

BARRIERS TO SEEKING SCREENING AND TREATMENT FOR HCV 20-39-YEAR-OLD PERSONS WHO USE DRUGS IN NEW BRUNSWICK, CANADA

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Background

Substance use among Canadians in their child-bearing years continues to rise resulting in increased incidence rates of hepatitis C (HCV). In 2014, it was estimated that there were 6,579 cases of HCV (29.3 per 100,000), with the main affected group being persons who use drugs (PWUD) due to sharing of contaminated equipment such as needles (Public Health Agency of Canada, 2014). The incidence for HCV reported for New Brunswick in 2017 was 247 cases, with 138 new cases reported amongst women and men from 20 – 39 years of age (Government of New Brunswick, 2017). However, it is estimated that 44% of people infected with HCV do not know their status (Trubnikov et al., 2014), which poses a risk for perinatal vertical transmission of HCV amongst PWUD.

Anecdotal stories suggest there is reluctance and barriers to seek screening and treatment for HCV in New Brunswick; however, there has been no formal exploration of these concerns for PWUD aged 20-39 years.

Objectives

The overarching research question for our study was “How do individuals at high risk for HCV make decisions in seeking access to screening and treatment?” for PWUD 20–39 years old .

The main objectives for this phase of the study were to:

- Understand PWUDs’ knowledge of, and access to, HCV testing;
- Understand PWUDs’ knowledge of, and access to, HCV treatment; and,
- Gain perspectives on the effective engagement of PWUDs with the healthcare system.

Methods

The methodological design for the overarching study was informed by Charmaz’s (2010, 2014) constructivist grounded theory that included 30 interviews with 28 participants. Interviews followed a semi-structured question guide, were recorded, and then transcribed verbatim.

Transcripts were analyzed with line-by-line coding during *Initial Coding* and then thematically sorted to create *Focused Codes*. In this phase of the study, the *Focused Codes* are represented as thematic categories to present the qualitative findings of participant interviews informed by methods for thematic coding described by Braun and Clarke (2006). The next phase of theory development will incorporate a literature search and synthesis of peer-reviewed evidence to round out the theory development on decision-making processes of PWUD in making choices to access screening or seek treatment for HCV.

Inclusion Criteria

Participants were included in the study if they:

- were 20 to 39 years old;
- used substances by injection or snorting; and,
- either had an unknown HCV status since last risk behaviour or were known to be HCV positive but were not engaged in care.

References

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Participant Characteristics

- Number of Participants: 28
- Age: Mean age 30.5 years (Range 20-39 years)
- Place of Residence: Charlotte County (22%), Kings County (14%), and Saint John County (64%)
- Sex: 39% (n = 11) female and 61% (n=17) male
- Drug Use: 78.9% were currently using drugs
- HCV Status: 89.3% **did not** know their HCV status

“To be honest, he almost made me feel shameful to even ask about getting tested...you shouldn’t be made to feel worse about it [asking for screening]” – B, age 37

“You can give it to yourself, just by re-using your own needles... and that’s how I got it because I gave it to myself by re-using my old ones.” – M, age 23

“Every three months welfare gets cut off if you’re homeless because you have no address and then I’ve got to fight for a month to get my meds back again” – S, age 33

Results

Five main themes were identified from this phase of the study. Structural and systemic barriers to screening and treatment were universally cited as major challenges amongst study participants, particularly in regards to accessing healthcare services and having a consistent primary care provider. Stigma and discrimination towards PWUD, particularly from healthcare providers, presented as the second most common barrier to screening and care.

Themes	Sub-themes	Description
Structural & Systemic Barriers	Policies and Mandates	Restricted access to care (e.g. age, need for referral, be “dry”)
	Resources	Availability of primary care and addictions treatment
	Time and Timing	Service hours of operations, wait times and personal schedules
	Fragmentation of Care	Disconnected services = ↓ continuity and consistency in care
Stigmatization	Shame	Blamed or made to feel guilty of HCV status /risk or addictions
	Interactions with Providers	Actions by healthcare providers that influence stigma
	Interactions with Society	Impact of social structures and agencies on stigma
	Hierarchy in Population	Distinctions within the PWUD population (e.g. “othering”)
Personal Factors	Fear and Anxiety of Testing	Concerns of confidentiality and privacy, and potential diagnosis
	Motivation	Not ready for change (impact on life) and effects of medications
	Lack of Connection	Relationship/experience with services, providers and support
	Mental Health	Impact of concurrent mental health challenges
Socioeconomic Barriers	Housing	Impact of housing on access to care (e.g. address for Medicare)
	Social Environments	Influence of social networks on seeking screening and care
	Finances	Ability to afford basic necessities to promote health
	Transportation	Implications for access given geography and location of services
Knowledge Barriers	Perceptions on Risk	Understanding of HCV transmission; confusion with HIV risks
	Availability of Information	Sources of information on HCV and accessibility to PWUDs
	Misunderstanding/Confusion	Assumptions on testing and treatment

Conclusion

Given what is known about addictions and treatment, as well as the psychosocial burden to PWUD and costs of untreated HCV to the healthcare system, it is surprising that many common factors (e.g. stigma and access to services) remain obstacles to seeking screening and treatment for HCV. Programs and infrastructure may be strengthened to more effectively move people of child-bearing age through the cascade of care to decrease the incidence, prevalence, and associated morbidities of HCV for the PWUD population.