I will pose a suggestion for an improvement to customary international law to achieve higher deployment of DAA’s and easier access to other emerging technology in medicine.

In conclusion, I will deliver short representative messages from other hep C survivors, sourced from global forums, with permission but anonymised. These messages will address stigma, recovery, support and hope for the future. A larger collection of these messages is proposed to be put into a book for display in the NoHep village. The presentation will broadly be in three parts of 2-3 min:

1. Case study
2. The legal landscape
3. Quotes from forum

References: [1] www.fixepc.com
Global-Terrorism-Index-2016.2.pdf
[6] https://www.youtube.com/watch?v=cu0xSoqWG6I

Disclosure of Interest: None declared.

P2-131 | Health evaluation in the response to viral hepatitis in Brazil

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Objective: Evaluate the Brazilian response to viral hepatitis (VH) at different levels of healthcare.

Method: Evaluative study with mixed approach. A review of quantitative data on reported viral hepatitis cases from the Notifiable Diseases Information System (SINAN) and qualitative data from records of discussion fora involving health professionals and members from civil society. Qualitative data were analyzed according to similarity of content.

Results: Number of notified cases in Brazil in 2016: 161 605 cases of hepatitis A; 196 701 cases of hepatitis B; 289 459 cases of hepatitis C; and 3660 cases of hepatitis D. Regarding five geographical regions, the North and Northeast regions accounted for the greatest number of hepatitis A cases; the North, Southeast and South regions concentrated most cases of hepatitis B; the Southeast and South regions had most cases of hepatitis C; and the North region, the largest number of reported hepatitis D cases. Qualitative data allowed the identification of relevant aspects to inform a response that is pertinent to the Brazilian reality, considering the regional specificities/peculiarities, which differ widely in this continental country. The following needs emerged from this study: invest in health systems and services organization expanding access and integrity of viral hepatitis care; encourage permanent health education as a tool to strengthen prevention, diagnosis, treatment, and monitoring, as well as to stimulate responses to vertical transmission of VH; scale up communication about and raise awareness towards viral hepatitis; increase prevention, diagnosis, and treatment activities for indigenous, riverside and quilombola populations; encourage activities to improve patient adhesion to treatment; and include universities as strategic support to respond to viral hepatitis. The magnitude of these diseases is evident as well as the need to adopt strategies that are geographically specific, based on the availability of services, and that take into consideration vulnerabilities of different populations.

Conclusion: These results may guide the elaboration of a national viral hepatitis plan, aligned with the World Health Organization strategies and the 2030 Sustainable Development Goals, by informing public policies on health systems, healthcare management and assistance actions appropriate to the regional contexts of the viral hepatitis infection.

Disclosure of Interest: None declared.

P2-132 | Implementation of a hepatitis C elimination plan with a view on access expansion and integrity of viral hepatitis care

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Introduction: In Brazil, until 2016, 320 000 cases of hepatitis C had been reported. Approximately 140 000 received public treatment, a total investment of 3.6 billion reais, including 65 000 treatments with the new direct-acting antivirals (DAA) between 2015 and 2017. The government distributed 17 million rapid tests from 2011 to 2017. Nonetheless, it is noted the need to better understand the HCV epidemics in the country, in addition to elaborate a plan to achieve WHO goals to eliminate hepatitis C by 2030.

Methodology: Intervention plan. Sequential mixed method (quantitative and qualitative). A mathematical model estimated the HCV prevalence in Brazil and supported the discussions to identify elimination strategies. Program managers from federal, state
and municipal levels gathered and discussed the core components of the elimination strategy, which was approved by the Tripartite Committee (CIT).

**Results:** HCV prevalence in Brazil is 0.7%, with 657 000 viremic cases between 15 and 69 years, and affecting 30% more men than women. The strategy is divided into three axis: Diagnosis: expansion of diagnosis and strengthening of epidemiological surveillance (VE). The first, aims to: expand rapid test (RDT) services network; intensify RDT reporting; strengthen diagnostic confirmation flow; expand the use of RDT to day-care centers, primary health care (elderly health, men’s health, women’s health), indigenous health and prison health system. The second refers to improve HCV surveillance on diabetic, hemodialysis and hospitalized patients; reported cases confirmation flows; and linkage to care of cases identified in blood banks. **Treatment:** aims to treat infected patients. **Crosscutting Axis:** divided into management and permanent education and communication. Management includes the construction of lines of care, expansion of the service network and strategic information. Permanent education and health communication includes educational activities for qualification of healthcare providers and awareness of the population about viral hepatitis.

**Conclusion:** Eliminate hepatitis C in a continental country with universal health care is a challenge. Brazil presents theoretical and technical tools, and the political will to achieve the elimination by 2030. This strategy will assist health services organization and care of infected patients, expanding access to care, focusing on the integrality of the viral hepatitis response.

**Disclosure of Interest:** None declared.

**P2-133 | Development of HepFriend: a community hepatitis C peer support model**

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**Background and Aims:** Peer support models are thought to be effective in engaging hard to reach individuals with Hepatitis C (HCV). However, whilst peer support is used on an ‘ad hoc’ basis by homeless and addiction community based services there is an urgent need to develop an evidence based peer support model to enhance access to the HCV care Pathway to ensure that those with the most significant disease are supported to get appropriate care & treatment

**Method:** A community consultation process was initiated by the HepCare team and representation was sought from organisations with expertise in the needs of this particular cohort, in particular input from those with a lived experience of HCV. Through community collaboration & partnership a Peer Support model was developed between the study team & three key organisations along with a welcome commitment to deliver a twelve month pilot project in the community. Each organisation has nominated four HepFriend peer workers with a lived experience of HCV to volunteer on the project during the pilot phase, this gives a collective number of twelve HepFriend peer workers. Each peer will work with up to ten individuals giving capacity to work with one hundred and twenty individuals over the course of the pilot. The types of intervention carried out by the volunteers include support and information on the HCV care pathway; peer facilitated referral and attendance at clinical appointment if required. Peers received a 2 day training programme and certification upon completion. To date we have a number of instructive case reports to illustrate the value of the peer support intervention. In anticipation of the completed analysis of this project please see case report highlighted below.

**Results:** On first hospital visit, following three DNA’s (did not attend) Mary (37 years) tested 58 kPa on transient elastography exam with evidence of Child-Pugh B with significant clinical manifestations of liver disease. Mary was assigned a peer worker to ensure adherence to follow up and treatment. Mary was started on treatment within two weeks of her initial appointment and was supported by her peer worker to attend eight clinical appointments and successfully complete treatment and cure over a twelve week treatment duration.

**Conclusion:** Any planned intervention for HCV must engage many services and not just focus on treatment alone, making peer support a particularly important element in working with this vulnerable population.

**Disclosure of Interest:** None declared.

**P2-134 | Strengthening integrated laboratory capacity and surveillance programs to improve strategic information to eliminate viral hepatitis in Mongolia**

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Mongolia has the highest rate of liver cancer mortality in the world, with eight times the global estimate. 98% of liver cancer is attributable to viral hepatitis, with HBV infection accounting for 50%, HCV infection accounting for 27% and coinfection for 21%. Mongolia has a successful HBV vaccination program however national representative serosurveys in 2017 estimated 10.6% of adults living with chronic HBV and 7.9% with chronic HCV.