

Prisons

OPINION FOLLOWED BY RECOMMENDATIONS ON HEPATITIS C PREVENTION, SCREENING AND TREATMENT IN PRISONS

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OPINION
GLOBAL CARE

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The French National AIDS & Viral Hepatitis Council (CNS) is an independent, consultative French agency comprising 26 members, chaired by Professor Patrick Yeni, that delivers opinions and recommendations on the issues facing society as a result of these epidemics. It is consulted about the health plans and programs drawn up by the public authorities.

Its papers are addressed to the French public authorities and to all those involved in or concerned by the epidemic. The CNS participates in the development of public policy, within a framework that promotes respect for fundamental ethical principles and human rights.

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SUMMARY

PREAMBLE	4
FACTS	5
1. THE EMERGENCE OF DIRECT-ACTING ANTIVIRALS (DAAS) HAS BROUGHT ABOUT A RADICAL PARADIGM SHIFT IN THE FIGHT AGAINST THE HEPATITIS C VIRUS.....	5
2. CONSIDERATION OF THE KEY POPULATION OF PRISONERS IN THE STRATEGY TO ELIMINATE THE HCV EPIDEMIC BY 2025 IS A DECISIVE FACTOR IN ITS SUCCESS.....	5
2.1. Prisoners represent a particularly high-risk population in terms of HCV infection.....	5
2.2. The lack of epidemiological data concerning this population is a major barrier to the development of an appropriate health response.....	5
2.3. Transfer to a secure custody environment provides individuals often with no available medical care in open environments with an opportunity to access screening and treatment.....	6
3. SCALING UP SCREENING FOR HCV AND, IN CONJUNCTION, FOR HBV AND HIV, UPON ENTERING AND WHILST IN PRISON, IS THE MAIN CHALLENGE TO BE TAKEN UP.....	7
3.1. Inadequate screening is the weak link in the care pathway.....	7
3.2. Prison healthcare units (USMPs) can simplify and fast-track their screening circuits, especially by taking up rapid diagnostic tests (RDT)	7
3.3. Developing partnerships with other stakeholders involved in screening processes can round off the care provision available in prison healthcare units (USMPs) and increase the options for accessing it.....	7
4. THERE IS ROOM FOR IMPROVING THE TIMEFRAMES AT THE DIFFERENT STAGES UP TO THE COMMENCEMENT OF TREATMENT	8
5. MOREOVER IT IS VITAL TO STRENGTHEN PREVENTION AND, IN PARTICULAR, TO END THE ILLOGICAL RESTRICTION OF ACCESS TO RISK REDUCTION TOOLS IN PRISONS.....	9
5.1. Provision in terms of harm reduction policies where drug use is concerned is incomplete and unequally rolled out.....	9
5.2. Developing a meaningful harm reduction strategy requires stronger partnerships with the competent external stakeholders and awareness-raising and training of prison and health workers in this approach.....	10
5.3. Access to information and tools for reducing sexual risks – and to condoms in particular – is inadequate	10
6. ROLL-OUT OF AN EFFECTIVE STRATEGY ON COMBATING HCV IN PRISONS CALLS FOR ENHANCED MULTI-LEVEL OVERSIGHT AND MAJOR EFFORTS TO COORDINATE AND SUPPORT PROFESSIONALS ON THE GROUND	11
6.1. At national level, interministerial and ministerial oversight has been inadequate to date for political and structural reasons.....	11
6.2. At regional or interregional level, collaboration between the DISPs and ARSs is inconsistent, not least because of the low or wavering interest of some ARSs.....	12
RECOMMANDATIONS	14
INDEX OF ACRONYMS AND ABBREVIATIONS	16

PREAMBLE

By letter dated 13 November 2018, the Prison Administration Director, General Director for Health and General Director for Healthcare Services jointly tasked the French National AIDS & Viral Hepatitis Council (CNS) with conducting an assignment on the procedures for managing hepatitis C virus (HCV) infection in prisoners.

As part of this formal request, the CNS was asked to:

- assess the current situation regarding the management of HCV-infected prisoners, particularly in line with the therapeutic context that has changed significantly since direct-acting antivirals (DAAs) became available;
- outline proposals for improving screening of HCV, HIV and hepatitis B virus (HBV) as well as treatment of HCV infection, in order to contribute to the strategy to eliminate the HCV epidemic by 2025, which forms part of the headline measures under the National Public Health Plan (PNSP) defined by the Government.

To that end, the CNS set up a committee tasked with performing a literature review, processing the national data available, interviewing the main national stakeholders and carrying out hearings and observation missions with pilots and stakeholders on the ground in three regions in mainland France (the East, the South and the Parisian Region). Eleven penal institutions were visited in this context. The committee wrote a *Report* setting out its findings and analyses from this work.

The information presented in this *Statement* and the *recommendations* issued as a result bear solely on the specific, restricted scope of HCV infection screening, treatment and prevention in prisons – as well as, by extension, of HIV and HBV as regards the first two aspects.

At the same time, the CNS is aware that the matters it is examining form part of a broader series of political, social and health issues concerning the prison system, which go far beyond the purpose of the assignment with which it has been entrusted, and which have an impact on the recommendations that the CNS is able to issue.

