HCV in Key Populations: HCV Testing and Treatment in Incarceration Settings

Prevalence of HCV Infection in Incarceration Settings

HCV infection disproportionately affects individuals in incarceration facilities, which include jails (short-stay facilities that typically house persons for sentences of up to 1 year) and prisons (long-term facilities for persons with a felony conviction). A systematic review and meta-analysis of HCV seroprevalence in carceral facilities between 2013–2021 estimated that the HCV seroprevalence among incarcerated populations in the US ranges from 3.0% to 34.6% (Busschots, 2022). Similarly, investigators conducting an analysis of HCV seroprevalence among persons in US state prison systems from 2019–2023 reported HCV seroprevalence rates of 2.8% to 38.8% (Spaulding, 2023). Thus, HCV seroprevalence in US carceral settings far exceeds the 1.7% HCV seroprevalence in the US general population (Hofmeister, 2019). HCV prevalence in incarcerated populations is not geographically uniform and vary by state and region (Spaulding, 2023); (Varan, 2014). Injection drug use is the most common risk factor for HCV transmission in carceral settings (Spaulding, 2023);(Spaulding, 2006);(Ruiz, 1999). HCV-associated liver disease is a frequent cause of death among incarcerated persons and has surpassed deaths from HIV (Carson, 2021); (Spaulding, 2015); (Spaulding, 2011).

Approximately 30% of all persons with HCV infection in the US spend at least part of the year in an incarceration facility (Varan, 2014); (Hammett, 2002). Unfortunately, most individuals with HCV infections in carceral facilities are unaware of their infection (Spaulding, 2012). Given the high prevalence of HCV infection in incarceration facilities coupled with the fact that more than 10 million individuals in the US pass through jails and prisons each year, as many as 1 million persons with undiagnosed HCV infection might come into contact with the carceral system each year (Rich, 2014);(Spaulding, 2012). More than 90% of these individuals are eventually released and re-enter the general population, where they can contribute to HCV spread in the community (Rich, 2014); (Macalino, 2004) and may have little contact with the health care system (Rich, 2014b); (Bushway, 2006); (Fox, 2005). Moreover, up to 68% of persons who have been sent to an carceral facility are reincarcerated within 3 years of their release (CSG, 2024); (Alper, 2018). Recidivism can further promote the spread of HCV within carceral settings.

Both the US Preventive Services Task Force and the World Health Organization recommend that all incarcerated persons undergo HCV testing (WHO, 2022); (WHO, 2016); (Moyer, 2013b). Despite these recommendations and the high prevalence of HCV infection in carceral facilities, HCV testing is not universally performed in this setting.

Current Approaches to HCV Testing and Treatment in Short-Term Incarceration Facilities (Jails)

HCV testing and treatment have been historically uncommon in short-term carceral facilities (ie, jails) primarily because of the short duration of incarceration and lack of available resources (Maurer, 2015). With approximately 11 million jail admissions annually (Minton, 2016), these facilities represent important public health settings in which to test for HCV infection and treat persons with chronic HCV infection (Wennerstrom, 2023); (Abe, 2019).

Jails have also not had the resources and systems to enable continuation of community-initiated HCV therapy. If detained persons are unable to continue HCV treatment while incarcerated in a short-term carceral facility, the interruption in therapy will adversely affect the likelihood of achieving HCV cure and could promote development of viral resistance. Without systems to facilitate continuation of antiviral therapy, jails may interfere with community HCV treatment efforts and societal payers will suffer losses on investments.

Current Approaches to HCV Testing and Treatment in Long-Term Incarceration Facilities (Prisons)

The bulk of the evidence on current HCV testing and treatment in the long-term carceral facilities (ie, prisons) is based on a 2015 national survey conducted by the American Correctional Association and the Coalition of Correctional Health Authorities research and health outcomes working group (Maurer, 2015). According to this survey, some type of HCV testing is performed in the majority of long-term carceral facilities. However, routine opt-out HCV testing is generally not conducted across the US carceral system. Additionally, there are major differences in approaches to HCV testing and prevention counseling. The most common triggers for HCV testing in a carceral setting were physician request, identified risk factors, and the request of the incarcerated person. Only 16% of carceral facilities tested all detained persons with an HCV antibody test upon entry. Selection of candidates for antiviral therapy also varied across various carceral systems. The survey found that antiviral therapy for chronic HCV infection was available in 90% of long-term incarceration facilities. However, few detained persons actually received HCV treatment, primarily due to antiviral therapy expense and lack of availability of trained staff. Moreover, despite the fact that injection drug use is the major risk factor for HCV transmission in this population, only half of the carceral facilities combined substance use disorder treatment with HCV therapy, a practice that should be growing (Irvin, 2024); (Mazur, 2019).

