



Filtering inequality:  
screening and  
knowledge in  
Senegal's  
topography of  
hepatitis B care



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Who *has* hepatitis B (in Senegal)?

## Find The **Missing** Millions.

“Right now, out of the 325 million people living with viral hepatitis, more than 290 million people are living with hepatitis B or C unaware. That’s 9 in 10 men, women and children who are going on about their lives not knowing they have a cancer-causing virus.”

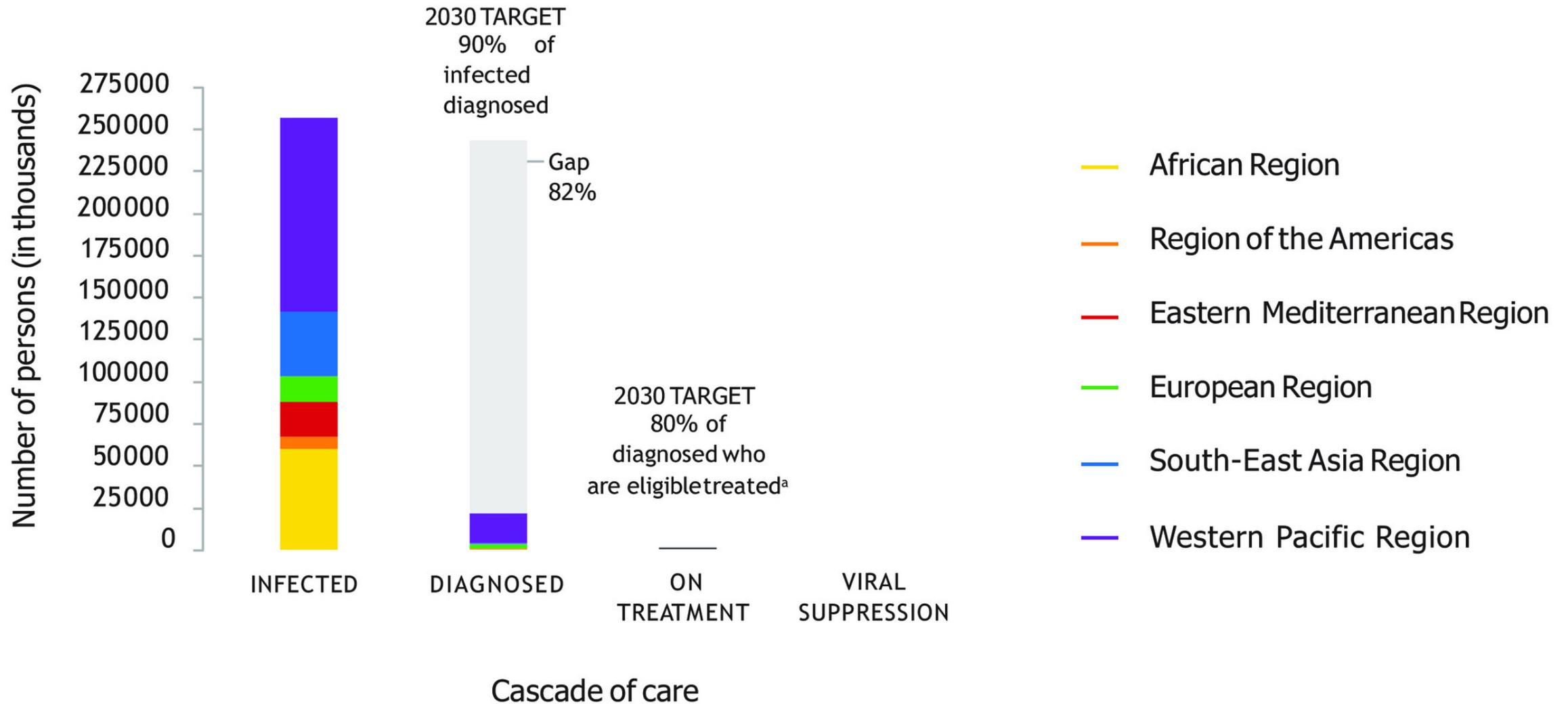
