ACCESS TO HCV RELATED SERVICES IN PRISON SETTINGS IN EUROPE:
A community perspective

Hand Project
2018

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EXECUTIVE SUMMARY

In 2015, governments across Europe and Central Asia committed themselves to achieve the Sustainable Development Goals (SDGs) and combatting hepatitis by 2030. The following year, at the World Health Assembly, they adopted the first WHO strategy on hepatitis, which calls for eliminating viral hepatitis as public health threat. They then all then approved the WHO Europe action plan to eliminate viral hepatitis as public health threat in September 2016.

The disproportionately higher prevalence of HCV and other communicable diseases in the prison population puts at risk the health of people incarcerated, prison staff and the general population since most people are eventually released. It is a threat to public health that urgently needs to be tackled to achieve the above- mentioned targets.

Governments, across the WHO Europe region are also legally bound to respect, protect and advance fundamental rights according to the international and European human rights conventions they are party to. It entails the inherent principle that prisoners should enjoy an equivalent standard of care to persons outside prisons. Experts increasingly stress the need to look at end results beyond equivalence of care due to the greater health problems amongst prisoners. It is also the responsibility of the prison authorities to ensure that risks to health are reduced to a minimum; and that the dignity and human rights of every prisoner are respected. The Committee on the Prevention of Torture has long recognised that an inadequate level of health care can lead rapidly to situations falling within the scope of the term “inhuman and degrading treatment”.

Yet, while prevalence among prisoners in the WHO Europe region is generally than in the general population and is a major cause of morbidity and mortality both among HCV-mono- and HIV- co-infected among them, they have a more limited to access to HCV prevention, treatment, care and support services. This situation presents thus present both a public health and human rights emergency that needs to be tackled together by local authorities, civil society and health professionals.

In order to better understand and document challenges and ways to enhance access to HCV related services in prison, EATG and local civil society partners examined the situation in 6 countries from the WHO Europe region, namely Bulgaria, Finland, Italy, Kazakhstan, Moldova and Portugal.

The desk research and interviews carried out as part of the HAND project pointed to the following challenges:

1. Organisation of health services provision: lack of clarity under which jurisdiction the HCV services are; high turn-over and lack of willingness of external to penitentiary system medical staff to work in prisons; geographic compartmentalisation of the services provided; entangled budget streams for different components of care.

2. Monitoring and surveillance: no national repositories where data on epidemiology are sent at regular intervals; lack of system for unified data collection.

3. Prevention: no state funding for prevention services, sporadic and unsustainable NGO projects; lack of normative documents that regulate and normalise the NGOs' activities in prisons; lack of essential harm reduction programmes in many countries; lack of tailored to the recipient information; lack of broader prevention measures (e.g. alcohol and cannabis addiction help).

4. Access to testing: testing not provided as per agreed standards; blood sampling organised in a cumbersome manner and not implemented as a result; HCV tests not anonymous; there is coercion to get tested.

5. Access to treatment and care: lack of treatments, complicated to impossible treatment provision systems; requirement of uninterrupted health insurance for access; lack of peer support; no algorithms for follow-up; depending on prisoner's duration or severity of sentence; issues of anonymity; questionable criteria for medicines selection and procurement.

6. National guidelines, programmes and protocols: no particular stipulations on the penitentiary system and outdated normative documents.

Based on these findings, the following recommendations account could be made to recommendations to different stakeholders:

RECOMMENDATIONS

I. Organisation and delivery of health services provision:

HCV related services in detention under the jurisdiction of the national health system rather than the Ministry of Justice.

Ensure dialogue between the ministry of health, justice and interiors

Introduce contracting systems for NGOs to deliver services in prisons in a sustainable manner and according to agreed standards.

Community programmes can reduce the workload of prison healthcare staff by delivering complimentary services to prisoners

Ensure support of ministry of justice and prison management and staff for NGOs interventions

NGOs delivery services should address the possible negative consequences for the prisoners of voluntary testing and counselling programmes.

Provide HCV related information that is tailored to specific groups.

Enable NGOs to provide peer support.

II. Monitoring and surveillance:

Create a national repository for the collection of medical data from the penal system centrally.

Include prisoners as a key population in national programmes and have indicators for monitoring of progress.

WHO/ECDC could provide technical support to national authorities to improve the quality and reliability of data for evidence-based interventions

Pan-European reporting and platform for dialogue with governments by the ECDC, WHO and Committee for the Prevention of Torture and and Inhuman or Degrading Treatment or Punishment (CPT)

Monitoring the implementation of guidelines and evaluate their impact

III. Prevention:

Implement comprehensive harm reduction programmes, OST, HBV vaccination and alcohol/cannabis addiction support.

IV. Access to testing:

Make testing widely available, including via trained community workers.

Provide testing for other infections in integrated manner as appropriate.

Ensure that testing and counseling is voluntary and that the confidentiality of result is ensured

V. Access to quality treatment and care:

Make DAAs available and prescribed as per current EASL/EACS treatment guidelines and train doctors working in prisons.

Procurement should take into account possible interactions with antiretrovirals and other medicines.

Introduce incentives for medical professionals to work in or regularly visit prisons and provide services there.
Ensure access to the treatment lasts even where the person is not covered by a health insurance.
Create algorithms with treatment mechanisms, including follow-up after release.
Include prison health aspects in medical training curricula, including on risk factors added of community-led initiatives.

VI. Guidelines, programmes and protocols:

Update national guidelines as appropriate and monitor their implementation and impact

INTRODUCTION

Despite the huge achievements in the area of treatment, care and support for people with viral hepatitis, Hepatitis C Virus (HCV)-infection still remains a major morbidity and mortality cause among co-infected with HIV people. This is particularly true for countries with limited resources (e.g. some countries in Eastern Europe and Central Asia-EECA), as well as in those where medical systems that face challenges at political, decision-making or infrastructural levels.

Recognising these facts and following its mission statement, the EATG has been working in the field of community education and mobilisation, advocacy and policy around viral hepatitis since 2010. The overall aim being to improve access to viral hepatitis prevention, comprehensive, modern and cost-effective treatment, care and support for people living with HIV in Europe and Central Asia.

Through this work and contact with local and national HIV communities, we have come to realise that certain sub-populations have significantly more severe problems in accessing HCV services than others. Based on this feedback, the EATG started a project tailored to the revealed issues. It is called HAND (Hepatitis Access Needs). Its distinct objectives are: to address the specific access needs within co-infected key populations to hepatitis prevention, testing, treatment and care services in Europe (with a special focus on EECA region), and to improve the capacity of key community leaders to educate and support local community members and improve community involvement in treatment related advocacy.

The project has two main components: research and training. The research focuses on the access to hepatitis testing, treatment and care among people in detention and migrants. The training part provides targeted information on treatment and prevention of Hepatitis B and C through webinars in English and Russian and contributes to community mobilisation via advocacy-focused workshops, organised in collaboration with local partners.

The following report is a part of the research component and has been prepared by EATG members and associates. It covers the topic of HCV in the penitentiary system and consists of a general overview of the situation in the WHO Europe region and a more in-depth snapshot of six case countries. All data collection on the case countries was conducted by local people, working with non-governmental organisations (NGOs), or EATG staff.

The purpose of the report is to document gaps and positive developments in the treatment and care for prisoners in selected European and Central Asian countries. With this, we intend to support the advocacy activities of community groups and organisations by providing them with information and insights of both problems and possibilities of how their local systems may be improved and as a result expand the access to services for inmates. To achieve our objectives, we chose the following methodology.

METHODOLOGY

Our initial step was a general literature review. For it the research topic was defined as "HCV services in the penitentiary systems in the countries of the WHO Europe region". The selected data collection platforms were Google and PubMed. Upon analysis of the topic the following keyword list was produced "HCV+prisons+name of a country", "Hepatitis+prisons+name of a country", "HCV+HIV+prisons+name of a country", "HIV+HCV+co-infection+name of a country", "HCV+treatment+prisons+name of a country", "HCV+treatment+care+support+prisons+name of a country". The keyword search procedure was repeated for each of the 53 countries in the WHO Europe region in English language only. All publications before 2012 were excluded, so that we can present a more up-to-date picture of the situation. The slightly broad time-range was selected because regardless of the developments in the treatments of HCV with directly-acting antivirals (DAAs) and their more-or-less wider use in the Western countries nowadays, there are still establishments in EECA where older therapies with interferons and ribavirin are still in place, hence publications from 2012 onwards were quite relevant for some settings. Information was collected by one person centrally.

Based on the findings six countries were selected for an in-depth exploration. Those were: Bulgaria, Finland, Italy, Kazakhstan, Moldova and Portugal. The choice was by geographical coverage, economical diversity, community development and previous publications, where we put an emphasis on countries that have received less attention in the past.

All keywords were translated into a local language by a specifically appointed for the data collection person. He/she identified also the search engines (apart from Google) that are more commonly used in the respective countries, as well as would yield the largest numbers of data returns. The reason for this was that on many occasions some countries do not translate important specific data in English, but publish only in their official language(s). In addition, some interviews with people in the know and grey data could be found only through the local search engines.

All data collectors had to fill in a standardised questionnaire (data collection tool) with all possible findings. Interviewing professionals who work in the field of service provision for people with HCV/HIV co-infection was also allowed and the occasions when the data come from those particular interviews are clearly indicated in the report.

The standardised questionnaire included the following topics with the penitentiary system as a denominator:

Epidemiology: prevalence and incidence of HCV in the penal establishments of the country, co-infection cases, most affected groups and prisons, prevalent modes of transmission and genotypes, fibrosis stage, number of hospital admissions as a result of HCV and number of people with end stage liver disease, projections of disease burden.

