Hepatitis C cure as a ‘gathering’: Attending to the social and material relations of hepatitis C treatment

Adrian Farrugia1,2 | Renae Fomiatti1 | Suzanne Fraser1,3 | David Moore1 | Michael Edwards4 | Elizabeth Birbilis5 | Carla Treloar1,6

1Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Victoria, Australia
2National Drug Research Institute, Curtin University, Perth, Western Australia, Australia
3Centre for Social Research in Health, University of New South Wales, Sydney, New South Wales, Australia
4National Drug and Alcohol Research Centre, University of New South Wales, Sydney, New South Wales, Australia
5Prevention and Population and Health Branch, Public Health Division, Department of Health, Victoria State Government, Melbourne, Victoria, Australia
6Centre for Social Research in Health, Social Policy Research Centre, University of New South Wales, Sydney, New South Wales, Australia

Abstract

Since the advent of direct-acting antiviral hepatitis C treatments, widespread enthusiasm about disease elimination has emerged. This article examines experiences of hepatitis C treatment and cure in this period. Mobilising Fraser and Seear’s (Making disease, making citizens: The politics of hepatitis C, Ashgate, 2011) approach to hepatitis C as a ‘gathering’, we analyse cure not as a biomedical phenomenon but as a social and material event. To do so, we take a Science and Technology Studies-inspired approach to analyse three complementary cases drawn from an Australian project on experiences of hepatitis C, treatment and cure. First, we analyse the ways a friendship between two women combines with adjustments to treatment access to produce a gathering that makes cure possible. Second, we analyse the forces that gather and distribute responsibility when a cure does not occur in a context shaped by oversimplified treatment logics. Third, we analyse a gathering of relations in which hepatitis C lingers, thereby limiting the cure’s possible transformative effects. We argue that, even in an era defined by highly effective medicines, the
HEPATITIS C CURE AS ‘GATHERING’

INTRODUCTION

Since the advent of direct-acting antiviral hepatitis C treatments, widespread enthusiasm for disease elimination and ‘cure’ has emerged internationally. Focussing on their minimal side effects and much improved efficacy, the new treatments are regularly positioned as ushering in a ‘revolutionary’ ‘new era’ of treatment (for analysis of this discourse, see Seear et al., 2021). However, sociological research on the social dynamics that shape treatment uptake and experiences emphasises that meaningful freedom from hepatitis C encompasses more than effective biomedical interventions. It requires specific strategies and policies that address enduring stigma and marginalisation, as well as broader improvements to healthcare systems. In this article, we ask how to account for such issues in a context in which access to a much-improved treatment has made hepatitis C elimination a tangible goal (for analysis of some of the political implications of the elimination agenda, see Lancaster et al., 2020). While social and structural impediments to treatment, including stigma and onerous treatment regimens, were regularly foregrounded in socially oriented hepatitis C research on interferon-based treatment, there is a risk that critical issues such as these and others will be backgrounded or forgotten in the enthusiastic rush to embrace ‘revolutionary’ treatment and simple cures (Seear & Lenton, 2021). To ensure these issues do not fall from view, in this article we offer an approach that positions them not as separate factors that impact treatment experiences but as ontologically inseparable from cure itself.

Working with Fraser and Seear’s (2011) approach to hepatitis C as a ‘gathering’, made and remade by social and material forces rather than distinct from them, this article analyses cure not simply as a biomedical phenomenon but as a social and material event. In a move similar to Fraser and Seear’s effort to denaturalise hepatitis C, our analysis denaturalises cure, sidestepping notions of ‘heroic’ medicine and focusing on the social and material forces that make cure possible. We take an approach informed by Science and Technology Studies (STS) to analyse three cases of hepatitis C gathering, mapping the social and material relations that help generate and impede cure as well as shape its lasting effects for those who experience it. The first case explores an account in which a friendship between two women, a new housing situation and adjustments to treatment access together produce a particular gathering that makes cure possible. The second case analyses the forces that gather and distribute responsibility when cure does not occur in a context that assumes treatment adherence will necessarily result in success. The third and final case examines an account of cure that would often be understood as relatively straightforward. However, we analyse it as a gathering of relations in which hepatitis C lingers and thereby limits the ‘transformative’ and other meaningful effects that cure can achieve. Together, these cases demonstrate that, even in an era defined by highly effective and tolerable medicines, hepatitis C cure is not necessarily easy or transformative,

Funding information
The project was funded by an Australian Research Council Discovery Project grant (DP200100075).

hepatitis C cure is not necessarily straightforward, but an unpredictable gathering constituted by a fragile coalescing of social and material forces.

KEYWORDS
Bruno Latour, cure, elimination, hepatitis C treatment, qualitative research
but an unpredictable gathering made possible by a fragile coalescing of social and material forces. In concluding, we argue that efforts to increase uptake and cure in order to achieve hepatitis C elimination goals could benefit from a similar focus on the gatherings that help to realise or impede cure and shape its lasting effects.

Background

An estimated 71 million people worldwide live with hepatitis C (Stanaway et al., 2016), with approximately 143,580 of those living in Australia (Kirby Institute, 2018). With the advent of direct-acting antiviral hepatitis C treatments, the World Health Organization announced a new goal of eliminating the virus as a health concern by 2030. Subsequently, the Australian government adopted this goal (Australian Government Department of Health, 2018) and fully subsidised direct-acting antiviral treatment in Australia's Pharmaceutical Benefits Scheme. Compared to many other Western countries, this means direct-acting antiviral treatment is an accessible and affordable medication for people with hepatitis C. This is important as people who inject drugs are particularly overrepresented among people with hepatitis C, with an estimated prevalence of 39% globally (Degenhardt et al., 2017), experience significant financial disadvantage and have been a particular focus of treatment promotion efforts in Australia (Australian Government Department of Health, 2018). Alongside subsidised treatment, the Australian Government Department of Health has outlined a series of guiding principles to support treatment uptake in the Fifth National Hepatitis C Strategy 2018–2022 (2018), one of which is to increase meaningful involvement of priority populations in all aspects of the hepatitis C response.

