

CORRESPONDENCE

The Ethics of Hepatitis C “Treatment as Prevention” Among Prisoners

To the Editor:

Hepatitis C virus (HCV) infection is highly prevalent among prisoners.¹ The development of new therapeutics for HCV infection has given rise to recommendations (including by one of us, S.L.) that opt-out HCV testing be implemented in correctional settings,^{2,3} with infected individuals linked to treatment. Increasing testing and treatment of HCV infection in prisons is in line with the paradigm of “treatment as prevention”: that by reducing the pool of prevalent HCV infection through treatment, onward transmission will cease.⁴ There are two important issues to consider in discussions of HCV treatment as prevention in the prison context.

First, prisoners are in unequal power relationships with custodial and health staff. How can we be sure that consent for HCV testing in an opt-out environment is truly voluntary and free from coercion? Requiring prisoners to choose to not opt-out of an HCV test, and opt-in to an HCV test, may be an effective approach to ensuring voluntariness that also maximizes testing uptake. Furthermore, ensuring that the responsible staff do an adequate job of pre-test counseling in an opt-in setting may be a more ethical approach to increasing testing uptake than imposing a policy of opt-out testing.

Second, an important aspect of “treatment as prevention” is the converse: “prevention as treatment,” or the prevention of reinfection of treated individuals. In community settings, people successfully treated for HCV infection can usually obtain treatment for substance use disorders, including opioid substitution therapy, to assist in reducing or ceasing injecting drug use, or can access sterile needles and syringes if they do inject. Implementation of these interventions and other harm reduction measures is poor in prisons. The limited options for prisoners wishing to protect themselves against reinfection pose a significant challenge to the success of HCV “treatment as prevention” in prison settings.⁵ Anecdotally, prisoners are choosing to defer treatment entry in the absence of the ability to protect themselves from reinfection.

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References

1. Larney S, Kopinski H, Beckwith CG, Zaller ND, Jarlais DD, Hagan H, et al. The incidence and prevalence of hepatitis C in prisons and other closed settings: results of a systematic review and meta-analysis. *HEPATOLOGY* 2013;58:1215-1224.
2. Spaulding AC, Thomas DL. Screening for HCV infection in jails. *JAMA* 2012;307:1259-1260.
3. Larney S, Mahowald M, Scharff N, Flanigan TP, Beckwith CG, Zaller ND. Epidemiology of hepatitis C virus in Pennsylvania state prisons 2004-2012: limitations of 1945-1965 birth cohort screening in correctional settings. *Am J Public Health* [Epub ahead of print].
4. Martin NK, Vickerman P, Grebely J, Hellard ME, Hutchinson S, Lima VD, et al. Hepatitis C virus treatment for prevention among people who inject drugs: modeling treatment scale-up in the age of direct-acting antivirals. *HEPATOLOGY* 2013;58:1598-1609.
5. Bate JP, Colman AJ, Frost PJ, Shaw DR, Harley HAJ. High prevalence of late relapse and reinfection in prisoners treated for chronic hepatitis C. *J Gastroenterol Hepatol* 2010;25:1276-1280.

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