

## GAMES MAKE LEARNING FUN!

*Heather Lusk, Hepatitis C Coordinator Hawai'i Department of Health*

While hepatitis C is no laughing matter, there is often room for fun and games during hepatitis C trainings. Games incorporated into trainings can reinforce knowledge, emphasize key take-home messages, serve as an energizer and provide an outlet for participants' friendly competitiveness. Ensuring that games are created appropriately with fair rules and facilitating games effectively so everyone has fun is important and will enhance the experience for all while ensuring the objectives of the game are met.

The first decision is to determine the goals for your hepatitis C game. Is it purely for fun or to reiterate important points and diversify the learning experience? When will the game be played? Games in the morning are often utilized as an icebreaker or energizer whereas games in afternoon can reinforce content pre-

sented during the morning session. Games may also serve as personal awareness tools, where participants are able to identify their own beliefs or understanding of hepatitis C. Such values clarification activities provide opportunities for discussion of potentially controversial topics while remaining in the context of an enjoyable game. Once the rationale behind the game is identified, the creative fun begins to determine how to have the most fun in meeting your objectives.

Typically, games are either for all individuals to play independently or for teams to play together, which may depend on the size of your group or the amount of time allotted. One of the more popular ways to create a hepatitis C game is to adapt old favorites. Hepatitis bingo has been used, as has hepatitis "Jeopardy" (or "Hepardy"). Some trainers use hybrid games, such as

part "Family Feud," part "Who Wants to be a Millionaire," which allows teams to play against each other. These games are relatively easy to create using the structure of the existing game and adding your own questions and answers. Some of these games have already been created and posted on the CDC hepatitis website under the Resources section. Beyond re-creating existing games, there are many other options in developing games. Many trainers have used the "Scavenger Hunt" or "Find Someone Who" activity which encourages participants to find other people in the room who have experienced or believe certain statements which can be amusing or hepatitis C related, or both. Brainstorming can become competitive when small groups are charged with coming up with a list of unique items within

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## HEPSQUADS

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# HEPATITIS C COVERAGE IN THE RYAN WHITE CARE ACT

Liz Highleyman

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More than 4 million people in the United States are believed to have hepatitis C virus (HCV) infection, though most are unaware they are infected. What's more, an estimated 25% to 30% of people with HIV also have HCV. Among some groups (for example, young injection drug users), the HIV/HCV co-infection rate is even higher.

As effective antiretroviral therapy has reduced the rate of illness and death due to AIDS-related opportunistic illnesses, more people with HIV are dying from liver disease, and many of these individuals are co-infected with HCV or hepatitis B virus (HBV). In fact, end-stage liver disease due to chronic hepatitis C is now a leading cause of death among HIV-positive people in the United States.

## NEW CO-INFECTION LANGUAGE

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act – which provides funding for HIV/AIDS prevention and treatment, including the state AIDS Drug Assistance Programs (ADAPs) – was first enacted in 1990 and was reauthorized in 1996 and again in 2000.

Recognizing the increasing importance of HCV and HBV co-infection among HIV-positive people, activists argued that the Ryan White Act should include hepatitis care. The most recent version of the legislation, passed in 2006, takes these concerns into account, and for the first time includes language on HIV/HCV and HIV/HBV co-infection. Under the previous version, states and cities were allowed to provide hepatitis care, but not required to do so.

According to a House of Representatives report, “this is not just a matter of ADAP providing HCV drugs for co-infected patients, it relates to all medical and social service providers recognizing the impact of HCV on persons with HIV, getting the proper training to help these individuals, and

integrating the appropriate services into their programs.”

Given the high rate of illness and death due to HCV among people with HIV/AIDS – especially in large cities – some AIDS service programs have started to integrate hepatitis care, but most still do not do so (though most do provide HCV testing). However, as noted in a recent Health Resources and Services Administration (HRSA) technical assistance conference call about implementing the new language, Ryan White programs are “well-positioned to tackle hepatitis C given their experience working with complex patient needs and the array of crucial medical and supportive services they provide that can support successful hepatitis C service delivery.”