The intention of the recommendations issued is not to encompass all of the problems identified, but rather to act on the drivers that the CNS believes are likely to significantly expand, within a reasonable timeframe, HCV-infected prisoners' access to treatments that could help cure them. But there is little point in improving HCV screening and treatment of infected prisoners unless this comes hand-in-hand with decisive action aimed at avoiding both new contamination and recontamination of people who have already been cured. Accordingly, the CNS also outlines a certain number of associated recommendations aimed at paving the way for effective prevention of infection risks in the prison setting.

The inclusion of this *Statement* and its recommendations under Action No. 11 of the *2019-2022 Road Map for Prisoners' Health*, recently published by the Government, is a programming milestone.

In light of the recurring problems observed in the dialogue between the Ministry for Health and Ministry of Justice, the CNS must stress, however, that the implementation of its recommendations calls for firm political commitment in their regard.

For it is important to leave behind the current stasis such that, at a time when effective HCV treatments are now available, a coherent and integrated strategy can be rolled out in prisons providing the broadest possible access to prevention, screening and treatment. This is not only a pressing requirement in ethical terms, but also a prerequisite to attaining the goal of eliminating the epidemic by 2025.

FACTS

The French National AIDS & Viral Hepatitis Council (CNS) has observed and borne in mind the following facts

1. THE EMERGENCE OF DIRECT-ACTING ANTIVIRALS (DAAS) HAS BROUGHT ABOUT A RADICAL PARADIGM SHIFT IN THE FIGHT AGAINST THE HEPATITIS C VIRUS

Second-generation DAAs have been available since 2014 to treat HCV infection. These treatments are more effective and better tolerated than 1st-generation treatments, and now allow for viral cure in the vast majority of cases at the end of eight or twelve weeks of treatment, depending on the proprietary product used, the viral subtype and degree of liver damage. Their use is indicated in all infected patients, irrespective of their degree of liver damage.

These therapeutic innovations represent a major paradigm shift in the fight against the HCV epidemic. At an individual level, it is now possible to cure HCV-infected people by means of short, well-tolerated treatments. In terms of public health, through a "Test and treat" type strategy involving early screening and immediate treatment, elimination of the HCV epidemic is now an achievable goal. This is what the Government is aiming for, having turned this goal into a priority of its health policy and set its sights on achieving this by 2025.

To that end, a three-pronged proactive public health strategy must be rolled out: large-scale screening of individuals unaware of their infection; treatment of all individuals diagnosed with an active infection to cure them and so break the transmission chains; at the same time, press on with and step up risk reduction and prevention efforts in a bid to avoid new contamination and recontamination.

2. CONSIDERATION OF THE KEY POPULATION OF PRISONERS IN THE STRATEGY TO ELIMINATE THE HCV EPIDEMIC BY 2025 IS A DECISIVE FACTOR IN ITS SUCCESS

→ *Recommandation # 1*

Prisoners represent a population that is highly exposed to the risk of HCV infection and which is largely responsible for driving the epidemic. Rolling out the three aforementioned strategic measures among this population is therefore a priority for attaining the goal of eliminating the HCV epidemic.

2.1. Prisoners represent a particularly high-risk population in terms of HCV infection

Prison populations are particularly concerned by sniffing inhalants or injecting drugs, as well as by other vulnerability factors associated with a higher risk of HCV, HIV or HBV infection such as high social and economic insecurity, social, family and/or emotional isolation, the high rate of psychiatric disorders with inadequate or no care, and the lack of available medical care in open environments. Moreover, prisons also represent an environment where the risks of HIV, HBV and HCV transmission are higher, not least in the event of ongoing injection practices during imprisonment.

HCV rates among prisoners are higher than in the general population which, from an epidemiological point of view, suggests that prisons are a "reservoir" for this infection. This aspect is compounded by the fact that the prison population is characterized by a high turnover rate, where a significant proportion of prisoners – drug users in particular – frequently come and go between open and secure environments.

2.2. The lack of epidemiological data concerning this population is a major barrier to the development of an appropriate health response

Paradoxically, there has been nowhere near enough research into the prison population to date, when in-depth, up-to-date knowledge of the situation regarding this key population, in light of the risks of infection, would be necessary to develop a response tailored specifically to the needs, both in terms of medical care and prevention.

When conducting this assignment, the CNS came up against a lack of descriptive and analytical epidemiological data concerning HCV in the prison population and gaps in and a lack of processing of data bearing on medical treatments in prison healthcare units (USMPs) when this has been collected.

As such, there is no robust, up-to-date estimate available today of the HCV prevalence in the prison population – especially among drug users. Indeed, there is no epidemiological monitoring mechanism for the routine collection

and processing of the results of screening tests performed in prisons, which means that neither the number of tests nor the proportion of prisoners who have tested positive is known, just as the number or proportion of individuals in which an active infection has been confirmed via diagnosis is not known either.

Against this backdrop, the only prevalence estimates available come from surveys – of variable scope and methodology. The most robust study is by no means recent, and provides an estimate of HCV seroprevalence in the prison population, in 2010, of 4.8% – which is six times higher than in the general population at that time. Although more recent data, from less exhaustive studies or studies conducted at the scale of a single prison, suggest that the prevalence has decreased, it would still seem to be much higher, in a variable proportion depending on the source, than the prevalence observed in the general population.