Investigators at Yale University administered a survey to the directors of the departments of corrections in all 50 US states that inquired about current HCV practices within state correctional facilities (Beckman, 2016). This survey included questions about the number of persons detained in the state's carceral facilities known to have HCV infection on or about December 31, 2014; the number of detained persons receiving any form of HCV treatment at that time; and the availability of relevant resources for detained persons with known HCV infection. Representatives from 41 states completed the questions on the number of detained persons with chronic HCV infection and the proportion receiving antiviral treatment. The overall number of detained persons who were reported to have chronic HCV infection in the 41 reporting states was 106,266 persons, corresponding to 10% of the overall incarcerated population in these states. Among those with known HCV infection, only 0.89% (n=949) received any form of HCV treatment on or about December 31, 2014. States used a variety of factors to prioritize HCV treatment among persons in their incarceration facilities, particularly cirrhosis, sentence length, likelihood of recidivism, potential for antiviral adherence, and chance of HCV reinfection. States with a relatively high proportion of persons reported to have HCV infection did not treat a greater number of persons with HCV infection than states with a lower proportion of infections. At the same time, cost-effectiveness studies project that testing and treatment in carceral facilities is cost-effective and would potentially advance the HCV elimination effort (Assoumou, 2020).

Representatives from 49 of the state departments of corrections completed the questions on resources related to HCV infection. Seventeen states reported offering routine opt-out HCV testing of persons detained in their carceral facilities. Among the 32 states without routine opt-out HCV testing, the main indications for HCV testing were abnormal results from other tests, HIV infection, or a substance use disorder (Beckman, 2016). Medication-assisted treatment programs for substance use disorders were available through 14 state departments of corrections. Four states reported that they followed all of the Federal Bureau of Prisons 2016 guidelines for the evaluation and management of chronic HCV infection (FBP, 2016).

Increased HCV Testing and Treatment in Facilities: Role in HCV Elimination

Given the high prevalence of HCV among persons detained in the US carceral system, the success of the national HCV elimination effort will depend on identifying chronically infected individuals in incarceration facilities, linking these persons to medical care for management, and providing access to HCV antiviral treatment (NASEM, 2017). Diagnosis of chronic HCV infection in carceral settings followed by linkage to care and successful antiviral treatment can ultimately reduce the risk of liver-related and extrahepatic complications,

and has the potential to decrease HCV transmission in carceral facilities and the community after release (Harris, 2016); (He, 2016); (van der Meer, 2012).

Recommendations for Screening and Treatment of HCV Infection in Short-Term Incarceration Facilities (Jails)

RECOMMENDED	RATING
Short-term incarceration facilities (jails) should implement opt-out HCV testing consisting of HCV antibody testing followed by confirmatory HCV RNA testing if antibody positive. • Persons chronically infected with HCV should receive counseling about HCV infection and be provided linkage to follow-up community health care for evaluation of liver disease and treatment upon release. • Persons chronically infected with HCV whose sentence is sufficiently long to complete a recommended course of antiviral therapy should receive treatment for chronic HCV infection according to AASLD/IDSA guidance while in the incarceration facility. Upon release, treated persons should be provided linkage to community health care for surveillance for HCV-related complications.	IIa, C

Recommendations for Screening and Treatment of HCV Infection in Long-Term Incarceration Facilities (Prisons)

RECOMMENDED	RATING
Long-term incarceration facilities (prisons) should implement opt-out HCV testing. • Persons chronically infected with HCV should receive antiviral therapy according to AASLD/IDSA guidance while in the incarceration facility. Upon release, treated persons should be provided linkage to community health care for surveillance for HCV-related complications.	IIa, C
To prevent HCV reinfection and reduce the risk of progression of HCV-associated liver disease, long-term incarceration facilities should provide harm reduction and evidence-based treatment for underlying substance use disorders.	IIa, C

Recommendation for Continuation of HCV Treatment in Incarceration Facilities	
RECOMMENDED	RATING
Short-term and long-term incarceration facilities (jails and prisons) should facilitate continuation of HCV therapy for individuals on HCV treatment at the time of incarceration.	IIa, C

Opt-Out Testing for HCV Infection in Incarceration Facilities (Jails and Prisons)

Interventions to reduce HCV transmission and HCV-related liver disease can only be implemented if persons with HCV infection are diagnosed. Given the variable approaches to HCV testing across US carceral facilities (Maurer, 2015), persons with chronic HCV infection in these settings may not have the opportunity to be diagnosed (Varan, 2014). Universal opt-out testing for chronic HCV infection among persons detained in carceral facilities is highly cost-effective (Assoumou, 2020) and has been shown to reduce ongoing HCV transmission and the incidence of advanced liver disease (He, 2016). Based on a microsimulation model of HCV transmission and disease progression, this approach would enable diagnosis of 122,700 new HCV infections in incarceration facilities in the next 30 years; prevent 12,700 new HCV infections caused by release of previously detained persons with active HCV infection into the community; and avert 11,700 liver-related deaths (He, 2016).

