

Harm Reduction Conference: Day 1

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The Harm Reduction Conference is one of the most important conferences in the nation because it is the only national conference that focuses on the needs of drug users and this population is at highest risk for HCV. This conference is comprised of many advocates from various groups around all areas of drug use and while the main focus of the conference is not hepatitis C, it does focus on many areas that affect people with HCV. These reports will mostly focus hepatitis, but may include other topics that directly or indirectly affect people living with HCV.

December 01, 2002

Today the National Harm Reduction Conference opened in Seattle, WA with a cast of thousands of harm reduction advocates from around the world.

Allan Clear, Executive Director and Paula Santiago, Conference Organizer, of the Harm Reduction Coalition started the opening session. Clear reminded the audience to take ownership of the conference by being involved and making the conference what they want it to be - by and for harm reductionists. To make this point various harm reduction groups from around the world spoke out on their efforts to advocate for their communities and what harm reduction meant to them.

Keynote Speaker

Dr. Joyceln Elders

The keynote speaker was Dr. Joyceln Elders, former Surgeon General under the Clinton Administration. Dr. Edlers was fired by the then president Clinton about remarks she made about masturbation. Since this time, Dr. Edlers has become a very popular special at various conferences and is considered somewhat of a legend.

Dr. Elders spoke about her term as the surgeon general and commented that the only thing she regretted about being fired was not being able to lift the ban on federal funds to support needle exchange before she left office. In addition she commented that legalizing drugs should be seriously studied because she views drug use and addiction as a public health issue and not a legal or criminal issue.

In 1985 the prison population in the United States was between 200,000-300,000 people. Now we have 2 million prisoners of which 60% are the result of non-violent drug related crimes and Elders commented that better drug treatment should be instituted in prisons. This is particularly important when you consider that high prevalence of HCV in the incarcerated population.

Dr. Elders talked about a variety of topics including harm reduction, HIV, HCV, needle exchange, overdose and drug treatment centers to name a few.

She ended her session with an inspiring series of quotes but the one that moved the audience to a

standing ovation was:

- ◆ Not to know is bad
- ◆ Not to want to know is worse
- ◆ Not to hope is unthinkable
- ◆ Not to care is unforgivable

There were three hepatitis C workshops today-

Part One -

- ◆ Integrating Viral Hepatitis Prevention in Harm Reduction Programs
- ◆ Accelerated hepatitis B virus immunizations in young injectors: a strategy for achieving rapid serologic immunity

Part Two –

- ◆ Hepatitis Overview – Hepatitis C 101 – the ABC's of Viral Hepatitis
- ◆ HCV Transmission in the Workplace

Part One

Session: Integrating Viral Hepatitis Prevention into Harm Reduction Programs

Presenters:

Tracy Badsgard- Centers for Disease Control and Prevention, Atlanta, GA
Bob Wood, MD – Seattle-King County Dept. of Public Health
Donald Torres – Harm Reduction Coordinator, New Mexico Dept. of Health, Albuquerque, NM
Jessica Guernsey-Camargo, Multnomah County Health Dept, Portland, OR

An estimated 120,000 new hepatitis B virus (HBV) and hepatitis C virus (HCV) infections occurred in 1998. Approximately 1.2 million Americans are chronically infected with HBV and an estimated three million are chronically infected with HCV. Injection drug users (IDU) are at very high risk of infection with HBV and HCV. Integrating hepatitis prevention services into existing harm reduction programs is an essential step towards prevention and control of these diseases.

The objective of this session was to explore strategies for, share experience and barriers to integrating hepatitis prevention activities, including education, counseling, testing, vaccination, and referral where appropriate, into existing harm reduction to track activities; to explore mechanisms for outreach to high risk populations; to measure the impact of integration on existing services.

Three of the CDC funded Viral Hepatitis Integration Projects (VHIP) were presented as models for effectively integrating viral hepatitis into existing programs.

Content experience in Multnomah County (Portland), OR, New Mexico, and Seattle/King County, WA on integrating hepatitis prevention into existing programs was discussed. Strategies for outreach to high risk populations, integration, evaluation, and tracking of counseling, testing, vaccination, and medical management services, and measurement of the impact of services on existing programs was explored.

Integration into existing programs of activities to prevent and control hepatitis among persons at high risk for

multiple infections (HIV, STDs, hepatitis) makes good public health sense. However, limited experience exists as to the feasibility, efficacy, and effectiveness of integrated services.

Successes and Barriers to Integration of Viral Hepatitis into Harm Reduction

Successes:

- ◆ Reaching clients where they are at
- ◆ Using existing staff
- ◆ Access to hard to reach population such as on site HAV and HBV vaccinations at needle exchange sites
- ◆ One stop services for providing many services which cut down costs compared to providing fragmented services
- ◆ Filling the gap in services

Barriers

- ◆ Lack of additional hepatitis services such as you test but cannot refer for additional care
- ◆ Staff feeling overwhelmed with additional tasks
- ◆ Challenge of providing licensed medical care such as blood draws and vaccinations at street based sites
- ◆ Doesn't reach some specific populations
- ◆ Many affected by hepatitis will not use these integrated services

The workshop ended with Joanna Buffington from the CDC noting that original VHIP funding ends this year and the CDC will be releasing a call for new proposals in Spring 2003. Unfortunately, there will be no increase in funds available for this grant because of budgetary reallocations to West Nile Virus and bioterrorism.

Session: Accelerated Hepatitis B Virus Immunizations in Young Injectors: A Strategy for Achieving Rapid Serologic Immunity

Presenter: Paula Lum MD MPH , The UFO Study UCSF Campus, San Francisco, CA

Nearly 60% of injection drug users (IDU) under age 30 in San Francisco are at risk of infection with hepatitis B virus (HBV), a vaccine-preventable disease. However, completing the standard six-month schedule of immunizations is often difficult for young IDU.

We conducted a randomized controlled trial to compare serologic immunity achieved by an accelerated versus standard immunization schedule in a cohort of HCV-negative young IDU.

119 HBV-naïve IDU under age 30 were enrolled.

- ◆ 59 participants were randomized to the standard 0-1-6 month vaccine schedule
- ◆ 60 to an accelerated 0-1-2 month schedule.

All participants received vaccine reminders from outreach workers and \$15 for each 20 mcg dose received. Protective antibodies (anti-HBs > 10 mIU/mL) were measured one month after receipt of the third vaccine dose and again at 12 months. A fourth dose was offered to all accelerated arm participants and to standard arm participants with anti-HBs <100 at 12 months.

The results of this study showed that of the 91 participants who did not move, die, or withdraw from the study, 28/43 (65%) in the standard arm and 41/48 (85%) in the accelerated arm completed their immunization schedules ($p=0.02$).

Serologic immunity (anti-HBs > 10 mIU/mL) was achieved in 91 percent (20/22) of the standard arm and 79 percent (23/29) of the accelerated arm ($p=0.27$).

The authors of this study concluded that compared to the standard HBV immunization schedule, an accelerated schedule achieves better completion rates and evokes a comparable seroprotection rate in young HCV-negative IDU.