Prevention: available prevention programmes (needle and syringe exchange and opioid substitution, condoms), provision of information.

Testing: algorithm of testing in prisons (available or not, compulsory or not, anonymous or not, paid or free of charge), number of tests performed in the detention institutions, type of tests used, targeted testing among specific sub-populations (people who inject drugs-PWID, men who have sex with men-MSM, inmates with foreign nationalities from endemic areas).

Diagnosis: algorithm of diagnosis and inclusion of the prisoner in the medical system for treatment, peer support for newly diagnosed and people on treatment.

Treatment and care: regulatory documents and specific to the penitentiary system national guidelines, number of people in detention treated, specialism of medical stuff that can provide treatment, how is the financial coverage of the treatment organised, registered antiviral medicines to be used in prisons, pricing, volume and procurement structure of HCV antivirals for the detention establishments, monitoring of the treatment, companies that provide treatment.

HCV budget: current treatment budget and financial projections for future.

National programme: does it exist and are there any stipulations for prisons, does local legislation allow conduct of clinical trials in the penitentiary system.

All filled questionnaires were translated in English and also analysed with NVivo for a possible trends identification.

BACKGROUND

This section presents a snapshot of HCV-infection in the penitentiary system in the countries from the WHO Europe region.

General information: Since people who inject drugs (PWIDs) constitute a substantial proportion of prison population in many European countries, HCV prevalence

among prisoners is higher than in the general population [1]. The HCV seropositivity is reported to be 4.9% in Hungary, 4.8%-5.2% in France, 7%-24.2% in England and Wales, 11% in Portugal, 19% in Scotland, 20% in Macedonia, 22.7% in Spain and 38% in Italy [2]. Different studies showed association between the HCV seroprevalence and history of injecting drug use (IDU). Among prisoners who reported IDU, rates vary from 60.2% in Ukrainian, 69% in Portuguese, 74.7% in Italian to a high 87% among Danish prisoners [Ibid.]. In three Croatian studies conducted among detainees the seroprevalence ranged from 4.9% in people with multiple sex partners to 52% in IDUs [Ibid.]. Some studies considered tattooing and piercing are risk factors for HCV infections, especially those done in nonprofessional settings [3]. In contrast, a Dutch study showed no evidence for an increased HCV seroprevalence among people in confinement with multiple tattoos and/or piercings. The study suggested that this might be due to the introduction of hygiene guidelines for tattoo and piercing shops in combination with the low observed prevalence of HCV in the general population [Ibid]. Compared to similar studies, the prevalence of HCV among prisoners in Northern Ireland is lower (1.1%) than in other European countries (only 11% of Irish prisoners reported ever injected drugs) [2].

According to ECDC, monitoring, testing and treatment for hepatitis C is reported to be available only in some prisons in almost all EU/EFTA countries (96% in 2012). Many countries highlight difficulties with providing treatment for HCV in the penal establishments though, for example, because of lack of funding or because of treatment only being available to those with health insurance. Testing and treatment for hepatitis C in prison is not so readily available in non-EU/ EFTA countries – only 50% report testing being offered and 27% report treatment being offered [4]. A map of the countries with screening programmes for HCV in penitentiary in Europe can be found in the ECDC report "Surveillance and prevention of hepatitis B and C in Europe"

published at the following link: http://ecdc.europa.eu/en/publications/Publications/101012_TER_HepBandC_survey.pdf

In a further development ECDC and EMCDDA are working on public health guidance on active case finding for communicable diseases in prison settings to be released in 2018. This guidance will be part of a broader set of guidance documents on prevention and control of communicable diseases in prison settings, which will encompass other specific interventions such as vaccination, and specific disease prevention and control methods (http:// www.emcdda.europa.eu/news/2017/joint-publication-communicable-diseases-prison_en).

Opioid substitution therapy (OST) in prisons is sporadically available and a map of the availability can be seen at the following link: http://ecdc.europa.eu/en/publications/Publications/dublin-declaration-monitoring-report-prisoners-october-2013.pdf

The next table presents some specific information for each country of the WHO Europe region. Its brevity is a result of the lack of available or published data which is already a major problem that needs addressing.

Basic facts on HCV in prisons from countries where published data are available on the Internet (WHO Europe 53 countries are in alphabetical order)	
Albania	There are no official numbers describing the situation regarding HCV in prisons. 3-4 HCV infections are diagnosed each year (information from field workers). The country has a methadone programme in the detention institutions but does not have any needle exchange programme there [5].
Andorra	No recent data on HCV in prisons.
Armenia	More than 35% of the detainees are infected with HCV. The country has the third largest prevalence in the Commonwealth of Independent States (CIS) region after Georgia and Uzbekistan [6]. No DAA treatment is registered or officially available, hence no treatment in prisons. Medicines are available on the black market though and there are concerns about their origin and possible counterfeiting. Prices (paid by the patients) for the traditional interferon+ribavirin combination may reach 16,000 $US [information from a local patients group].
Austria	There is no clear figure for the number of people with HCV in prisons [7], however the country has Guidelines for provision of care in prisons where it is stated that treatment should be provided as a part of the prevention procedures. The sentence for the possession of drugs for personal use is up to six months in detention or a fine. Prisons provide OST.
Azerbaijan	There are reports only from small ad-hoc studies in prisons from which no extrapolation for the general population is possible [8].
Belarus	Inmates are included as a target group in the national prevention programme. There is no substitution therapy in prisons [9].
Belgium	There are prevention programmes in prisons and NGOs are allowed to have campaigns there. However, there are no provisions for supplying sterile injecting equipment to people in confinement [10]. The published data on incidence and prevalence are from before 2010 and this makes them somewhat obsolete. Part of the problem with the missing data is that GPs and prisons are not a component of the registration system.

Bosnia and Herzegovina	13% HCV prevalence reported from an ad-hoc study in the high security prison in Zenica with a statistically significant correlation between HCV infection and IDU [11].
Bulgaria	28.6% prevalence of HCV in penal institutions. The state provides treatment in prisons but follows very strict medical criteria, where a preference is given to HIV/HCV co-infected people [12]. The country has a dynamic patients' society and at points the NGOs take the role of the state in providing prevention programmes for the inmates both on HCV and HIV.
Croatia	Compared to the prevalence in the Croatian general population (0.9%), higher prevalence is found in penitentiary populations (8.3%-44%). Genotypes 3 and 1 are equally distributed (52.4% and 47.6%) [1]. This high prevalence reflects a high proportion of PWIDs within this group. Incarcerated people account for 0.4% of a total Croatian population, among which PWIDs comprise about 25%-30%. In a study, significant differences in seropositivity were found in prisoners who reported unprotected sexual activity compared to prisoners who used condoms (22% vs 4%). A history of tattoos was another risk factor associated with higher HCV antibody positivity in this population group. HCV-infected prisoners were significantly more likely to have a history of a tattoo exposure (27%) than HCV-uninfected prisoners (8%). However, it is not clear whether tattooing is a real risk factor for HCV transmission since many of anti-HCV positive inmates reported other potential exposure to HCV (sharing injecting equipment or risky sexual behaviour). In addition, higher seroprevalence rates are found in detainees who were unemployed and in those who resided in urban areas [Ibid.].
Czech Republic	OST is delivered in specialised psychiatric facilities and has also been available in prisons since 2009. Treatment for HCV is available to PWID in 39 clinics across the Czech Republic, including those in prisons [13].
Denmark	No detailed data available. The sources published in English are too old (i.e. year 2000).

Estonia	Although opioid substitution treatment (OST) with methadone, directly observed TB treatment (DOTS) and other health-related services are available in Estonian prisons, syringe exchange is not provided and the availability of condoms is relatively low [14].
Finland	There are regular screening programmes in prisons [15]. The country also provides treatment that follows the standards for the general population.
France	The prevalence of HCV in the penal system is higher than in the general population. It ranges from 4.8% to 6.5% [16]. The management of HCV in prisons is bound by different constraints, both in terms of screening and therapeutic management (particularly regarding treatment dispensing procedures). However, therapeutic regimens not containing interferon, easier to use and allowing shorter treatment durations, facilitate access to treatment among inmates. The Association Française pour l'Etude du Foie (AFEF) recommendations for treatment in prisons in France state: 1. Annual screening for hepatitis C is recommended for all inmates 2. Treatment of all inmates is recommended in order to reduce the viral reservoir 3. Non-interrupted continuation of treatment should be maintained in the event of a change in penal establishment, detention centre or release 4. The choice of treatment should be the same as that in the non- prison population
Georgia	The subpopulation with highest HCV prevalence in the country is the prisoners-50%. The Hepatitis C elimination programme was a Government initiative that has been carried out in the Georgian penal system since 2013. The programme involves raising awareness of infection, prevention, diagnosis and treatment. The programme is a part of the HCV elimination programme in the general population (supported by Gilead Sciences) and initial results show 90% cure rate [17].
Germany	The country ended six of its seven programmes for needle and syringe exchange in prisons in the past decade and currently there is only one prison with a programme [18].

