Behind the hidden epidemic of chronic hepatitis B in Ghana

Summary

Ghana is highly endemic of hepatitis B infection with a prevalence estimate of 12.3% (Ofori-Asenso & Agyeman, 2016). To contribute to efforts that aim at achieving hepatitis B elimination by 2030, these studies were designed to better understand the hepatitis B testing and treatment cascade, in addition to, exploring psychosocial concerns for PWHB (PWHB) in Ghana.

Chapter 2 presents a cross-sectional study that examined the role of knowledge, stigma endorsement and knowing someone with hepatitis B as correlates of hepatitis B testing in Ghana. A population-based sample from the general population was drawn from the Greater Accra and Northern regions of Ghana. The result showed that more hepatitis B knowledge and knowing someone with hepatitis B positively associated with hepatitis B testing but higher stigma endorsement impeded testing. The results highlighted the need to create safe and non-judgmental contexts for people with hepatitis B (PWHB) to disclose their status if they want to. Also, interventions that increase hepatitis B knowledge and reduce stigma are needed as part of efforts to encourage hepatitis B testing.

Chapter 3 describes data from in-depth interviews and focus group discussions with PWHB and HCPs. The purpose of the study was to explore the barriers to hepatitis B treatment and care in Ghana paying particular attention to beliefs about aetiology that can act as a barrier to care. The study identified three main beliefs that act as barriers to care and treatment: (1) the belief that chronic hepatitis B is a punishment from the gods to those who touch dead bodies without permission from their landlords, (2) the belief that bewitchment contributes to chronic hepatitis B, and (3) the belief that chronic hepatitis B is caused by spiritual poison. Also, individual-level barriers including, absence of chronic hepatitis B signs and symptoms, perceived efficacy of traditional herbal medicine, and PWHB's perception that formal care does not meet their expectations were identified. Health system-related barriers, namely, the high cost of hospital-based care and inadequate hepatitis B education for patients from HCPs were reported. The study has demonstrated the need for hepatitis B awareness campaign that targets both PWHB and HCPs to correct myths and false beliefs about the aetiology of hepatitis B. The result also emphasises the need to include the cost of hepatitis B clinical monitoring and treatment in the National Health Insurance Scheme to remove the financial barrier to access to care.

Chapter 4 investigates the reasons for and against hepatitis B status disclosure by PWHB using a qualitative approach. The results indicate that the PWHB were selective disclosers, disclosing in some contexts and not in others. Fear of stigmatisation and previous negative experiences with disclosure were the two reasons against disclosure. But reasons for disclosure included wanting close contacts to get tested or vaccinated, trusting the disclosure target(s), and needing social and/or financial support. Development and implementation of theory and evidence-based stigma reduction interventions that are culturally appropriate, and that prioritise the participation of PWHB are needed in Ghana.

Chapter 5 presents the result of a qualitative inquiry into beliefs that contribute to hepatitis B stigma and how stigma manifests in the sociocultural environment and the healthcare settings

in Ghana using a sample of PWHB and HCPs. The belief that hepatitis B is highly infectious, that hepatitis B is very severe, and that hepatitis B is caused by a curse contribute to stigma. Hepatitis B stigma was found to manifests as avoidance and social isolation in the sociocultural environment. In the healthcare setting, stigma manifested as excessive cautiousness, procedure postponement, task shifting, and breaches of confidentiality.

Chapter 6 ascertained the adequacy of the Berger HIV Stigma Scale as a measure of hepatitis B stigma among a sample of PWHB in Ghana. This study was considered necessary given that no scale capturing hepatitis B stigma among PWHB exists in the SSA context. We employed the procedure of exploratory factor analyses (EFA) as the first step in a scale validation for hepatitis B stigma in SSA. Although the revised hepatitis B stigma scale demonstrated sufficient concurrent validity and reliability, a follow-up study using a CFA with a new data set will be appropriate in concluding the adequacy of the 18 items that emerged from the EFA in measuring hepatitis B stigma in Ghana.