in PWID HCV testing and treatment work to prevent of spreading the infection, and modelling studies suggested that they could reduce prevalence and incidence of HCV infection as well as disease burden among PWID. A viral hepatitis resolution approved by the World Health Assembly in 2014 called on all countries to develop and implement national strategies for preventing, diagnosing and treating viral hepatitis. After that PWID were recognized as a group that should get HCV testing and treatment including direct acting antivirals (DAAs) in all the international recommendations.

A study of 27 European countries performed by European Liver Patient Association (ELPA) in 2016 has shown some improvements in testing for HCV infection. In some countries HCV testing has become available for general population and high risk populations including PWID and it has become included in routine screening as well as performed at various screening sites outside the medical settings, however the data vary immensely among the European countries.

In 2016 a first study evaluating the real-life realization of the updated international treatment recommendations was performed by the Correlation Network, The Netherlands, University Medical Centre Ljubljana, Slovenia, and University of Copenhagen, Denmark. Its aim was to present current data from 33 European countries on the existence of national strategies, action plans and guidelines for HCV treatment in the general population and in PWID in particular and to compare them to the same data collected in 2013, with the purpose to evaluate possible positive trends after the publication of the updated recommendations on the management of HCV infection in PWID. Concomitantly, current data on access to treatment with DAAs in different European countries were collected by means of a structured questionnaire and the respondents were drawn from a database of the Correlation Network with most participants from non-governmental organizations. When comparing the answers on the existence of the national strategies, action plans and clinical guidelines between 2013 and 2016, changes were detected in many European countries and a positive trend has been noted in recognizing PWID as a group of individuals where strategic action is needed to

increase HCV treatment. In the majority of European countries DAAs were reported to be available; however, restrictions for their use were reported from a majority of them, with fibrosis stage and current or/and injecting drug use the two major ones. In order to reduce the number of HCV-positive individuals and HCV related disease burden, international clinical recommendations have to be brought into real-life practice. National strategies, action plans and guidelines that specifically address recommendations on HCV testing and treatment in PWID further need to be developed or upgraded and treatment with DAAs should become available for all HCV-positive patients in all European countries in order to eliminate HCV as a public health threat, as set out in the WHO Global health sector strategy on hepatitis, 2016-2021.

A4 From peer to research

Magdalena Harris, London School of Hygiene and Tropical Medicine, London

New developments in hepatitis C treatment can overshadow the crucial role of the community in an effective elimination response. Engagement in care – encompassing prevention, testing, treatment, and social structural supports – requires more than a bio-medical response. In this talk, Magdalena reflects on her journey living with, and receiving treatment for, hepatitis C and how this informed and impacted on her research practice. She also draws on over a decade of research with people living with hepatitis C and/or who use drugs to illustrate the vital role of peers at all stages of the care continuum. Researchers, clinicians, and other stakeholders must work in collaboration with affected populations and their organisations if the hope of hepatitis C elimination is to become a reality.

A5 From patient to advocate

Anton Basenko, Alliance for Public Health, Kiev

In this talk, Anton reflects on his journey as a street injection drug user, living with HIV and Hep C and how Harm Reduction and Opioid Substitution Treatment changed his mind in understanding the need of access to Hep C treatment and turned him to advocacy activism for PWID community and other key populations. He also pays attention on the special access programs for key populations and how the civil society and communities advocacy can reduce costs for Hep C diagnostics and treatment, stimulate governmental support and funding for those in need. He calls for strong linkages between Hep C treatment and harm reduction and the role of communities' involvement not only as advocates, but as peer implementing supporters.

A6 Engaging Migrants - barriers to testing and treatment

Mesfin Ali, Embrace UK Community Support Centre, London

The presentation examines some of the barriers for HIV and HCV positive people to get tested and treated, with special attention to exploring ways of engaging migrant populations to be beneficiaries of the services available to them. In addition, it discusses how the importance of early testing and treatment can be communicated to this specific target group. Methods used include partnering with other community based organisations in order to reach this vulnerable and high risk group.

A7 Thirty years of harm reduction in the Netherlands - HCV elimination ahead?