Greece	A small study showed a 6.5% prevalence in prisons [19]. The treatment options are limited to non-existent. Free and anonymous testing is available. A new programme between the University of Athens and 2 local NGOs that aims to provide screening in a major Greek prison has started in the last quarter of 2017 [20] .
Hungary	4.9 % prevalence in prisons. No treatment is provided for inmates [21].
Iceland	A nationwide treatment effort was launched in Iceland in January 2016, where patients infected with HCV are contacted and offered treatment with DAAs according to the Icelandic national guidelines. All patients undergo hepatic elastography. Individuals with currently active IDU, prisoners and patients with advanced liver disease are prioritised for treatment. People are encouraged to bring their friends who may have been exposed to the virus for testing. Active drug users get additional support to facilitate adherence to the treatment regimen. The aim is to treat up to 200 patients every 4 months so that every HCV-infected individual in Iceland is treated within 36 months (end-2018) [22].
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Ireland	No information on the prevalence in prisons. The following is an extract of the country national report on prisons "It is noteworthy that there are no hospital facilities within Irish prisons, and prisoners have to be transferred under security escort for treatment. This is cause for concern because effective measures for HIV and Hepatitis C prevention are not readily available to prisoners due to medical services remaining inadequate or inconsistently accessible. The Irish Prison Service provision for HIV and Hepatitis C prevention measures does not meet standards of best practice models in Europe and North America. The current response of the Irish Prisons Service to the HIV and Hepatitis C crisis falls far short of the Service's stated objective of the provision of primary health care (prevention, treatment and health rehabilitation) to offenders of at least an equivalent standard to that available to citizens in the general community. The National Drugs Strategy recognises the importance of harm reduction for the community, and similar emphasis and parallel prioritisation of harm reduction for prisoners is necessary, as is equality of access and indeed consistent access to primary health care." [23].
Israel	An excerpt from the main newspaper in the country Haaretz states "New treatment for Hepatitis C is included in the state-funded health basket, but the Prison Services refrain from treating this serious viral infection among inmates. The Service also avoids taking preventive measures such as diagnostic tests and providing prisoners with information. The reason for this, according to the Service, is the high costs involved. The Prison Service is obliged to provide prisoners with the same services provided by health maintenance organisations to the general public, including the diagnosis and treatment of diseases such as Hepatitis C. Last May, the central District Court ruled in favour of a petition by a prisoner with Hep C. The court instructed the Prison Service to provide him with medication included in the health basket. Prison service medical personnel had argued that the costs would exceed their budget but the judge ruled that this could not justify withholding treatment." "Studies show that 25 percent to 30 percent of prisoners are infected," says Julio Borman, the head of Hetz, a liver health advocacy group. "A prisoner told me how four people in a cell share a razor, with one inmate carrying the virus." Infection rates are high, Borman says, due to needle sharing while consuming drugs, sexual intercourse, tattooing and fighting [24].

Italy	A figure of about 10-15% HCV prevalence in prisons is cited by different sources. More information in the detailed country profile below.
Kazakhstan	There are no published data in English available.
Kyrgyzstan	Ten people with viral hepatitis were identified in the State penitentiary system of the Kyrgyz Republic at the end of 2011, which is 0.1 % of the total prison population, while in previous years the numbers of detected cases were as follows: 3 in 2010; 33 in 2009; 12 in 2008; 25 in 2007; 21 in 2006; 19 in 2005; 38 in 2004. The prevalence of viral hepatitis in the prison system of the Kyrgyz Republic is not known due to the difficulties to conduct seroprevalence studies in this setting [25]. When it comes to testing IDUs and prison inmates access is provided through needle-exchange/prison programmes supported by the Global Fund.
Latvia	There are 12 prisons in Latvia with a total capacity of 6 500 inmates. Currently, 4 895 people are imprisoned. Following a criminal law reform, the number of prisoners was reduced. It is anticipated that the prisoner population will continue to fall because of electronic tagging of offenders. Each of the 12 prisons in Latvia has its own medical unit. The national prison hospital at Olaine was opened in 2007 and has a capacity for 200 prisoners. Olaine prison includes a closed high- security wing, an open-prison wing, and the prison hospital. The whole prison currently has 269 prisoners (29 female, 240 male: 116 male prisoners in the closed wing, 70 prisoners in the open-mixed wing, and 83 male and female prisoners in the hospital.) HBV and HCV tests are only offered to prisoners with HIV, clinical symptoms, or if the prisoner requests to be tested. Reimbursement rules for HCV treatment were recently changed: now only 75% of the costs are reimbursed, while the remaining 25% need to be covered by the MoJ. It is difficult for the prison authorities to pay the remaining 25% out of their budgets. However, a review of prison health policies is underway, and this issue may get resolved in the process [26].

Lithuania	The Lithuanian prison population rate is the highest in Europe. Free voluntary testing for infectious diseases is available in prisons, accompanied by some health education measures to reduce behaviours associated with a risk of contracting HIV, HBV and HCV. Drug treatment activities in prisons are focused on the socio- psychological rehabilitation of dependent prisoners [27].
Luxembourg	A study is being carried out in two prisons in Luxembourg with prisoners admitted between July 2015 and June 2017. A previous study conducted in a penitentiary centre showed that 17.2% of prisoners who were treated in prison and recovered from the disease got re-infected within a period of three years. The new study therefore aims to accurately assess HCV re-infection in prison and after discharge. It will also allow to monitor the HCV treatment rate in prison and the response to treatment with current and new HCV therapies. In addition, the study will link the participants with the OST programme in an attempt to help drug users to stop their consumption [28].
Macedonia	The prevalence of HCV among people in detention is about 15%. The most common mode of transmission is injecting drug use (IDU) [29].
Malta	Latest published data on prisons are more than 6-7 years old and currently obsolete.
Moldova	The Republic of Moldova is one of the few countries in the world where the comprehensive package (15 key interventions as defined by UNODC) is available in prisons. This has resulted in a marked decrease of HIV and HCV prevalence. The needle and syringe programme in Moldova was initially piloted in one prison and gradually extended to 13 prisons in 2014, an average of 90,000 syringes are distributed annually. OST is also available in 13 prisons. Investments have been made to expand access to needle and syringe programmes and OST in prisons located in Transnistria [30].
Monaco	No data on HCV in prisons available.

Montenegro	The country provides OST in prisons and some publications indicate that there is free HCV treatment in the penitentiary system, however there is no information on what exactly is considered treatment and how it is provided. OST is provided only to those inmates who have been on maintenance therapy prior to incarceration [31].
The Netherlands	Exact figures about the prevalence of hepatitis C in prisons in the Netherlands do not exist yet. An estimation study cites prevalence somewhere between 2.0% and 10.7%, however the publication is from 2010 [32].
Norway	Available published information dates back to the 90's.
Poland	According to the Polish Prison Service, approximately 4,000 prisoners are voluntarily tested for HIV and 9,000 for HCV every year. Of these, between 30 and 50 new HIV infections and nearly 400 new HCV infections are detected every year. Needle and syringe programmes and information on safer injecting are not currently available in Polish prisons because authorities believe this would imply support for drug use during incarceration. Of the 31 OST programmes available throughout Poland, seven are operating across 27 prisons. Although methadone is the most common agent prescribed, buprenorphine, suboxone and other substitutes are also available. Since OST became available in 2003, only 468 prisoners have accessed the service, and according to data obtained from the Polish Prison Service, the number of prisoners accessing the service is decreasing every year. For prisoners, the treatment is not holistic. There is an apparent lack of HIV and HCV prevention, treatment and care and no real provision of social support, including in the process of re-integrating into the broader community. Furthermore, there is no evaluation on the effectiveness of OST in prisons. The European Committee on the Prevention of Torture has said that interviews with prison doctors revealed a high amount of scepticism around the implementation of OST in Polish prisons. The monitoring mechanism has recommended that the Polish government develop and implement a comprehensive policy for the provision of care to prisoners with a drug dependence, though there are still no signs that steps are being taken to this effect [33].

Portugal	At the time of the data collection despite the integration of prison healthcare into the National Healthcare Service in 2007, many health services were still being provided by the prison system and there appears to be a growing trend towards outsourcing prison healthcare to private contractors. Prisoner complaints collected by civil society expose prison health care as being highly ineffective due to a lack of medical staff, treatment, access to basic diagnostic care and transportation. There are currently 49 prisons in the country, including one prison hospital. As of 31 December 2014 there were 14,003 prisoners, about 16 % (2,217) of which were incarcerated for drug-related offences. Official data on drug use and prevalence rates of HIV and HCV within prisons is scarce due to the absence of an information system on prison health, as well as difficulty in getting prison authorities to collaborate with information requests. A National Inquiry into Addictive Behaviours within Prison recently undertaken revealed that of a 20 % sample of all prisoners from 47 of the 49 prisons, 42 % were with HCV [33]. In 2017 new regulations have been accepted and the situation is/will be changing. Those have been described in the detailed profile of the country later in this report.
Romania	Treatment is delivered in prisons in specialised prison treatment units, or by outside specialists. Methadone maintenance treatment was introduced in 1998, and opioid substitution therapy (OST) with buprenorphine in 2007, and the combination buprenorphine/ naloxone in 2008. The legal procedures for entering into OST were revised in 2005 in order to simplify access to treatment. Currently, the government provides OST in nine MoH hospitals and three Centres for Anti-Drug Prevention, Assessment and Counselling in Bucharest, as well as in prisons. In addition, three private providers and one NGO provide OST. Needle and syringe programmes are available in two prisons, although they are not used by the inmates [34].
Russian Federation	No governmental/official information on HCV in prisons is available. Some reports from NGOs available though and they are more on personal experiences in prison.

San Marino	There is only one prison and only one prisoner in the country as on the 17th of September 2017. The 30-year-old man has his meals brought to him from a local restaurant because it is not economical to lay on a canteen service for him alone [35].
Serbia	Seroprevalence of chronic HCV in correctional facilities ranges from 16% to 49% [36].
Slovakia	Viral hepatitis C remains the most widely spread blood-borne infection among the Slovak prison population. In 2013, the share of HCV seropositive prisoners nearly doubled (20.9%), with the number of screening tests conducted being roughly the same as in 2012 (n=1,512). One of the reasons behind a sharp increase in HCV-positive cases is the better targeting of prisoners during their selection for tests. Confirmatory PCR tests for HCV were conducted in 193 cases in 2013. There was a slight increase in the share of those convicted persons in respect of whom the presence of HCV virus has been confirmed by a PCR test – rising to 21.8% against 2012, which implies an ongoing and increasing trend in the prevalence of this blood-borne infection in the prison population [37].
Slovenia	All inmates have access to free, voluntary and anonymous testing and treatment for hepatitis and HIV infections [38].
Spain	Hepatitis C virus infection is 15 times more prevalent among inmates at a prison in the Northern region of Spain compared with the general population [39]. The country has programmes for HCV elimination in controlled environment [Ibid.].
Sweden	Published data in English predate 2010, hence obsolete for the purpose of this report.