In October 2016, the Federal Bureau of Prisons recommended an opt-out strategy of testing for HCV infection for all sentenced persons in carceral facilities (FBP, 2016). With this approach, a detained person is informed of the indications and plan for HCV testing, and the test is ordered and performed unless the individual declines. However, the Federal Bureau of Prisons clinical guidelines state that HCV testing is not required by policy or law. Thus, it is unclear if US carceral facilities are complying with these recommendations.

Persons with HCV infection who are detained in short-term incarceration facilities (jails) frequently cycle in and out of this setting, are unaware of their infection, and can contribute to HCV transmission in the community (Rich, 2014). Therefore, providing opt-out HCV testing in short-term carceral settings followed by linkage to community health care for those found to be infected is an advantageous approach to HCV case finding. A prospective cohort study evaluated an HCV testing and linkage-to-care program implemented in selected jails in North Carolina and South Carolina from December 2012 to March 2014 (Schoenbachler, 2016). HCV testing and linkage-to-care services were conducted by noncorrectional staff in parallel with carceral facility health care staff. Forty-eight percent of detained persons with chronic HCV infection who were referred for HCV management after release attended a follow-up appointment. Similar programs have been established in New York (Akiyama, 2016), Texas (de la Flor, 2017), and Rhode Island (Beckwith, 2016) with the latter using rapid, point-of-care HCV antibody testing. These studies demonstrate the feasibility of HCV testing in short-term incarceration facilities (jails) followed by linkage to medical care after release for those who have chronic HCV infection.

HCV Direct-Acting Antiviral Treatment in Short-Term Incarceration Facilities (Jails)

An observational cohort study demonstrated the feasibility of initiating and completing direct-acting antiviral (DAA) HCV treatment in a short-term incarceration facility (jail) setting (MacDonald, 2017). In this study, 104 persons detained in the New York City jail system received DAA treatment between January 1, 2014 and June 30, 2016; 60% (n=62) entered the jail on DAA therapy and 40% (n=42) initiated DAA treatment in jail. HCV viral loads were undetectable in 94% of the people with community-initiated DAA therapy and 97% of persons in whom DAA therapy was initiated in jail. This study provides evidence that jail-based initiation of HCV treatment is feasible and prompt access to DAAs during incarceration can preserve the effectiveness of community-initiated HCV regimens. Modeling studies demonstrate that HCV interventions are inefficient and a poor use of available resources if they do not consider linkage to care as being as important as screening and treatment initiation themselves (Linus, 2014).

HCV Direct-Acting Antiviral Treatment in Long-Term Incarceration Facilities (Prisons)

HCV DAA therapy for chronic HCV infection is now logistically feasible within the long-term incarceration (prison) setting and would aid the HCV elimination effort (Spaulding, 2013). The availability of all-oral DAA regimens that commonly require no more than 12 weeks of therapy and cause few adverse effects overcomes many of the logistical challenges associated with interferon-based HCV treatment (Spaulding, 2013). Directly-observed therapy is the norm in prison settings, and the risk of drug diversion is low. Returning formerly detained persons to their communities cured of HCV infection would be an invaluable step toward HCV elimination. In addition to these clinical benefits, treating chronic HCV infection in persons who are incarcerated is cost-effective. Analysis demonstrated that sofosbuvir-based treatment for genotype 1 monoinfection met the benchmark for cost-effectiveness in terms of the benefits gained (Liu, 2014). Louisiana is role modeling the potential for universal HCV screening and treatment in its prison system by using a fixed pricing scheme, whereby the state guarantees a lump sum payment to the pharmaceutical manufacturer in exchange for an unlimited number of HCV treatment courses in its correctional health system over the life of the contract. The program is currently being evaluated (Irvin, 2024).