When compared with the notoriously long, arduous and unreliable interferon-based hepatitis C treatments, direct-acting antiviral therapies have been lauded as a treatment revolution (e.g. de Graaff et al., 2018; Martinello et al., 2018). Depending on genotype, older treatments were between 6–12 months and often produced serious side effects including flu-like symptoms, fatigue, depression, anxiety and insomnia, placing great strain on people undergoing treatment, their social relationships, work commitments and sense of wellbeing (Harris & Rhodes, 2013; Hopwood & Treloar, 2005). The new medications offer much shorter treatment durations (approximately 8–12 weeks), far fewer side effects, far superior cure rates of around 95% and are delivered orally rather than through regular injections (Fierer & Wyles, 2020). These differences are key to much research on and promotion of direct-acting antiviral treatments. As discussed by Bryant et al. (2019), the notion that new treatments are essentially 'side-effect' free is central to much of this messaging. This difference has, for example, informed promotional campaigns targeting people who inject drugs through needle and syringe programs and opioid pharmacotherapy clinics, and in related health sector publications (e.g. de Souza, 2021). The focus on reduced side effects is unsurprising given the extensive documentation of negative experiences with interferon-based treatments, which have often been positioned as an important impediment to treatment uptake (Harris & Rhodes, 2013). While hurdles and barriers to direct-acting antiviral treatment uptake and achieving hepatitis C elimination at the national and global scale have been the subject of recent research, the focus on reduced side effects and high efficacy has come to form part of a discourse in which cure is conceptualised as an inevitable endpoint of treatment. This article questions this view, offering an approach that analyses the social dynamics shaping treatment uptake and outcomes as co-productive forces that, only when appropriately gathered, generate the potential offered by new treatments for individuals and the elimination goal more broadly.
Literature review

A large body of qualitative research on hepatitis C treatment offers insights into experiences and understandings of hepatitis C cure. While improvements in physical health, such as an increase in energy levels, are significant (Goutzamanis et al., 2021; Mora et al., 2020), experiences of cure are also imbued with deeper meanings. Some research indicates that people affected by hepatitis C primarily value the broader effects of cure such as the relief of not having a looming chronic illness (Mora et al., 2020) and, as such, treatment benefits need to be understood beyond clinical outcomes alone (Goutzamanis et al., 2018). In this sense, hepatitis C cure is not solely defined by the accepted definition of cure, sustained virological response (or SVR) (Kirby Institute, 2018), or by improved physical health, but is invested with meanings beyond the virus and its effects. Multiple articles argue, for example, that hepatitis C cure offers a symbolic break from a past life and stigmatised subjectivity linked to a history of injecting drug consumption (e.g. Harris, 2017; Madden et al., 2018a; Pourmarzi et al., 2020; Richmond et al., 2018; Vega et al., 2021; Williams et al., 2019). Such analyses sometimes position cure as part of ‘recovery’ from illicit drug consumption, in which consumers can start a new ‘normal’ life (Richmond et al., 2018) without this consumption (Vega et al., 2021; Williams et al., 2019). One important implication of these accounts is that they tend to position those who continue to consume drugs during or after treatment as failed subjects who have not taken up the opportunity of full citizenship offered by treatment and possible cure (see Fraser & Seear [2011] for similar observations about earlier accounts). Reflecting the complexity of treatment experiences, some research emphasises that individuals accessing treatment often hope for outcomes beyond cure, such as new social connections and strategies to manage health and wellbeing (Madden et al., 2018a). Similarly, writing before the widespread availability of direct-acting antiviral treatments, Harris and Rhodes (2018) argue that the transformative potential of hepatitis C treatment does not stem from achieving cure alone but also from the intensive interpersonal forms of care that characterised some experiences of interferon-based therapies. Overall, this area of research emphasises that hepatitis C treatment and cure are valued not only in relation to the biomedical clearance of the virus, but also in their connection to understanding of health, normality, citizenship and what it means to live a good life (Fraser & Seear, 2011; Harris, 2017).

Research on hepatitis C treatment access before and after the availability of direct-acting antiviral treatments also identifies a series of social issues shaping and often impeding uptake. This scholarship tends to organise different impediments to treatment uptake into separate categories such as individual, provider, system and social level factors. Reflecting this approach, Harris and Rhodes’ (2013) review of literature on access to interferon-based treatments explores ‘individual’ and ‘social’ level impediments. Individual level impediments include mental health issues, comorbidities, concerns about treatment side effects and concerns about the need for treatment given the risk of reinfection. Social level impediments include stigma, housing availability, geographic isolation, criminalisation of people who consume drugs and those related to gender and cultural background. Significantly, recent research mobilising a similar approach indicates that many of these issues continue to impede access to direct-acting antiviral treatment. In Australia, Madden et al. (2018b), for example, identify a range of barriers to treatment at the ‘personal’ level including being asymptomatic, needing to find the ‘right time’ for treatment and poor vein health. At the ‘provider’ level, they identify gaps in continuity of care as the key treatment barrier, while at the ‘system’ level, they identify the need to manage multiple health and social priorities, and the challenge of finding supportive and non-judgmental care as key barriers. Most recently in Australia, Heard et al. (2021) argue that barriers at the ‘personal’ level include mental
and physical health conditions, at the ‘provider’ level include stigma in healthcare settings and at the ‘system’ level include complex treatment pathways and cost. They also identify enablers at the personal level such as the support of social networks, at the provider level such as trusting and respectful general practitioners, and at the system level such as fully subsidised costs and simple treatment pathways. Similar issues are identified in research on the views of hepatitis C-related health professionals and stakeholders conducted in Canada, with housing and strained healthcare services identified as central concerns (Goodyear et al., 2020). While direct-acting antiviral treatments have vastly fewer side effects than interferon-based treatments, concerns about side effects also continue to shape treatment access and experiences (Bryant et al., 2019; Wright et al., 2019). In this respect and others, ensuring efforts to increase uptake fully engage with the meanings given to treatment as they circulate within affected communities is key (Bryant et al., 2019). Together, this important body of research emphasises that people living with hepatitis C are often juggling multiple pressing health and other concerns that shape and frequently impede treatment uptake (Harris & Rhodes, 2013; Madden et al., 2018b).

Building on and extending this literature, our analysis examines the notion of cure itself, analysing how material and social forces commonly considered separate from treatment are implicated in generating it. In this way, our approach differs from this literature by analysing these forces not as distinct ‘factors’ (individual, system or social) fully formed prior to their coalescing but as co-productive, the character and effects of which materialise through encounters with each other. By approaching cure in this way, these forces are analysed not as separate from, but as ontologically part of cure and the action of direct-acting antiviral treatment. In doing so, our approach works towards a more expansive account of the elimination project in which addressing social and material forces cannot be separated from cure itself and emphasises further that cure and elimination are fragile and dynamic, requiring ongoing work even after successful hepatitis C treatment.

**Approach**

An analysis that approaches hepatitis C cure not primarily as a biomedical phenomenon but as a social and material event requires a theoretical orientation that effectively foregrounds the social and political forces that shape the virus, treatments and outcomes. To this end, we work with conceptual resources drawn from Suzanne Fraser and Kate Seear’s (2011) book *Making disease, making citizens: The politics of hepatitis C*, primarily their concept of disease as a ‘gathering’. In this book, they introduce a range of concepts drawn from STS and Feminist Science Studies in order to:

formulate an approach to disease able to acknowledge the ways in which social and political forces – namely poverty, disadvantage and stigma – directly shape the disease hepatitis C.

