Hepatitis C and drug user health:

The latest international research and its implications for the front lines

PRESENTED BY

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October 21, 2019

INHSU

CATIE

Canada's source for HIV and hepatitis C information

Webinar Agenda (1.5 hours)

Moderator: Christopher Hoy, Knowledge Specialist, Hepatitis C Community Health Programming, CATIE

- Overview of key themes and research presented at the 8th International Symposium on Hepatitis Care in Substance Users

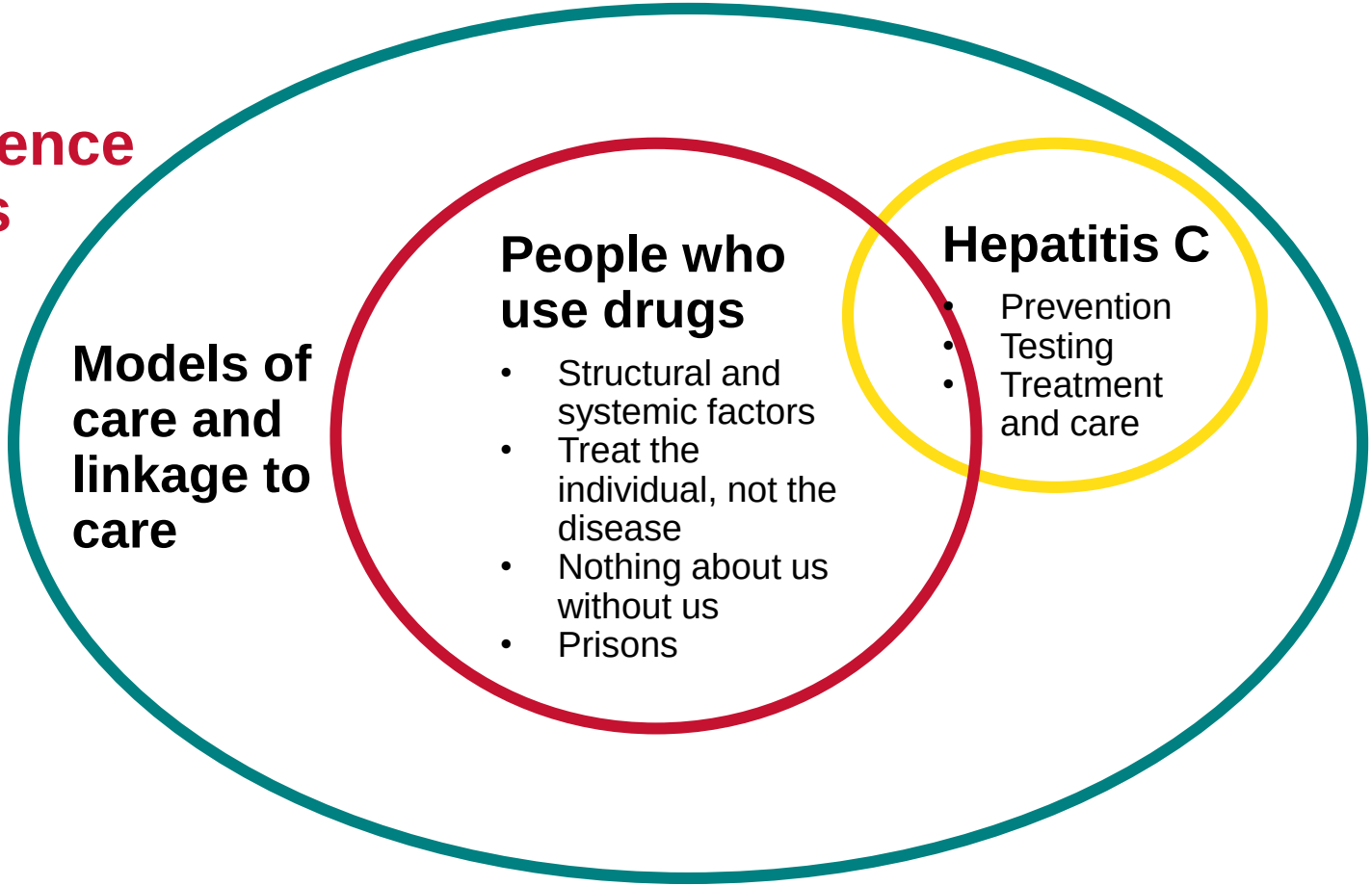
  Rivka Kushner, Knowledge Specialist, Hepatitis C, CATIE, Canada
- Reflections and implications for frontline practice
- *Kellie Guarasci, Nurse Clinician, Cool Aid Community Health Centre*
- *Carrielynn Lund, DRUM & SASH/CanHepC Coordinator, Canadian Aboriginal AIDS Network*
- *Alexe Morgan, Harm Reduction Project Coordinator, AIDS Committee of Newfoundland and Labrador*
- Q & A

INHSU 2019 Conference in Montreal

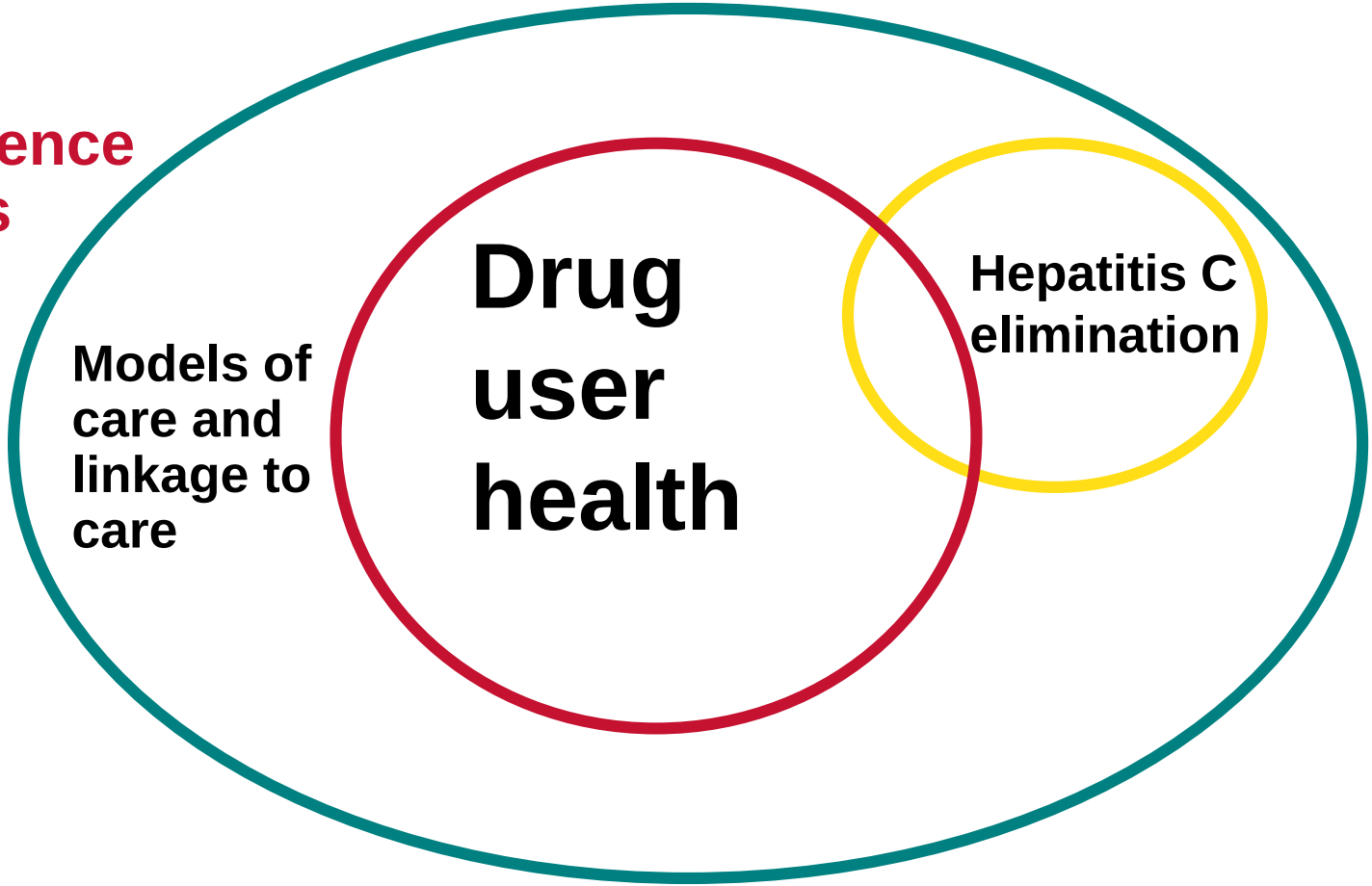
Pre-conference Associated Events

- INHSU 2019 Community Day.
- INHSU International Prisons Hepatitis Network (INHSU Prisons) Inaugural Annual Workshop.
- Project ECHO Workshop: A Comprehensive Introduction to the ECHO Model.