The data required for assessing care afforded to prisoners at different stages of the HCV care pathway is also missing. There are no overall estimates regarding the number and proportion of prisoners actually screened in prison. The only data subject to standardized and centralized collection at USMP level concerns the number of screening tests for HCV – as well as HBV and HIV incidentally – performed over the year. Furthermore, this data has not been consistently entered or analyzed by the Ministry for Health departments. It is not possible to know how many individuals have benefited from DAA therapy in the prison setting or the number of patients cured of their infection by the end of their treatment either.

Without the necessary information for assessing the effectiveness of HCV treatment through a "cascade of care" model regarding access to the different stages of the care pathway, the CNS has been obliged to try, whenever possible, to estimate some of these parameters by its own means. It has thus been possible to establish an order of magnitude of the number and proportion of prisoners screened, even though the indicators on which this is based are far from perfect. One survey conducted in the three regions visited also enabled an estimate of the number of prisoners having benefited from DAA therapy, and to get an idea of the prevalence of active infections.

Such gaps are at odds with the Government's stated ambitions. In this regard the CNS backs the goals of Action no. 2 of the *2019-2022 Road Map for Prisoners' Health*, concerning the roll-out of tools for monitoring prisoners' overall health. The tools developed must allow for precise data to be produced on HCV, HIV and HBV. For that, it is necessary not only to shore up the existing collection systems by ensuring the exhaustiveness and quality of the data compiled, but also to round off these systems by organizing the collection of missing data and perform and coordinate the analysis and monitoring of all of the data collected, with a view to eventually measuring the impact of treatments on the trends of the epidemic.

2.3. Transfer to a secure custody environment provides individuals often with no available medical care in open environments with an opportunity to access screening and treatment

Prisons are places providing access to medical care. For individuals living in very vulnerable circumstances, with no available medical care in open environments, transfer to a secure custody environment provides an opportunity to (re-)engage with the health service, benefit from an assessment of their health, including screening for the hepatitis viruses and HIV and, where necessary, receive appropriate medical treatment.

The brevity and effectiveness of DAA therapies now makes it possible to treat and cure HCV-infected prisoners while they are still in prison, in the majority of cases. This requires the whole of the care pathway to be organized as effectively as possible.

Patients with active HCV infection usually follow a so-called "simplified" care pathway, which can be organized, all stages included, such that the patients are cured within four months of entering prison.

Where their prison term is shorter, or for complex cases requiring a care pathway that lasts a few more weeks, treatment may and should have been started in prison, and its continuation and completion organized in an open environment if necessary.

3. SCALING UP SCREENING FOR HCV AND, IN CONJUNCTION, FOR HBV AND HIV, UPON ENTERING AND WHILST IN PRISON, IS THE MAIN CHALLENGE TO BE TAKEN UP

→ *Recommendations # 2 to 5*

As things currently stand, only one in two prisoners is actually screened at the start of their prison term for HCV, HIV and HBV – taking all the reasons for non-screening together, and with major disparities between penal institutions. The result is that a proportion of HCV-infected individuals do not access DAA therapy.

3.1. Inadequate screening is the weak link in the care pathway

The low screening rates observed are doubly detrimental: first of all for the infected individuals themselves, in terms of loss of therapeutic opportunity with, in cases of no treatment, a risk of hepatitis C becoming chronic and developing into multiple and severe complications of liver disease; secondly, insofar as the infected individuals who are unaware of their infection continue to transmit HCV, driving circulation of the virus inside and outside prisons.

The screening options currently available in prisons, organized as they are in a disparate manner depending on institution, do not appear to be entirely effective, not least in the context of the compulsory health assessment on arriving in prison and during the first weeks of a prison term.

Most prison healthcare units are woefully understaffed in terms of medical staff, mostly because of the low appeal of careers and difficult working conditions in prison settings. "Just-in-time" management of all types of incoming requests for treatment and emergencies hinders the teams' ability to perform their routine prevention and screening missions.

Although the offer of screening is normally made, at least officially, during the admission assessment, its performance in practice is put off to a subsequent session which the prisoner is asked to attend at the healthcare unit for samples to be taken – which, depending on the institution, may not take place for another few days, weeks in most cases, but even months in some cases. Given these conditions, various factors ultimately lead to many screenings never being carried out – and new offers of screening are hardly ever made during prison terms.

What is more, negative screening results are seldom shown, which represents a missed opportunity for prevention.

In addition, in order to increase prisoners' acceptance of screening, it is crucial that they be informed of the merits of screening and access to new treatments for curing HCV.

3.2. Prison healthcare units (USMPs) can simplify and fast-track their screening circuits, especially by taking up rapid diagnostic tests (RDT)

Except in a rare few cases, clinical teams do not seem to question this situation or these highly unsatisfactory results, which call for an overhaul of screening circuits – even if, in some institutions, the CNS' visit did help to set a thought process on the subject in motion.

The CNS is particularly struck by the almost complete lack of RDT uptake in USMPs and the unfamiliarity and reluctance often expressed by teams in using them, when the evidence points to there being several advantages to using such tools: easy and quick to perform as soon as screening has been offered; immediate results, including for negative results; and their use can be delegated entirely to nursing staff. Information and training on RDT use for health workers in prison settings is a prerequisite for their roll-out.