(Fraser and Seear, 2011: 5)

In line with this approach, Fraser and Seear argue that diseases such as hepatitis C are best approached not as self-evident objects waiting to be discovered, measured and, eventually, eliminated through cure, but as ‘emergent phenomena, constantly being made and remade by social forces’ (Fraser & Seear, 2011: 5). In this sense, drawing on the work of Duffin (2005) and reflecting their broader STS-inspired theoretical commitments, they suggest that diseases do not merely impact on
HEPATITIS C CURE AS ‘GATHERING’

society and culture but are partly constituted by them (2011). This argument contrasts with conventional accounts that suggest hepatitis C moves between disadvantaged populations (such as people who inject drugs) most easily. In these conventional accounts, this movement happens in two ways. First, hepatitis C is seen as pre-existing the populations and moving between them, rather than as emerging within and in relation to them. Second, this movement is understood as occurring through the individual actions of members of affected populations, and these individuals are considered the primary target of interventions (see also Fraser, 2011). The STS-inspired approach offered by Fraser and Seear (2011) challenges these framings, understanding disease as co-emergent with the stigmatisation and marginalisation of populations, and therefore as fundamentally driven by complex social and institutional actions beyond, or in interaction with, individual actions. The history of hepatitis C offers ample examples of why an approach that positions society and culture as both making and being made by disease is useful. By way of example, Fraser and Seear (2011) point to the different social dynamics shaping hepatitis C epidemiology in Western nations and Egypt. While hepatitis C is generally understood as caused by injecting drug use in many Western contexts such as Australia and the UK (Fraser & Seear, 2011), the conflation of the two is the result of specific social and material circumstances. In Egypt, by contrast, the country’s extremely high rates of hepatitis C can be tracked to a World Health Organization-informed national health campaign that relied on non-sterile injecting practices (Elgharably et al., 2017) (see Fraser [2011] for an analysis of this case). In the West, then, hepatitis C is synonymous with the highly stigmatised practice of injecting drugs (and seen as the result of the actions of people who inject drugs); in another context, Egypt, it is produced by the public health apparatus and accompanied by quite different forms of stigma. Following Latour (2004), Fraser and Seear (2011: 9) argue that such cases emphasise that hepatitis C is best approached as a:

‘thing’ in the Heideggerian sense – a gathering that exceeds any notion of simple fact or object [...] Things, in this sense, are as much made, or ‘gathered’, in culture and action as they are given prior to culture and action.

Importantly, when hepatitis C is understood as made or gathered in culture and action, rather than as a stable entity awaiting discovery and cure, it must be approached as ‘made in many moments and in many ways’. Here, it is ‘the responsibility – and the “fault” – of many individuals, groups and forces, not just of those who “have” it’ (Fraser & Seear, 2011: 11). This relational approach suggests that hepatitis C, injecting drug consumption, healthcare services, treatment uptake and stigma are emergent phenomena not so much affected by as produced through each other. This insight has significant political utility for Fraser and Seear, who quote Latour (2004: 237) to argue that when hepatitis C or treatment are approached as gatherings, they ‘cannot be thrown at you like objects’. In other words, when agency, responsibility and causation are conceptualised as shared in and throughout a gathering, this gathering cannot operate as a stigmatising object or weapon to be ‘thrown’ at individuals affected by it (Fraser, 2011). Given the social dynamics that shape hepatitis C and impede elimination efforts, the utility of distributing responsibility in this way is clear. Hepatitis C elimination cannot be understood solely as the responsibility of those living with the virus, or those providing treatment, when it gathers meaning and force through political and economic apparatuses, widespread cultural associations, and localised institutional and healthcare practices.

What does an account of disease as a gathering offer an analysis of hepatitis C cure specifically? Drawing on Fraser and Seear’s approach, we analyse cure not simply as a biomedical phenomenon but as a social and material event, made possible through the gathering of various social and material forces. In this sense, it is these forces – which we explore in this article – that
realise the promise of cure offered by treatment. Such an approach sidesteps notions of a ‘heroic’ medicine that makes cure inevitable – a significant move because such accounts of scientific progress risk obscuring the same forces that produce suffering (Seear et al., 2021). Overall, approaching cure as a gathering denaturalises it, thereby challenging the view that it is a simple biomedical state bestowed by science and medicine alone. As we argue below, cure is not only realised through a sustained virological response but through broader social and material forces and changes. For the purposes of our analysis, approaching hepatitis C cure as a gathering has three primary implications:

1. It draws attention to the social and material relations beyond medicine that work together to generate cure;
2. It offers a relational and shared understanding of responsibility when treatment works and when it does not; and
3. It affords understanding that even when it does occur, cure remains an emergent and always unstable social and material phenomenon defined by more than a sustained virological response.

**METHOD**

This article draws on data generated by a qualitative research project on hepatitis C treatment uptake and experiences. Focussed on gathering detailed and nuanced perspectives on the meanings of hepatitis C, treatment and cure for people affected by the virus, the project analyses the dynamics shaping uptake in Australia during a period in which the federal government has officially committed to the World Health Organization 2030 elimination goal (WHO, 2016).

The project used a purposive data collection strategy to recruit and interview 50 people affected by hepatitis C with various experiences of treatment. Participants were recruited across Australia’s two most populous states: New South Wales and Victoria. Prospective participants were screened to ensure variation in the types of treatment experienced, including participants who had not accessed treatment, hepatitis C acquisition routes, reinfection and treatment outcomes, as well as gender, sexuality, age, ethnicity and socioeconomic background. All participants provided audio-recorded informed consent. Three research team members, including the first and second author, conducted in-depth, semi-structured interviews exploring participant experiences of hepatitis C, diagnosis, treatment, cure and life following treatment.

Interviews were conducted via audio or video conferencing, phone calls and in person, and ranged between 30 and 90 min in length. These collection methods were adopted because the project was conducted during the outbreak of COVID-19 in Australia, meaning in-person contact was highly restricted for much of the data collection period. Interviews were digitally recorded, and all participants were reimbursed AUD$50 or an AUD$50 gift voucher for a major retail chain in recognition of their time and contribution to the research. The study was approved by La Trobe University’s Human Research Ethics Committee (HEC20078).

Interviews were transcribed verbatim by a professional transcriber. All transcripts were imported into QSR NVivo 12 for management and coding. A coding framework was generated using a combination of methods: codes were identified in response to the project’s aims and previous research on hepatitis C treatment, on the basis of themes emerging in the data and in consultation with the project’s advisory board. The interview transcripts were coded by the first
and second author using an iterative process, in collaboration with the lead investigator (author three) to maximise coding consistency and comprehensiveness.