Conference themes



Conference themes



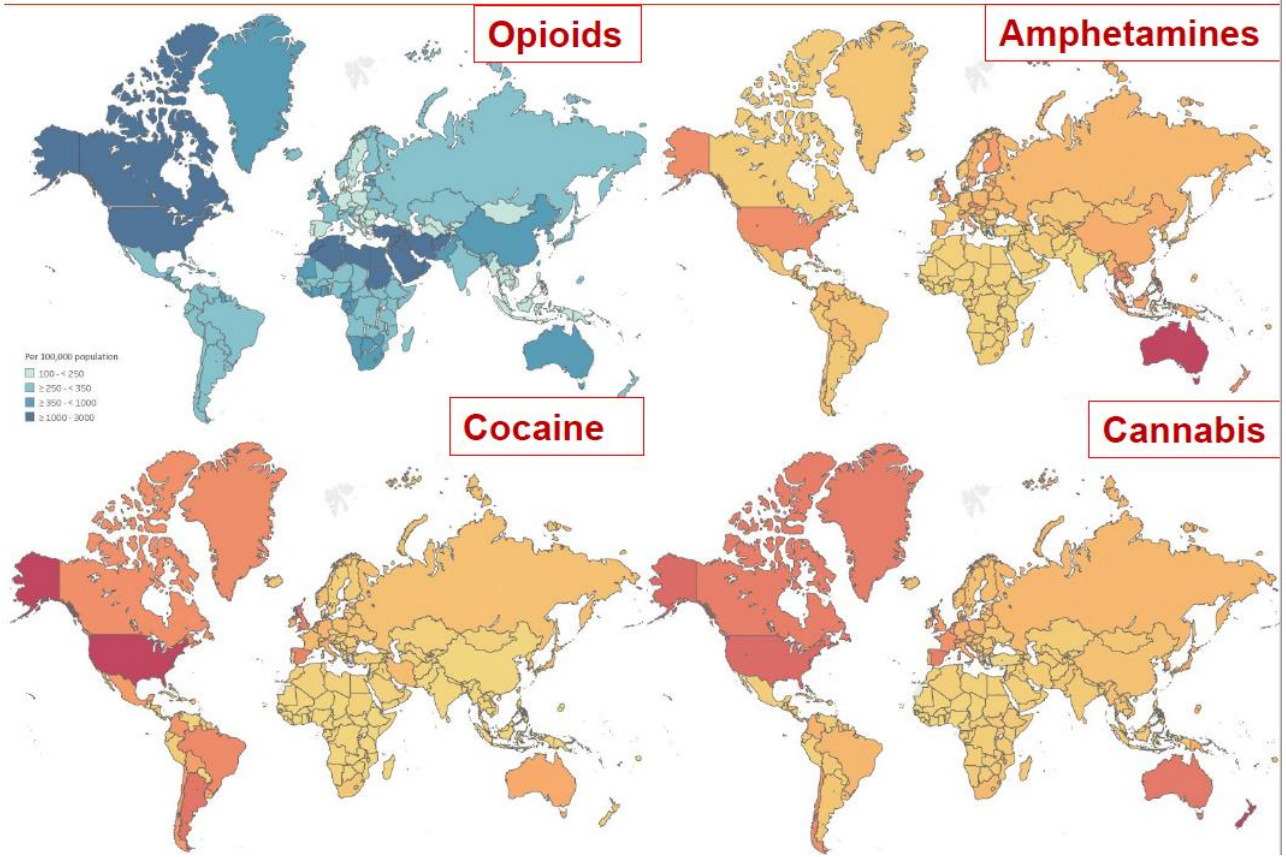
Drug user health

- Considers holistic health of people who use drugs: physical, mental, emotional, spiritual.
- Works to support people who use drugs to achieve the highest health/ wellness possible.
- Hepatitis C is part of that picture, but not the only part, and may not be a priority.

Hepatitis C elimination

- Considers how to achieve World Health Organization elimination targets by 2030, including 90% reduction in new infections, 65% reduction in mortality, needle and syringe distribution targets.
- May consider highly simplified approaches that reach the maximum number of people in the most cost-effective way.

Prevalence of drug dependence (GBD 2017)



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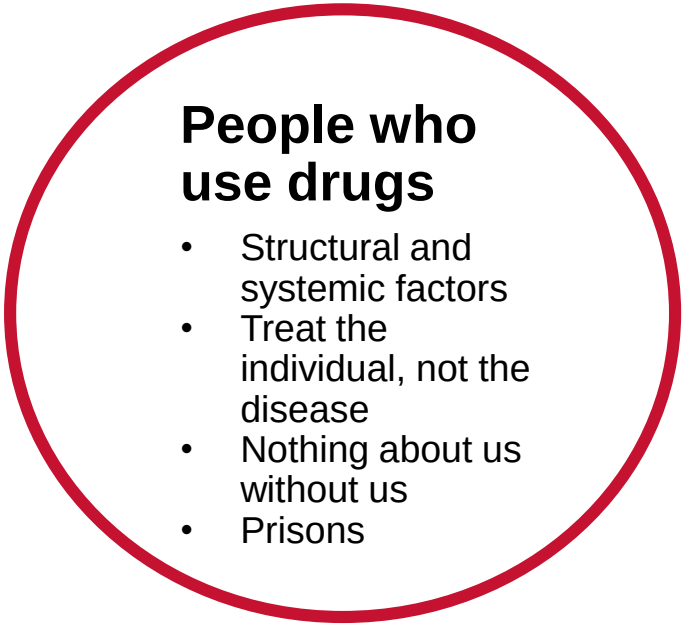
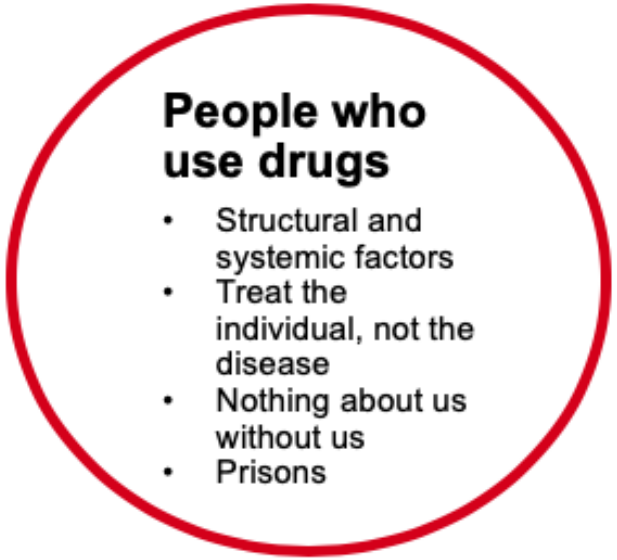
Demographics of people who inject drugs

	Globally	Canada
Women	21%	30-35%
Unstable housing	22%	30-55%
Ever incarcerated	58%	70-80%
Under 25 years	28%	15-20%

Conference themes



Structural and systemic factors



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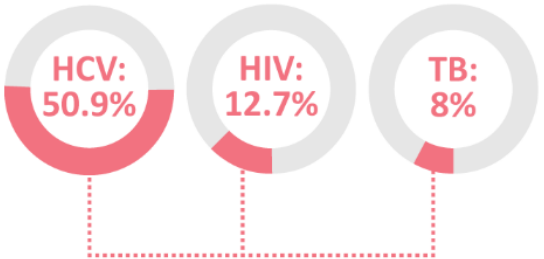
A public health crisis



The global prevalence of HIV, HCV and tuberculosis among people who inject drugs has remained relatively unchanged between 2011 and 2017.

(The percentage for TB corresponds to the 2011-2016 period)

585,000

drug-related deaths in 2017

more than
one preventable
DEATH
every minute

IDPC Shadow Report, 2018, data revised based on 2019 World Drug Report

Marie Nougier, International Drug Policy Consortium

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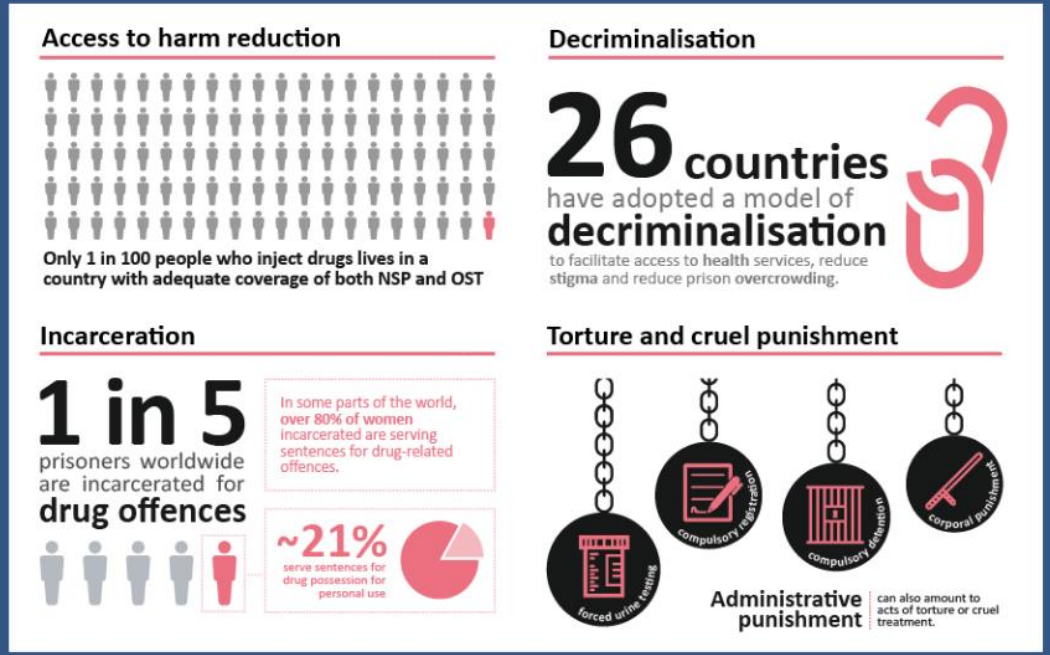