Switzerland	The country provides clean injecting equipment in prisons. An interesting initiative is the BIG Project. In 2008, the Federal Office of Public Health (FOPH), the Federal Office of Justice (FOJ) and the Swiss Conference of Cantonal Justice and Police Directors launched the BIG Project. Four areas of activity were defined: gathering data on infectious diseases in prisons; providing information and training to prisoners and staff; prevention, testing and treatment and addressing structural matters, including language barriers [40]. On completion of the BIG project, the cantons created the Santé Prison Suisse organisation, or SPS ("Prison Health Switzerland"). SPS makes the information and recommendations resulting from the BIG project on the prevention of infectious diseases available to people in custody and prison staff. However, the prime objective of SPS as a national platform for health issues in law enforcement is to help develop consistent healthcare across all prisons, numbering more than 100 [41]. The estimated prevalence of HCV in the penal system is 6.9% [42].
Tajikistan	No data on HCV in prisons available.
Turkey	An ad-hoc study cites the following results: "Anti-HCV was positive in 17.7% (n = 47) of the Kahramanmaras prison inmates and genotypes 3 and 1 were 68.1% (n = 32) and 2.1% (n = 1), respectively. The ratio of anti-HCV positive and HCV RNA negative individuals who had not received treatment was 29.8% (n = 14). It is not clear whether these 14 subjects demonstrated the presence of infection or it was false anti- HCV positivity. While there was a history of intravenous substance use in eight subjects and a history of dental treatment in one, however, no risks were found in five subjects. The ratio of anti-HCV positive and HCV RNA negative individuals who had received treatment constituted 3.8% (n = 10) of the study population. HCV-RNA values were 2070-170999068 IU/mL. The coupling of HBV and HCV infections was not detected. Anti-HIV positivity was not encountered in any individuals included in the study." [43].
Turkmenistan	Official statements of the MoH of the country claim that there are no cases of HIV and HCV in the country, at the same time for the reporting on Dublin Declaration Turkmenistan says that they provide OST in prisons [40].

Ukraine	Unlike HIV, there are very limited published data and conflicting statements depending on the source of the publication on HCV in prisons. A representative prison bio-surveillance study showed HCV to be extremely high (60.2%) [44].
United Kingdom	The last comprehensive survey of hepatitis C prevalence in prisoners in England was undertaken in 1997. The then Public Health Laboratory Service (PHLS) undertook an unlinked, anonymous survey of the prevalence of blood borne viruses among prisoners in England in 1997–98. This indicated that 9% of adult men, 11% of women and 0.6% of male young offenders had evidence of previous exposure to hepatitis C. A recent study in Scotland showed the overall prevalence of hepatitis C antibodies among prisoners to be 19%. Injecting drug use is the primary risk factor for infection in the UK (over 90% of new infections are acquired through intravenous drug use, where risk factors are known). Research from the Ministry of Justice on a sample of newly sentenced adult prisoners from 49 prisons in England and Wales found that 68% had used an illicit drug in the past year and 40% had injected a drug during the four-week period prior to custody. Close to 50% of people who inject drugs and 30% of former injecting drug users in England are believed to have hepatitis C. Potential transmission routes for hepatitis C include sharing needles, sharing tattooing equipment, sharing tooth brushes and sharing hair clippers, all of which may occur more frequently in the prison setting. To date, efforts to diagnose and treat hepatitis C patients within prisons have varied widely. In July 2012, a survey of hepatitis C services in prisons in England was published by the Health Protection Agency's Prison Infection Prevention team (HPA PIP team) in partnership with the Offender Health Division and the Liver Disease Strategy team in the Department of Health (DH). This revealed variation in the structure, accessibility and quality of hepatitis C services delivered in prisons across England [45].
Uzbekistan	No data on HCV in prisons available.

The above information shows that the issue of HCV in the penitentiary systems of different countries is far from an uniform picture. Countries like Moldova, Estonia or Slovenia provide more advanced services than countries that have provide good standards to the general populations such as UK or Ireland. Nevertheless, our research It is clear though that not a single country has a system of care that meets at least the standards that apply to or the general population receives.

The spectrum of differences is so broad that we see places where no services are available and others where treatment in prisons is better than what some of the general population in other countries receives. Communities should work with governments and other key players to reach a common high standard that is achievable throughout the WHO Europe region. The following in- depth look into some sample countries and the ensuing analysis makes some recommendations on the problems, gaps and improvements that the CBOs may consider for inclusion in their long-term programmes and action plans.

BULGARIA

Even though the country does not have any exact data on the number of people with HCV mono- or co-infection with HIV in the penitentiary system, medical professionals indicate that the most affected groups are MSM and PWIDs [46]. The main difficulty in obtaining data is that the medical establishments within the penitentiary system of the country fall under the jurisdiction of the Ministry of Justice and have a fairly large independence in their decision-making on what they should or should not do. Often this leads to a discrepancy between medicinal practices that are in place for the general population and those that are implemented in the penal system.

There are no particular differences in terms of prisons that do “better” or “worse” in the country when it comes to HCV. Most prevalent modes of transmission are sexual contacts, sharing of injecting paraphernalia and tattoos. For the last year (end of July 2017) the number of hospital admissions as a result of HCV was 15.

The prevention activities are in the form of sporadic visits by NGOs who mainly distribute printed materials. There is no access to clean needles and syringes in any prison in the country. As for OST, it is available only in the Sofia (the capital) prison. The availability, however, is only for those inmates, who have been on OST before they have been imprisoned. In other words, one can continue the treatment, but

cannot start it while incarcerated. An additional limitation is that the treatment is provided by a private programme and the prisoner (or his/her) family needs to pay for it. In 2017 the Ministry of Health and the Ministry of Justice reached an agreement whereby methadone will be provided, but there are major drawbacks as few medical professionals with expertise in OST (i.e. nurses) are willing to work in prisons.

There are no data about the number of HCV tests performed in the penal system and how one can get tested, unlike HIV where voluntary, anonymous and free testing is regularly supplied by NGOs (supported by the Global Fund). However, Global Fund funding programmes were ending in 2017. There are no compulsory forms of testing (HIV, HBV, HCV) in Bulgarian prisons. People possibly exposed to HCV are not followed either in prison or upon release. In rare cases when someone tests positive for HCV in prison, he/she is informed personally, usually by an NGO representative and the genotype is determined at the point of hospitalisation. Newly diagnosed people do not receive peer or other non-medical support.

National regulations on treatment for HCV do not have any stipulations for patients in the penal system. In 2017, five patients have received treatment. All they have been hospitalised in the hospital of the Ministry of the Interior. The reason for hospitalisation is that the prison doctor cannot prescribe treatment directly. He/she can only give a referral to the inmate who in turn is escorted to the hospital of the Ministry of Internal in Sofia that is the only one that can accept patients with liver diseases from the penal system. There the person with the disease receives all necessary tests and manipulations and a protocol called A1 is prepared. With this protocol he/ she can apply for treatment to the National Health Insurance Institute. One needs to have uninterrupted payments (regular taxation) into the National Health Insurance Institute in order to receive a free treatment. All criteria are published at: http://www.nhif.bg/web/guest/207. For example, a man with confirmed chronic HCV infection from a Bulgarian prison has been waiting for more than two years to get access to treatment, because no specialized gastroenterology clinic outside the prison wants to accept him as a patient

Since the beginning of 2017, all registered treatments in the EU are available in Bulgaria, namely:

- ombitasvir/paritaprevir/ritonavir/3dasabuvir/3ribavirin
- sofosbuvir/3ledipasvir/3ribavirin
- grazoprevir/elbasvir/3ribavirin

All they can be prescribed and reimbursed by the National Health Insurance System accordingly.

There is no national programme on HCV in the country, but only “Conditions when treatment should be provided” that were created by leading gastroenterologists in the country and approved by the National Health Insurance Institute. They follow loosely the international guidelines (e.g. EASL) and deal with the types of therapies that can be prescribed and the medical conditions when this should be done, i.e. genotype, level of liver damage, viral load, concomitant conditions and diseases. There are no prevention, screening, services provision programmes.

Conduct of clinical trials in prisons is not allowed as there are fears of coercion of inmates to participate, low level of education of some of them and as a result inability to understand the informed consent and also creation of opportunities for corruption.

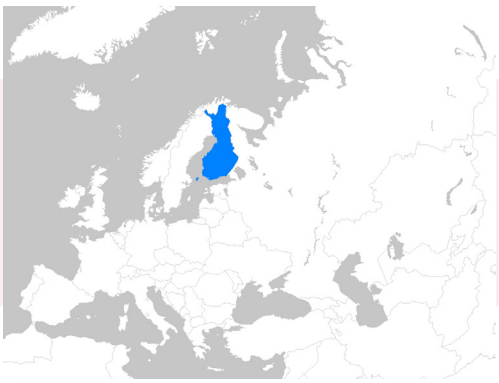
One of the major problems that the NGOs meet in their work is the lack of desire by the prison heads to cooperate. They often hinder the peers or social workers to access the penal institutions as this puts further pressure on the staff. For that reason, the activities are sporadic and are limited to printed information distribution and occasional information providing lectures. Apart from the lack of interest, the system is bureaucratic and heavy and this also serves as a barrier for prisoners with HCV to access treatment. A respondent from Bulgaria who works for an NGO in a prisons' project cited two cases of hers where it took more than a year of communication with the prison administration before any actions were taken. In the first instance the inmate was cured while in the second the communication is still ongoing.