Our analysis takes a case approach. Informed by STS scholarship, it draws primarily on Mol and Law’s (2002) argument that the utility of ‘cases’ rests not in their claims to representativeness but in their capacity to sensitise us to previously obscure events, situations and possibilities (see Fraser & Seear [2011] for more on this approach). Whereas ‘examples’ aim to illustrate specificities through recourse to an assumed larger order, cases can be used to study the specificity of phenomena, with ‘each [case] differing slightly in some (unexpected) way from all the others [...] still instructive beyond its specific site and situation’ (Mol & Law, 2002: 15). Inspired by this approach, our goal in analysing three cases of hepatitis C gathering is to offer new insights into how hepatitis C cure in the direct-acting antiviral treatment era takes shape. Reflecting this goal, the three cases were identified for analysis because they reflect broader trends in the dataset and because they provide specific insight on issues pertinent to hepatitis C treatment uptake, such as treatment approaches that position direct-acting antiviral therapies as heroic (see Case 2: Kylie). Further, these three cases were identified because they reflect other socio-demographic characteristics of the dataset, for example, experiences of homelessness and injecting drug consumption, as well as various forms of participant income. While our approach does not claim representativeness, specific aspects of these cases will shape their potential relevance for other analyses. For example, all three participants are women and cure may gather in different ways for other genders, including trans and non-binary gender identities. Similarly, while experiences of imprisonment were significant for several research participants, such issues are not addressed in these cases. In choosing the three cases presented for analysis, we focussed on those offering nuanced and detailed accounts of the different ways social and material relations work to co-produce cure and its lasting implications. In this way, while our analysis focusses on hepatitis C cure, the cases presented here have the potential to generate new insights into the gathering and treatment of other health issues and concerns (see, for example, Farrugia et al. [2019] for an STS-inspired analysis of take-home naloxone cases). For example, all three cases highlight issues that are backgrounded in commonplace discourses of ‘heroic’ direct-acting antiviral treatments and ‘easy’ cures.

Analysis

Our analysis explores three specific cases of hepatitis C cure, demonstrating key ways cure is realised or gathered through a complex web of relations. Read together, these cases illustrate the various ways in which elimination is contingent on the broader social and material forces that gather alongside biomedical intervention. We turn first to case one, in which a gathering of relations made the biomedical effects of direct-acting antiviral treatment possible.

Case 1: Amelia: Homelessness, friendship and treatment access

Our first case is Amelia’s account of using direct-acting antiviral treatment for hepatitis C cure in 2018, an event she described as ‘really satisfying’ and offering a ‘feeling of accomplishment’. Amelia is 41 years old, lives with her four children in Melbourne, Victoria, and her primary source of income is a social security benefit for primary carers. She acquired hepatitis C through injecting drugs when she was younger but was not injecting at the time of her interview in 2020.
When she was diagnosed in 2016, her initial question was ‘Am I going to die?’. Being pregnant with her fourth child at the time, she decided to postpone treatment until after she gave birth. In her interview, Amelia described initially struggling to take her medication regularly as she was experiencing homelessness and intimate partner violence while also caring for her young child:

I had gone through some DV [domestic violence] stuff so [my partner and I] had sort of, like, broke[n] up and I’d left the home. I was renting and then, yeah, ended up sort of homeless living on a stranger’s couch, like, a friend of a friend. [I was] living there for a little bit and then moving from there and having DH[H]S [Department of Health and Human Services] involved and whatnot, so yeah, it’s been a crazy-ISH couple of years.

Amelia went on to describe how these difficult circumstances impacted her treatment schedule:

I guess, like, [taking my hepatitis C treatment] was last on my list to do, which probably harmed my health. [...] It’s a 12-week medication and three quarters of it was taken in, like, dribs and drabs pretty much. So, like, out of seven days of the week, I was lucky if I took it four times a week.

As this account emphasises, even in a context of highly affordable and tolerable oral medications, enduring barriers to treatment completion can continue to limit ability to use medication and be cured of hepatitis C.

Amelia further detailed the ways her insecure housing arrangements and hepatitis C-related stigma meant she took her medication sporadically:

Yeah, it was [difficult to manage treatment] and especially, like, you are not really wanting certain people to know, because they will judge you [...] Then you kind of [are] hiding your medication and then you’re not taking it anymore and then you’re taking it whenever. So, it was extremely hard and then, yeah, you kind of just stop all together [or] you see it once a month or you go, ‘Oh hang on, I’ll take it’ – as if it’s going to do anything.

In Amelia’s case, the right social and material circumstances had not yet gathered in such a way as to generate the cure afforded by direct-acting antiviral treatment. Not only was it difficult to manage taking the medications amidst pressing and competing personal concerns and responsibilities, but she also felt pressured to hide her medication for fear it would identify her as unwell or, presumably, someone who had or did inject drugs. These forces – homelessness, insecure housing, childcare, intimate partner violence, stigma – gather to render the highly efficacious new medications weak and inoperative. In this gathering, hepatitis C cure is unlikely.

However, Amelia’s circumstances changed dramatically over time partly because she was able to find stable accommodation and partly due to a friend’s suggestion to change the way she stored and accessed her treatment. As she said:

My best friend, like, was trying to help me, so I moved into the place [house] that I’m in now, so my own place. She was just trying to help me get sorted and some sort of routine and whatever. So she’s like, ‘Amelia, why don’t you take the medication to the chemist?’ [...] ‘[You] go to the chemist every day [to get your methadone dose], so
while they are dosing you, they might as well dose you your Zepatier, and then you are not forgetting’. And yeah, so that’s what I did.

The chemist was amenable to this arrangement, which worked well for Amelia:

I found that really worked, because then the last quarter [of my treatment], I took it really seriously and I actually got cured just on that quarter.

Much of what is being described here in Amelia’s account of treatment difficulties and cure has been characterised in the literature as the ‘problem’ of treatment adherence. Research has often focused on individual adherence to prescribed treatment regimens as key to understanding medication failure in the treatment of hepatitis C (e.g. Campos Fernández de Sevilla et al., 2019; Larrey et al., 2014). However, analyses that would position Amelia as ‘forgetting’ or even ‘failing’ her treatment or not taking it ‘seriously’ enough, or as primarily focussing on her housing issues alone, would offer a highly partial account of how and why treatment worked in this case. Via Fraser and Seear (2011), we argue that Amelia’s experience of cure was generated through a gathering of relations that made the biomedical effects of direct-acting antiviral treatment possible. ‘Cure’, and its actualisation or impediment, can be understood as dispersed and shared, articulated through a diverse set of actors such as housing stability, flexible provision practices, friendship, and stigma and secrecy, which – in their specific gathering – work to generate the action and implications of treatment. As we go on to argue below, understanding and indeed foregrounding cure as an event gathers a wider and more inventive set of actors and forces, beyond those usually identified and responsibilised in discussions of treatment adherence.

