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The biology of marginalization

FRA REDAKTØREN

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The government must take the initiative for an action plan to eradicate hepatitis C.

Photo: Sturlason

All over the world, homeless people, persons with substance use disorders, prison inmates and sex workers are stigmatised and marginalised. Multiple overlapping risk factors and negative life events help reinforce social exclusion mechanisms, giving rise to extreme levels of morbidity and mortality among these groups even in high-income countries (1). Women are at particular risk. Social exclusion kills.

Hepatitis is one of the biggest problems (2). Intravenous drug users have an especially high risk, and most of the users will be exposed to the infection after only a few years. Homelessness, incarceration and sex work increases the risk of infection. In Norway, HIV is a minor problem among intravenous drug users, but hepatitis C is common. In a study of 327 users of the programme that distributes free syringes in Oslo, one-half suffered from chronic hepatitis C. Three out of four had shared syringes, the same number had been in prison, and one-half of those who had injected drugs while in prison had shared syringes (3). In Norway, approximately 20–30 000 people have been infected with the hepatitis C virus. Of these, 70–80 % develop chronic hepatitis, which may cause cirrhosis, liver failure and hepatocellular carcinoma. An estimated 9 000 persons with experience of drug use live with untreated chronic hepatitis C (4).

Globally, prisons are a hotbed of HIV and hepatitis infection (5). Inmates have poorer health, less access to preventive health services and higher risk of infection than the population in general. In Norway, inmates are permitted to use bleach to clean their drug-use equipment, but have no access to sterile syringes (which provide far better protection against infection) (6). The time of release and reintegration into society is a vulnerable period when the risk of infection is heightened. The risk of overdose and being forced into sex work is also higher (5). We have virtually no knowledge whatsoever on the health condition of sex workers in Norway.

Blood is the main transmission route for hepatitis C (7). Sexual transmission occurs far more rarely, although there have been outbreaks in European cities among men who have sex with men, especially associated with having sex while under the influence of recreational drugs (so-called 'chemsex') (7, 8).

What must be done? Hepatitis C is a complex socio-medical problem that needs to be countered with integrated social and medical interventions. Social housing programmes must be combined with opioid agonist maintenance treatment (OAMT) into new measures, including preventive measures, such as distribution of drug-use equipment. Many small municipalities do not distribute sterile syringes. The number of individual users in these municipalities constitute a large group (9). Only a minority of the municipalities distribute clean filters and cooking utensils, although sharing such user equipment is likely to increase the risk of infection (10).

Prevention and treatment must be seen as one: new direct-effect antiviral drugs for hepatitis C became available in 2014 (7). They have negligible adverse effects, and after taking the pills for 8–12 weeks, virtually all patients will be permanently virus-free. The cost of these drugs has been unreasonably high, but new agreements will enter into effect on 1 February 2018, with lower prices. The hospital trusts, which pay for these drugs, have therefore removed their restrictions on treatment, and patients of all ages and in all stages of the disease can now be treated. Treatment benefits not only the individual concerned, it is also a means of combatting the epidemic: the new drugs offer the hope that hepatitis C may be eradicated (11).

Too little attention has been paid to the negative health effects of criminalising sex work, such as infection with HIV and hepatitis (12). Most likely, efforts to prevent infection in prisons – access to syringes, information campaigns, contact tracing and treatment of hepatitis – are a neglected opportunity. Having poorer access to infection prevention than the general population should not be used as an additional punishment (6). Now that the Storting has signalled a change in its anti-drug policies from punishment to treatment, those who seek help and are at risk of becoming addicted must be provided with help by the health services.

In what other group would we have tolerated a similarly high prevalence of infection? Drug users are especially liable to fall between the cracks in the ever more subspecialised health services. However, could part of the reason be that hepatitis C has been a 'silent epidemic' among intravenous drug users, and has never become a major threat of infection to the general population?

We urgently need coordinated efforts, prepared in consultation with the user organisations. We need to analyse our knowledge gaps on the situation in Norway with regard to infection, thus to steer research. We need to examine structural problems in the access to health services for marginalised groups. Not least, prevention and treatment must be seen as one whole. The government must take the initiative for an action plan to combat hepatitis C without delay. There is no reason for inaction.

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