Esther Croes, Trimbos Institute, Utrecht

With regard to hepatitis C (HCV), The Netherlands has an atypical situation. The number of existing HCV-infections (or: the prevalence) in the general population is estimated to be low (0.1 - 0.4%) and even decreasing due to effective prevention measures. However, in several risk groups, the burden is high. Chronic HCV infections are found in first generation migrants from high HCV-endemic countries (around 40% of prevalent HCV-infections) and (ever) injecting drug users (around 28%). As many of these were infected decades ago, complications become manifest nowadays. The positive news, however, is that new infections (or: the HCV-incidence) in these risk groups are rare. Injecting drugs is not popular in the Netherlands and the availability of harm reduction measures is high. Only in HIV-positive MSM (a small, but significant group) new HCV-infections are found.

The Netherlands is characterised by a pragmatic drug policy. For heroin users, methadone is available widely (and heroin-on-prescription for non-responders) as are needle and syringe exchange programs. For heroin and basecoke users, drug consumption rooms, sheltered housing and many other forms of active support and treatment are offered. With regards HCV-treatment,

DAA's are reimbursed for all infected patients, irrespective of fibrosis stage or mode of HCV transmission. In the last couple of years, the major challenge has been to trace HCV carriers and lead them into care.

For migrants, local initiatives targeting specific migrant populations have tried to trace chronic HBV and HCV-carriers. The efforts were often large compared to the yield. For drug users, both low threshold (open house) initiatives (e.g., from the Regenboog Groep) and national projects linking addiction care and hospitals (like the HCV Break Through projects) aimed to increase the number of chronic HCV patients in DAA treatment. With regard to MSM, the size and problems have been explored first. On a national level, the Hepatitis Initiative Group wrote a National Hepatitis Plan (2016) and the Dutch Health Council advised the Minister of Health about screening for hepatitis B and C (2016), which both helped in the agenda-setting. For physicians, a clear guideline for treating hepatitis C has been developed that is updated every 3 months.

A8 Hepatitis in prison settings

Heino Stöver, University of Applied Science, Frankfurt

Globally, over 10 million people are held in prisons and other places of detention at any given time. People who inject drugs (PWID) comprise 10-48% of male and 30-60% of female prisoners. The spread of hepatitis C in prisons is clearly driven by injection drug use, with many infected prisoners unaware of their infection status. Risk behaviour for acquisition of hepatitis C via common use of injecting equipment is widespread in many prison settings.

In custodial settings, effective and efficient prevention models applied in the community are very rarely implemented. Only approximately 60 out of more than 10,000 prisons worldwide provide needle exchange. Thus, HCV prevention is almost exclusively limited to verbal advice, leaflets and other measures directed to cognitive behavioural change. Although the outcome of HCV antiviral treatment is comparable to non-substance users and substance users out of prison, the uptake for antiviral treatment is extremely low.

Based on a literature review to assess the spread of hepatitis C among prisoners and to learn more about the impact for the prison system, recommendations regarding hepatitis C prevention, screening and treatment in prisons will be formulated in this presentation.

A9 Access in EECA countries

Natalia Kravchenko, Alliance for Public Health, Kiev

In this talk, Natalia will present the results of the survey - the team work of 11 NGOs from 11 countries in Eastern Europe and Central Asia (EECA), which highlights key facts about viral hepatitis epidemics in EECA region, possibilities and barriers on accessing treatment for general and vulnerable populations in EECA countries. She also will share the examples of country response to the epidemics and civil society role in this process. In addition, the recommendations for stakeholders, based on the conducted survey, will be provided.

Parallel Session 1: The treatment cascade

A10 "HIV/HCV Continuum of Care Model Among Hard to Reach Drug-Addicted People in Rome: Meet, Test and Treat."

Elisabetta Teti, Villa Maraini Foundation ONLUS, Rome

HIV/HCV prevalence among drug-addicted people is 15.6% and 80.9% respectively, but only 35% and 54% of these ones is tested. It's important to investigate among Hard to Reach drug-addicted subjects to better estimate real HIV/HCV prevalence and to improve treatment and health services access. Villa Maraini Foundation ONLUS in Rome, engaged in the field of drug addiction since 1976, tested Hard to Reach drug-addicted key population and created an information and care pathway to accompany users from testing to treatment. Using a harm reduction model, with campers placed in two strategic areas in Rome, low-threshold testing was offered to the drug-addicted population. Overall 1204 subjects were screened on HIV and HCV, and 0,9% was found positive for HIV and 7,48% tested positive for HCV. Questionnaires showed that efforts should be focused on improving access to HIV/HCV testing and increase information on transmission. In addition, there is an urgent need for strategies to link positive subjects to care.