Raquel Peck, World Hepatitis Alliance

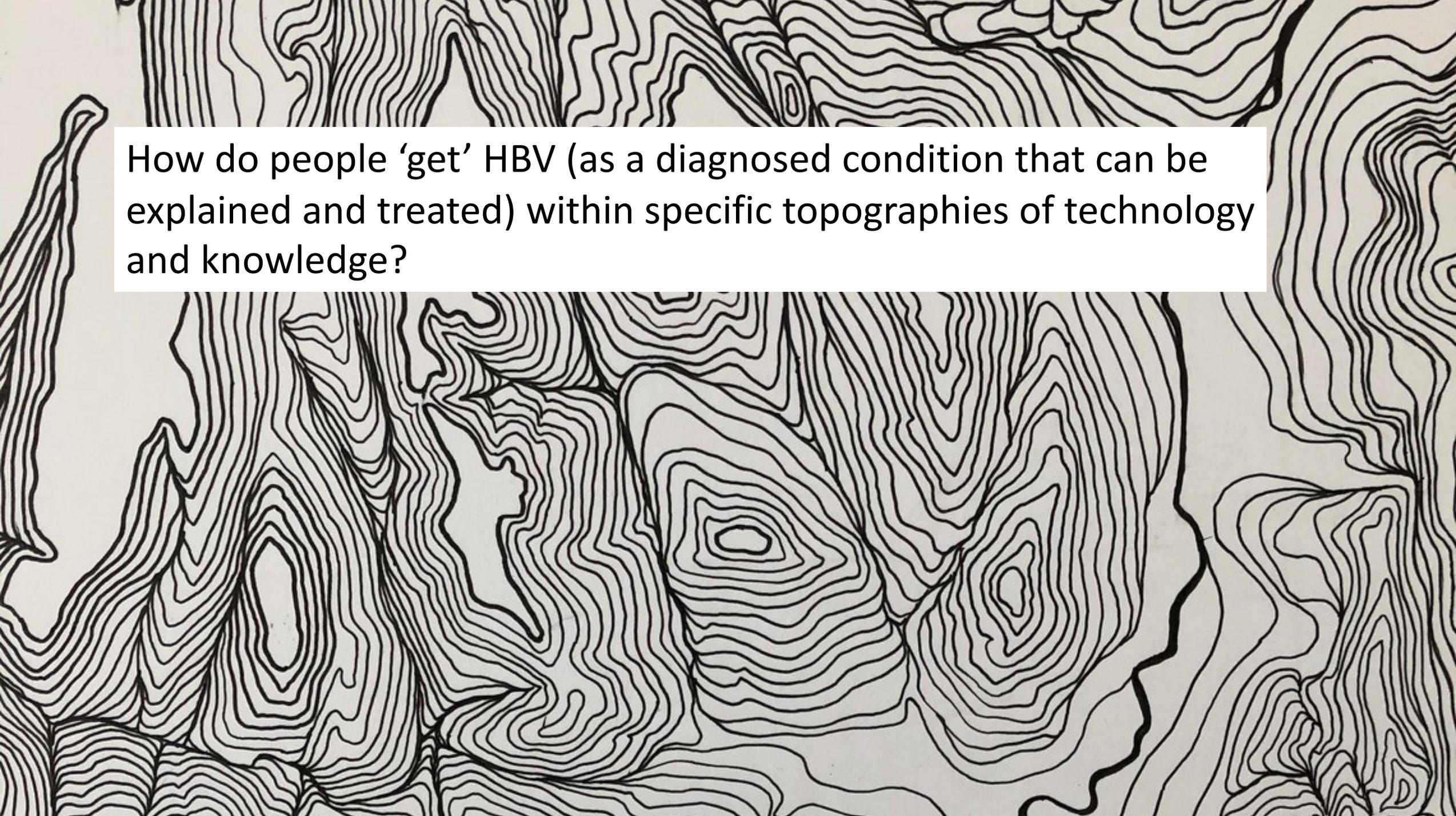
World Hepatitis  
Alliance

ELIMINATE HEPATITIS



# How do we get more people (who already 'have' HBV) screened, assessed and onto treatment?

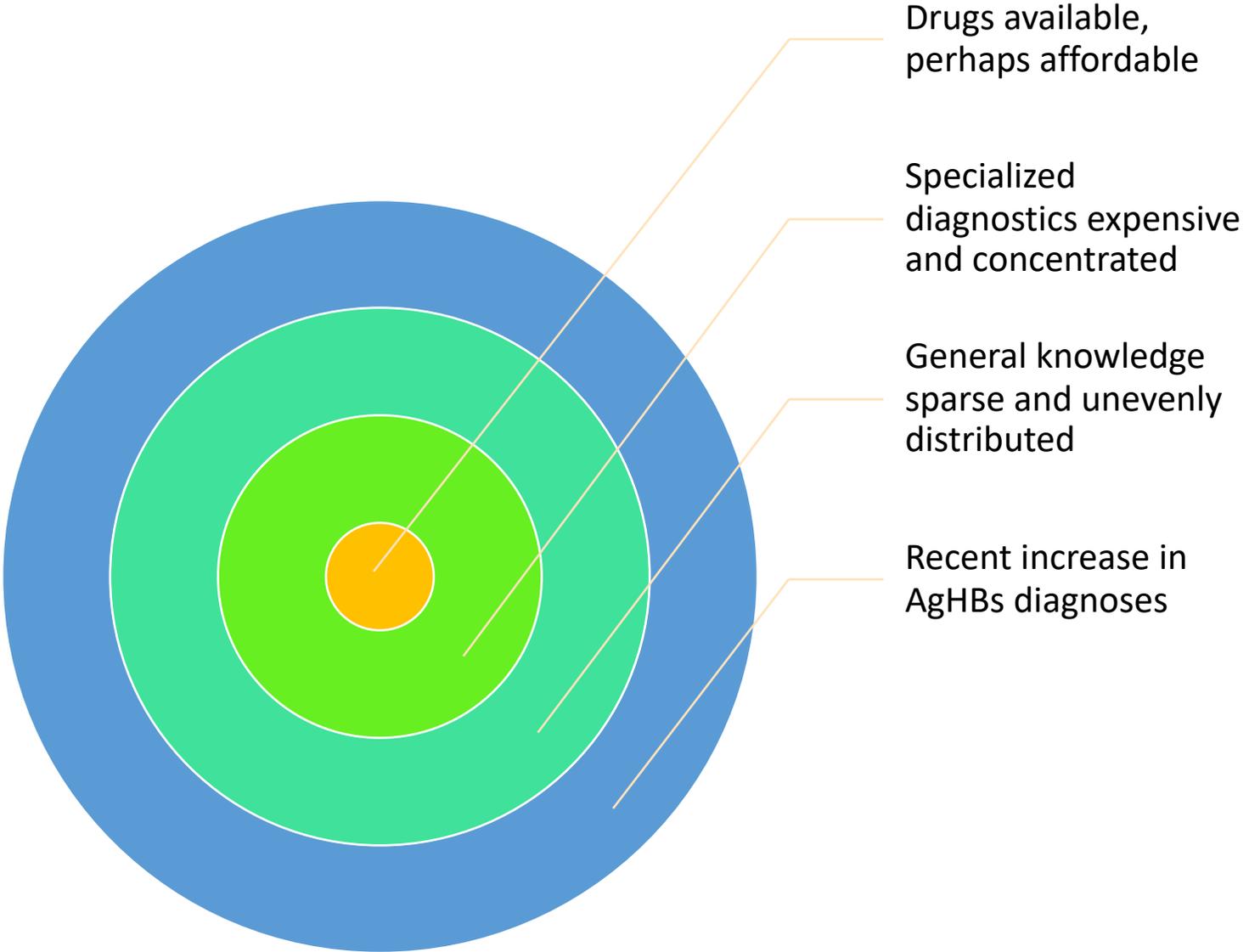




How do people 'get' HBV (as a diagnosed condition that can be explained and treated) within specific topographies of technology and knowledge?

# Situation of HBV in Senegal

- Prevalence of AgHBs: recent local sero-survey found **12.4%** in 15-34 age-group. Estimates of circa 10% nationally, but age and geographical variations.
- Systematic vaccination of infants since 2004 (birth dose 2016)
- Tenofovir subsidized and available in cities (about 9 USD per month)
- Assessment and monitoring tests mainly in capital city (Dakar), costing 80-350 USD
- Screening historically concentrated in blood donors
- Recent increase in prenatal screening, including in rural/primary HC
- Little (but growing) non-specialist knowledge of HBV, but familiarity with end-stage liver disease