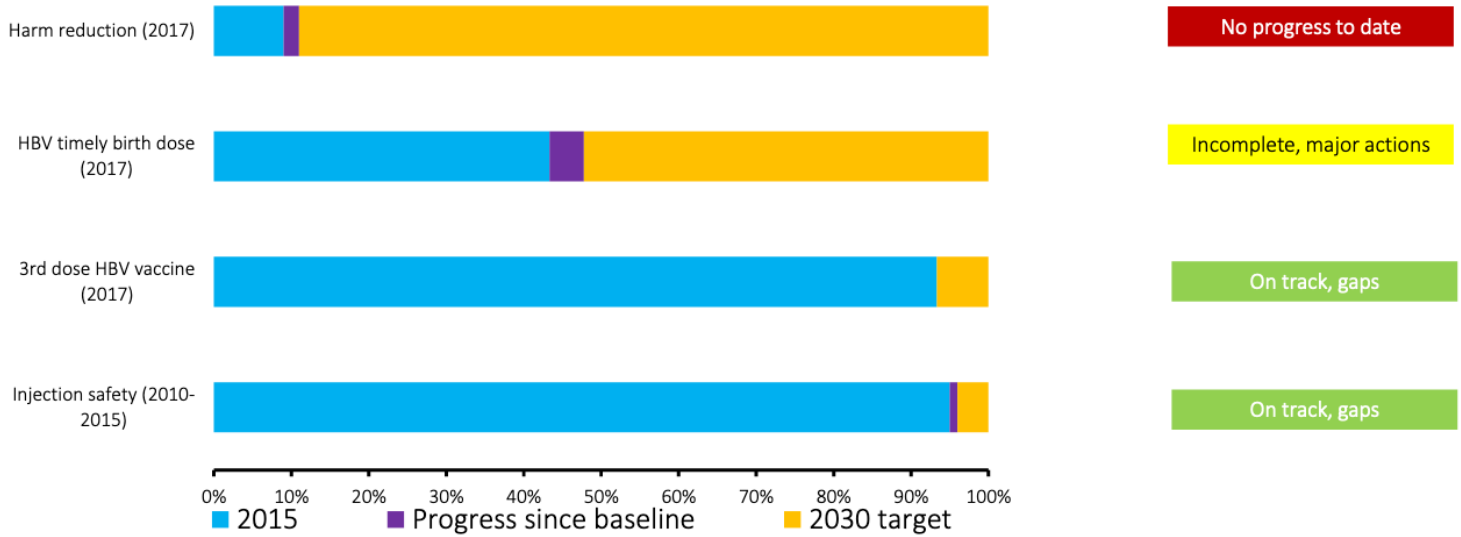
IDPC Shadow Report, 2018, data revised based on 'What have we learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters', 2018

Where are we now?

World Health Organization

- Coverage of interventions as proportion of 2030 target at baseline

Source: WHO / UNICEF, Demographic and Health Surveys, and Lancet publication



No progress to date	Incomplete, minor actions taken	Incomplete, but major actions	On track, gaps	On track, only minor gaps

Niklas Luhman, WHO Geneva

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STRUCTURAL VIOLENCE

"Structural violence is one way of describing social arrangements that put individuals and populations in harm's way.... The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people."

PIH co-founder Paul Farmer
Pathologies of Power

Beyond Hepatitis C: Improving the health and lives of people who use drugs

Dr. Mark Tyndall, University of British Columbia

Structural and systemic factors

What sorts of conditions are people living in, and what are the legal and structural barriers?

- We can’t talk about hepatitis C without considering poverty, criminalization, overdose, stigma etc.
- Interview participant: “Let’s face it. Hepatitis is not a priority of people who can’t even afford to feed themselves every day.”

Kari Lancaster, Australia

Stigma and criminalization

- Provider stigma is a real barrier and issue (Lisa R Metsch, USA; Rod Knight, BC).
- Criminalization is the greatest example of institutionalized stigma (Mark Tyndall, BC).
- For decriminalization to have an impact, it needs to work in tandem with policy, education, programs and training (José Queiroz, Portugal).
- Research from Mexico emphasizes that insufficient education and supports to enact decriminalization can inhibit the success of this policy (Natasha Martin, USA).

Safe drug supply programs

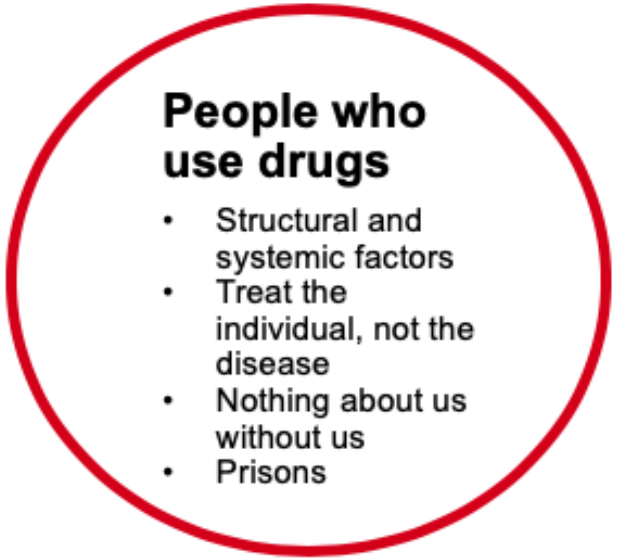
- Criminalization results in an illegal and unregulated drug supply
- Safe drug supply programs exist in Canada that offer heroin and hydromorphone injections for example, but the model is supervised use.
- Low barrier models are necessary: pilot with biometric dispending vending machines

Mark Tyndall, BC

Unstable housing

- People who inject drugs have high rates of unstable housing (Emmanuel Fortier, QC).
- Unstable housing is associated with initiating injection drug use, relapse, sharing injection equipment, public injecting, and hepatitis C infection (Emmanuel Fortier, QC).
    - Less likely to: stop injecting and access treatment for hepatitis C, HIV, or addiction.
    - Housing first programs for people who use drugs have promise.
- Homelessness is a barrier to accessing hepatitis C treatment and requires additional interventions (Norah Palmateer, Scotland).

Treat the individual not the disease



Session I: Moving from clinical trials to the real-world

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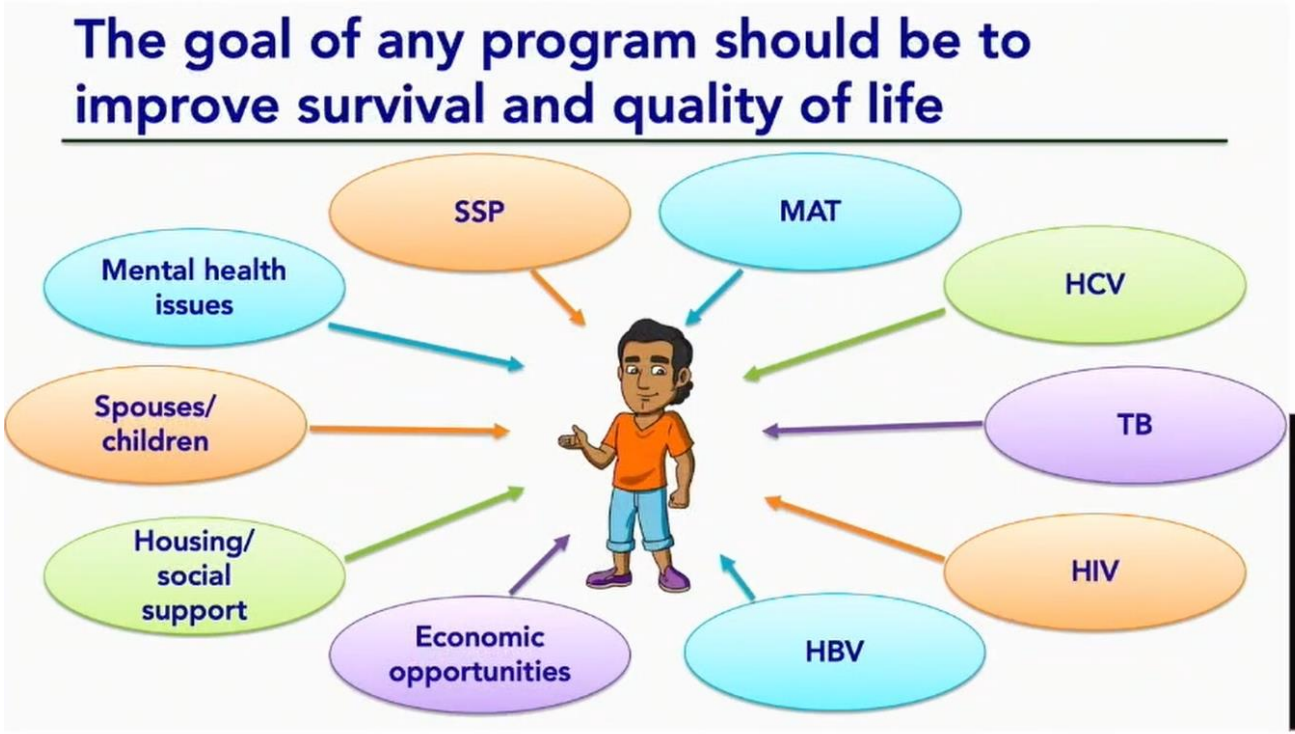
Overcoming barriers to integrating hepatitis C testing, linkage to care and treatment into existing services: success stories from low and middle income countries