Case 2: Kylie: Treatment failure and responsibility

In the first section, we analysed a case in which cure was realised through a gathering of social and material relations beyond the action of the new medications alone. In this section, we explore a gathering of cure in which the presumed inevitability of the new treatments impeded carefully and considered communication and regathered familiar patterns of responsibilisation. Kylie is 46 years old, lives with her young son in Melbourne, Victoria, and her primary source of income is a social security benefit for people living with a disability. She is unique in our data-set in that she needed two courses of direct-acting antiviral treatment before being cured – an outcome that she described as making her ‘happier within myself’ and an achievement that she wanted to ‘shout from the rooftops’. Kylie described being surprised and upset that she was not cured of hepatitis C after the first course of treatment:

I was just really upset […] They did the last test on me and it came up saying that it [hepatitis C] was gone and then I had a phone call saying that I had to come back into the doctors because it was back. And I couldn’t understand [it].

It is perhaps unsurprising that Kylie struggled to understand this outcome given that before starting treatment, she had been encouraged to approach cure as a foregone conclusion:
There was no information about whether it didn’t work [...] to even think about [the possibility]. It was like I always heard: ‘Yeah, yeah, you have it [treatment] and you are cured’.

Kylie’s reflection that information about unsuccessful treatment was not widely available highlights the current discursive environment shaping understandings of hepatitis C treatment in Australia. In an effort to increase uptake of the new medications, health promotion campaigns position current treatments as a revolutionary, almost miracle, cure, with near 100% success rates (e.g. de Souza, 2021). While we do not contest the efficacy of these treatments, it is notable that Kylie reports not being given any information about the possibility that the medications might fail.

This gathering of cure, in which it is delivered as a simple foregone conclusion, has important implications for people who are, in medical parlance, deemed to ‘fail’ treatment. From Kylie’s perspective, the health professionals who administered her treatment struggled to understand the situation and it seemed to her that ‘even they were shocked’ and ‘were all learning as they were going’. Kylie later explained that amidst this professional uncertainty, questions about her sexual and drug consumption practices, as well as treatment adherence, emerged as possible reasons for why the new medications did not work:

They asked if I was using [injecting drugs] during [the treatment], which I had stopped. [They asked ...] whether I had shared a needle or if I had unprotected sex, but yeah, they asked if there was some reason why I still had hepatitis if I had done the program properly.

This issue continued when she began her next course of treatment. As she recounts:

Going to the chemist and, like, having to get the prescription again [and] everyone asking the same old questions: ‘Why are you having to do it again?’, ‘What happened the first time?’, ‘Why has everyone else passed it and you haven’t?’ It was just very annoying, and I couldn’t answer the questions, because I didn’t know why.

Through both treatment courses, Kylie faced heightened scrutiny from health professionals. We can see here how oversimplified logics of treatment success gather cure as inevitable, with medication failure largely framed as a problem of adherence and flawed individual behaviour. This cure gathering led to Kylie feeling that she had ‘to reassure them that I hadn’t done anything wrong and I had done everything step by step to what I was supposed to have done’. Despite Kylie explaining that she had carefully followed all instructions, her actions were called into question, and she found herself, somewhat ironically, having to reassure the health professionals managing her treatment rather than being reassured after receiving deeply disappointing news.

This dynamic of responsibilisation in hepatitis C treatment is not new. Writing before the availability of direct-acting antivirals, Fraser and Seear (2011) identified how patients’ agency and actions were scrutinised when interferon-based treatment did not work yet ignored when it did. As they argue, when treatment works, science and medication are positioned at the centre – a ‘heroic’ force and the primary reason for cure. When it does not work, science and medication move to the periphery at the expense of the patient, who is centred and enacted as the reason for treatment failure. What is significant here is how understandings of cure as simple and inevitable can efface how these social and material relations cohere, thereby centring the individual as wholly responsible for negative outcomes. While the new treatments
are understandably positioned as an improvement on interferon-based treatments, the ways they gather ‘cure’ nevertheless rely on established forms of power, knowledge-making and expertise that complicate easy claims about change or transformation (see Fomiatti et al., forthcoming). Significantly, unlike interferon treatments, which were known to be unreliable, unsuccessful treatment with direct-acting antivirals is positioned as almost impossible. This dynamic holds individual action at the centre of failure perhaps even more tightly than during the previous treatment period. As with the previous case, Kylie’s case emphasises the importance of distributing responsibility for treatment success, failure and ‘cure’ beyond treatment adherence or medical progress.

Case 3: Julia: Cure and lingering hepatitis C

Our final case further nuances contemporary discussions of ‘cure’ by drawing attention to the limitations of approaching it as a discrete biomedical outcome. Below, we explore the ways the socio-political material traces of hepatitis C linger, gathering a fragile and fraught experience of cure. Julia is 43 years old, lives with her partner and two children in regional New South Wales, and works full-time in community services. She acquired hepatitis C through injecting when she was younger but at the time of her interview in 2020, she had not been injected for over 10 years. In 2017, she was cured of hepatitis C after a course of direct-acting antiviral treatment, an outcome she described as ‘exciting’. Being cured of hepatitis C was a significant event in Julia’s life, reinforcing the break between a previous part of her life that included regular heroin consumption, intimate partner violence and an overall sense of not caring whether she lived or died (Harris, 2017; Pourmarzi et al., 2020). As she explained:

I just loved the idea of actually saying goodbye to the hep C, because it felt like that last link to that whole part of my life.

She also went on to describe the sense of relief that accompanied her cure:

I still have antibodies of hep C and I am aware of it. But to lose that notion, you know, [that] the virus [is] running through my blood, was lovely.

The new medications and ‘saying goodbye’ to hepatitis C were significant for Julia because they offered the opportunity to put the stigma associated with hepatitis C behind her, an issue she had encountered and lived with for many years, through her early pregnancy, motherhood, and maternal and general healthcare. However, as she explained, although ‘treatment itself was simple’, hepatitis C-related stigma lingers in health systems and records, re-emerging to gather cure as a fraught and ongoing event:

Hep C was something I couldn’t avoid in healthcare. It was the reminder that I had this history of drug dependence […] even my daughter’s … you know, the maternal child healthcare books you get? The blue books that chart their first five years of life? The first page of that just talks about my drug dependence in pregnancy and my hep C status. So, even her first health document, you know, has my stigmatised health history on it […] It’s awful.
Despite experiencing cure and not having injected drugs for a decade, Julia’s hepatitis C status remains encoded into deeply personal documents with significant sentimental value, both for herself and her family. In another example, Julia described a dyslexia assessment her daughter had in Grade 6 (ages 11–12) that resulted in a report foregrounding her ‘drug dependence in pregnancy’ and hepatitis C status. As well as the antibodies Julia mentioned earlier, these documents mean she and her family remain ‘marked’ by hepatitis C. Despite being ‘cured’ of the disease, the virus and the feeling of stigma associated with it continue to appear in ‘random’ places where they do not ‘belong’:

I guess it is still tied up a bit in that self-identity stuff, like, there is still thoughts around you know, the sense of damage, the sense of contamination, yeah, they are pretty strong themes, and something I lived with for a long time. I still see it in my maternal and child health book or in my daughter’s dyslexia report, in really random places where I don’t feel it belongs.