Treatment of Substance Use Disorders

Given that injection drug use is the major risk factor for initial HCV infection and reinfection, and because alcohol use disorder/dependence is a major cofactor in HCV-related liver disease progression, treatment of concomitant substance use disorders along with HCV therapy is of major importance in persons detained in incarceration facilities. The most effective way to prevent HCV transmission in people who inject drugs is to combine harm reduction strategies that improve the safety of injection (ie, needle/syringe exchange) with interventions that treat the underlying addiction, particularly medication-assisted treatment (Volkow, 2014); (MacNeil, 2011) (see Identification and Management of HCV in People Who Inject Drugs). Alcohol prevention and treatment programs have not been given the same priority as those for drug addiction in carceral settings, and access to treatment for alcohol use disorder/dependence after release is often limited. Addressing hazardous alcohol use among persons with chronic HCV infection detained in carceral facilities with could help slow liver disease progression, decrease HCV transmission, and might reduce recidivism. However, according to the 2015 survey by the American Corrections Association (Maurer, 2015), slightly more than half of carceral systems treat the fundamental substance use disorders among persons receiving HCV antiviral therapy.

Overcoming Barriers to HCV Testing and Treatment in Incarceration Facilities

To expand HCV testing and prevention counseling and increase access to HCV therapy in carceral institutions, it will be necessary to overcome several important barriers. First, appropriately trained staff are needed to screen persons in these facilities for HCV infection and, depending on the result, provide counseling on HCV prevention, linkage to care, and access to antiviral treatment. Offsite practitioners can assist in these endeavors but add expense and logistical complications. The use of telemedicine to link detained persons to specialists has been shown to be effective for the evaluation and treatment of chronic HCV infection in underserved settings (Arora, 2011). The National Commission on Correctional Health Care supports telemedicine in carceral facilities. However, only 30 of the 45 states responding to the 2016 National Survey of Prison Health Care reported using telemedicine (Maruschak, 2016).

Second, unplanned transfers and releases could disrupt ongoing HCV treatment (Spaulding, 2013). Most state incarceration facilities do not have a process in place to smoothly transition a person receiving DAA treatment in an incarceration setting to continuing community-based care without a lapse in HCV antiviral therapy. However, the New York State Hepatitis C Continuity Program demonstrated that it is possible to establish a network of community-based practitioners to facilitate continuation of HCV treatment without interruption after release (Klein, 2007). In this program, persons who initiated HCV treatment while incarcerated were transitioned to a community-based practitioner for completion of therapy after release. Detained persons diagnosed with chronic HCV who remained untreated during their period of detainment were referred to a community provider for HCV treatment evaluation after release.

Finally, the costs of HCV testing and antiviral treatment in carceral facilities are also formidable barriers. Strategies for financing HCV treatment have been put forward by the National Academies of Sciences, Engineering, and Medicine committee for a national strategy for the elimination of hepatitis B and C (NASEM, 2017). These strategies might help overcome cost barriers to HCV testing and treatment in carceral settings.

Addressing these barriers will help ensure that persons residing short-term and long-term carceral facilities can undergo HCV testing and be diagnosed; have access to HCV prevention counseling; and receive treatment for HCV infection and underlying substance use disorders. Improving the diagnosis and management of HCV infection in carceral settings will greatly facilitate efforts to eliminate HCV infection in the US.

Related References

Abe CM, Aguwa M, Zhao M, Sullivan J, Porsa E, Nijhawan AE. Hepatitis C virus infection in the Dallas County jail: implications for screening, prevention, and linkage to care. *Public Health Rep*. 2019;134(6):626-633. doi: 10.1177/0033354919874081.

Akiyama MJ, Kaba F, Rosner Z, Alper H, Holzman RS, MacDonald R. **Hepatitis C screening of the "birth cohort" (born 1945-1965) and younger inmates of New York City jails**. *Am J Public Health*. 2016;106(7):1276-1277.

Allen SA, Spaulding AC, Osei AM, Taylor LE, Cabral AM, Rich JD. **Treatment of chronic hepatitis C in a state correctional facility**. *Ann Intern Med*. 2003;138(3):187-190.

Alper M, Durose MR, Markman J. US Department of Justice, Bureau of Justice Statistics. *2018 Update on Prisoner Recidivism: A 9-Year Follow-up Period (2005-2014)*. Published May 2018. Accessed May 1, 2025. https://bjs.ojp.gov/content/pub/pdf/18upr9yfup0514.pdf.

Arora S, Thornton K, Murata G, et al. **Outcomes of treatment for hepatitis C virus infection by primary care providers**. *N Engl J Med*. 2011;364(23):2199-2207.

Assoumou SA, Tasillo A, Vellozzi C, et al. Cost-effectiveness and budgetary impact of hepatitis C virus testing, treatment, and linkage to care in US prisons. *Clin Infect Dis*. 2020;70(7):1388-1396. doi: 10.1093/cid/ciz383.