Sunil Solomon, *Johns Hopkins University, United States*



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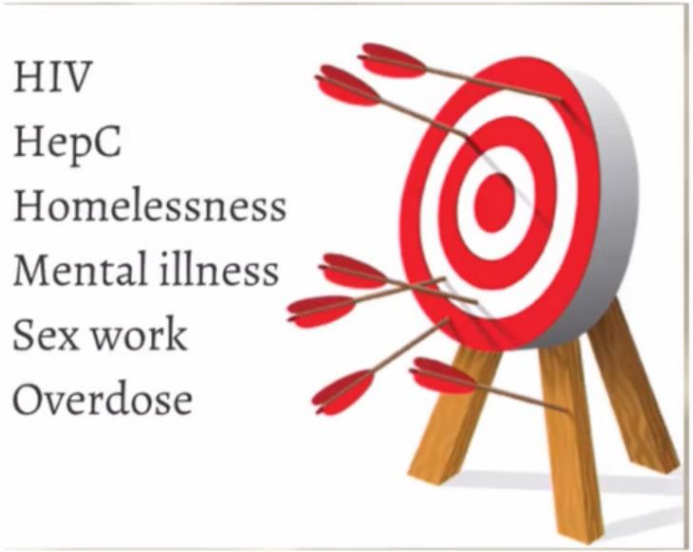
MISSING THE MARK



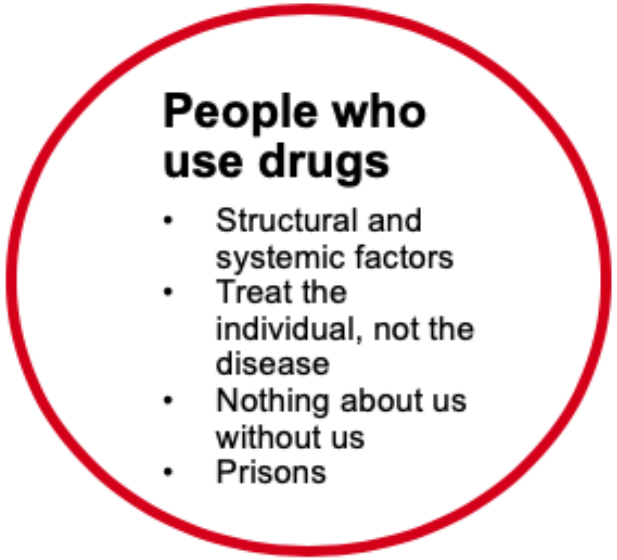
Beyond Hepatitis C: Improving the health and lives of people who use drugs

Dr. Mark Tyndall, University of British Columbia

Women and harm reduction

- Women who inject drugs can experience additional stigma and barriers (Gladys Nqwei, Kenya).
- Programs that support women who use drugs include reproductive health, family planning, gender-based violence.
- Opportunities: female peer educators (Gladys Nqwei, Kenya), support groups for women (Médecins du Monde), networks for women who use drugs (Vielta Parkhomenko, Ukraine).
- Sheway, BC: provides health and social services to women who use drugs to support them with pregnancy and postpartum (Janine Hardial).

Nothing about us without us



Nothing about us without us

- People with lived experience should be involved in designing public health strategies, programs, services.
- Meaningfully include people with lived experience from the very beginning, for example through patient advisory boards, peer workers (Jennifer Broad, ON).
- Listen to people who use drugs and to their priorities: often the priorities relate to structural violence, such as prohibition, police brutality, homelessness, justice, poverty, colonization.

Hiring people with lived experience

- People with lived experience can engage with peers in a unique way: trust, community buy-in, existing relationships.
- Many structural barriers exist for people with lived experience to be hired in hepatitis C programs. There is also concern of creating an underclass of cheap workers who are paid significantly less than clinical workers.
- Suggestions (Jennifer Broad, ON):
  - See every client as a potential worker
  - Prioritize capacity building of clients at each stage
  - Capacity building can take time – make time for it
  - Treat them as equal to all other staff

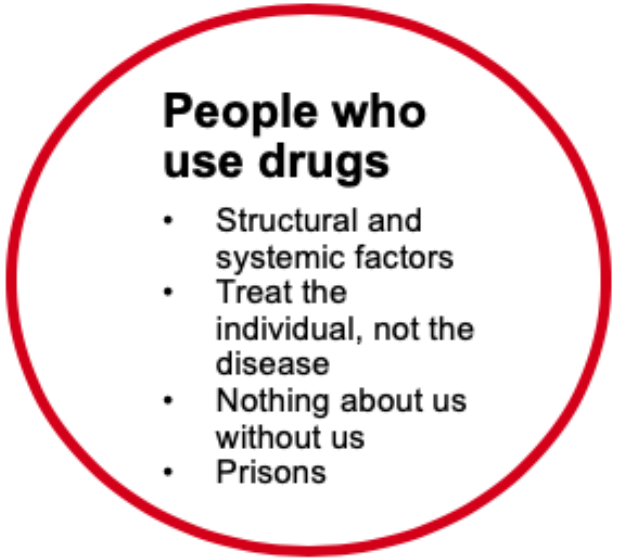
Workshop led by Jennifer Broad, ON and June Byrne, Australia

Roles for people with lived experience

Task-shifting:

- Peer outreach workers trained and recruited people within and beyond their personal networks for a research project on hepatitis C testing. Suggestion to expand this role to include system navigation and accompaniment to appointments (Jennifer Broad, Ontario).
- Harm Reduction Victoria is a state-based drug user organization. They focus on prevention work and have recently started an outreach peer-navigation program to support hepatitis C treatment (Sione Crawford, Australia).

Prisons


People who use drugs
• Structural and systemic factors
• Treat the individual, not the disease
• Nothing about us without us
• Prisons

The war on drugs

- Criminalizing people who use drugs is a huge barrier to everything that we do (Mark Tyndall, BC).
- Incarceration and post-release: interruptions in medical treatment and care, overdose, homelessness, inadequate economic resources, poor social support, and integration into the community (Andreea Adelina Artenie, Quebec).
- Estimated 25% prevalence of hepatitis C in prisons in Canada (Nadine Kronfli, Quebec).

Session K: Hepatitis C risk and prevention

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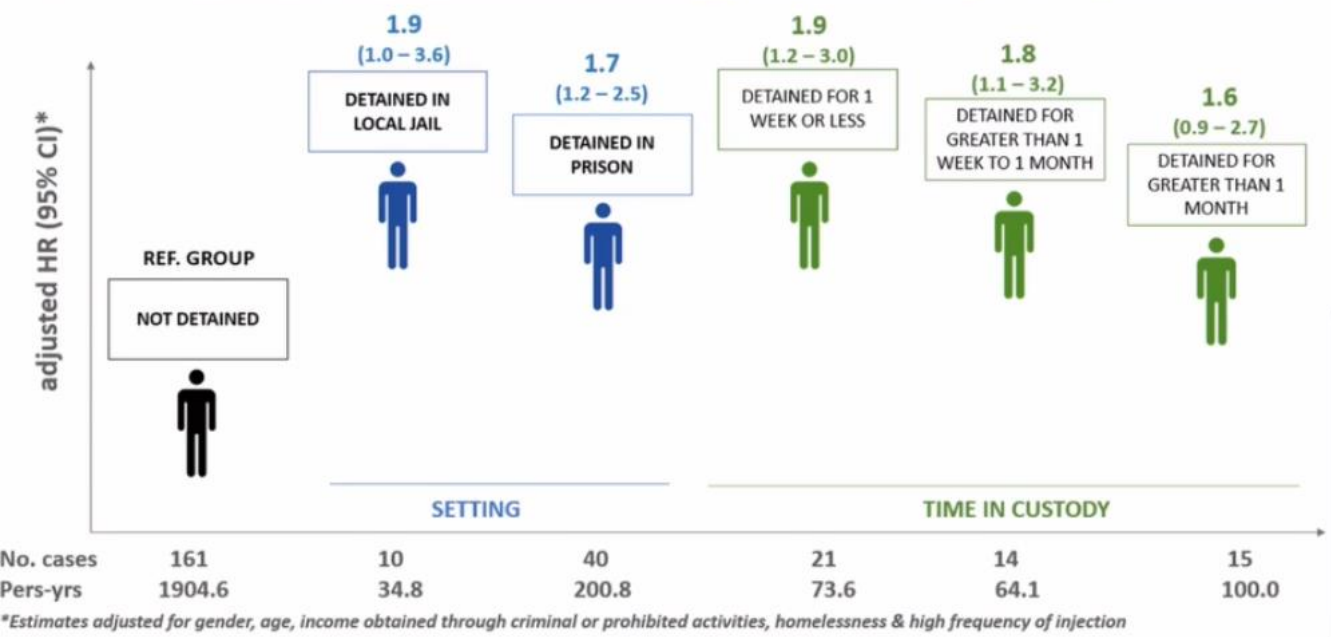
Associations between patterns of detention and risk of HCV infection among people who inject drugs



*Estimates adjusted for gender, age, income obtained through criminal or prohibited activities, homelessness & high frequency of injection

DIVERSITY OF DETENTION PATTERNS AMONG PEOPLE WHO INJECT DRUGS AND THE ASSOCIATED RISK WITH INCIDENT HEPATITIS C VIRUS (HCV) INFECTION: IMPLICATIONS FOR HCV PREVENTION

Andreea Adelina Artenie, PhD Candidate, University Of Montreal

Release from prison

- People are “set up to fail”: released to homelessness, poverty-related stresses, past housing records.
- Involuntary drug exposure when released into the same environment that they went to prison from.
- Maintaining opioid agonist therapy post-release was not straight-forward.
- Over time, participants learned to expect a potential return to custody.