One section of the updated legislation says that local planning councils, which allocate Ryan White funding, should include HIV-positive people with HBV or HCV co-infection. In addition, the bill gives “priority to qualified applicants...experiencing an increase in the burden of providing HIV-related services due to the number of individuals co-infected with HIV/AIDS and hepatitis B or C.”

Grant recipients are now expected to provide information on prevention of HBV and HCV transmission. Clients should also be educated about HBV- and HCV-related liver disease progression, which occurs more rapidly in people with HIV. In addition, they should be informed about hepatitis treatments, as well as the availability of an effective vaccine to prevent hepatitis B (there is not yet a vaccine for hepatitis C).

The 2000 version of the Ryan White legislation required grant recipients to offer home- and community-based care services for HIV positive individuals, assistance in continuing their health insurance coverage, and drugs to treat HIV disease and opportunistic illnesses. The new language

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## RYAN WHITE

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adds that health service providers should “include coordination of specialty care for individuals with hepatitis co-infection,” though it does not mandate funding of HBV or HCV therapy.

As HRSA’s Laura Cheever noted on the conference call, money is not the only barrier to HCV treatment. “Both medical providers and patients may not prioritize hepatitis C among myriad health and social issues that patients face,” she said. “Both medical providers and patients are skeptical about the efficacy of treatments we have today, especially given potential toxicity. Hepatitis C therapies have many relative and actual contraindications – so many that patients are excluded from therapy, sometimes unnecessarily. Beyond these barriers, Ryan White grantees may also lack the capacity to provide these services. It is more than money. It is about improving systems and expanding capacity.”

### ADVOCATES WANT MORE

Patient advocates are working to ensure that more attention and resources are focused on hepatitis C. The Hepatitis C Appropriations Partnership was formed to lobby for increased funding of HCV programs through the Centers for Disease Control and Prevention (CDC). Activists are also working to pass the federal Hepatitis C Epidemic Control and Prevention Act, which would fund comprehensive prevention programs, research, and medical care.

Enacted before the availability of effective HIV treatment, the Ryan White Act demonstrates some of the problems with funding health care on a disease-by-disease basis.

As HIV-positive people live longer, they are susceptible to other chronic conditions, such as hepatitis, diabetes, and heart disease. Some advocates would like to see ADAPs cover prevention and treatment of such conditions, along with antiretroviral therapy and medications for opportunistic infections. About 20 states already include HCV therapy in their ADAP formularies. But on the whole, ADAP funding is stretched thin, and adding hepatitis treatment would further strain inadequate state budgets.

“We strongly support maintaining HCV screening and treatment services as authorized services under the CARE Act,” states the American Academy of HIV Medicine and the HIV Medicine Association. “We also strongly support states having the option to add HCV medications to state ADAP formularies.” But, they add, “A substantial infusion of additional resources is needed and warranted to address the medical needs of uninsured and underinsured persons who are co-infected with HIV and HCV.”

And what about HIV-negative people with hepatitis B or C, who may also require treatment to prevent progression of a life-threatening disease? Taking a broader approach, activists are increasingly working to improve Medicare and Medicaid coverage, and ultimately calling for universal health coverage, which would provide care and treatment for people with all diseases.

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--<http://www.hcvinprison.org/>



### Got an Event?

Have your events listed on the HCV Web site. Send the following to [cdmazoff@hcvadvocate.org](mailto:cdmazoff@hcvadvocate.org)

Event: \_\_\_\_\_

When: \_\_\_\_\_

What: \_\_\_\_\_

Where: \_\_\_\_\_

Contact information: \_\_\_\_\_



# THE ABC'S OF VIRAL HEPATITIS

Alan Franciscus, Editor-in-Chief

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At the recent 2<sup>nd</sup> National Conference on Methamphetamine, HIV and Hepatitis, Heather Lusk gave a presentation titled “Ass – Booty – Cooker, the ABCs of Viral Hepatitis.” The presentation was a great overview and an update of information about the most common types of viruses that cause hepatitis in this country. I found it a great review for those of us who educate and support the hepatitis communities so I decided to ‘borrow’ Heather’s presentation for a two part series on the basics of hepatitis A, B, and C. Part one in this series will review hepatitis A and B.