Another problem is that the prison doctor is often not well versed in hepatitis and cannot understand why PCR is necessary and why a prisoner needs to go to Sofia (the capital) and to be escorted as all of these put financial pressure on the prison budget. Generally, the attitude is "They will get treated when they are out of here, we will not deal with this now, it is way too complicated". Last but not least, the issue becomes even more problematic because anything that has to do with testing or treatment of HCV is not compulsory or a subject of "Order" by the Ministry of Justice. In other words, anything HCV related happens only if the prison head has the goodwill for it.

Conclusion: Bulgaria is an example of a country where the HCV treatments should be moved from the jurisdiction of the Ministry of Justice to the Ministry of Health. The system of provision of care where medical professionals and administration within the penitentiary institutions are allowed to make decisions in a void and have the power to approach the health of the prisoners based on their own convenience or goodwill should be abolished. The Ministry of Justice, including experts from the Ministry of Health, community representatives, treatment doctors and other key players, should issue guidelines for the provision of HCV treatments to inmates that should be followed by all prisons in the country.

Given the urgency of starting hepatitis C treatment for people living in prisons, simplifying the procedure for getting it is the first step. Most importantly, this would entail that Bulgarian authorities including Ministry of justice, Ministry of Health and the Bulgarian Society of Gastroenterology, should remove the mandatory requirement to perform a liver biopsy (replacing it with non-invasive tests, such as elastography) and create procedure for receiving the medication directly through the prison ambulatory. These measures will shorten the time for getting access to treatment, minimize institutions' engagement and reduce treatment costs by removing unnecessary hospitalizations under convoy.

FINLAND



There are 26 prisons in Finland [47]. On average, the number of prisoners in 2012 in the country was 3,236; 224 of which were women [48]. The predominant age group of inmates in 2011 was 30-39 years [49], while the proportion of prisoners over 50 years of age has steadily increased in the 21st century from 9% to 14% [Ibid]. It is of note that there is an overrepresentation of persons with lower socio-economic status and ethnic minorities [Ibid].

The people in the penitentiary system in Finland are divided into several categories, namely remand prisoners, sentenced prisoners, fine defaulters, life sentence prisoners and also offenders sentenced to community service. Remand prisoners are in the pre-trial phase of their possible imprisonment and have not yet been sentenced. Sentenced prisoners serve their time either in closed or open prison units or on supervised parole. Fine default prisoners serve conversion sentences for unpaid fines. Life sentence prisoners serve sentences with no predetermined duration; at present a life sentence is considered usually any imprisonment duration over 12 years but release from prison may be granted based on the strength of an application and a court order [49].

The general state of prisoners' health is considerably worse than that of the general population of same age and the mortality is high [48].

As in the other countries included in this report, data on HCV in the penitentiary system when available are not uniform and vary by source. Different publications are in agreement that on average about 50% of the prisoners (56% male and 47% female) are HCV antibody positive [50, 49, 48, 47].

HCV is especially common among young females and the highest prevalence is in the youngest age group (16–24 years; 71%) whereas among males the predominant group is 25–34 year [49].

The predominant mode of transmission according to a study from 2013 [49] that adjusted for age, cumulative years in prison, unsafe sex, sexual abuse, IDU, syringe/needle sharing and tattoo in a multivariate analysis, only IDU and sharing injecting paraphernalia was linked to HCV in a statistically significant manner among women whereas among men also tattoos, cumulative years in prison and age.

In addition to pre-existing hepatitis B and C infections, new infections are also

diagnosed in prison which suggests that there are infections caused by sharing syringes [52].
No recent data were published on the number of deaths from HCV or hospital admissions. The latest discovered information is only from 2006 where no deaths were reported [48].

In a study from 2010, it was reported that in 75% of chronic HCV infections, the level of alanine aminotransferase (ALT) was changing or was steadily increasing (Färkkilä, 2010). However, it is noteworthy that 21% of HCV-negative female inmates also had elevated ALT, whereas men showed a significant association between high ALT and HCV. One possible explanation is that 70% of the female subjects in this study were diagnosed with alcohol abuse/dependence and that women are more susceptible to liver damages caused by alcohol than men. From a biomedical perspective, smoking and especially cannabis use may increase the risk of liver fibrosis in hepatitis C. A study found out that 70% of women prisoners smoked regularly and

90% had used cannabinoids at some point in their lives (Lintonen et al., 2011). Although the Finnish female prisoners with HCV are young, and young females seem to develop chronic hepatitis C infection less often/more slowly, HCV infection associated with heavy alcohol use and regular smoking makes them high risk patients (Freeman et al., 2001; Seeff, 2002) while HCV is one of the leading causes of chronic liver diseases [49].

In another study from 2013, out of all HCV positive women prisoners, 96% already knew of their infection, among men the figure was 92%. The few HIV positive prisoners (one female and two males) knew of their infection [49].
Finland officially follows WHO recommendation to target prisoners and former prisoners as a key population for HCV testing and they are tested accordingly [53]. When it comes to prevention measures in the penitentiary system, it is possible to receive a hepatitis-B vaccination in prison [47].

Of the PWID women 63% and of the PWID men 60% had been vaccinated against hepatitis B (one or more vaccine doses) up till 2013 [49]. In 2013 alone, hepatitis A or B (or combination) vaccines were given to 134 prisoners [48].

Prevention activities are focused on health education and protection measures. It is not possible to exchange used injecting paraphernalia in prisons in Finland. Instead, each prisoner is given a pack of hygienic products containing written information about the use of condoms and the cleaning of injection equipment. The pack contains products for disinfection which can also be further obtained from the prison clinic or anonymously from specific public areas [52].

OST which has been started before the incarceration is continued in the prison. There have only been a few cases of OST initiated in the prison (filled documents and preparation), but these have usually not been implemented due to short sentence periods [53].

All prisoners are offered the possibility to test for HCV. The testing and linkage to care follow the algorithm and recommendations that are in place outside the penitentiary system [53]. In line with that, tests are not compulsory and are free of charge.

The current legal and medical practice discourses in prisons are largely defined by the laws and regulations that apply to the general population. This includes confidentiality. The rules for patient information security are also valid and data related to the patient's health can only be given out with relevant permission. It can only be used for the needs of treatment and when dealing with patient's needs. It is difficult to achieve this confidentiality level as the internal safety aspects of the prison can be barriers to it. Guards may generally not be present during the consultation with the medical professional and they do not have access to the patient data system. However, in order to keep the diagnoses between the doctor and the patient only and at the same time prison authorities to be able to provide the medicines, the labels are masked so that those handing out the pills do not know which disease they are for [48].

Healthcare in Prisons is now under Ministry of Social Affairs and Health.

An automated system for dosing of medicines has been introduced and facilitates the work of the clinic staff as they no longer have to fill the dosettes themselves. Strictly sticking to the agreed provision of medicines and competitive tender biddings for the supply of these products have brought significant financial benefits as there is no waste of medicines and also many person-hours from the work is saved [48].

All expenses for the provision of medical care in the prisons is covered financially by the Finnish state. The use of sub-contracted services is a notable financial and functional challenge as the cost of the work of a doctor from a sub-contracted institution is higher and doctors often change which leads to lack of continuity in care. The reasons for remitting patients to these services are not known from the statistics – but other somatic diseases different to hepatitis C are rare. It is likely that prisoners remitted to external services are in need of urgent care [48].

The country has a national programme on HCV, Sosiaali- ja terveysministeriö 2016, Suomen C- hepatiitti strategia 2017-2019. In it, prisoners are defined as an at-risk group.

Conclusion: Finland is an example of a country that is trying to adopt a pragmatic approach to the problem of HCV treatment in the penitentiary system. Even though there are structural hindrances for achieving the same level of care in the prisons as in the medical establishments that provide care to the general population, the lessons learnt via the country's attempt to reach the same standards could be copy-smart pasted by other governments. Communities could include those lessons in their advocacy work.

ITALY

Data from a multicentre study that was conducted in 2014 on 15,800 prisoners in 6 Italian regions showed 7.4% HCV prevalence [59], while data from 2015 showed a 50% estimate of prisoners unaware of their status [60]. A member of the Italian Society of Penitentiary Medicine (SIMSPe) estimated 3,000-3,500 co-infections out of about 5,000 people with HIV.

The most affected groups in the penitentiary system are the PWIDs and migrants and the predominant HCV genotypes are 1a and 3 [61]. The most prevalent modes of transmission are IDU, tattooing and traumatic sexual practices within the establishments [62].

In October 2015 the Italian National Plan on Hepatitis called PNEV (Piano Nazionale Epatiti Virali) was accepted. It identifies 5 major areas:

1. Epidemiology
2. Prevention
3. Information campaigns
4. Access and treatment
5. Social impact

Some of the main objectives of the PNEV is to guarantee access to treatment across the whole country; guarantee equity of access and quality of treatment/care; guarantee access to all patients to innovative DAAs.

In March 2017, a three-year eradication plan funded by the Ministry of Health was adopted. Treatment is to be provided to 240,000 estimated patients (80,000 per year). According to it, precedency for treatment is given commensurate with 11 criteria, where patients with co-infection HIV/HCV and HCV/HBV will be treated with priority.