Sophia Schroeder, Australia

Prisons in Canada

- Federal prisons: opt-out screening for hepatitis C results in high screening, treatment is provided (Nadine Kronfli, Quebec).
- Provincial prisons: survey of 16 prisons in Quebec found variable testing policies including on-demand, risk-based or opt-in (Nadine Kronfli, Quebec).
    - Shorter stay, movement between prisons.
    - May be opportunity for linkage planning for release (Arnaud Godin, QC).

Prisons and harm reduction

- Lack of harm reduction in prisons results in new infections and re-infections.
- Access to opioid agonist therapy was variable. It was often easier to continue therapy than to initiate therapy (Nadine Kronfli, Quebec).
- In Australia, hepatitis C treatment is integrated into prisons but there is no needle and syringe program.
    - Minimum change in injecting culture post-treatment scale up because no structural or policy changes exist beyond hepatitis C treatment (Lise Lafferty, Australia).

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What next for the coming decade?
Community mobilisation & solidarity

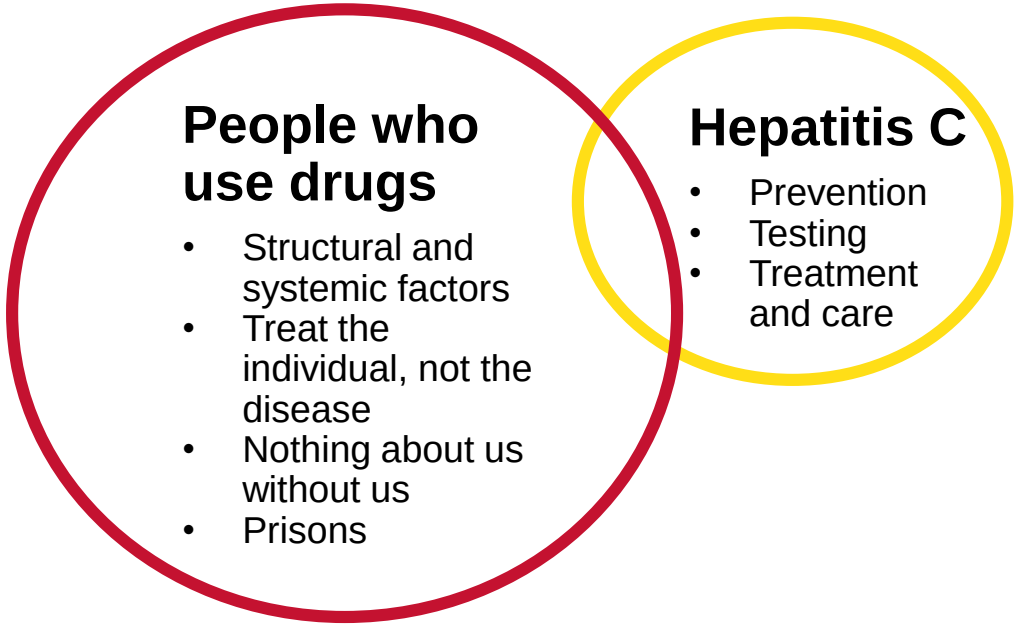
DECLARATION OF THE HEPATITIS COMMUNITY

NO ELIMINATION WITHOUT DECRIMINALIZATION!

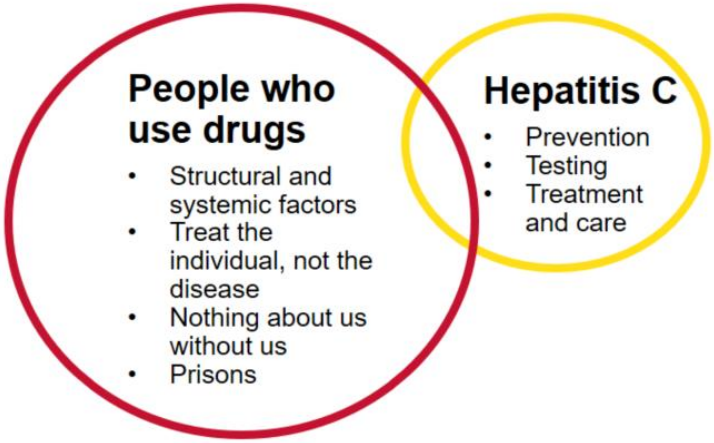
We, members and representatives of the viral hepatitis community—a community that includes people living with viral hepatitis, doctors, nurses, social workers, researchers, public health experts, and people who use drugs—are concerned over the growing gap between the enormous impact of hepatitis B and hepatitis C over people who use drugs and their almost non-existent access to prevention, diagnosis and treatment services around the world.

Marie Nougier, International Drug Policy Consortium

Conference themes



Hepatitis C prevention



Session F: Prevention of Hepatitis C

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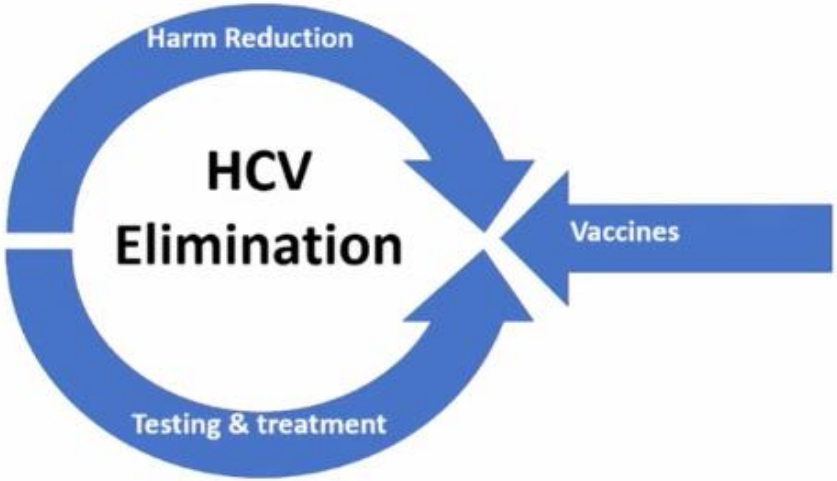
Take Home Message



What does the future hold for a hepatitis C vaccine?

Dr. Naglaa Shoukry,
Université de Montréal

CRCHUM
CENTRE DE RECHERCHE

Session F: Prevention of Hepatitis C

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Hepatitis C reinfection among people who inject drugs: Should we worry?

Dr Håvard Midgard, MD PhD,
Oslo University Hospital

Cochrane Library

Cochrane Database of Systematic Reviews

Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs (Review)

- **High-coverage needle and syringe provision (NSP)** (5 studies)
  - 76% risk reduction in Europe
- **Opioid agonist treatment (OAT)** (12 studies)
  - 49% risk reduction
- **Combined OAT and high-coverage NSP** (3 studies)
  - 74% risk reduction

Platt et al. Cochrane Database Syst Rev 2017

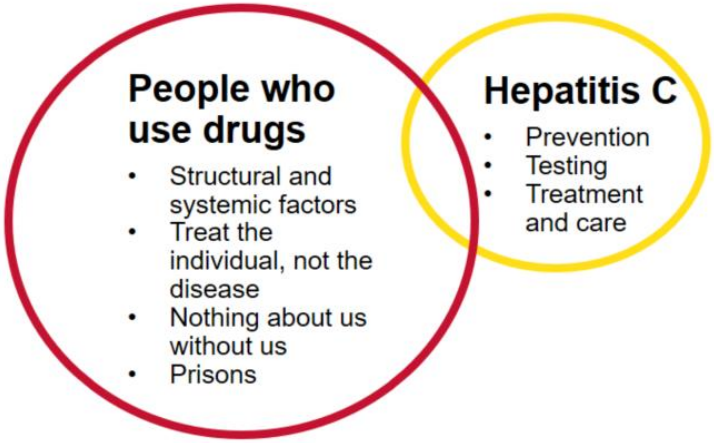
Opioid agonist therapy (OAT)

- OAT can significantly reduce drug-related harms, although poor retention in care and interruptions due to incarceration are challenges (Jack Stone, UK).
- People need appropriately high doses of OAT to maintain treatment and experience benefits of OAT. Many people are prescribed doses below the minimum considered necessary for a clinical benefit (Sarah Larney, Australia).