3.3. Developing partnerships with other stakeholders involved in screening processes can round off the care provision available in prison healthcare units (USMPs) and increase the options for accessing it

Although screening within penal institutions should primarily be carried out by USMPs, other partner facilities or departments could play a role. There are definite merits in developing such partnerships if they make a qualitative contribution to diversifying the provision by providing a different screening context from the one in USMPs, which is likely to appeal more to prisoners, or to bolster the opportunities for reiterating screening offers.

There are partnerships in place particularly in some institutions with free information, screening and diagnosis centres (CeGIDD). But too often, such partnerships are a pretext for USMPs to offload part or all of their screening requirements onto these centres, even though the latter have very limited scope for operating within penal

institutions. The role of CeGIDDs is thus reduced to a technical screening service, when the value of a partnership would, in light of the CeGIDDs' tasks and competences, be in offering screening as part of a comprehensive sexual health and prevention provision – which is lacking in the prison setting, incidentally.

Addiction treatments also represent opportunities that are currently not sufficiently tapped into for offering and performing screening – by RDT in particular. The involvement of internal or external facilities and departments operating in this area (psychiatric care staff in prison healthcare units, hospital departments specializing in addiction, regional medico-psychiatric services (SMPR), specialized addiction treatment support and prevention centres (CSAPA), risk reduction support centres for drug users (CAARUD)) appears to be uneven and could be scaled up.

The involvement of associations working more widely in the spheres of health education, prevention and support for the most vulnerable groups can help to improve information about the merits of screening, scale up its access and, for facilities authorized to perform RDTs, offer screenings outside of a medical setting.

4. THERE IS ROOM FOR IMPROVING THE TIMEFRAMES AT THE DIFFERENT STAGES UP TO THE COMMENCEMENT OF TREATMENT

→ Recommendations # 6 and 7

For prisoners who have been screened positive for HCV the CNS notes that treatment is then provided in correct conditions overall. Once active infection has been confirmed by diagnosis, it does not observe any major hurdles to accessing DAA therapy in particular.

However, the timeframes for performing assessments to confirm the diagnosis, explore liver fibrosis and begin DAA therapy for patients compatible with a so-called simplified care pathway, according to the criteria defined by the French National Authority for Health (HAS), still vary widely and improvements could be made in many institutions in this regard. In extreme cases, these timeframes can drag on for more than four months. What's more, biological monitoring of treatment efficacy and viral cure is not carried out constantly across all units. As such, the number of patients for whom treatment has been effective is not systematically compiled. Finally, biological monitoring to identify any recontamination is seldom suggested.

Some USMPs have nevertheless established short timeframes for performing assessments and, for patients following the simplified care pathway, for swift prescription of DAA therapy. Identification within the USMP of a lead physician for HCV and/or infectious diseases, acting as a direct correspondent with the specialist department of the affiliated hospital, particularly seems to be a simple and effective way to fast-track care pathways. This organization also strikes as beneficial for improving management of complex cases requiring review by a multidisciplinary consultation meeting (RCP).

In the context of a simplified care pathway, which is appropriate for most prisoners, the CNS considers that starting treatment within two weeks of receiving positive HCV serology results is an achievable goal.

The fact that all physicians now have the possibility of prescribing the main pangenotypic DAA regimens should provide a further springboard towards achieving this, provided that USMP physicians harness this option and can get training in prescribing and monitoring such treatments.

5. MOREOVER IT IS VITAL TO STRENGTHEN PREVENTION AND, IN PARTICULAR, TO END THE ILLOGICAL RESTRICTION OF ACCESS TO RISK REDUCTION TOOLS IN PRISONS

→ *Recommendations # 8 to 12*

The overall inadequacy in prisons of information and prevention measures concerning the risks of infection, and particularly the lack of access to key tools for reducing the risks of transmitting HIV and the hepatitis viruses via bodily fluids (blood/sexual transmission), is scuppering the health strategies in place to combat these epidemics.

More specifically as regards the goal to eliminate the HCV epidemic, it should be noted that although DAA therapy can cure an infected patient, it does not confer any protection against the risk of being reinfected if newly exposed to the virus.

So it strikes as illogical, when major efforts are being taken to screen, treat and cure as many infected patients as possible, not to address the conditions driving continuing transmission of this infection – especially reinfection of individuals who have already been treated and cured.

5.1. Provision in terms of harm reduction policies where drug use is concerned is incomplete and unequally rolled out

The availability in prison settings of psychoactive drugs, and therefore of trafficking, and their consumption, are phenomena well-known to all prison and health workers. These prohibited practices are poorly documented and their scale difficult to ascertain.

Although, overall, opioid substitution treatment (OST) appears to be accessible in penal institutions (despite local prescription and distribution procedures that can sometimes be complex), this does not cover all needs.

For some drug users continue to inject and/or sniff drugs while in prison. The risk of transmitting HCV, HBV and HIV is particularly high during such practices when there is no access to sterile syringes or low-risk inhalation devices.