In this way, Julia is not meaningfully free from hepatitis C despite having cured it three years prior to her interview. She feels a lingering sense of contamination (Fraser & Treloar, 2006), complicating the binaries (e.g., diseased/cured) on which cure as a biomedical status is premised. Recent research by Seear et al. (2021) explores the notion of a post-cure subject position. As in Julia’s case, they point to how the presence of antibodies after cure can rematerialise a stigmatised subject (Seear et al., 2021), but also how hepatitis C and related stigma are encoded into legislation, such as identifiable notification laws, insurance policies and blood donation exemptions. In this way, they argue, individuals can be medically cured but remain ‘marked’ by the presence of hepatitis C antibodies and enacted as hepatitis C subjects through forms of legislation and regulation (Seear et al., 2021). Clearly, the encoding of hepatitis C status beyond serostatus is an issue for Julia too but in ways perhaps even more pervasive than the formalised legislation analysed by Seear et al. (2021).

Unlike Kylie or Amelia, Julia described the treatment itself as ‘simple’ and in this sense, she had the easy, side-effect-free experience often depicted in health promotion. Yet even though Julia achieved a sustained virological response after this ‘simple’ treatment experience, hepatitis C has lingered for her, waiting to be encountered in highly personal and sensitive contexts to remind her of aspects of life she hoped to leave behind. While established approaches to understanding treatment uptake might suggest that the factors generally impeding it have been overcome in Julia’s case, we argue that they continue to shape or co-produce what cure can be and its ongoing implications. Approached as a co-productive gathering, this case emphasises that while one may be ‘cured’, the formal and informal relations that allow a desired break with the past and a hepatitis C-free life remain to be gathered.

CONCLUSION

In this analysis, we have argued for the benefits of approaching hepatitis C cure not solely as a biomedical and public health policy event but, following Fraser and Seear (2011), as a social and material gathering. Each of the three cases analysed here demonstrated, in different ways, that while elimination may be possible, it is certainly not inevitable unless we attend to the broader social and material forces that gather with, and are gathered by, biomedical intervention. In this sense, our analysis emphasises the significance of broadening the elimination project beyond removal of the virus by incorporating a range of other forces active in the lives of those affected by it. A more capacious notion of elimination is by no means unprecedented, for example,
elimination discourses shape approaches to longstanding issues in Australia such as sexism (see Male Champions of Change, 2017) and international efforts to support human rights (see Convention on the Elimination of All Forms of Discrimination against Women 1979; International Convention on the Elimination of All Forms of Racial Discrimination 1969; see also International Day for the Elimination of Racial Discrimination 2021 [United Nations]). While appearing in quite different contexts, such examples suggest that even in the case of hepatitis C, an elimination project need not be focussed on the biomedical elimination of the virus alone but also on the social and material forces that shape who is affected by it, its long-term implications, and the power and potential of cure. While much socially oriented hepatitis C research points to various forces, or ‘factors’, that impact treatment uptake (e.g. Harris & Rhodes, 2013; Heard et al., 2021), our analysis is distinct in its focus on the ontological inseparability of diverse phenomena (medicine, housing, stigma, responsibility and so on) in the materialisation of cure. As such, we argue that even removal of hepatitis C, while crucial, does not necessarily eliminate the multiple and complex ways the virus permeates the social fabric of daily life for those affected by it. With these issues in mind, our analysis emphasises that cure and elimination are impeded by longstanding inequalities that shape lives, opportunities and priorities in ways that complicate treatment and create lingering stigma and discrimination. Beyond this though, in focussing on three cases in depth, we point to the various ways individual experiences of cure and broader goals of elimination can be achieved when a range of issues and practices such as sufficient housing, flexible treatment access, supportive social relationships, and careful and considered treatment practices are appropriately gathered.

Most broadly, in drawing these cases together, we have argued that cure is not an easy or inevitable end point of access to direct-acting antiviral treatments. While we focus on how these dynamics shape experiences of hepatitis C treatment in particular, our case analysis approach can be used to analyse the social dynamics shaping other health concerns, especially those implicated in related issues such as stigma and material disadvantage. Importantly, this approach can be used to draw a range of forces into view that tends to be backgrounded when solutions are imagined primarily through biomedical means. For example, even, or especially, in a context in which highly efficacious treatments are available, understandings of treatment success and failure must remain deeply attuned to the political implications of who or what is centred as the cause of either outcome. Relatedly, our analysis suggests that approaches to cure need to maintain a broader analytical focus than ‘treatment adherence’, one able to account for the wide array of actors that shape how cure is realised. This also suggests that approaches discounting the possibility of treatment failure or the experience of side effects (Bryant et al., 2019) may be counterproductive. Additionally, simple narratives of cure as inevitable may conceal the resources and relations needed to generate and fully experience cure in its biomedical and social senses, instead regathering problematic patterns of responsibilisation and blame. In this sense, we suggest it is necessary to temper claims about the transformative potential of treatment (Madden et al., 2018a) in order to cultivate conditions now for improved treatment practices, health and well-being, and broader social change for people living with or ‘cured’ of hepatitis C (Seear et al., 2021).

In making this argument, it is not our intention to underplay the significance of the advent of direct-acting antivirals, especially the highly positive impact they have had on patient experiences which, until their availability, had often been defined by acute suffering and life upheaval (e.g. Hopwood & Treloar, 2005; Sgorbini et al., 2009). Rather our analysis emphasises that efforts to achieve hepatitis C elimination must think beyond and perhaps more ambitiously than cure – as it is usually understood – alone (Seear et al., 2021). In conceptualising cure as a gathering, we position the social and material relations usually thought to impact uptake as intrinsically part
of cure itself. When analysed in this way, cure must be approached as a process, as an ongoing struggle held together by social-material relations that work to generate the promises offered by access to direct-acting antiviral treatment, including cure. As such, hepatitis C elimination efforts may need a broad focus too, one that accounts for the social and material relations generating cure alongside traditional public health efforts to increase treatment uptake, completion and follow up. When cure is conceptualised as a gathering, these broader issues must be understood not as extra concerns but as intrinsically part of individual experiences of cure and of ambitious efforts to eliminate hepatitis C.

ACKNOWLEDGEMENTS
We express our thanks to the participants who gave so generously of their time, insights and experiences. We also thank the expert advisory panel for guiding aspects of the research. The interviews were conducted by Adrian Farrugia, Renae Fomiatti and Emily Lenton. The research reported in this article was funded by the Australian Research Council (DP200100075). Thanks go also to the anonymous reviewers whose comments helped to improve the article. Open access publishing facilitated by La Trobe University, as part of the Wiley - La Trobe University agreement via the Council of Australian University Librarians.