## HEPATITIS A (HAV)

In 2005 there were an estimated 42,000 new infections of hepatitis A in the United States. This is compared to the estimated 180,000 new infections estimated in 1997. The decrease in new infections is due to the introduction of the hepatitis A vaccine in 1995 and educational efforts to prevent the transmission of hepatitis A.

Hepatitis A is primarily transmitted via the fecal-oral route (**Ass**). HAV can also be transmitted through blood exposure, but this is rare. Hepatitis A is highly infectious and can be stable in the environment for months. The hepatitis A virus is transported alive through bile to the stool or feces which makes the HAV infected feces highly infectious. The most common transmission is through close personal contact with an HAV infected person. In this country the groups that are at highest risk for hepatitis A include:

- People who work at, and children who attend, day care centers,
- Visitors to foreign countries where there are unsanitary sewage conditions,
- Persons who engage in anal/oral sex, and
- People who come in contact with food service workers who may have contaminated the food or liquid with HAV infected feces.

The vaccine to protect against hepatitis A is considered safe and effective. The vaccine is given in two doses with the second dose given approximately 6 to 18 months after the first dose. The HAV vaccine is recommended for:

- Injection and non-injection drug users,
- Men who have sex with men,
- Travelers to HAV endemic countries,
- Persons with chronic liver disease,
- Persons with clotting-factor disorders,
- Children living in communities with historically increased rates of hepatitis A, and
- Household and sex contacts of HAV positive persons.

In addition to vaccination there are other steps that people can take to prevent the transmission of HAV, including careful hand washing especially after using the toilet or changing diapers. People with active HAV infection should avoid preparing food for others. Additional prevention measures include the practice of safer sex, including latex condoms, and latex or plastic barriers for oral/anal sex.

The symptoms of hepatitis A are the typical types of liver related symptoms – fatigue, nausea, vomiting, night sweats, fever, jaundice, loss of appetite, and flu-like syndrome. When symptoms occur in adults, they appear suddenly and may include fever, exhaustion, loss of appetite, nausea, abdominal discomfort, dark urine and jaundice (yellowing of the skin and eyes). Generally, children do not exhibit symptoms so caregivers, parents and household members are at risk of contracting HAV from infected children.

Once a person becomes infected with hepatitis A his/her immune system will fight it off and s/he will develop antibodies that will provide immunity. Hepatitis A is rarely fatal, but there have been deaths reported in people infected with chronic hepatitis C who have become infected with hepatitis A.

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# VACCINE NEWS

Alan Franciscus, Editor-in-Chief

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## TWINRIX

In April 2007 GlaxoSmithKline announced that they had received approval from the FDA for an accelerated dosing schedule for Twinrix in adults. Twinrix is a hepatitis A and hepatitis B combination vaccine. The new accelerated dosing schedule is now available at a dosing schedule of 0, 7, and 21-30 days followed by a booster dose at 12 months. The previous dosing schedule was 0, 1, and 6 months. The study found that individuals who completed the new dosing schedule had an immune response comparable to those who received the separate hepatitis A and hepatitis B vaccines.


## HEPATITIS E VACCINE

A study of 2,000 healthy adults (armed forces personnel) in Nepal found that 96% of those given the vaccine developed protective antibodies against hepatitis E.


Hepatitis E is spread in a similar manner as hepatitis A – fecal to oral contamination. Hepatitis E is seldom seen in the United States but it is widespread in developing countries that do not have a sanitation process to separate fecal matter from water for daily use such as drinking water and water used for food preparation. It is estimated that approximately 1/3 of the world population has been infected with hepatitis E.

Most people who become infected with hepatitis E do not have serious ongoing consequences except for women in the third trimester of pregnancy – in this group of women about 20% will die of complications from hepatitis E. Once infected with hepatitis E the body's immune system will develop antibodies that will protect against future HEV infection.