As of March 2017, about 75,000 patients had already been treated with DAAs (access was limited to most serious cases with F3-F4). Provision of treatment in prison settings was limited mostly due to difficulties in diagnostics (Fibroscan) which was necessary to identify fibrosis stage and eligibility. Access to treatment for co-infection was also limited to F3-F4. The national plan does not have any particular stipulations for the penitentiary system and all patients there should be treated as patients from the general population [54, 55, 56].

No systematic monitoring of HCV infection is performed in prison settings in Italy. The responsibility for healthcare in the penitentiary system has changed hands in 2008 from the Ministry of Justice to the Ministry of Health [57].

As the National Healthcare System is decentralised, it is managed at a regional level and consequently each prison facility needs to refer its patients to the local medical authorities. This leads to discrepancies in the quality and availability of services based on geographical location, regardless of the fact that current legislation states that health for prisoners must be guaranteed as for the general population. It also affects the communication with penal establishments. Official data from prisons are extremely difficult to obtain, even when available. Most of the data come as estimates from official sources and from specific research or service provision projects. The only region as of today which has monitored HCV in its local prisons is Emilia-Romagna (with a centre Bologna). Community workers with experience covering over 40 prisons and more than 5000 inmates also indicate that there are huge disparities in the screening and treatment between the establishments.

HCV prevalence has certainly gone down in the last 5 years, mostly due to a reduction in number of active PWIDs in prisons as they have increasingly been provided with addiction treatment. In conversations doctors in charge indicate a figure of about 10-14% prevalence of HCV [58].

So far there are no governmental programmes on raising awareness of HCV infection in prisons, however there are places mainly in northern Italy (Milan, Turin, Genoa, etc.) where through the goodwill of the staff and the excellent work of some NGOs the screening rates for HBV, HCV and HIV reach 90-97%. Currently most awareness work is done by patient organisations with the help of the scientific community. The organisation NPSItalia, for instance, has pioneered this work over the past 7 years through a project called ‘La Salute non conosce confini’ together with SIMSPEe and an ongoing project on HIV (raising awareness also on HCV and other STIs) FLEW (Free to LivE Well in prison) with the introduction of rapid HIV tests. A new project ENEHIDE which has just started by the organisation EPAC is very successful with its prevention activities and raising awareness [63, 64, 65].

In Italy, OST has been guaranteed in all prisons for over 30 years now. No needle exchange programmes or condoms are available though.

When it comes to testing, in some prisons blood samples are taken directly in prison infirmary, in other less organised settings (mostly the smaller establishments) inmates are taken to the local infectious disease unit for blood sampling. All testing is free of charge. Although tests are not compulsory, they are heavily recommended at the point of entry into the system and can be proactively suggested by the medical staff or performed upon request by the individual. Unlike

HIV tests, testing for HCV does not require a written consent. Some prisoners opt for a routine comprehensive battery of STIs (including HCV) and other conditions tests. HCV tests are not anonymous and there is discrepancy between prisons on what data are collected as this depends entirely on the healthcare staff [66, 67].

Possibly exposed to HCV people are followed for the duration while they are in the establishment, but not after release.

Screening is not targeted at specific sub-populations (i.e. PWIDs, ethnic populations, blood donors, etc.), but PWIDs are strongly urged by the penitentiary medical staff to get tested as they represent around 70% of all HCV infections in prisons. Italian prisoners are allowed to donate blood [68].

A diagnosis is communicated to an inmate by a medical professional and a psychologist and after an RNA test the HCV genotype is determined [69]. Newly diagnosed people receive peer support where available.

The 2 documents that regulate the provision of treatment and care in the penitentiary system are:

1. Passage of healthcare in prisons from Ministry of Justice to Ministry of Health (1 April 2008) http://www.ipasvi.it/archivio_news/leggi/320/DPCM010408.pdf
2. Conferenza Unificata stato-regioni (31 March 2012) http://www.trovanorme.salute.gov.it/ norme/dettaglioAtto?id=42045&completo=true

The national guidelines for treatment of HCV in the the general population are applied to prisoners.

Each individual prison has data on number of people treated with DAAs, but as there is no national or regional (apart from Emilia Romagna) registries, it is impossible to establish the total number. Prescription of treatment for HCV can be done only through the authorised prescription centres designated by the MoH. The specialists who have the right to prescribe may include hepatologists, infectious disease specialists or gastroenterologists.

The National Health System covers the costs of treatment and it is free of charge for all citizens, regardless of the fact that they may be in prison and this also includes undocumented migrants [70]. There is no specific registration process for medicines that can be used in prisons. Currently all DAAs that have marketing authorisation for the EU are available [71].

There is no special pricing for medicines that are used in prisons. Pricing is negotiated at national level between AIFA (Italian Agency of Medicines) and pharmaceutical companies. The negotiated prices are secret, but AIFA has unofficially indicated that prices per treatment are about 4-5,000 Euros [72].

All prescribers from the aforementioned authorised prescription centres are obliged to fill in an online request to AIFA, which gives the final approval of a therapy. The treatment is then transferred to the hospital pharmacy of the prescription centre which sends it to the prison. As the penitentiary system has certain specificities and requires high level of security, the administration of therapy has a particular procedure described at the following link: http:// www.sanitapenitenziaria.org/articoli/379-la-liberta-di-farsi-curare-in-carcere-l-esperienza-di- milano

There is no specific ring-fenced budget for HCV in prisons: testing and treatment are covered by the NHS while prevention is carried out mostly through specific privately funded projects. The current budget for HCV treatment in Italy is part of the budget made available by the MoH for 'innovative drugs' (mostly HCV medicines) which amounts to €500,000 per year for the next 3 years.

Conclusion: Italy is a very good example of how changing the discourse on prison health from being a "criminal issue" to being the responsibility of the medical system leads to positive developments. While the current situation of provision of HCV care requires further resources (human, material, etc.), the financial commitments made should be recognised. This cooperation between community groups and academic institutions can be looked as a potential model for other countries.

KAZAKHSTAN

For the period of 2011 until July 2017 around 700 people have been in the penitentiary system of Kazakhstan [73]. HCV prevalence among prisoners with HCV is about 90%. Often people are admitted into prison already diagnosed with hepatitis and their data are on the files of the local medical establishments the catchment area of which covers the person's permanent residence. There have not been any new diagnoses in the prisons for the aforementioned period. The highest concentration of inmates with HCV is in the Karaganda districts and this is as a result of the fact that the district has the highest number of prisons in the country.

All sentenced people have fluorography and tests for syphilis and HIV. A test for HCV is done only in the cases of medical symptoms and is free of charge. Blood is taken in the prison hospital and the samples are transported to a regional AIDS Centre in the laboratory of which the HCV tests are done.

The medical record of imprisoned people is transferred to the hospital that covers the prison within its catchment area. That hospital is responsible for the provision of treatment for inmates depending on the necessities and diagnoses. The prison hospital provides symptomatic treatment (hepatoprotectors, vitamins, etc.).

There are permanently ongoing information campaigns in the penal system establishments about the so called "socially significant diseases" and HCV infection is among them as per the Order of the Minister of Health from the 21st of May 2015 with a number of 367. As a result of this, since 2011, HCV infection is included in the guaranteed array of free of charge treatments about which stipulates Article 29 from the Constitution of the Republic of Kazakhstan.

Patients with confirmed HCV diagnosis (ELISA followed by PCR) have access to all necessary monitoring (including but not limited to PCR and elastography) as per Decree by the Government of the Republic of Kazakhstan from the 15th of December 2009 with a number of 2136.

As of the end of 2017, the available in the country treatments for HCV are pegylated interferons alfa 1a and 1b, ribavirin and Viekira Pak.

There is no OST in the penitentiary system of Kazakhstan.

Conclusion: In recent years Kazakhstan showed a major leap in access to and quality of treatments, with the support of the politicians, especially the President's office. At the same time further developments are necessary in order to reach a high standard of care for the citizens, including the ones in the penal system. In this respect perhaps the most urgent ones are the provision of harm reduction and OST in prisons, as well as a more careful selection of the HCV treatments to make it more compatible to the ARVs, thus not excluding certain sub-groups from modern care. The latter is based on the statistics of the large number of HCV/HIV co-infection in the country.

MOLDOVA

In 2016 401 people with HCV were at one point or another in the penitentiary system of Moldova [74]. At the end of 2016 their number was 201. For the same year 50 people in prison had confection with HIV. 83 people received their HCV diagnoses in prison. The most common transmission route in the penal system is IDU and PWIDs are the most affected group. 49 people died during 2016 in prisons and 5 among them from HCV or related complications [Ibid.].

Information sessions and lectures on HIV and HCV are regularly organised both for inmates and prisons' staff and printed materials are distributed. In Moldova OST is available in all prisons since 2005, while needles and syringe exchange programmes since 1999 [75, 76].

289 tests for HCV were done in prisons during 2016 (83 positive). Inmates can get tested free of charge when there are symptoms of liver disease and if the prison doctor decides that a test is necessary. Testing is performed in the prison hospital, in a medical establishment of the MoH that provide the service on a contractual

basis or by personal decision using the service of the NGOs using rapid tests. Tests are not compulsory. Anonymous testing is only possible through NGOs. All other institutions collect the standard demographic data that includes name and address. The numbers of newly diagnosed cases are reported monthly to a national public health centre.

A positive diagnosis is announced to the patient verbally by a doctor and he/she fills in the necessary medical documentation. The prisoner then follows the general algorithm for inclusion in medical care in the penitentiary system, as described in the following document: http:// lex.justice.md/viewdoc.php?action=view&view=doc&id=319608&lang=2. People receive peer support through the HIV NGOs.