Preventing hepatitis C re-infection

- Hepatitis C re-infection has not increased (Havard Midgard, Norway):
  - Fewer hepatitis C infections = re-infection will also reduce.
  - Re-infection should be acknowledged without stigma.
  - Access to treatment for re-infection is essential.
- Hepatitis C re-infection is rare among people engaged in integrated or multidisciplinary care that addresses medical, addiction, social and psychological health (Brian Conway, BC; Claudia Bernardini, Switzerland).

Hepatitis C testing



Expanding testing efforts

- We need to increase testing in order to achieve elimination:
  - Modelling for Australia suggests is it necessary to scale up testing efforts by 50% (Nick Scott, Australia).
- Specialized pathways for testing and treating people who use drugs can be more effective:
  - More cost effective and even cost-saving.
  - Promising settings: harm reduction services, prisons, drug treatment centres, community pharmacies.
  - People with lived experience can play an important role.

Testing for hepatitis C

1. 

The **antibody test** checks whether you have ever had a hepatitis C infection.

2. 

The **RNA/ confirmatory test** confirms if you currently have a hepatitis C infection.

Session Q: Strategies to enhance testing and diagnosis

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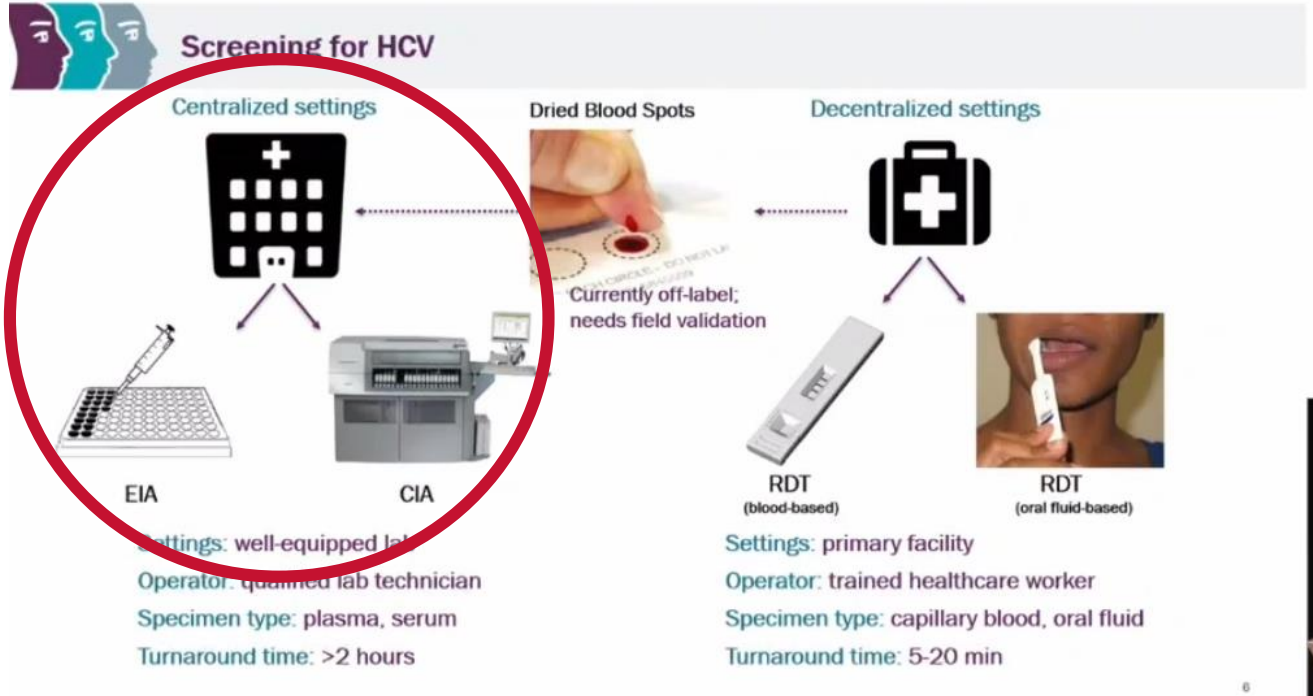

Ms Sonjelle Shilton
Deputy Head Hcv Access
Foundation For Innovative
New Diagnostics (find)

Session Q: Strategies to enhance testing and diagnosis

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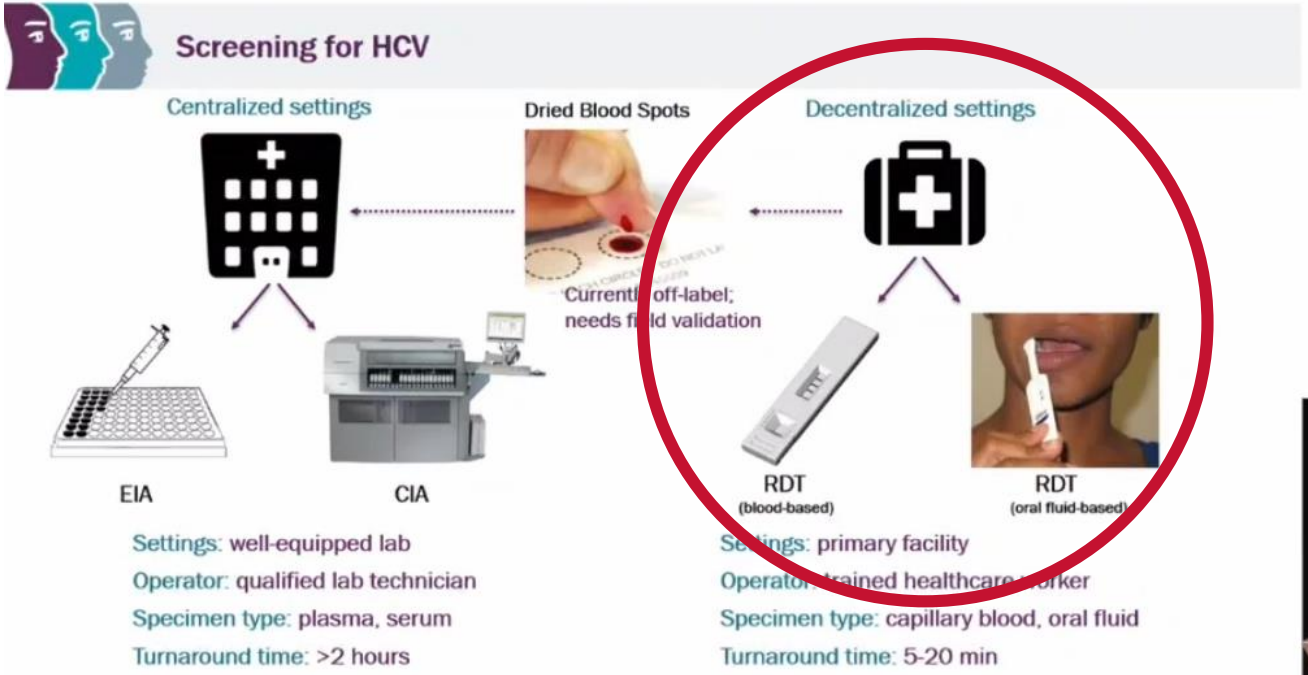

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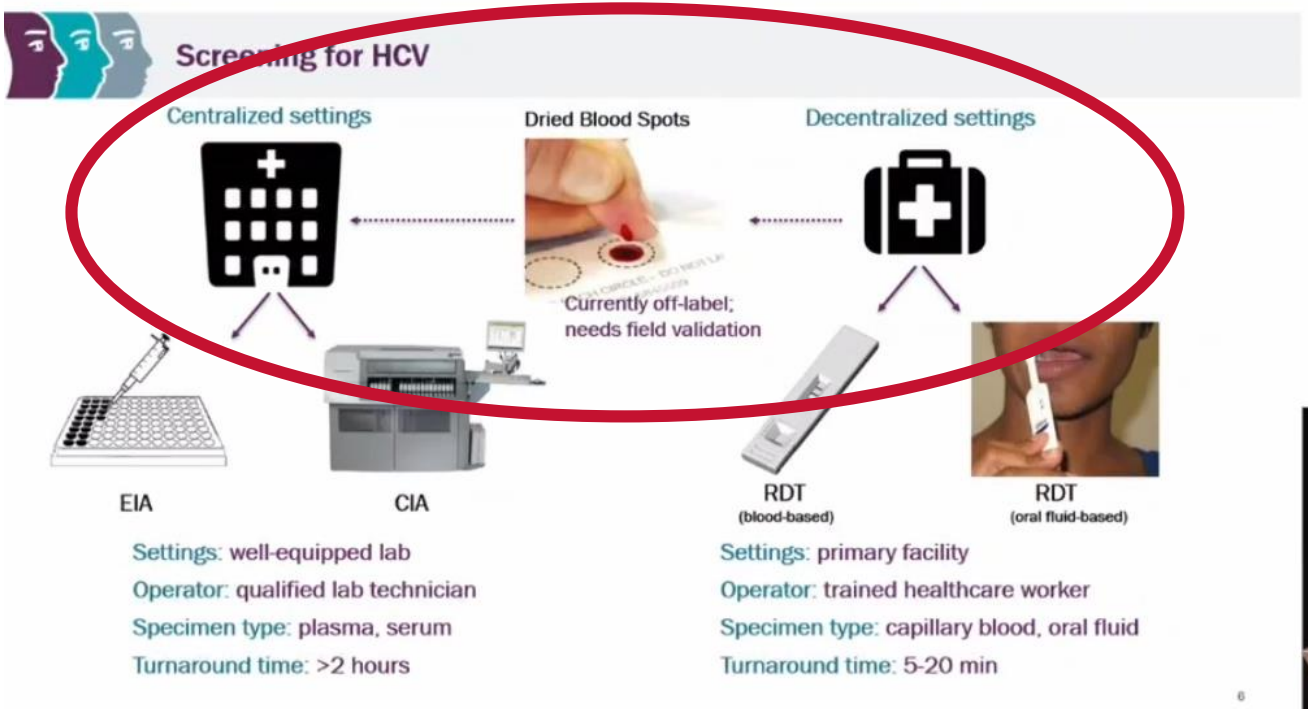