A11 “The experiences of GIRUGaia; a portugese outreach team.”

Teresa Sousa, Cláudia Rodrigues, Ximéne Rego, APDES, Porto

GIRUGaia, a Portuguese outreach team, has been working with drug users (DU) since 2003; this population is particularly vulnerable to Hepatitis C, HIV and tuberculosis. The team aims to achieve the ideal conditions to guarantee this group's access to the healthcare network, since they are many times conditioned by prejudice and stereotypes against DU, thus limiting their access to diagnosis, testing and treatment. The daily contact with these individuals is vital to establish a relationship of trust and proximity that usually motivates DU to be part of different therapies. This proximity helps the team making the DU co-responsible for their daily intake of methadone, antiretroviral or tuberculostatic drugs. During this talk APDES will talk about their successes from their CTP (Combined Therapy Program) and the “ADERE+: Promotion of DUs adherence to the HCV Therapeutic, in an outreach context” project.

A12 Directly observed therapy of chronic Hepatitis-C with interferon-free regimens at a low-threshold drug treatment

Raphael Schubert, Suchthilfe Wien, Vienna

Directly observed therapy of chronic Hepatitis-C with interferon-free regimens at a low-threshold drug treatment

Background: An important subgroup of people who inject drugs (PWID) receives opioid agonist therapy (OAT) under direct observation of a physician or nurse at a low-threshold drug treatment facility or pharmacy on a daily basis. Most of these patients suffer from psychiatric comorbidities and are reluctant or unable to go to specialized hepatitis centers. Our hypothesis was that chronic hepatitis C in these difficult-to-treat patients could be optimally managed if modern, interferon-free regimens were applied together with OAT under direct observation of a physician or nurse at a low-threshold drug treatment facility.

Method: Eighty-seven PWID with chronic hepatitis C and borderline compliance started interferon-free treatment of chronic hepatitis C at a low-threshold drug treatment facility in Vienna, Austria. Seven patients were coinfecting with HIV and 25 had liver cirrhosis. Patients received antiviral treatment together with OAT under direct observation of a physician or nurse. For each patient, the individual treatment regimen was selected according to GT, fibrosis stage, pretreatment, HIV-status and current reimbursement policy of insurances.

Result: Following this concept of directly observed therapy, adherence to antiviral therapy was excellent: Only nine scheduled dates for ingestion of the antiviral therapy in combination with OAT were missed by the 87 patients. To this date, 66 patients have completed treatment and a 12-week follow-up period. Virologic healing of hepatitis C infection could be confirmed in all 66 patients.

Conclusion: Directly observed therapy of chronic hepatitis C with interferon-free all-oral regimens at a low-threshold drug treatment facility represents a promising new concept for treatment of patients with borderline compliance receiving OST. By this concept chronic hepatitis C can be cured in a group of difficult-to-treat patients, who are unable to be treated at hepatologic centers. It should be stressed that successful treatment of these patients is not only beneficial for themselves but also for the general population because further transmission of the virus may be prevented.

A13 Free Clinic's HCV treatment and peer model

Stephan Bourgeois, ZNA and **Tonny van Montfoort**, Free Clinic Antwerp, Antwerp

In the last years, treatment of hepatitis C has evolved substantially with shorter regimens, with almost no side-effects and a very high success rate. Moreover, (ex-)PWIDS are no any longer considered ‘a special population,’ and can be treated as easily as other infected patients. But there is still a wide gap to bridge in organizing hepatitis C care and treatment.

Firstly, the very strict reimbursement criteria need to be tackled: in Belgium, patients can only be treated if they at least have F2 fibrosis. Exceptions are made when patients are co-infected with hepatitis B or HIV, in that case, they are always treated. Secondly, for (ex-)PWID patients, hepatologists need to be able to stage them and ensure that compliance and lifestyle of patients are good enough to ensure a positive outcome. And lastly, prevention after treatment is needed. Certainly, it is important to stress taking the necessary measures to avoid re-infection. Yet, prevention of alcohol is also very important within this population, where a lot of patients already have advanced liverfibrosis.