The trial participants were recruited from the Nepalese army and 99.6% were males. Although there are similar response rates in men and women, there are differences in the effectiveness of vaccines in people based on a person's



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*It is estimated that approximately 1/3 of the world population has been infected with hepatitis E.*  
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weight – people who are thin have a tendency to respond better to vaccines. Since the study participants were from the Nepalese armed forces there is concern that the lower weight among generally healthier soldiers may have produced higher response rates to the new vaccine. Still this is very good news for the millions of people who are at risk for hepatitis E.

## HIV POSITIVE VACCINE RESULTS

The development of HAART has dramatically increased the survival of people infected with HIV. Now the leading cause of complications and death for people living with HIV is liver disease. As a result, prevention of hepatitis B infection is of utmost concern and importance. Since HIV suppresses the immune system, the effectiveness of HBV vaccination has been between 24 to 60%. This compares to a response rate of greater than 90% in people who are immunocompetent.

A study presented at the recent 14<sup>th</sup> Retrovirus Conference looked at revaccinating those people who did not respond initially to a regular vaccination schedule. In this study by T.E.M.S. de Vries-Sluijs and colleagues, 135 patients who did not initially respond to a regular vaccine series were revaccinated using a dose containing 20 µg HBV vaccine at monthly intervals. It was found that 57.8% of the revaccinated group developed antibody titers. Predictors of response were younger age, female gender and undetectable HIV RNA viral load.

# ABC's

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## HEPATITIS B (HBV)

In 2005 there were an estimated 51,000 new infections of hepatitis B in the United States. Unlike hepatitis A, hepatitis B can become a chronic infection. In this country there are about 1.25 million people who are chronically infected with hepatitis B.

Hepatitis B is primarily transmitted by blood, semen, and vaginal fluids (**Booty**). HBV is highly infectious and is stable in the environment for at least 7 days. The most common transmission routes are perinatal (mother to child), unprotected sex, and percutaneous (through the skin).

Techniques that prevent the transmission of hepatitis B include:

- Safer sex including the use of male and female condoms, and preventing blood, semen and vaginal fluids from entering the body. Use of barriers for vaginal, anal, oral, and oral/anal sex. Use of lubricants during sex to avoid skin abrasions. Cleaning sex toys between use
- Safer injection practices including a new syringe, cooker, cotton, clean water, and washing hands
- Standard or universal precautions
- Not sharing personal or hygiene items such as razors and toothbrushes
- Covering any open cuts or wounds
- Making sure instruments used for tattoos, piercing, acupuncture are new and sterilized

A hepatitis B vaccine is available that is safe and effective and is given in three doses – the second dose one month after the first, and the third dose 6 months after the first dose. The vaccine is believed to provide lifelong protection. The hepatitis B vaccine is recommended for:

- Men who have sex with men
- Persons with more than one sex partner in a six month period
- Persons diagnosed recently with a sexually transmitted disease
- Sex contacts of infected persons
- Injection drug users

- Household contacts of chronically infected persons
- Infants born to infected mothers
- Infants and children of immigrants from areas with high HBV rates
- Health care and public safety workers
- Hemodialysis patients
- Developmentally disabled in long-term care settings
- People living with HIV

In December 2006 the recommendations for adult vaccinations were revised to include recommendations for all adults at-risk (*see February 2007 HepSquads*).

Many people who become infected with hepatitis B have few or no symptoms in the acute stage. If people **do** exhibit symptoms of acute HBV these can include fatigue, depression, loss of appetite, nausea, muscle and joint pain, mood swings, abdominal pain, fever, vomiting, jaundice, cognitive dysfunction, fluid retention and lack of concentration. For most people who contract HBV their bodies will resolve the infection and they will develop protective antibodies that will give lifelong immunity. However, about 6% of adults and 90% of infants who are acutely infected develop chronic infection or long-term infection. If infants born to HBV infected mothers are vaccinated and given HBV immune globulin at birth, the rate of chronicity is reduced to about 10%.