Bleach is currently the only means of reducing the risks associated with injection in prisons, but its use (for which the prison authorities are responsible) is not very effective in institutions. This is an anachronistic situation. For it has been demonstrated for more than two decades that using bleach for the purposes of reducing harm is less effective than the single use of sterile injection devices, which has been the priority strategy recommended by the World Health Organization since 2007. Since then, several countries similar to France have set up programmes for accessing injection kits in prisons, and these have unquestionably proven to be reliable, safe and effective.

As far as inhalants are concerned, there are no recommended devices. In rare cases, a risk reduction support centre for drug users (CAARUD) may come to a prison to distribute ready-to-roll single-use sterile sheet type kits, or safer crack use kits in even rarer instances. Because these initiatives depend on local tolerance, their supply is by no means certain.

Whereas the provisions of Article 41 of the Act of 26 January 2016 have bolstered the legal framework for deploying in prisons an equivalent harm reduction strategy to what is available in open environments, the CNS can only lament the lack of texts for applying these new provisions more than three years after the legislation was adopted – which has only further entrenched the stasis it had already denounced in a *Statement* issued in 2009, along with other expert bodies back then and since.

Concerning these issues, the CNS would like to stress that it fully subscribes to the analysis and recommendations presented by the French Government Inspectorate for Social Affairs (IGAS) in the report it published in December 2017 on access to harm reduction tools. The CNS was able to consult that report for this assignment, but regrets that it is unable to share its conclusions and recommendations owing to the confidential nature of the report, which the CNS believes should be made public.

Moreover, the CNS deeply regrets that the *2019-2022 Road Map for Prisoners' Health* does not contain any action on deploying a harm reduction strategy in prisons.

5.2. Developing a meaningful harm reduction strategy requires stronger partnerships with the competent external stakeholders and awareness-raising and training of prison and health workers in this approach

Beyond questions regarding access to tools, deployment of a harm reduction strategy requires competent professionals to promote and implement it, and the conditions conducive to helping all prison stakeholders to understand and accept this approach, in keeping with their respective specialities and duties.

Prison healthcare units currently spend little time on prevention aspects in general and harm reduction policy in particular, for want of sufficient time and human resources, as well as trained staff. Competent specialized addiction treatment support and prevention centres (CSAPAs) mainly focus on care and treatment, and most do not, or only marginally, display harm reduction support; some centres even uphold a vision of care that excludes such an approach. Whilst some nursing staff may show a personal interest in training in this area, most are not particularly motivated or are reluctant to develop these types of skills.

Strengthening the role of CAARUDs, often run by associations, would be a way to address these shortcomings. Although instances of CAARUDs working directly in prisons are few and far between today, the examples we do have are striking, both in terms of provision of information in formats tailored to the target groups (and in some instances jointly produced with them) and support based around individual needs. Rolling out these partnerships more widely – or even introducing the principle of contractually appointing a competent CAARUD for each penal institution, similar to the scheme that exists for CSAPAs – would go some way to providing these skills in institutions, which are sorely lacking at present. This would involve, on the one hand, directly providing prisoners with harm reduction support and, on the other, developing training, where applicable, for healthcare professionals working in USMPs. On the latter point, one option could be for the Regional Health Agency (ARS) to appoint a CAARUD as a lead centre at regional level.

It is also paramount to improve the cooperation of prison authority staff, as they are still by and large unfamiliar with the harm reduction approach and often have a poor grasp of it – two reasons why it is commonly rejected out of principle. These spontaneous reactions are the result of a serious lack of information and basic knowledge on not only the risks of infection and means of transmission but also addictive behaviors and how best to treat them. Regarding HCV infection, these staff are not aware that it can now be cured.

Prison staff's lack of initial training and continuing professional development in these areas, as well as the lack of awareness-raising measures in institutions, thus spawn mistaken risk assessments, belief in illusory safeguards and prejudices that stigmatize drug users. This series of mistaken perceptions are a major barrier to the adoption of appropriate professional conduct, both in terms of correctly treating detained drug users and of the security of staff themselves.

5.3. Access to information and tools for reducing sexual risks – and to condoms in particular – is inadequate

Whilst the risks of sexual transmission may only be marginal where HCV is concerned, their prevention is nonetheless essential with regard to HIV and HBV, and this therefore forms part of a holistic approach to combating these three diseases.

Neither authorized nor banned, sexual relations in prison settings are an acknowledged fact by all stakeholders, and yet they are seldom talked about – whether as regards practices during family visits or practices between prisoners, including in terms of the coercion and violence that such practices can involve in some cases. The taboos surrounding sex are exacerbated in prisons, where macho values and chauvinistic, homophobic attitudes are rife.

In such a context, where the simple matter of getting hold of condoms can be a delicate business for prisoners, tackling questions surrounding sexual relations and sexual risk prevention is certainly a challenge for healthcare professionals – especially when they have not been given specific training. Most medical staff avoid taking the initiative in this regard, in the belief that their role is limited to answering any requests that might be made by individuals.

So despite a context where the risks are higher, sexual risk prevention is given short shrift. Beyond condoms, the key tools today in the diversified HIV prevention strategy are not promoted widely, or at all, such as information about the effect of antiretroviral therapy on secondary transmission (known as TasP, Treatment as prevention),

and/or remain very difficult to access in practice, such as pre-exposure (PrEP) or post-exposure (PEP) prophylaxis.