To overcome these gaps, ZNA, a hepatology unit in a large community hospital, engaged in an intensive collaboration with the Free Clinic (a low-threshold addiction centre). This collaboration will be highlighted by some of the addiction clinic co-workers. Specifically, they will discuss the ‚C-buddy‘ system, in which a dedicated hepatitis C nurse and a team of peers are linked to patients. A specific case study will show the added value in this system of care, set up as a ‚not under one roof‘ approach. The latest results of the ZNA database will also be presented.

Parallel Session 2: Reach your crowd

A14 “MapCrowd: A community-based tool for advocating toward universal access to hepatitis C prevention and care”

Céline Grillon, Julie Bouscaillou, Annette Gaudino, Bryn Gay, Niklas Luhmann, Chloé Forette, Médecins du Monde, Paris

Despite the scope and severity of the epidemic caused by HCV the response to reduce the burden of this disease has been very limited globally. Using the Mapcrowd platform, a community-based tool for HCV advocacy, national epidemiological, diagnostic, treatment and policy data was collected, with specific attention to the situation of people who use drugs (PWUD). The platform now displays a consistent dataset on HCV for more than 40 countries, building further on an expanding network of contributors. The latest analysis of data collected through the tool was published in the second mapCrowd report: “Dying at these prices: generic HCV cure denied”. It paints a contrasting picture of the road to HCV elimination. According to this data 14 out of 17 countries in Western Europe established treatment restrictions for people with HCV within their territory. DAAs are often limited to those exhibiting the most severe conditions. While people who inject drugs face the highest burden for HCV infection, they are more frequently excluded from health policies and HCV treatment uptake among people who inject drugs remains very low. Stigma and criminalization act as powerful restrictions to access life-saving care and treatments.

A15 A creative action guide around a „Pill Proposal“ developed by Universities Allied for Essential Medicines

Peter Grablitz, Universities Allied for Essential Medicines, Halle

The Universities Allied for Essential Medicines has created a creative action guide around a “Pill Proposal” with the specific aim to increase awareness for high drug prices and the mobilize people to act and protest those high drug prices. By staging a false wedding proposal in the public sphere, where the ring is replaced by a pill, the actors who are part of the proposal create a context for the audience to discuss this issue. Afterwards, the real purpose of the proposal is revealed, such as signing a petition/letter, inviting the audience to a meeting, making donations, a Town Hall Meeting with School, etc. A short film is also attached to this creative action, and uses the same messages. Results so far were positive, those who witnessed the proposal were more likely to be interested and were mobilized easily. This approach can be easily scaled up and adapted for different contexts.

A16 Advocacy video’s from drug users in community health action

Antoni Llorca Suárez, ARSU, Reus

ARSU, a Spanish non-profit drug user union and advocacy group, was founded in 1999 with the specific aim of creating a peer support group that can fight against prohibitionist drug policies and that can supporting drug users living with HIV and Hepatitis C. They use short video’s, which they distribute via social media, to show the fatal effects of drug users who use drugs in public spaces, and transforms them into safer spots by cleaning them up, providing exchange syringe machine’s and many more things.

A17 Amsterdam MSM Hepatitis C Free

Freke Zuure, GGD Public Health Service, Amsterdam

In the Netherlands, unlike in many other countries, current transmission of HCV occurs primarily among HIV-positive MSM as HCV incidence dropped to nearly zero among PWID. Since 2000, there has been an unexpected and substantial increase in acute HCV infections among HIV-infected MSM. Early testing and treatment of HCV-infected HIV-positive MSM in combination with upscaling of preventive measures may curb the HCV epidemic among this population. As Part of the MC Free (Amsterdam MSM Hepatitis C Free) project, aiming to develop an innovative, integral strategy to eliminate HCV among MSM in Amsterdam, we initiated the Ctest.nl service in its related webapp.