Disease progression in people with chronic HBV infection is usually slow, and it can take decades before the virus causes severe damage. But for some people with chronic hepatitis B disease progression can be faster. It is important that people with chronic hepatitis B are carefully monitored and evaluated for drug-based therapies with HBV antivirals or interferon, if appropriate. Many people with chronic HBV also use complementary and/or alternative therapies. It is recommended that people inform their medical providers of any prescribed, street, over-the-counter drugs, herbs, vitamins and any supplements they are using.

*Part 2* of this article will appear in the next issue of *HepSquads* and will provide a basic overview of hepatitis C. To view Heather Lusk's slide presentation go to:

<http://www.hcvadvocate.org/Training/abcsofhepmeth.htm>



# LEARNING GAMES

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two minutes. This “Two Minute List” activity can be fun (list kids’ breakfast cereals) or hepatitis-related (list functions of the liver) and the team with the most unduplicated items wins. The Hepatitis C Support Project (HCSP) has created hepatitis crossword puzzles which are available for download and can be used during trainings. HCSP has also created hepatitis C playing cards that can be used as a game by having individuals or teams quiz each other using the questions on the cards. There are many other potential games that can be created with minimal resources with a bit of creativity and by talking with other trainers and encouraging the sharing and friendly stealing of others’ ideas for games.

The framing and facilitation of the game is very important to ensure everyone understands the guidelines and process and feels comfortable participating in the activity. Some participants become very competitive and participants may revolt if rules aren’t explained clearly or changed mid-game. Some people may have anxiety about publicly answering questions, so it is important to create safety by reminding everyone it is a GAME and to not judge others if they are incorrect. Likewise, when a participant answers inaccurately, the facilitator will want to be gentle in sharing the accurate answer to minimize potential embarrassment. Clearly lay out the ground rules for how the game is played and reiterate them several times. Define what is acceptable and what is not, and how decisions will be made. For example, if two teams are squaring off against each other, explain how you will choose which team has indicated they know the answer. The best strategy is to have someone else (a neutral person) be the judge. Otherwise, participants may argue over who truly was first. Instead of having people raise their hand (always a point of contention who really had their hand up first) have them ring a bell or another type of noisemaker. After the game, the trainer may want to go over all of the answers. This is another opportunity to reinforce knowledge as well as correct any potential misinformation. Trainers may or may not want to provide a small prize for the winner(s), it can be a motivation for participants but may also fuel competitiveness.

It is important to effectively set-up, facilitate and debrief a game during your hepatitis C training, this will ensure it meets the training objectives while creating an enjoyable experience for participants. Taking the time to flesh out every aspect of the game, clearly framing and giving instructions and maintaining neutrality while facilitating the game will promote a safe environment and allow participants to have fun while learning about hepatitis C.



## Attn: New Web Address for Educational Tools!

The Hepatitis C Support Project has launched a new program to help trainers with their educational efforts. Included are tools to help you educate others. Listed below are various files to download and use for your training needs.

1. **One Day 2006** is the entire slide presentation that we are currently using for our trainings. Included in the slides are notes – just click on the note function. *Format:* MS PowerPoint
2. **Overview of HCV in English** is a template for general information about hepatitis C in English. Included in the slides are notes – just click on the note function. *Format:* PowerPoint
3. **Overview of HCV in Spanish** is a template for the above file in Spanish. *Format:* PowerPoint
4. **HCV Myths** is a presentation about various myths about hepatitis C. Included in the slides are notes – just click on the note function. *Format:* PowerPoint
5. **Game:** Heparady contains a sample game board, questions/answers. *Format:* MS Word.
6. **Crossword Puzzle:** Puzzle #1 and answers. *Format:* Adobe pdf.
7. **The ABCs of Viral Hepatitis** is an overview and an update of information about the most common types of hepatitis. *Format:* Powerpoint

To access these files go to:

<http://www.hcvadvocate.org/Training/Trainers.htm>

Please keep checking back – we will be posting additional files to help educate people about hepatitis C. If you have any suggestions for information that will help you, please email [alanfranciscus@hcvadvocate.org](mailto:alanfranciscus@hcvadvocate.org)