Within prison healthcare units, availability of information concerning sexual risk prevention varies widely. It does not appear to be systematic, and the information formats provided have seldom been designed for prisoners – and are even obsolete in some cases.

Concerning condoms, provisions are organized differently depending on the institution and do not always enable discreet access – not least as regards warders or other prisoners. Except in a rare few cases, the only type available are male condoms, which are not always supplied with lubricant gel. Some institutions are beset by long-term stockouts. In theory, condom supplies are the responsibility of the prison authorities, but in a number of institutions the CNS has found that both the prison authorities and medical staff are incapable of identifying a sustainable and organized supply chain for condoms. Their availability is therefore often reliant on the goodwill and ability of one member or a handful of healthcare professionals to come up with supply solutions – at times quite creative – especially by calling on associations.

The provision of information and condoms alike, as stipulated in the various pieces of legislation and regulations, remains, moreover, limited to prison healthcare units, which in turn limits access thereto to prisoners with grounds for medical consultations. Such lack of access in other places of detention is at odds with the recommendations in force. In some institutions, it is thus particularly shocking to observe that there are no male or female condoms available in family visiting rooms or family living units (UVF), whether such lack is the result of an omission or, in a certain number of cases, a decision taken by the institution's management staff.

6. ROLL-OUT OF AN EFFECTIVE STRATEGY ON COMBATING HCV IN PRISONS CALLS FOR ENHANCED MULTI-LEVEL OVERSIGHT AND MAJOR EFFORTS TO COORDINATE AND SUPPORT PROFESSIONALS ON THE GROUND

→ *Recommandations # 13 and 14*

Whilst acknowledging the relevance of certain local initiatives, the CNS nevertheless finds that the goal to eliminate the HCV epidemic, the pressing need to reconsider the importance of screening and the need to refocus discussions on HCV infection around healing have not yet prompted the necessary or expected level of mobilization across most penal institutions in light of the challenges and possibilities opened up by the introduction of DAAs. As such, the sheer scale of the paradigm shift has not been sufficiently grasped or taken on board on the ground, which suggests a lack of information, coordination and oversight at different levels.

6.1. At national level, interministerial and ministerial oversight has been inadequate to date for political and structural reasons

Until very recently, the Government's goal to eliminate the HCV epidemic by 2025 was not supported by any particular strategy concerning its achievement in prisons – whether within the Health-Justice coordination bodies at interministerial and inter-Directorate level, or on the part of the Ministry for Health as regards the ARSs.

The CNS therefore heralds the progress represented by the inclusion of this goal in the *Road Map for Prisoners' Health* (published in July 2019), through Action No. 11 which is devoted to it. The recommendations set forth in this *Statement* must inform the operational content of this focal point of action to be implemented over the 2019-2022 period.

In this regard, a number of difficulties cannot be ignored in terms of ministerial and interministerial oversight and governance.

The decision-making body set up by the interministerial Health-Justice committee meets once a year. In view of the reference framework that the Prisoners' Health Strategy represents, two bodies are planned to monitor and coordinate its implementation. On the one hand, a monitoring committee bringing together the relevant directorates of the two ministries and representatives of stakeholders at national and regional level meets twice a year, for the purposes of informing and consulting with the parties. On the other hand, an interministerial project team, with a purely technical skill set, is tasked with drawing up the operational application of the strategy. Coordinated by a project leader positioned within the General Directorate for Health, this team brings together representatives of the two ministries' relevant directorates and departments.

In this very vertical setup, where the policy-making processes are particularly long, dialogue and action at interministerial Health-Justice level do not appear to flow smoothly. With no arbitration on some questions, no action is possible in the areas concerned. The lack of consensus over the roll-out of harm reduction policies, after representing a major sticking point, has now reached a point where the subject is being avoided altogether. The interministerial process in terms of drafting the implementing decree for Article 41 of the Act of 26 January 2016, after a positive start during a first stage, has been on hold for more than two years. The progress sought by the lawmaker has no longer seemed to benefit from any major ministerial oversight, whether in terms of the Minister for Health advocating the merits of such a measure for public health, or the Minister of Justice adopting the necessary provisions for implementing the legislation, through social dialogue with the prison authorities. The CNS thus deeply regrets the lack of political clarification at the highest level of these issues, which are crucial for strategic public policy coherence in tackling the risks of infection and combating HCV in particular.

Regarding oversight within the health sector, the tools available to central government for fostering regional health agencies' effective application of the actions now enshrined in the road map are structurally limited by the agencies' independence. Moreover, it has taken two years for an operational application to be defined at interministerial and inter-Directorate level of the *National Prisoners' Health Strategy* adopted back in April 2017. The *2019-2022 Road Map for Prisoners' Health* thus comes too late in relation to the five-year programming cycle for regional health policies, such that the ARSs have not been able to factor its focal points of action into the Regional Health Plans (PRS) for 2018-2023.

The central health authorities are, however, empowered to provide guidance to the ARS prisoners' health correspondents, for which it convenes an annual meeting. It also has some scope for initiating specific action via the allocation of exceptional funding – without having the means to ensure that this is actually used as intended. Accordingly, the General Directorate for Healthcare Services (DGOS) granted short-term funding worth €8.2m in total to the ARSs in 2017 and 2018, for the purposes of scaling up the human and material resources for harm reduction policies in remand prison healthcare units, encompassing managing addictions, information for prisoners about the risks of infection and harm reduction, screening of HIV and hepatitis viruses, coordination between the somatic, psychiatric and specialist addiction teams, or staff training in harm reduction.