AUTHOR CONTRIBUTION
Adrian Farrugia: Formal analysis (lead); Project administration (lead); Writing – original draft (lead); Writing – review & editing (lead). Renae Fomiatti: Project administration (supporting); Writing – original draft (supporting); Writing – review & editing (supporting). Suzanne Fraser: Funding acquisition (lead); Methodology (lead); Writing – review & editing (supporting). David Moore: Funding acquisition (supporting); Methodology (supporting); Writing – review & editing (supporting). Michael Edwards: Funding acquisition (supporting); Methodology (supporting); Writing – review & editing (supporting). Elizabeth Birbilis: Funding acquisition (supporting); Methodology (supporting); Writing – review & editing (supporting). Carla Treloar: Funding acquisition (supporting); Methodology (supporting); Writing – review & editing (supporting).

DATA AVAILABILITY STATEMENT
No data for this article is available.

ORCID
Adrian Farrugia https://orcid.org/0000-0003-3751-9060
Renae Fomiatti https://orcid.org/0000-0001-6193-9634
Suzanne Fraser https://orcid.org/0000-0003-1018-5865
David Moore https://orcid.org/0000-0002-5860-3109
Michael Edwards https://orcid.org/0000-0002-5392-2901
Carla Treloar https://orcid.org/0000-0002-8230-0386

REFERENCES
Australian Government Department of Health (2018). Fifth national hepatitis C strategy 2018–2022. Department of Health.
Bryant, J., Rance, J., Hull, P., Mao, L., & Treloar, C. (2019). Making sense of ‘side effects’: Counterpublic health in the era of direct-acting antivirals. International Journal of Drug Policy, 72, 77–83. https://doi.org/10.1016/j.drugpo.2019.06.002
Campos Fernández de Sevilla, M. Á., Gallego Úbeda, M., Tovar Pozo, M., García-Cabrera, E., Monje García, B., Tutau Gómez, F., Delgado Téllez de Cepeda, L., & Iglesias-Peinado, I. (2019). Measure of adherence to direct-acting antivirals as a predictor of the effectiveness of hepatitis C treatment. *International Journal of Clinical Pharmacology*, 41, 1545–1554. [https://doi.org/10.1007/s11096-019-00917-0](https://doi.org/10.1007/s11096-019-00917-0)
de Graaff, B., Yee, K. C., Clarke, P., & Palmer, A. (2018). Uptake of and expenditure on direct-acting antiviral agents for hepatitis C treatment in Australia. *Applied Health Economics and Health Policy*, 16, 495–502. [https://doi.org/10.1007/s40258-018-0392-8](https://doi.org/10.1007/s40258-018-0392-8)
de Souza, T. (2021). ‘Hep hep hooray! The miracle drug beating hepatitis C’ reprinted from. *The Bulletin*, 17(3), 3–6.
Degenhardt, L., Peacock, A., Colledge, S., Leung, J., Grebely, J., Vickerman, P., Stone, J., Cunningham, E. B., Trickey, A., Dumchev, K., Lynskey, M., Griffiths, P., Mattick, R. P., Hickman, M., & Larney, S. (2017). Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: A multistage systematic review. *The Lancet Global Health*, 5(12), e1192–e1207. [https://doi.org/10.1016/S2214-109X(17)30375-3](https://doi.org/10.1016/S2214-109X(17)30375-3)
Duffin, J. (2005). *Lovers and livers: Disease concepts in history*. University of Toronto Press.
Elgharably, A., Gomaa, A. I., Crossey, M. M., Norsworthy, P. J., Waked, I., & Taylor-Robinson, S. D. (2017). Hepatitis C in Egypt – Past, present, and future. *International Journal of General Medicine*, 10, 1–6.
Farris, D., & Wyles, D. (2020). Re-treatment of hepatitis C infection after multiple failures of direct-acting antiviral therapy. *Open Forum Infectious Diseases*, 7(4), ofaa095. [https://doi.org/10.1093/ofid/ofaa095](https://doi.org/10.1093/ofid/ofaa095)
Fomiatti, R., Farrugia, A., Fraser, S., Moore, D., Edwards, M., & Treloar, C. (Forthcoming). Post-crisis imaginaries in the time of direct-acting antiviral hepatitis C treatment.
Fraser, S. (2011). Beyond the ‘potsherd’: The role of injecting drug use-related stigma in shaping hepatitis C. In S. Fraser & D. Moore (Eds.), *The drug effect: Health, crime and society* (pp. 91–105). Cambridge University Press.
Fraser, S., & Seear, K. (2011). *Making disease, making citizens: The politics of hepatitis C*. Ashgate.
Fraser, S., & Treloar, C. (2006). ‘Spoiled identity’ in hepatitis C infection: The binary logic of despair. *Critical Public Health*, 16(2), 99–110. [https://doi.org/10.1080/09581590600828683](https://doi.org/10.1080/09581590600828683)
Goodyear, T., Ti, L., Carrieri, P., Small, W., & Knight, R. (2020). ‘Everybody living with a chronic disease is entitled to be cured’: Challenges and opportunities in scaling up access to direct-acting antiviral hepatitis C virus treatment among people who inject drugs. *International Journal of Drug Policy*, 81, 102766. [https://doi.org/10.1016/j.drugpo.2020.102766](https://doi.org/10.1016/j.drugpo.2020.102766)
Goutzamanis, S., Doyle, J., Higgs, P., & Hellard, M. (2018). Improving hepatitis C direct-acting antiviral access and uptake: A role for patient-reported outcomes and lived experience. *Journal of Viral Hepatitis*, 26, 218–223. [https://doi.org/10.1111/jvh.13020](https://doi.org/10.1111/jvh.13020)
Goutzamanis, S., Horyniak, D., Doyle, J., Hellard, M., & Higgs, P. (2021). Perceived physical health outcomes of direct-acting antiviral treatment for hepatitis C: A qualitative study. *Harm Reduction Journal*, 18(73), 1–6. [https://doi.org/10.1186/s12954-021-00516-1](https://doi.org/10.1186/s12954-021-00516-1)
Harris, M. (2017). Managing expense and expectation in a treatment revolution: Problematizing prioritisation through exploration of hepatitis C treatment ‘benefit’. *International Journal of Drug Policy*, 47, 161–168.
Harris, M., & Rhodes, T. (2013). Hepatitis C treatment access and uptake for people who inject drugs: A review mapping the role of social factors. *Harm Reduction Journal*, 10(7), 1–11. [https://doi.org/10.1186/1477-7517-10-7](https://doi.org/10.1186/1477-7517-10-7)
Harris, M., & Rhodes, T. (2018). Caring and curing: Considering the effects of hepatitis C pharmaceuticalisation in relation to non-clinical treatment outcomes. *International Journal of Drug Policy*, 60, 24–32. [https://doi.org/10.1016/j.drugpo.2018.07.015](https://doi.org/10.1016/j.drugpo.2018.07.015)
Heard, E., Smirnov, A., Massi, L., & Selvey, L. (2021). Personal, provider and system level barriers and enablers for hepatitis C treatment in the era of direct-acting antivirals: Experiences of patients who inject drugs accessing treatment in general practice settings in Australia. *Journal of Substance Abuse Treatment*, 127, 108460. [https://doi.org/10.1016/j.jsat.2021.108460](https://doi.org/10.1016/j.jsat.2021.108460)
Hopwood, M., & Treloar, C. (2005). The experience of interferon-based treatments for hepatitis C infection. *Qualitative Health Research*, 15(5), 635–646. [https://doi.org/10.1177/1049732304273932](https://doi.org/10.1177/1049732304273932)
Kirby Institute (2018). *HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2018*. Sydney: Kirby Institute, UNSW Sydney. https://kirby.unsw.edu.au/report/hiv-viral-hepatitis-and-sexually-transmissible-infections-australia-annual-surveillance