# 'Access to treatment' needs to be situated:

- Topography: how different resources for care, including knowledge, are distributed
- Filtration: how this topography acts and is acted upon to draw some into care and push others out
- Distribution of knowledge, includes:
  - Lay, non-specialist and specialist
  - Technologically-mediated diagnostic knowledge of status, risk, eligibility to ttmt (antigen screening, liver assessment, viral testing)
  - Infrastructural knowledge: where services are, how much they cost, what their purpose is
  - Epidemiological knowledge: how HBV circulates and what are the stakes of infection
- Compare, for example, with HIV/AIDS

# Methodology

- Interviews:
  - urban specialists (n~20)
  - rural primary care nurses (n=15) and midwives (n=10)
  - initiators of community/public HBV communication and screening (focus on 3 case studies)
- **No** extensive observation in sites of care or along patient 'itineraries'
- Part of broader study on history of liver cancer in West Africa



# Some mechanisms of filtration

- Cost of prenatal testing bundle
- Cost and urban concentration of specialist care (diagnostic bottleneck)
- Referral ambivalence:
  - Self-care advice
  - Delayed referral (postnatal)
  - Selective referral
  - Referring without conviction
  - Non-biomedical referral
- Small-scale private 'awareness-raising' initiatives: not oriented towards treatment

# Selective referral

- N.T.: ... what do you tell people to convince them that it's important to do the follow-up...?
- Dr. T: Well! *It depends*, eh, it depends ... on age ... on sex too, it depends on the patients you have. Because there are people who are educated, who know something about it ... but for others ... you tell them clearly that there is a disease inside you, well, sometimes ... it can manifest itself, but *it can also not* ... we explain to them, the treatment how it goes, the diet you need to follow ... *Especially the diet, because sometimes there is a lack of means, with respect to the correct treatment...*

# Delayed and half-hearted referrals

- Midwives wait until women have given birth
- Doubt referral will lead anywhere (district health center for diagnostic confirmation and reinforcement of dietary advice)
- Dietary management is more accessible and effective:
  - Have seen AgHBs+ revert to AgHBs- : '...so you see the value of educating them in relation, especially, to the diet they have to follow!'
  - Local aetiologies of proximity: 'Hepatitis is a problem ... here ... Because Saloum ... peanuts, there are a lot here [she repeats this]. So people eat fatty food all the time. All they eat is peanuts [...] So their whole consumption is based on peanuts. It's because of this that there is an excessive rate of positive antigens here. Liver cancer, yes, there's a lot of it.'

# Referral ambivalence

- Arises not from 'ignorance', but from:
- Limited distribution of biomedical knowledge about HBV and treatment possibilities
- ALSO:
- Response to the geographical and financial inaccessibility of treatment (including diagnostic assessments/monitoring)
- Local forms of knowledge about HBV management, etiology and consequences

# 'Awareness-raising' initiatives

- Access to treatment is **not** the primary goal
- Instead, the main concern is 'neutralize' -- and render as a collective problem – both HBV exposure and etiologies of liver cancer

## Village with recurring cancer deaths

- “Will we let this disease destroy us? Let inaccurate beliefs dictate our actions?”
- With screening: “many cases were revealed, that’s when we knew that it is hepatitis that brought this problem.”

# Ibrahima Gueye, *Saafara Hépatites*

Refuting a risk-group-based prevention strategy:

“The *whole population* is at risk, the numbers show it!” (2STV 2019)

Treating sexual transmission as a delicate issue:

“It cannot be said that it does not exist. It can exist. But I bring it up last, starting upstream. When someone is positive, they cannot know when they were infected. The first possibility is that they were born with it. That’s to reassure [...] for the majority here in Africa, that’s it. In any case, it lifts a weight. I summon the past first.

Speaking about mass vaccination as a potential source of transmission:

“My goal is that the person does not feel responsible.”

# Implications for dialogue with African immigrants in U.S.?

- High infection rate as historical product of inequalities in vaccination
- Multiple, contradictory sources of information
  - Family/community histories of liver-related deaths
  - Private/personal awareness efforts: world hepatitis day, social and mass media, Gilead advertising, radio and TV, 'neotraditional' healers on youtube
  - 'Cut-and-paste' information about risk groups and sexual transmission
- De-stigmatization efforts very limited
- 'Local biologies' of HBV, includes local explanations of infection and disease, but also material interactions in place (e.g. with aflatoxins/peanuts).