Priorities for action, representatives of Civil Society and Community Networks present advocacy priorities from their respective organisations

HEP-C
Community Summit
Lisbon 18 Sept 2018

Network	Priority	Talking points rationale	Talking points for change
Correlation	Provide testing and treatment in harm reduction and community settings	The One Stop Model increases access Testing and treatment in HR and community services is (cost) effective It's a necessary step to achieve elimination in key populations	Legal barriers must be abolished HR and community services have to be an integrated element of the cascade of care The medical sector has to acknowledge the competence of community health care workers
Coalition Plus	Involvement of communities in the development and implementation of elimination plans at national level	Community involvement will support the accountability, equitability, and people-centered approach of the HCV response.	Formal community and civil society engagement crucial to oversight and transparency of program responses Community feedback is crucial to monitoring and improving the HCV response HCV services must adapt to needs of PLHCV, not vice versa

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EHRA	Reducing the inequality in the access to HCV testing and treatment in CEECA for people who use drugs (PWUD)	HCV treatment access in CEECA happens mostly through out-of-pocket payments, (in)formal exclusion of PWUD, and outdated/non-existent treatment protocols. There is, however, strong community treatment activism (as in Russia, Ukraine and Georgia). Community efforts led to best practices on negotiations with the state and pharmaceutical companies, and increasing treatment demand and literacy (still unevenly distributed across the region).	Intensified horizontal cooperation between community networks, including groups of PWUD

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EATG	No Elimination without decriminalization: The impact of repressive drug policies on health and quality of life	Repressive drug policies fuel the HIV/Hepatitis/TBC epidemics, strongly impact the health and quality of life of PWUD and hinder effective prevention and treatment. They lead to PWUD invisibility, discrimination and stigma; harassment and violence by police, increased incarceration and infringement of Human Rights; poor health and quality of life and barrier to PWUD access to testing and treatment.	Drug use must be primarily a health and social problem. Best practices on progressive and evidence-based drug policies must be disseminated to reduce new infections, improve public health, and the lives and health of PWUD. Civil society can advocate with governments for adopting effective HR approaches as well as to map/respond to PWUD social needs.
EATG	Reaching out to key populations in prison settings	The more repressive the drug laws, the more time PWUD tend to spend in correctional institutes. High-risk drug injection often continues when in prison, with an increase in the risk of acquiring HIV/hepatitis	Peers should be involved in service design and implementation Dissemination of best practices National guidelines must include peer work in prisons

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		Having ever injected drugs in prison is a the strongest predictor of HIV/Hepatitis infection among PWUD	HR including NPS and condoms must be made available in prison settings
ELPA	Testing and micro-elimination as targeted national elimination of viral hepatitis C in well-defined populations	Highest-risk groups are left behind in the pursuit of HCV elimination in Europe Systematic gaps where high-risk populations are ignored if they are difficult to access outside of existing pathways Not enough attention is given to hepatitis testing, which is the key to diagnosis and elimination	A viral hepatitis strategy, with specific goals for addressing the highest-risk populations, is the first step for any country to begin facing this epidemic. Breaking down national elimination goals into smaller goals focusing on individual population segments. Continue carrying out a testing week focused on hepatitis

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EuroNPUD/ **INPUD**	HCV programs should not focus on reducing drug and alcohol use. Care programs must not individualize or blame PWUD. Structural barriers should be brought to the fore.	Many health programs concerned with reducing client's drug use risk alienating PWUD. Health and social programs for PWUD propose biomedical solutions which blame PWUD and portrait them as a problem. Treatment "failures" are blamed on patient non-compliance, and problems such as poverty, housing, social welfare and inequality fail to be addressed.	Eliminate abstinence and use reduction as the goal of any treatment, and refer to harm reduction Eliminate stigma and discrimination in, and integrate health and social programs Service users should regularly review treatment programs Medical professionals should understand legal barriers and be allies in advocating for decriminalization
IDHDP	People who are currently injecting should be prioritized. Treatment and prevention should occur at the same time.	Once people commence treatment for HCV they soon no longer pose a risk of infecting others. Current injectors are much less likely to pass on the virus after only two weeks into treatment	Doctors working in addiction services, front line workers working in harm reduction and outreach services and PWID peer groups should be provided authority to offer incentives first for people to be tested and then to start, continue and complete treatment