Lancaster, K., Rhodes, T., & Rance, J. (2020). ‘Towards eliminating viral hepatitis’: Examining the productive capacity and constitutive effects of global policy on hepatitis C elimination. *International Journal of Drug Policy*, 80, 102419. https://doi.org/10.1016/j.drugpo.2019.02.008

Larrey, D., Ripault, M.-P., & Pageaux, G.-P. (2014). Patient adherence issues in the treatment of hepatitis C. *Patience Preference and Adherence*, 8, 763–773. https://doi.org/10.2147/PPA.S30339

Latour, B. (2004). Why has critique run out of steam? From matters of fact to matters of concern. *Critical Inquiry*, 30(2), 225–248.

Madden, A., Hopwood, M., Neale, J., & Treloar, C. (2018a). Beyond cure: Patient reported outcomes of hepatitis C treatment among people who inject drugs in Australia. *Harm Reduction Journal*, 15(42), 1–8. https://doi.org/10.1186/s12954-018-0248-4

Madden, A., Hopwood, M., Neale, J., & Treloar, C. (2018b). Beyond interferon side effects: What residual barriers exist to DAA hepatitis C treatment for people who inject drugs? *PLoS One*, 13(11), e0207226. https://doi.org/10.1371/journal.pone.0207226

Male Champions of Change (2017). *We set the tone: Eliminating everyday sexism*. Champions of Change Coalition. https://championsofchangecoalition.org/wp-content/uploads/2018/04/We-Set-The-Tone_Eliminating-Everyday-Sexism.pdf

Molina, M., Hajarizadeh, B., & Dore, G. (2018). Observations on the launch of new drugs for hepatitis C. *Australian Prescriber*, 41(1), 4–5.

Mol, A., & Law, J. (2002). *Complexities: Social studies of knowledge practice*. Duke University Press.

Mora, M., Goodyear, T., Marcellin, F., Shoveller, J., Di Beo, V., Calzoliao, C., Sogni, P., Wittkop, L., Zucman, D., Poizot-Martin, I., Lacombe, K., Salmon-Céron, D., Knight, R., & Carrieri, P. (2020). Life after hepatitis C cure in HIV-infected people who inject drugs and men who have sex with men treatment with direct-acting antivirals in France: Health perceptions and experiences from qualitative and qualitative findings. *Journal of Viral Hepatitis*, 27, 1462–1472.

Pourmarzi, D., Smirnov, A., Hall, L., FitzGerald, G., & Rahman, T. (2020). ‘I’m over the moon!’: Patient-perceived outcomes of hepatitis C treatment. *Australian Journal of Primary Health*, 26, 319–324. https://doi.org/10.1071/PY20013

Richmond, J., Ellard, J., Thorpe, R., Higgs, P., Hellard, M., & Thompson, A. (2018). Achieving a hepatitis C cure: A qualitative exploration of the experiences and meanings of achieving a hepatitis C cure using direct-acting antivirals in Australia. *Hepatology, Medicine and Policy*, 3(8), 1–9.

Seear, K., Fraser, S., Farrugia, A., & valentine, k. (2021). Beyond a ‘post-cure’ world: Sketches for a new futurology of hepatitis C. *International Journal of Drug Policy*, 94, 103042.

Seear, K., & Lenton, E. (2021). Becoming posthuman: Hepatitis C, the race to elimination and the politics of re-making the subject. *Health Sociology Review*, 30, 229–243. https://doi.org/10.1080/14461242.2021.1971102

Sgorbini, M., O’Brien, L., & Jackson, D. (2009). Living with hepatitis C and treatment: The personal experiences of patients. *Journal of Clinical Nursing*, 18(16), 2282–2291. https://doi.org/10.1111/j.1365-2702.2009.02806.x

Stanaway, J. D., Flaxman, A. D., Naghavi, M., Fitzmaurice, C., Vos, T., Abubakar, I., Abu-Raddad, L. J., Assadi, R., Bhala, N., Cowie, B., Forouzanfrou, M. H., Groeger, J., Hanafiah, K. M., Jacobsen, K. H., James, S. L., MacLachlan, J., Malekzadeh, R., Martin, N. K., Mokdad, A. A., ... Cooke, G. S. (2016). The global burden of viral hepatitis from 1990 to 2013. *The Lancet*, 388(10049), 1081–1088.

United Nations (1969). *International convention on the elimination of all forms of racial discrimination*. United Nations.

United Nations General Assembly (1979). *Convention on the elimination of all forms of discrimination against women*. http://www.un.org/womenwatch/daw/cedaw/

Vega, T., Levander, X., Seaman, A., Korthuis, P., & Englander, H. (2021). ‘Sobriety equals getting rid of hepatitis C’: A qualitative study exploring the interplay of substance use disorder and hepatitis C among hospitalized adults. *Journal of Substance Abuse Treatment*, 127, 108337. https://doi.org/10.1016/j.jsat.2021.108337

Williams, B., Nelons, D., Seaman, A., Witkowska, M., Ronan, W., Wheelock, H., Zaman, A., & Garcia, J. (2019). Life projects: The transformative potential of direct-acting antiviral treatment for hepatitis C
among people who inject drugs. *Injectional Journal of Drug Policy*, 72, 138–145. https://doi.org/10.1016/j.drugpo.2019.03.015

World Health Organization (2016). *Combating hepatitis B and C to reach elimination by 2030: Advocacy brief*. WHO.

Wright, C., Cogger, S., Hsieh, K., Goutzamanis, S., Hellard, M., & Higgs, P. (2019). ‘I’m obviously not dying so it’s not something I need to sort out today’: Considering hepatitis C treatment in the era of direct-acting antivirals. *Infection, Disease and Health*, 24(2), 58–66. https://doi.org/10.1016/j.idh.2018.10.006

**How to cite this article:** Farrugia, A., Fomiatti, R., Fraser, S., Moore, D., Edwards, M., Birbilis, E., & Treloar, C. Hepatitis C cure as a ‘gathering’: Attending to the social and material relations of hepatitis C treatment. *Sociology of Health & Illness*. 2022;44:830–847. https://doi.org/10.1111/1467-9566.13467