Treatment follows the Clinical Protocol of the MoH (http://old.ms.gov.md/public/info/Ghid/protocolls/gastroenterologiesihepatologie/adult7/pcn24/) and there are no specific stipulations on the treatment in the penal system. Currently the treatment is only symptomatic and it was expected that antiviral treatment in prisons will be available in 2017. In the period 2005-2017 antiviral treatment was used by two inmates and they covered personally the cost for it. The plan

is the treatment to be prescribed by an infectionist from the MoH while the monitoring will be provided by the prisons' medical staff. Medicines will be bought using the budget of the MoH while the monitoring assays will be provided from the budget of the MoJ.

Currently the registered DAAs in Moldova are: Nucleobuvir (sofosbuvir) 400 mg (Eva Pharma, Egypt) with a registrational price of $US 584.87 which makes $US 1,754.61 for a 12-week treatment course; Daclavirdin (daclatasvir) 60 mg (Eva Pharma Egypt) with a registrarional price of $US 524.00 which makes $US 1,572.00 for a 12-week treatment course; and Twinvir (sofosbuvir+ledipasvir) (Incepta Pharmaceuticals Ltd., Bangladesh) with no registrational price published [77]. Treatment is provided free of charge through a national programme. All registration and procurement is done on national level by the National Medicines Agency and the penitentiary system does not participate in the process directly. There is no ring-fenced budget for the treatment in prisons.

Unlike other countries where clinical trials in prisons are either completely forbidden or allowed with large number of conditions and exclusions, clinical trials in the penal system of Moldova are allowed [78].

Conclusion: Moldova is an Eastern European country that can be an example of successful provision of harm reduction services in prisons and many other countries can learn a lot of how the process is organised. Even though the provision of HCV treatments in places of confinement is far from ideal at the moment, Moldova is trying to do that against the rigid and often outdated system of medical care. The knowhow that they are accumulating in the process could serve well to other countries with similar health systems, including some member states from the EU (e.g. Romania and Bulgaria).

PORTUGAL

Similar to other countries in the European region, Portugal does not have a special registry on infections with viral hepatitis in the penitentiary system. The National Drug Agency (SICAD) however has detailed data on the PWIDs who participate in the addiction treatment programme. For 2015 the Agency announced that of the 1,162 prisoners in their programme 61% had HCV [79]. The total number of inmates in 2015 was 12,591 [80]. SICAD provides also information on the number of co-infections for 2015 in their programme; of the aforementioned 1,162 prisoners on addiction treatment 17% were HIV-positive of which 58% had HCV too [79].

There is no information about the most affected sub-groups in prisons but judging by the fact that the predominant mode of transmission is injecting drug use in the country, then it is highly likely that the pattern is the same [85].

A recent research that had 71.1% of the study subjects from the prison setting showed that the predominant HCV genotype is 1 and the distribution was as follows: genotype 1 – 55%; genotype 2 – 1.5%; genotype 3 – 28.2%; genotype 4 – 13.4% [92].

The main document that regulates the provision of treatment, care and support in prisons is the Manual of procedures for the provision of health care in prisons, but it has not been updated since 2009 [84]. Further to that, some of the procedures are described in the Law nº 5/2011 from 11.04.2011 [91]. In addition, there are national clinical guidelines for the provision of HCV treatment (with latest version from 28.12.2017). However, there are no stipulations for the treatment in the prison settings.

Tests are free of charge and if the prisoner refuses to get tested, he/she has to sign a declaration [84]. If the doctor considers that the person must be tested (even without consent), he/she writes to the establishment director for a decision. The prison director can make the test compulsory for public health reasons. After that, the prison director is informed about positive results and preventive measures to be taken [Ibid]. Tests are not anonymous and all the information is registered in the individual clinical file.

In an interview with A.C. (a 53-year old man who has been in and out of prison between 1984 and 2010 and who is HIV-positive and has HCV) conducted by our local informant, it was indicated that HCV testing at prison entry is not a routine procedure. Only those who present risk factors (like injecting drug use) are invited to take the test. “I had never been tested for HCV in prison; no health professional in prison ever talked to me about hepatitis C, never”; “this is completely different

from HIV, they invited people to take the test and to go into treatment"; "I can only remember some people being treated for hepatitis C in prison, but these were very few cases and these people were dying with cirrhosis. They were transferred to the prison hospital."

A positive diagnosis is conveyed by a health professional [84]. After a confirmation with an HCV RNA test, the genotype is also determined, as well as the viral load. The patient also receives an abdominal ultrasound and liver function tests. If his/her sentence is longer than one year and the person has a treatment compatible profile then the he/she needs to sign an informed consent and is referred to the prison hepatology services [Ibid.]. It is likely that some of these procedures will be changed as a result of the new regulations.

There is a collaboration between the Directorate General of Prisons and some specialised drug treatment centres (under the auspices of the Ministry of Health) which allows continuation of OST in prison (in case a patient is already on OST). Initiation of OST is only available in 4 prisons and the programme in these cases is run by the Directorate General of Prisons [87].

Upon prison release, the person is referred to the competent health unit and all the relevant clinical information is passed (with the person's consent).

Under a special agreement between Hospital São João (NHS, Ministry of Health) and Prison of Custóias in Porto (Directorate General of Prisons, Ministry of Justice), there is an NHS medical team that goes into prison of Custóias every week to treat HCV (this pilot project started in January 2017). The agreement allows to overcome one major barrier for the access to HCV treatment - the logistics to transport prisoners to the NHS hospitals [93]. This model will be extended to other prisons. There is a similar pilot project being planned for the Lisbon region, but is still under consideration by the Ministry of Justice. This project, unlike the Porto one, is partially privately funded [90, 94].

In recent months, there have been two statutory orders from the MoH and MoJ regarding prison health and in particular HCV treatment. In the first document (Statutory order nº 6542/2017 from 28.07.2017), the estimated prevalence of HCV is 10.1% and HIV 4.5%. The document does not define the exact timing of the estimation. The latest data about prevalence of HCV and HIV in 2016 in prison (data reported by the Directorate General of Prisons) were different: 12.16% for HCV and 4% for HIV [82].

The issuance of the above orders was based on the assumption that access to health and particularly in the case of communicable diseases (HIV and HCV) differed for people in confinement as compared to the general settings.

The first order establishes a period of 60 days for the Directorate General of Health to propose a referral network within the NHS for HIV and viral hepatitis for the provision of treatment and care for detainees in the actual prisons. This means that specialists from NHS hospitals will go to places of confinement to treat HIV and viral hepatitis. This is an important decision because previously inmates had to go to the NHS hospitals and this was a major barrier to access care and treatment, especially

for HCV. This also means that DAAs will be available for prisoners in prison, through the NHS specialist doctors.

This order also established the responsibilities of both Ministries in the health provision to detainees related to communicable diseases. The hospitals (Ministry of Health) will be responsible for the transportation of doctors from the hospital to the prison. The prisons (Ministry of Justice) will provide the logistics inside prisons that allow NHS doctors to work there. Storage and provision of medicines is under the auspices of prison pharmacies. Prescription and monitoring examinations are done following the NHS rules and by NHS doctors. If the inmates need to go outside of prison for medical reasons then the logistics responsibility stays with the prison services.

The second order (Statutory Order nº 283/2018, from 05.01.2018) [81] establishes the referral network – each prison has a reference hospital that will provide care and treatment in the cases of HIV- and HCV-infection. There is a stipulation in it regarding testing, namely it is the responsibility of the prisons and should occur at admittance, annually thereafter and upon release-both HIV and HCV. It also mentions that needle and syringe exchange programmes should be in place, but nothing more concrete about the actual implementation of these.

New HCV treatments (DAAs) are not available in the penitentiary healthcare services, however this is expected to change with the new regulations. Only NHS medical doctors can access the INFARMED platform (National Medicines Agency) to request these kinds of medicines. Prison healthcare facilities are not part of the NHS, as they are under the auspices of the Ministry of Justice. Prisoners have to be referred to the NHS to have access to the new HCV treatments. There are no official data on the number of prisoners referred to NHS to receive HCV treatment.

Reported discrimination of prisoners in terms of their access to the new HCV treatments has been reported [83]. It motivated the changes in the health provision to improve the level of care in prison settings.

Portugal has a specific programme for viral hepatitis, under the Directorate General for Health. The plan has been published in July 2017 [90, 94].

Conclusion: Portugal can serve as an example of how multifaceted the problem with HCV in the penal system can be. As the country started to deal with viral hepatitis a long time ago, we can follow the developments and practical solutions that were tried and what their results were. This is particularly important as Portugal has a high HCV prevalence similar to some other Southern European countries. Migrants in Portugal, which are one of the affected communities, come from different geographical areas. As a result, the system needs to deal with a broad spectrum of issues beyond the provision of treatment. Following the logical development of the HCV services in prisons, it is clear that Portuguese decision makers have reached the conclusion that specialists from NHS hospitals need to go to places of confinement to treat viral hepatitis and HIV and provide care on the spot rather than transport patients or any other arrangements. As this is a formula that comes after trying different models, perhaps it can be explored by other countries in a similar situation.

FINDINGS AND RECOMMENDATIONS

The analysis of the collected data and the discourses, problems identified and suggestions by the informants indicated gaps in access to hepatitis related service on macro (systemic)-, meso (at the level of individual institution)- and micro (personal)-levels across countries. The following section lists those in relevant topics and then makes recommendations. Positive developments and examples from different countries are included as illustrations.