Oversight as far as the decentralized departments of the prison administration are concerned relies, on the other hand, on a direct reporting line between central government and the Interregional Directorates for Prison Services (DISP).

The joint organization by the Prison Administration Department (DAP) and relevant departments of the central health authorities of joint annual meetings between the DISP health correspondents and ARS prisoners' health correspondents is a framework which should be leveraged to galvanize these officials as regards Action No. 11 of the *Road Map* and foster experience-sharing between regional pilots.

6.2. At regional or interregional level, collaboration between the DISPs and ARSs is inconsistent, not least because of the low or wavering interest of some ARSs

Regional health-justice committees have been set up in a bid to equip the prison regions or interregions with a governing body tasked with delivering prison health policies at regional level and with ensuring the coordination of all the contributing stakeholders. But this ambition is proving difficult to put into practice. In a significant number of regions, the committee has either never held a meeting, or only done so at irregular intervals, and less often than the expected minimum of one meeting a year. In regions where there is an operational committee, some participants consider it to play a primarily formal role with no operational scope.

Discussions and efforts to coordinate oversight at regional and interregional level between the prison and health authorities appear more effective through the regular, sometimes intense, interaction that exists between the DISP health correspondents and the ARS prisoners' health correspondents. Regional momentum seems to depend heavily on these officials' personal dedication and the quality of interpersonal relationships, and as such it is fragile. Above all, the DISP health correspondents typically assume this role on a full-time basis, while the Regional Health Agencies often only assign a fraction of full time equivalent – sometimes very little – to the role of prisoners' health correspondents. These correspondents often express the sense that they fulfil this duty not with the support of their Directorate, but in spite of it. Such disparities can sometimes lead to unbalanced dialogue between correspondents and misunderstandings between the two authorities. Some DISPs have found there to be no prisoners' health correspondents at the ARS at all, since their absence is an accepted fact by the latter's Management team – sometimes for periods lasting several years. With no dialogue to speak of, everything needs to begin again from scratch.

These scant resources assigned by most Regional Health Agencies to overseeing prison health policy more broadly reflect the minimal importance that many agencies attach to this issue within their regional health policy. The Regional Health Plans or, in this context, the regional programmes for access to prevention and health care for the most deprived persons (PRAPS), seldom define ambitious targets or a clear, structured programme concerning prisoners' health. Monitoring of the actions programmed is also patchy given the ARS' limited or complete lack of scope for making sure the affiliated hospitals of the prison healthcare units or regional medico-psychiatric services are using the funding assigned as intended.

Such inconsistent management (which is often inadequate and even lacking at times) of prison health matters within Regional Health Agencies is undermining the mobilization and coordination of health and social stakeholders involved in the prison health provision – first and foremost the USMP. A number of professionals in these facilities feel that the agencies should support and listen to them more – including when it comes to sharing their needs with their hospital managements – and often say they feel isolated or even abandoned in some cases.

In this context, to implement Action No. 11 of the *Road Map* the ARSs must scale up and more effectively organize their actions both in terms of programming and oversight and monitoring – including by better supporting the professionals involved. This support particularly entails developing training and change management schemes in professional practices as well as organizing the care pathway with enhanced screening and optimized timeframes for treating prisoners infected with HCV. The ARSs could usefully rely on the expert hepatitis centres and/or the Regional Committees for Coordinating the Fight against HIV (COREVIH) to assess the territorial needs and coordinate the stakeholders to be brought on board.

RECOMMENDATIONS

In light of all the above, the CNS issues the following recommendations

In order to diagnose and monitor the health of HCV-infected prisoners:

1. *for the attention of the Minister for Health, General Director for Healthcare Services, Chief Executive of the national public health agency, Santé publique France, and the Chief Executive of the national health insurance fund (CNAMTS, now the CNAM)*

Organize the collection, provision, analysis and monitoring of descriptive and therapeutic epidemiology data concerning infection by HCV, HBV and HIV within the prison population.

In order to scale up screening for HCV and, in conjunction, for HIV and HBV:

2. *for the attention of all medical staff working in prison settings*
Systematically identify, upon entering and whilst in prison, the opportunities for informing prisoners of the merits of HCV screening and treatment, and particularly of the fact that the new antiviral therapies are better tolerated and can cure the disease in 8 to 12 weeks.
3. *for the attention of the Regional Health Agency (ARS) Chief Executives, heads of the affiliated hospitals of prison healthcare units (USMP) and medical coordinators and senior medical staff in USMPs*
Deploy rapid diagnostic tests (RDTs) as a priority tool in screening for HCV, HBV and HIV in prisons so as to ensure immediate testing as soon as an offer of screening is accepted, for the purposes of:
 - Providing healthcare professionals with information and training concerning RDTs
 - Delegating RDT-based screening to nursing staff
4. *for the attention of medical coordinators and senior medical staff in USMPs and addiction treatment services*
Ensure that combined screening for HCV, HBV and HIV is offered and carried out, and that results are received while the prisoner is still in the new arrivals' wing – including when these results are negative
5. *for the attention of ARS Chief Executives, Interregional Directors for Prison Services, heads of penal institutions, medical coordinators and senior medical staff in USMPs and regional medico-psychiatric services (SMPP) as well as the relevant external operators*
Organize for the offer of screening to be reiterated during a prison term, and particularly diversify the provision by bolstering the role of internal and external partners (CSAPA, CAARUD, CeGIDD, associations) in the context of broader strategies (health education, prevention and harm reduction):
 - support the development of external partner-led programmes in prisons
 - ensure that programmes are coordinated and complementary between the health unit and the partners