Ctest.nl is a low-cost internet-guided home-based testing service for HCV-RNA (home-collection testing involving a certified laboratory). This service allows men at high risk for HCV infection to take control and test on a regular basis using a highly sensitive test for the detection of acute HCV infection. Home-based testing can decrease barriers to testing as it increases convenience, anonymity, perceived control over the testing procedure and patient autonomy and control over their own health, and decreases time and efforts needed to visit regular health care facilities. In addition the webapp will provide tailored information about risk practices and related prevention measures, including special preventive initiatives, such as a sex tool-box to help men reduce risk of infection during group sex.

Parallel Session 3: Workshop:

A18 On the move – Infectious diseases in migrant populations

Julia del Amo, National Center for Epidemiology, Institute of Health Carlos III, Madrid
Denis Oyango, EATAN, London

Limited access to healthcare for vulnerable migrants in Europe is increasingly worrisome as immigration policies harden. Recent studies have shown large discrepancies between entitlements under international human rights law and the local implementation of care in diverse countries. Until now, the responsibility for the healthcare of migrants has fallen on emergency services. Generally speaking the care given addresses urgent needs but regrettably underlying chronic conditions are not identified or worse simply ignored. The issues surrounding migrant health are complex and beg institutional leadership and policy direction to support care workers and managers to better navigate this uncharted territory. Further, there is a growing body of evidence that migrants from outside the region are acquiring HCV, HIV and TB when they arrive in Europe. Is it therefore not a responsibility of our respective health systems to identify, test and treat these vulnerable people?

Parallel Session 4: Peer work is crucial

A19 Facilitating access to hepatitis C treatment to people who inject drugs (PWID) in Georgia: Results of a peer support intervention

Julie Bouscaillou, Médecins Du Monde, Paris

Georgia faces high HCV rates (7.1% in the general population) with a concentrated epidemic among PWID. An ambitious National Program and Elimination Plan was launched in 2015 and Médecins du Monde, an international NGO, and New Vector, a Georgian self-support organization of PWID, and the medical center Neolab, have developed and implemented a peer-support intervention to facilitate access to and retention of current PWID in first phase of the national treatment program. Using rapid testing and liver elastometry as a noninvasive affordable screening process within a harm reduction service program, support intervention delivered by peer workers before and throughout the treatment period, A focal person in the medical center, dedicated to mediation with PWID and peer workers team, good results were achieved. Results included an uptake in screening (21% increase in a five month period), successful linkage to care, a high treatment completed (98%), and model replication.

A20 HIV/HCV TREATMENT ADVOCACY FOR AFRICANS IN THE UNITED KINGDOM

Amie Joof, African Eye, Birmingham

Black Africans in the United Kingdom are disproportionately affected and infected by HIV and HCV. This migrant community accounts for the second largest infection rate in the UK and access to treatment, treatment information and support for this group is lacking. To address this gap, the African Eye Trust developed a training program in partnership with other HIV organisations to build the capacity of Africans to advocate for themselves, their peers and to increase their knowledge on HIV and HCV treatment and care. A total of 48 African men and women were trained as HIV/HCV treatment advocates across England, who in turn have trained their peers, creating a multiplier effect. This capacity building training facilitates the dissemination of HIV and HCV treatment information, leads to a possible reduction in poor adherence to medication, development of resistance, and a possible reduction in transmission. This type of training can be adapted to various other settings with migrant or disadvantaged communities, and can produce effective treatment outcomes and meet the goal of universal access to ARV and DAAs.

A21 Hepatitis C Network: Peer and Interagency Support Initiatives

John Loftus and Billie, Mid-West Hepatitis C Network, Limerick

In July 2015, GOSHH (Gender Orientation Sexual Health HIV) a group of people with Hepatitis C who were willing to share their experiences of living with the condition and representatives of a number of statutory and voluntary agencies that support people with Hepatitis C in the Mid-West region of Ireland met in Limerick City. Using methods such as Provision of Rapid Hepatitis C testing with full pre and post testing supports for World Hepatitis Day and European HIV-Hepatitis C Testing Week, Putting forward a motion for discussion by Limerick City & County Council advocating for the appointment of an infectious diseases expert in the hospital serving the area, and developing a 'no-jargon' information leaflets on Hepatitis C led to many concrete results. A key-aspect of the success of this network is the use of a partnership approach, involving both people with lived experience and professionals across a range of disciplines, in supporting people with Hepatitis C, with a large potential for replicability.