TITLE

Ms Sonjelle Shilton
Deputy Head HCV Access
Foundation For Innovative New Diagnostics (FIND)

Testing technologies

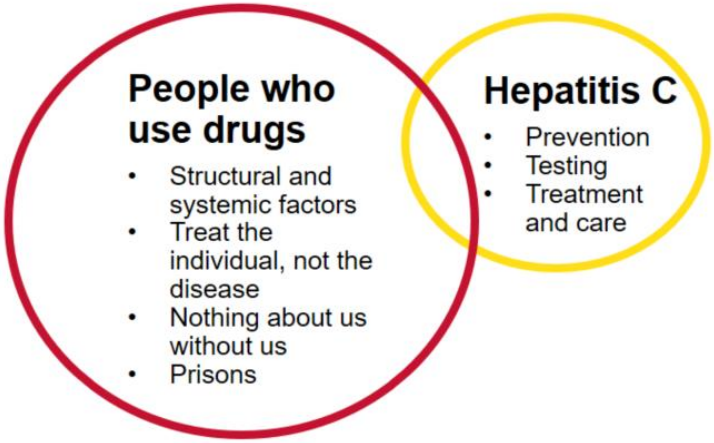
- Point of care tests are an opportunity to scale-up testing by providing immediate test results, but they need to be very quick otherwise people may not stay to get the results.
- Research suggests that existing point of care tests may be able to provider RNA+ test results more quickly than current guidelines/processes (Aaron Vanderhoff, Canada; Jason Grebely, Australia).

Testing technologies

- Early research on self-testing suggests potential acceptability among people who inject drugs, though concerns about linkage to care exist.
- Early research on combination testing to combine multiple infections in one point of care test, such as HIV, hepatitis C and hepatitis B.

Sonjelle Shilton, Switzerland

Hepatitis C treatment and care



Hepatitis C treatment and care

- Cure rates are very high regardless of drug use, mental health disorders, or alcohol use disorder (Stefan Christensen, Germany).
- Stimulant use does not increase treatment discontinuation in comparison to opioid use (Sigurdur Olafssen, Iceland).

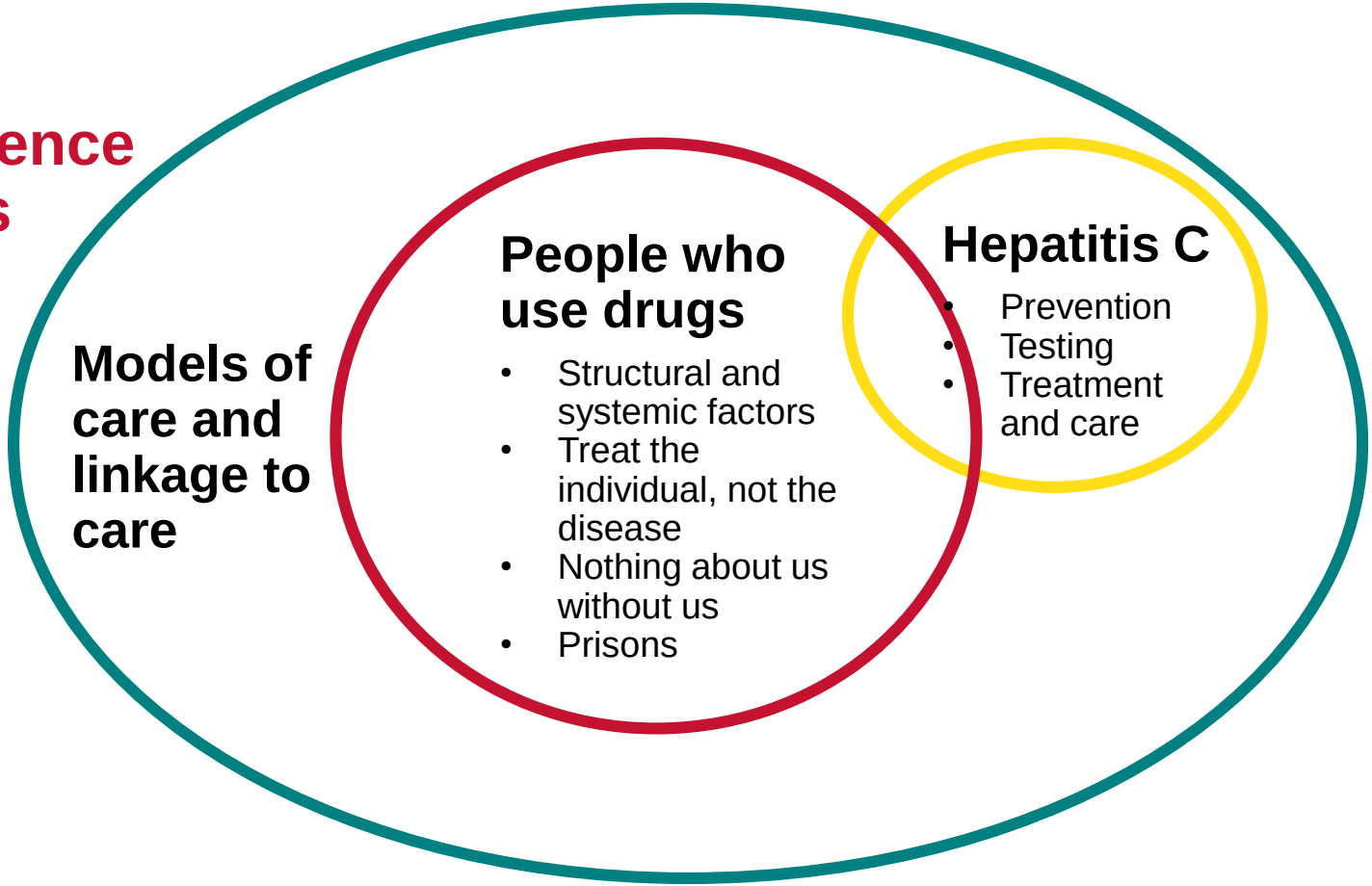
Dispensing method and adherence

- Daily versus weekly treatment dispending was not associated with higher treatment completion (John Koo, Canada) or higher treatment adherence (Phillip Read, Australia).
- Adherence overall was high (85%), but varied, and most people missed some doses (Phillip Read, Australia).
  - If increased the length of treatment beyond 8 or 12 weeks, adherence increased to 95%.
  - Of those tested, 96% were cured.

Scaling up treatment

- Addictions doctors who prescribe opioid agonist therapy are well positioned to receive training and offer hepatitis C treatment (Alison Marshall, Australia).
- Educational models to increase healthcare provider capacity to provide hepatitis C treatment, including to general practitioners:
  - ASHM/INHSU model: blended online and in-person program (Nikitah Habraken, Australia).
  - Project ECHO: online interactive and case-based learning model (Karla Thornton, United States).

Conference themes



Models of care – definition

A model of care (MoC) signifies a setting-specific framework that outlines how to provide the relevant services and interventions throughout the HCV cascade of care.

An MoC should address four key questions:

1. *where* to provide the services
2. *what* services to provide
3. *who* to provide them and
4. *how* to integrate them.

Source: Lazarus JV et al. We know DAAs work, so now what? Simplifying models of care to enhance the hepatitis C cascade. *J Int Med* 2019 In press.

Slide used with permission from Jeffrey Lazarus, INHSU 2019 Conference, Montreal, 2019.

Models of care and linkage to care

- Hepatitis C is one health care need and should be used as a route to other services and care.
- Models of care are specific to the location/context/ limitations.
- Location: keep it local, use the space you can get, bring it with you, and integrate with existing services.
- Simplify the care path for clients, including simplifying testing, fibrosis assessment, and genotyping.
- Train existing teams (de-doctor models) and co-design models with people with lived experience.

John Dillon, Models of Care Rapporteur, Scotland

Mobile clinics – meeting people where they are

- Mobile low threshold methadone program, Portugal: provides hepatitis C screening, assessment, and treatment dispensing in van, also offers other healthcare services and distributes needles/syringes, condoms, tinfoil (Claudia Pereira).
- The Kombi Clinic, Australia: mobile van for hepatitis C treatment with two doctors, one nurse, one phlebotomist. Prescription received in two visits, about one month apart (Mary O'Flynn).
- Mobile screening van, Spain: screen marginalized communities through van by rapid test and DBS, if HCV positive, referred to hospital on the same day with transportation to hospital and accompaniment (Jorge Valencia).