Organisation of health services provision in prison settings

1. Lack of clarity under which jurisdiction and the responsibility for individual components of the provision of treatment, care and support fall and which financial and budgetary flows should be used. This is particularly true for the countries with mixed systems where both MoH and MoJ are involved (i.e. Italy). A positive development is the fact that there is a clear trend to move the services under the auspices of the MoH in many European countries.
2. High turn-over and lack of willingness of external to the penitentiary system medical staff to work in prisons resulting in lack of continuity of care and follow up.
3. Geographic compartmentalisation of the services provided where some establishments are linked only to a regional decision-making body or medical provision system and this leads to inequality of services received based on the prison location, goodwill or competence of the administration and prison medical staff.
4. Entangled budget streams for different components of treatment, monitoring and care.

Recommendations:

A. Move treatment, care and support for people with HCV in detention under the jurisdiction of the national health systems where possible rather than the MoJ. This will remove obstacles to the provision of care flow, i.e. need to get approval for prescribing DAAs, bureaucracy that reduces the will in prison administrations to provide the treatments, etc. Further to that, the inmates will have the chance to be seen by professionals with expertise in hepatology, thus practically reaching the goal of providing equal level of care for all citizens, regardless of their legal status.
B. Introduce incentives for medical professionals to work in or regularly visit prisons and provide services there, in consequence avoiding the need to organise expensive and logistically challenging escort from prison to a medical institution, especially if this is linked to a hospitalisation where a guard needs to be permanently with the inmate.

Monitoring and surveillance

1. No national repositories where data on epidemiology are sent regularly either within the MoH or MoJ. Consequently, no possibility to develop and implement viable, targeted and effective programmes on prevention and treatment without the basic information needed.

Recommendations:

A. To create a national repository under the auspices of the MoH where all medical data from the penal system are collected centrally and information is sent by each prison at regular intervals (like in Moldova, for instance). Better data systems should enable prisons/health authorities to tailor effective prevention programmes thus reducing the morbidity and mortality among detainees. It should also facilitate a more effective allocation of resources and promote upward harmonisation in standards of prevention and care in prisons.

Prevention in prisons

1. No state funding allocated for prevention purposes.
2. NGOs' prevention work in the penal system is sporadic, non-uniform and with inconsistent standards as it is most often project-only based and there are no social contracts with the governments as a recognition that the NGOs replace the state where it fails. Consequently, the NGOs' work may be unsustainable in the long run.
3. Lack of normative documents that regulate and normalise the NGOs' activities in prisons. This is in part why in some cases they are looked as a nuisance by prison administration.
4. Lack of essential harm reduction programmes in many countries, e.g. needle and syringe programmes, OST.
5. Lack of information that addresses different age groups, genders, educational and social background, literacy and in different languages for foreign inmates.
6. Lack of comprehensive prevention measures: e.g. alcohol or cannabis addiction help to diminish the further negative effect on the liver and morbidity as a result; HBV vaccination; access to free condoms.

Recommendations:

A. Where government is unable to deliver prevention services, there should be a social contracting system so that NGOs deliver the services in sustainable manner and according to agreed standards.
B. Facilitate NGOs' access and work in prisons through a legal or regulatory framework.
C. Implementation of comprehensive harm reduction programmes in prisons, including free needles and syringes and opportunity to exchange those anonymously, staff trained to deal with overdoses, availability of free condoms.
D. OST should be implemented in prison and not only for those who have already started it before admission. There should be the chance to start it regardless of

the duration of the sentence. This measure is likely to stop or at least reduce both drug consumption and as a result the risk of acquiring HCV and also drug-related offences.

E. HBV vaccinations should be made available in prison for those who meet the medical criteria. As inmates are a "captive audience", they are in a particularly good position to benefit from this. The intervention is in the public health interest of society as well.

F. HCV-related morbidity is strongly affected by alcohol and cannabis consumption. Both of those are rife in many detention institutions. There should be addiction help that may reduce the negative effects on the health of the person with HCV, but also will have an impact on the expenditures for management of concomitant conditions or further liver complications.

G. Because of particular profiles of the detainees, i.e. age groups, gender, social background, ethnicity, education level, the information provided on HCV should be tailored to those and in languages that are understood by the respective inmates.

Access to testing in prisons

1. Testing is not organised in prison as per agreed standards either at admission or annually thereafter.

2. Since blood sampling is not done in some prisons, detainees need to be escorted to an external medical centre which decreases the testing levels as the administration tends to avoid the procedure.

3. HCV tests are not anonymous and as a positive test may be a reason for the ostracisation of a person from the offenders' society. As a result, people refuse to get tested.

4. Coercion exists in case of test refusal as a prisoner needs to sign a written declaration for the refusal.

5. There is no clear framework for community rapid detection testing.

Recommendations:

A. In order to avoid long-term complications and provide treatment in timely manner, testing should be widely available both as a part of the admission procedure, but also annually thereafter, especially for prisoners with long-term or life sentences.

B. Rapid tests should be used on the spot for ease of procedure or alternatively a medical professional should collect blood samples in the prison medical centre and then the samples could be transported to a laboratory, rather than detainees being escorted to an outside medical centre as it happens in some countries. This will decrease financial expenditures, but more importantly will remove the logistical complications.

C. Enable community testing by trained lay provider in prisons, as often inmates tend to be more open with peers rather than with medical professionals and more willing to agree to a test.

D. Ensure adequate training for pre-and post-counselling for both lay and medical providers. A particular emphasis should be put on voluntary and confidential testing.

Access to treatment and care in prisons

1. Often lack of treatment or plans to provide it with some exceptions. At best, in some countries treatment provided as a salvage therapy.
2. Complicated to impossible treatment provision systems with tiered approvals.
3. In some settings prisoners need to have national health insurance with the necessary contribution for a certain period before accessing treatment which almost immediately precludes them from any programme.
4. Lack of support at the point of diagnosis and adherence to the treatment regimen that may lead to a treatment failure.
5. No algorithms for follow-up of patients and treatment provision that takes into account the duration or severity of the sentence.
6. Where only limited set of medicines are available, the only criteria that is used is price without taking into account possible interactions with ART and treatments for other possible concomitant conditions and comorbidities, thus excluding patients with certain profiles from access.
7. Issues of anonymity: lack of algorithm for following the person once diagnosed and who are the people who are aware of the diagnosis.

Recommendations:

A. DAAs should be made available for any inmate who meets the clinical criteria for treatment as per current treatment guidelines, i.e. regardless of stage of liver damage (e.g. Iceland).
B. In the absence of a hepatologist, penal institution doctors ought to be trained and allowed to prescribe HCV treatment bypassing current lengthy, bureaucratic procedures of tiered approvals. Generally, a treatment one stop shop structure should be created or prioritised to avoid dysfunctional division of responsibilities, problematic communication between different parties involved and logistics challenges where inmates need to be escorted between institutions.
C. Prisoners should be exempt from the requirement of a national health insurance for the duration of their sentence and while their treatment lasts, so that they can be treated for HCV while in detention. This may prove financially beneficial as a public health and prevention measure in the long run. Refusing treatment on insurance status can be considered a violation of the right to health as per the international conventions.
D. An algorithm with treatment mechanisms and follow-up, including after release, and that take into account different types of prisoners, i.e. remand, light regime, etc., and sentence duration should be implemented in order to avoid treatment continuum interruptions and losses-to-follow up.
E. Although from community standpoint all commercially available DAAs should be made available in the penal systems, where there is limited availability, then priority should be given to treatments that can be used in conjunction with the ART, so that co-infected patients can be included in the treatment programmes.
F. NGOs and peer educators should be allowed to provide support, both psychological, but more importantly with adherence when an inmate is on HCV treatment, so that the full course of medicines is adequately taken and it does not fail.

National programmes, guidelines and protocols

1. Where national programmes exist, there are no particular stipulations for the penitentiary system.
2. Lack of national guidelines and algorithms specific for prisons or when they exist they are so outdated not to include DAAs and hence completely obsolete in the modern HCV treatment discourse.

Recommendations:

A. National programmes should mention detainees as a key population and include indicators for monitoring. Regularly update guidelines according to international standards to ensure

access to the best possible treatment and to inform medical staff, administrators and prison personnel with treatment and logistical decision-making. NGOs and community people should be included in the preparation of the documents.

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About HAND – Hepatitis Access Needs

The aim of the project was to address the specific access needs within co-infected key populations to hepatitis prevention, testing, treatment and care services in Europe (with a special focus on EECA region), and to improve the capacity of key community leaders to further educate and support local community members and improve community involvement in treatment related advocacy and activism. The project had two main components: research and training. The research focused on the access to hepatitis testing, treatment and care among people in detention and migrants. An initial step was a general literature review, for which the research topic was defined as "HCV services in the penitentiary systems in the countries of the WHO Europe region". The selected data collection platforms were Google and PubMed. All publications before 2012 were excluded, so that we could present a more up-to-date picture of the situation. Based on the findings, six countries were selected for an in-depth exploration. Those were: Bulgaria, Finland, Italy, Kazakhstan, Moldova and Portugal. The training part of the project provided targeted information on treatment and prevention of Hepatitis B and C through webinars in English/Russian and contributed to community mobilization via advocacy-focused workshops, organised in collaboration with local partners.

Duration: October 2016 – March 2018

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About the European AIDS Treatment Group:

Founded in 1992, the European AIDS Treatment Group (EATG) is a non-for-profit European network of nationally-based volunteer activists comprising of more than 175 members from over 40 countries in Europe. The members of EATG are representatives of different communities affected by HIV/AIDS. The EATG has been at the forefront of the development of the civil society response to the HIV/AIDS epidemic in Europe representing and defending the treatment-related interests of people living with or affected by HIV/AIDS. EATG's mission is to achieve the fastest possible access to state of the art medical products, devices and diagnostic tests that prevent or treat HIV infection or improve the quality of life for people living with HIV, or at risk of HIV infection. For more information, please visit www.eatg.org


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