A22 Tailored, peer driven interventions related to hepatitis C

Magda Ferreira, GAT, Lisbon

During this session, the experiences of peer workers from harm reduction centre in Lisbon are presented, with a specific focus on the persisting obstacles on access and adherence to HCV care, and treatment for people who inject drugs (PWID). Best practices to promote testing referral and access to care among this group will be discussed. This includes diversified and tailored peer driven interventions related to hepatitis C such as needle exchange, rapid testing, targeted information, case management, accompaniment to hospital, and advocacy for treatments. The peer work done in a harm reduction settings can have a key role in all phases of the process - prevention, testing and access to care - due to the proximity and knowledge of PWID difficulties and needs by peer workers. It is also very important for peer workers to be able to share information, increase awareness and promote political participation of PWID.

Parallel Session 5: Screening and monitoring

A23 HIV/HCV community-based counseling and testing in prison - an exemplary intervention

Peter Wiessner, Action against Aids, Berlin

In Germany, each year about 110.000 people get imprisoned for the first time, and among those incarcerated many use drugs. Yet, the testing rates for HIV and HCV in prison are low. Because of precarious testing standards, civil society has been reluctant to offer HIV/HCV counseling/testing in prison. The German AIDS Federation has developed the concept of an exemplary intervention to address these issues and has started its intervention in one of Germany's prisons. The concept of the exemplary intervention, the procedure to turn it into reality and the challenges faced will be discussed.

A24 One-step screening of active hepatitis C virus infection in HIV-negative men who have sex with men, male sex workers and trans women sex workers

Elisa Martró, IGTP, Barcelona

This research combined HCV-RNA detection assay in dried blood spots (DBS) as a one-step screening and confirmatory test with an alternative community outreach strategies, to improving the hepatitis C diagnosis and treatment among hard-to-reach populations at risk, including HIV-negative men who have sex with men (MSM), male sex workers (MSW) and trans women sex workers (TWSW) in Spain. The HCV-RNA assay showed a good performance in DBS, although a small number of false-positive results were obtained in line with the very low HCV prevalence observed. Data suggests that regular HCV screening of HIV-negative MSM is not justified in this setting. Nevertheless, given the observed high-risk behaviours and the prevalence of other STIs, HCV spread among MSM, MSW and TSW should be monitored.

A25 Unsafe use, knowledge and HCV infection: Results from a sero-behavioral survey of current injectors in Germany

Martyna Gassowski, Robert Koch Institute, Berlin

The main transmission route of hepatitis C (HCV) among people who inject drugs (PWID) is the use of contaminated injecting paraphernalia. To identify factors associated with the use and passing on of used injection equipment, data from the first, large German sero-behavioral survey of PWID (DRUCK-study) was used. The aim of this analysis was to generate evidence to inform public health action, including community initiatives, on how to reduce risk behavior and thus HCV transmission among PWID in Germany. Using a dataset of current injectors (recruited via a respondent driven sampling in eight German cities in 2011-2014) a uni- and multivariable logistic regression is applied for factors associated with use of used needles/syringes (N/S) or cookers/filters/water (C/F/W); passing on of used N/S or cookers/filters (C/F). Results show that the likelihood to share equipment increased with injection frequency, while being informed of risks of sharing decreased it. To improve HCV prevention among PWID, a combination of education measures and demand-oriented provision of sterile equipment, including C/F/W, is recommended. Following the findings of the DRUCK-study a project in which low threshold facilities in three different cities will offer education, testing and counseling to drug users has been initiated.

A26 Monitoring HCV infections and HCV testing behaviors among people who enter into treatment for drug use in Southern Denmark

Anne Øvrehus, Stine Nielsen, Peer Brehm Christensen, Odense University Hospital, Odense

In this study we investigate hepatitis C (HCV) testing uptake for a sub-population of people attending drug treatment centers in the southern region of Denmark. Combining the civil registration database with external testing data from the department of clinical immunology (KIA) at the Odense University Hospital, we report data on HCV test uptake and the correlation to risk behaviors and drug treatment history. Due to the Danish unique civil registration number which allows linking data from different registries – we have a special opportunity to investigate people in drug treatment centers access to HCV testing over time.