Co-locate/integration hepatitis C – one-stop shop

- ANCHOR Model, USA: partnership with harm reduction and drop-in centre to offer hepatitis C service resulted in providing culturally competent, low barrier care, provider continuity, and access to community support workers (Rachel Silk).
- Treatment in needle and syringe programs, Georgia: hepatitis C treatment services in needle and syringe programs using a testing and monitoring algorithm and online interactive education (Project ECHO) to train healthcare providers. Clients experienced less stigma, fear, more confident in confidentiality (George Kamkamidze).

Nurse-led models

- Cool Aid Foundation, Victoria, BC: Nurse-led model used a seek and treat model to run a micro-elimination project 13 supportive housing sites through providing treatment where people live, working with housing staff and peers (Karen Lundgren & Kellie Guarasci).
- Ahtahkakoop Health Clinic: hepatitis C screening, treatment and case management in a nurse-led multidisciplinary team offering a community delivered and client-centred model. Additional components: liver health events, harm reduction programs, peers, bring a friend testing (Noreen Reed).

Peer-supported models

- Toronto Community Hepatitis C Program, ON: critical role of people with lived experience co-designing the hepatitis C program, including through peer community support workers and peer advisory board (Jennifer Broad).
- Kirketon Road Centre, Australia: partnership with peer-based needle/syringe program to deliver hepatitis C treatment. Nurses do work-up, offer wound care, pills dispensed weekly and daily (John Lockwood).

Models of care – decolonizing hepatitis C programs

- Colonialism is for a risk factor for hepatitis C and a target of the hepatitis C intervention.
- ‘Wellness’ is a more integrated and wholistic concept than ‘health’.
- Two-Eyed Seeing.
- Trauma-informed care becomes very important, situated between Indigenous healing and mainstream hepatitis C care.

Alexandra King and Renee Masching, Canada

RESEARCH ARTICLE

In the eyes of Indigenous people in Canada: exposing the underlying colonial etiology of hepatitis C and the imperative for trauma-informed care

Sadeem T Fayed MPH(c)[1], Alexandra King MD, FRCPC[2], Malcolm King PhD, FCAHS[2], Chris Macklin MPH(c)[1], Jessica Demeria[3], Norma Rabbitskin BN, RN[4], Bonnie Healy RN[5], Stewart Gonzales (Sempulyan) BSW[6]

ABSTRACT

BACKGROUND: The distribution of hepatitis C (HCV) infection in Canada signals a widening gap between Indigenous and non-Indigenous people. Current evidence demonstrates that the rate of HCV infection among Indigenous people is at least five times higher than the rest of Canada. This analysis provides a reconciliatory response, which exposes the colonial etiology of the HCV gap in Canada and proposes potential anti-colonial approaches to HCV wellness and health care for Indigenous people. **Methods:** This analysis applies Two-Eyed Seeing as a reconciliatory methodology to advance the understanding of HCV burden and identify the key elements of responsive HCV care in the context of Indigenous nations in Canada. **Results:** The analysis underlines the colonial distribution of HCV burden in Canada, highlights Indigenous perspectives on HCV infection, hypothesizes a clinical pathway for the underlying colonial etiology of HCV infection, and identifies Indigenous healing as a promising anti-colonial conceptual approach to HCV wellness and health care among Indigenous people. **Conclusions:** In the eyes of Indigenous people, HCV infection is a colonial illness that entails healing as an anti-colonial approach to achieving wellness and gaining health. Future empirical research should elaborate on the colonial HCV pathway hypothesis and inform the development of a framework for HCV healing among Indigenous people in Canada.

KEYWORDS: colonialism; First Nations; healing; hepatitis C; historic trauma; Indigenous; Inuit; Métis; trauma-informed care; Two-Eyed Seeing; wellness

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Models of care – decolonizing hepatitis C programs

- Onentokon Healing Lodge and the Centre hospitalier de l'Université de Montréal (CHUM), Quebec: Onentokon provides cross-cultural training for CHUM, CHUM provides training on harm reduction, OAT, hepatitis C, naloxone (Arlette Ven Den Hende and Stéphanie Marsan).
- Indigenous research practice methodology: key elements include oneness, ancient wisdom, creating a safe space, honoring our stories, bringing in the elements (Elder Sharon Jinkerson Brass and Sadeem Fayed).

Session D: Ways to improve HCV testing, treatment and care

INHSU 2019

Sequential Sharing Circle

As a qualitative research tool, sequential sharing circles allow researchers to build rapport with the participants. Each sharing circle was co-led by the Elder, community research associates, and academic research associates

Portrait of Me

Portrait of Me is a self-assessment tool used to measure the effect of cultural interventions. Originally developed by Sturgeon Lake First Nation.

Land Based Healing

Indigenous peoples use land based activities and ceremonies for reviving and promoting physical, mental, emotional and spiritual wellness.

MWSSD

The Medicine Wheel Spirit Shadow Dance (MWSSD) is a strengths-based approach for participants to better understand and explore their substance use.

A TWO-EYED SEEING APPROACH TO WHOLISTIC HEALING AND WELLNESS FOR PEOPLE WITH DRUG USE EXPERIENCE

Mr Matthew Fischer
Community Researcher
Indigenous Wellness Research Group

Drug user health

- Considers holistic health of people who use drugs: physical, mental, emotional, spiritual.
- Works to support people who use drugs to achieve the highest health/ wellness possible.
- Hepatitis C is part of that picture, but not the only part, and may not be a priority.

Hepatitis C elimination

- Considers how to achieve World Health Organization elimination targets by 2030, including 90% reduction in new infections, 65% reduction in mortality, needle and syringe distribution targets.
- May consider highly simplified approaches that reach the maximum number of people in the most cost-effective way.

Reflections for frontline work

Kellie Guarasci

Nurse clinician, Cool Aid Community Health Centre

Kellie Guarasci graduated from the University of Western Ontario and has been a nurse for close to 25 years. She has experience in palliative care, HIV/infectious disease, community case management, extended care and teaching.

Kellie moved to Victoria in 2004 and left the workforce for a number of years to stay home and raise her three children. She returned to the nursing profession as an instructor at Camosun college but had her sights set on working with the downtown population in Victoria. Kellie joined the nursing team at the Cool Aid health center 3 and a half years ago and loves the social justice aspect of her work and also the intersection of mental health, addictions and infectious disease.

Kellie Guarasci

Nurse clinician, Cool Aid Community Health Centre

1. What are your general reflections of the conference content for frontline work?

2. What can Canada learn from other countries and where is Canada leading the conversation in hepatitis C and drug user health?

3. What were key takeaways from a clinical care/nursing perspective?

Carrielynn Lund

DRUM & SASH/CanHepC Coordinator, Canadian Aboriginal AIDS Network

Carrie is a Métis consultant whose primary focus is on assisting Aboriginal communities to identify and address health and social issues that have a negative impact on children and their families. She has done extensive work in the area of heath research, particularly with Aboriginal youth and resilience and research ethics, much of which is focused on Aboriginal protocols around community ethical guidelines, intellectual property rights, ownership of data and knowledge translation.

Her work includes extensive committee work, for example on the Canadian Institute of Health Research Ethics Standing Committee, and coordinating community-based research and capacity building with Aboriginal communities and organizations. She has been working with CAAN since 2012 and is the DRUM & SASH project and CanHepC Coordinator.

Carrielynn Lund

DRUM & SASH/CanHepC Coordinator, Canadian Aboriginal AIDS Network

1. What are your general reflections of the conference content for frontline work?

2. What can Canada learn from other countries and where is Canada leading the conversation in hepatitis C and drug user health?

3. What were key takeaways related to Indigenous hepatitis C or harm reduction programming?

Alexe Morgan

Harm Reduction Project Coordinator, AIDS Committee of Newfoundland and Labrador

Alexe is a registered social worker with the AIDS Committee of Newfoundland and Labrador. Alexe has been working within the ACNL organization for over two years, starting off her career as a counsellor in the Tommy Sexton Centre Emergency Shelter. In September of 2018, Alexe started her position as Project Coordinator on the Harm Reduction Education Project with the ACNL.

The Harm Reduction Education Project supports ACNL's prevention initiatives, which aim to reduce HIV and HCV risks related to people who use drugs. In addition to this, Alexe is involved with the Safe Works Access Program (needle exchange), a lead kit contact with the Naloxone Take Home Kit program, and conducts Harm Reduction and Safe Works Access Program education in the province.

Alexe Morgan

Harm Reduction Project Coordinator, AIDS Committee of Newfoundland and Labrador

1. What are your general reflections of the conference content for frontline work?

2. What can Canada learn from other countries and where is Canada leading the conversation in hepatitis C and drug user health?

3. What were key takeaways from a social work perspective, and as someone working across a province with rural and remote communities?

Questions?

Please type your question or comment into the chat box.

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NEXT STOP GLASGOW

Thank You

PRESENTED BY

Chris Hoy, CATIE

Rivka Kushner, CATIE

Kellie Guarasci, Cool Aid

Carrielynn Lund, CAAN

Alexe Morgan, ACNL

October 21, 2019

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