

Policy Briefing Note

Canadian Correctional Institutions and HCV Prevalence and Transmission

Correctional facilities represent unique opportunities to address HCV, from transmission, to treatment initiation and adherence. The World Health Organization (WHO) states, *"The health of prisoners is an issue of public health concern. Everyone in the prison environment – prisoners, prison staff, or their family members – benefits from enhancing the health of prisoners and reducing the incidence of communicable disease."*ⁱ

HCV is endemic within the incarcerated population where infection rates are often higher than those of HIV. While the national HCV burden among Canadians is approximately 1%, the prevalence of HCV in Canadian correctional facilities is between 20% and 40%.ⁱⁱ

Certain groups experience an increased incidence of HCV; according to Kouyoumdjian et al (2016), studies done within Canada, the United States, and Australian correctional facilities show that the prevalence of HCV in women (25.3% to 67%) tends to be far greater than among men (4% to 39.4%).ⁱⁱⁱ

Many individuals are not just entering correctional facilities with hepatitis C but are contracting blood-borne infections while in custody. The odds of HCV infection increase with the frequency of incarceration and duration of imprisonment.

This increased risk is primarily due to incarcerated individuals engaging in high-risk injecting practices, such as sharing injection drug use (IDU) paraphernalia with a large and homogeneous cohort of incarcerated individuals.^{iv}

There is often a high degree of mobility between correctional facilities and the community and the ramifications of someone entering the correctional system, acquiring HCV, and not accessing treatment before release, are staggering.

Vulnerable Populations for Incarceration and the Social Determinants of Health

Social determinants of health impact both who is in correctional facilities and who has their most significant exposure to health care while incarcerated, *"in many countries, prisons and jails house low-income individuals with many syndemic co-morbidities, many of whom do not have access to medical care and social services in the community."*^v

Low socioeconomic status, low education level, low employment rates and low-income status are much more common amongst the incarcerated population in Canada. Recent data showed that while 19% of Canadian adults have not completed high school, more than 50% of adults in custody, overall, have not obtained a high school diploma.^{vi}

HCV Model of Care Project Goal

Develop recommendations on the implementation of an HCV model of care which will create screening, treatment, and linkage to care pathways within the provincial correctional institutions of Ontario, and ensure continuity in healthcare engagement upon release.

One-Day Dialogue Goals

Identify strategies to overcome treatment access barriers, and ultimately promote health equity, for those experienced with/ experiencing incarceration.

Raise awareness of the inequities in access to healthcare, specifically access to HCV treatment and support, within provincial correctional facilities.

Bring multiple stakeholders to the table to discuss the roadmap to an HCV model of care for those who have experienced/are experiencing incarceration.

Effects of Incarceration on the Ability to Stay in Care

CTAC's HIV Cascade of Care work (<https://ctac.ca/hiv-cascade-of-care>) revealed barriers to remaining on treatment while incarcerated and living with HIV and/or HCV. For example, the pre-trial detention population has grown immensely in recent years, but *"In some correctional centres the pre-trial population can only access programs and services, such as medical care...through correspondence."*^{vii} This significantly affects HCV treatment access.

Discharge planning is often severely lacking upon release, especially from provincial facilities, *"...Attention to issues such as job placement; treatment of drug use; mental illness triage and referral... enhances the likelihood that medical discharge planning will be effective...Discharge planning and linkage to community aftercare also facilitates ongoing secondary prevention efforts..."*^{viii} A discharge plan gives a better chance of improved health outcomes in conjunction with other harm reduction measures.