In order to reduce the timeframes for introducing DAA therapy:

6. *for the attention of USMP medical coordinators, with input from expert hepatitis centres*
Establish in each institution, in partnership with a HCV correspondent:
 - a short process aimed at confirming diagnosis and, for patients following a simplified care pathway, introducing treatment within two weeks of receiving a positive serology result
 - an optimized process for complex cases requiring review by a multidisciplinary consultation meeting (RCP)
7. *for the attention of the heads of the affiliated hospitals of USMPs and medical coordinators in USMPs, with input from expert hepatitis centres*
Facilitate training for USMP physicians in:
 - implementing the right care pathway for each patient, as defined by the National Authority for Health (HAS)
 - prescribing treatment and monitoring it in the context of the simplified care pathway

In order to deliver a strategy for preventing and reducing the risks of infection that is coherent and meets requirements:

8. *for the attention of the Prime Minister, Minister of Justice and Minister for Health, with technical support from the DAP, DGOS and DGS*

Enable application of the provision of the Act of 26 January 2016, and, consequently:

- adopt the implementing decree stipulated by Article L. 3411-10 of the French Public Health Code (CSP)
- develop information for health and prison workers on harm reduction policies and tools where drug use is concerned
- make the recognized harm reduction tools available in prisons (injection and inhalation kits, safer crack pipes, etc.), where applicable in stages
- expand CAARUD-led programmes in prisons in order to shore up the harm reduction provision

9. *for the attention of ARS Chief Executives, Interregional Directors for Prison Services, heads of penal institutions and medical coordinators and senior medical staff in USMPs*

Ensure that condoms are effectively supplied in the new arrival's kit, in USMPs and in the other prison areas (family living unit, corridors and/or activity areas, etc.)

10. *for the attention of heads of penal institutions and medical coordinators and senior medical staff in USMPs, with input from the DISPs and ARSs*

Organize the distribution among prisoners and their next of kin of appropriate information on preventing the risks of infection in the areas of addiction and sexual health and on the merits of HCV screening in light of the benefits now presented by the new treatments

11. *for the attention of the Chief Executive of the national public health agency, Santé publique France, the Prison Administration General Director, ARS Chief Executives, Interregional Directors for Prison Services, heads of penal institutions and medical coordinators and senior medical staff in USMPs*

Design and organize the distribution of suitable information materials on preventing the risks of infection in the sphere of addictions and sexual health

- for prison workers
- for health workers

12. *for the attention of the DAP and DGS, ARS Chief Executives, Interregional Directors for Prison Services, heads of penal institutions and medical coordinators and senior medical staff in USMPs*

As part of initial training and continuing professional development for health and prison workers, organize information and awareness-raising sessions on the risks of infection and on the strategies and tools for harm reduction where drugs are concerned and for reducing sexual risks

In order to improve regional oversight and governance

13. *for the attention of ARS Chief Executives*

Unlock the necessary internal financial and human resources for sustained and sustainable regional oversight of prisoners' health

14. *for the attention of Interregional Directors for Prison Services and ARS Chief Executives, through the DISP health correspondents and ARS prisoners' health correspondents*

Run and coordinate forums with the facilities working in prison settings on the subjects of health education, prevention and screening

INDEX OF ACRONYMS AND ABBREVIATIONS

ARS: Regional Health Agency

CAARUD: Risk reduction support centres for drug users

CeGIDD: Free information, screening and diagnosis centres

CNS: National AIDS & Viral Hepatitis Council

COREVIH: Regional Committees for Coordinating the Fight against HIV

CSAPA: Specialized addiction treatment support and prevention centres

DAA: Direct-Acting Antivirals

DAP: Prison Administration Department

DGOS: General Directorate for Healthcare Services

DISP: Directorates for Prison Services

HAS: French National Authority for Health

HBV: Hepatitis B Virus

HCV: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

IGAS: French Government Inspectorate for Social Affairs

OST: Opioid substitution treatment

PEP: Post-Exposure Prophylaxis

PNSP: Public Health Plan

PRAPS: Regional programmes for access to prevention and health care for the most deprived persons

PrEP: Pre-Exposure Prophylaxis

PRS: Regional Health Plans

RCP: Multidisciplinary consultation meeting

RDТ: Rapid Diagnostic tests

SMPR: Regional medico-psychiatric services

TasP: Treatment as prevention

USMP: Prison healthcare units

UVF: Family living units

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¹ *Rapport sur la prévention, le dépistage et le traitement de l'hépatite C chez les personnes détenues*, CNS, 2020 : <https://cns.sante.fr/rapports-et-avis/avis-prisons-2019>