The results of this analysis shows that over time test uptake in the high risk population of injectors on OST is high (85%), but declines to 57% in injectors not on OST. Offering testing outside OST programs are important in our setting if we are to increase testing uptake and diagnosis. All persons in this cohort have been in contact with a treatment center highlighting the many missed opportunities for hepatitis C testing.

Parallel Session 6: Availability and pricing Effective strategies to scale up access to affordable DAAs. ”

A27 The fight of the Swiss Lever Patient Organisation to make DAA's available for every patient

Oli Wehri, Schweizerische Hepatitis C Vereinigung SHCV, Zürich

How to make treatment for hepatitis C available for all those in need if the prices are so high? How can we make sure that nobody is left behind? Oli Wehri from the Swiss organization of patients with hepatitis C shares his experience of overcoming numerous barriers in access to treatment for patients rejected by the official health care system in Switzerland.

A28 Generic DAAs, pricing and availability

Giten Khwairakpam, Treat Asia, Bangkok

While prices for DAAs from originator manufacturers are exorbitant and treatment remains unavailable for most patients, generic DAAs are entering the markets. Emergence of the generic DAAs for treating Hepatitis C, pricing for generic drugs in private and public markets, availability of the DAAs from an Asian perspective and current national regulatory status (registration) of the DAAs globally will be addressed by Giten Khwairakpam from Treat Asia.

A29 Buyer's clubs

James Freeman, Fix HepC, Hobart

Why have buyer's clubs sprung up? Why is it important? And how do they operate globally? These and many more questions will be addressed by James Freeman during this presentation.

A30 Accelerating access to quality-assured generics through patent pooling: the experience of the Medicines Patent Pool

Esteban Burrone, Medicine Patent Pool, Geneva

The presentation will provide an overview of the experience of the Medicines Patent Pool in facilitating access to affordable quality assured medicines in low and middle income countries. It will briefly explain how the model operates and what has been achieved in HIV, and then explain its work in hepatitis C to date and plans for the future.

A31 Compulsory license and patent opposition activities in Russia: efforts to increase access to DAA-based HCV treatment

Sergey Golovin, ITPCru, St. Petersburg

Sergey Golovin from Treatment Preparedness Coalition in Eastern Europe and Central Asia presents on the efforts undertaken by the civil society to improve access to DAA-based treatment in Russia and in the region of Eastern Europe and Central Asia through patent opposition and compulsory license activities.

A32 Pre-grant patent opposition as an instrument to avoid patent monopolies for medicines

Sergiy Kondratyuk, All-Ukrainian Network of People Living with HIV/AIDS, Kiev

For patients' organizations pre-grant patent oppositions may be a good instrument in work with patent monopolies. Sergiy Kondratyuk adds to the discussion by sharing a case of "informal" pre-grant patent opposition in Ukraine.

A33 "The 2016 Hep-CORE Report: Monitoring European policy responses to viral hepatitis"

Jeff Lazarus, Rigshospitalet, University of Copenhagen, and **ELPA members from 5 countries**

The year 2016 was pivotal for the field of viral hepatitis. In May, at the World Health Assembly in Geneva, 194 governments adopted the first Global Health Sector Strategy for Viral Hepatitis, which helped catapult the growing focus on viral hepatitis elimination to centre stage. This was followed up in September with the first European Hepatitis Action Plan. However, despite these major policy moves, critical gaps in regional and national commitments to combatting viral hepatitis in Europe remain.

The European Liver Patients Association carried out the Hep-CORE study with the aim of collecting information on the work that remains to be done in 25 European and two Mediterranean Basin countries regarding national and subnational implementation of hepatitis B and C policy recommendations in Europe. The Hep-CORE survey was administered online in mid-2016 as a 39-item cross-sectional survey. Specific questions were asked on overall national response, public awareness and engagement, monitoring and data collection, prevention, testing and diagnosis, clinical assessment, and treatment of hepatitis B and C.

In this session Hep-CORE principal investigator Jeffrey V. Lazarus and representatives of ELPA member organisations present the report and select key findings.