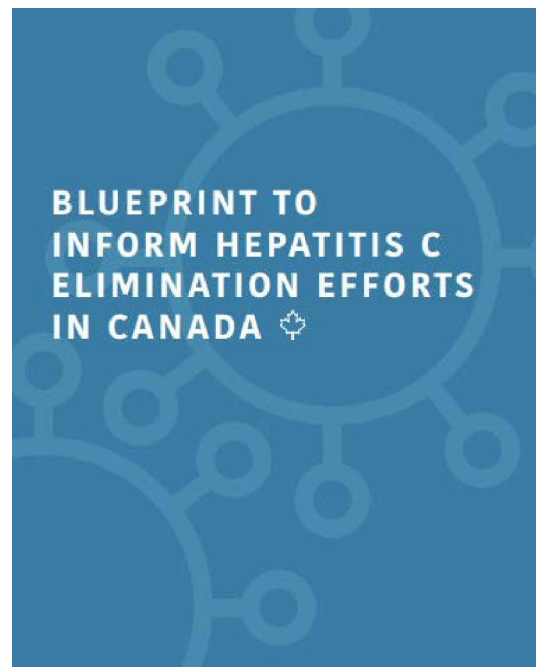
This gap in the linkage to care was highlighted by the Correctional Investigator for Ontario in 2017: *"There is no policy direction regarding when the discharge planning process should begin, how discharge needs are identified, establishing linkages to community-based services, or the process by which identified discharge needs should be met in the community."*^{ix} This results in uneven application across institutions, and an uneven standard of care for those who are incarcerated and are trying to start/remain on hepatitis C treatment.

The CanHepC Blueprint

In 2016, Canada signed onto the WHO *Global Health Sector Strategy on Viral Hepatitis (GHSS)*^x which calls for viral hepatitis to be eliminated as a public health threat by 2030.

CanHepC's *Blueprint to Inform a Hepatitis C Elimination Strategy in Canada*^{xi} represents a fantastic step forward in achieving this target. Created with nationwide stakeholders, its measurable objectives/actions will aid policy makers, and provincial/territorial governments, in constructing elimination plans.

People experiencing/who have experienced incarceration face enhanced, specific barriers to HCV treatment. It is vital the Blueprint is used to develop a tailored, comprehensive action plan that meets their specific needs.



References

ⁱWorld Health Organization, UNODC, UNAIDS; "Evidence for Action Technical Papers: Effectiveness of Interventions to address HIV in prisons", WHO, 2007.

ⁱⁱSkoretz, S., Zaniewski, G., Goedhuis, N.J., "Hepatitis C virus transmission in the prison/inmate population". *CCDR 2004: Volume 30 (16)*; accessed online

ⁱⁱⁱKouyoumdjian, K., Schuler, A., Matheson, F., Hwang, S.W. "Health status of prisoners in Canada." *Canadian Family Physician*, vol. 62, March 2016, 215-22

^{iv}Skoretz, S., Zaniewski, G., Goedhuis, N.J., "Hepatitis C virus transmission in the prison/inmate population". *CCDR 2004: Volume 30 (16)*.

^vRich, Josiah D., Beckwith, Curt G., Macmadu, Alexandria, Marshall, Brandon D.L., Brinkley-Rubinstein, Lauren., Amon, Joseph J., Milloy, M.J., King, Maximillian, R.F., Sanchez, Jorge., Atwoli, Lukoye, Altice, Frederick L. "Clinical Care of incarcerated people with HIV, viral hepatitis, or tuberculosis". *Lancet*, Vol. 388; accessed online February 2017.

^{vi}Kouyoumdjian, K., Schuler, A., Matheson, F., Hwang, S.W. "Health status of prisoners in Canada." *Canadian Family Physician*, vol. 62, March 2016, 215-22.

^{vii}Corrections in Ontario: Directions for Reform; © Queen's Printer for Ontario, September 2017

^{viii}World Health Organization, UNODC, UNAIDS; "Evidence for Action Technical Papers: Effectiveness of Interventions to address HIV in prisons", WHO, 2007.

^{ix}Corrections in Ontario: Directions for Reform; © Queen's Printer for Ontario, September 2017

^xWorld Health Organization; "Global Health Sector Strategy on Viral Hepatitis 2016-2021 towards Ending Viral Hepatitis 2016-2021", WHO/HIV/2016.06

^{xi}<http://www.canhepc.ca/en/blueprint/rationale-scope>