Beckman AL, Bilinski A, Boyko R, et al. **New hepatitis C drugs are very costly and unavailable to many state prisoners**. *Health Aff (Millwood)*. 2016;35(10):1893-1901.

Beckwith CG, Kurth AE, Bazerman LB, et al. **A pilot study of rapid hepatitis C virus testing in the Rhode Island Department of Corrections**. *J Public Health*. 2016;38(1):130-137.

Bushway SD. **The problem of prisoner (re)entry**. *Contemp Sociol*. 2006;35(6):562-565.

Busschots D, Kremer C, Bielen R, Bielen R. **Hepatitis C prevalence in incarcerated settings between 2013–2021: a systematic review and meta-analysis**. *BMC Public Health*. 2022;22(1):2159. doi: 10.1186/s12889-022-14623-6.

Carson, EA; US Department of Justice, Bureau of Justice Statistics. *Mortality in State and Federal Prisons, 2001–2019 – Statistical Tables*. Published December 2021. Accessed May 1, 2025. https://bjs.ojp.gov/content/pub/pdf/msfp0119st.pdf

Council of State Governments Justice Center. *50 States, 1 Goal: Examining State-Level Recidivism Trends in the Second Chance Act Era*. Published April 2024. Accessed May 1, 2025. https://csgjusticecenter.org/wp-content/uploads/2024/04/50-States-1-Goal_For-PDF_with508report.pdf.

de la Flor C, Porsa E, Nijhawan AE. **Opt-out HIV and hepatitis C testing at the Dallas County jail: uptake, prevalence, and demographic characteristics of testers**. *Public Health Rep*. 2017;132(6):617-621.

Edlin BR, Eckhardt BJ, Shu MA, Holmberg SD, Swan T. **Toward a more accurate estimate of the prevalence of hepatitis C in the United States.** *Hepatology*. 2015;62(5):1353-1363.

Federal Bureau of Prisons. ***Clinical Guidance for the Evaluation and Management of Chronic Hepatitis C Virus (HCV) Infection***. Published October 2016. Accessed May 1, 2025. https://www.bop.gov/resources/pdfs/hepatitis_c.pdf.

Fox RK, Currie SL, Evans J, et al. **Hepatitis C virus infection among prisoners in the California state correctional system**. *Clin Infect Dis*. 2005;41(2):177-186.

Hammett TM, Harmon MP, Rhodes W. **The burden of infectious disease among inmates of and releasees from US correctional facilities, 1997**. *Am J Public Health*. 2002;92(11):1789-1794.

Harris RJ, Martin NK, Rand E, et al. **New treatments for hepatitis C virus (HCV): scope for preventing liver disease and HCV transmission in England**. *J Viral Hepat*. 2016;23(8):631-643.

He T, Li K, Roberts MS, et al. **Prevention of hepatitis C by screening and treatment in US prisons**. *Ann Intern Med*. 2016;164(2):84-92.

Hofmeister MG, Rosenthal EM, Barker LK, et al. **Estimating prevalence of hepatitis C virus infection in the United States, 2013-2016**. *Hepatology*. 2019;69(3):1020-1031.

Irvin R, Landry G, Jones MR, et al; Louisiana hepatitis C elimination plan team. High prevalence of hepatitis C virus infection among incarcerated persons: results from the Louisiana hepatitis C elimination plan's opt-out testing program in prisons. *J Viral Hepat*. 2024;31(7):432-435. doi: 10.1111/jvh.13941.

Klein SJ, Wright LN, Birkhead GS, et al. **Promoting HCV treatment completion for prison inmates: New York state's hepatitis C continuity program**. *Public Health Rep*. 2007;122(2 Suppl):83-88.

Linas BP, Barter DM, Leff JA, et al. The hepatitis C cascade of care: identifying priorities to improve clinical outcomes. *PLoS One*. 2014;9(5):e97317. doi: 10.1371/journal.pone.0097317.

Liu S, Watcha D, Holodniy M, Goldhaber-Fiebert JD. **Sofosbuvir-based treatment regimens for chronic, genotype 1 hepatitis C virus infection in US incarcerated populations: a cost-effectiveness analysis**. *Ann Intern Med*. 2014;161(8):546-553.

Macalino GE, Vlahov D, Sanford-Colby S, et al. **Prevalence and incidence of HIV, hepatitis B virus, and hepatitis C virus infections among males in Rhode Island prisons**. *Am J Public Health*. 2004;94(7):1218-1223.

MacDonald R, Akiyama MJ, Kopolow A, et al. **Feasibility of treating hepatitis C in a transient jail population**. *Open Forum Infect*. 2017;4(3):ofx142.

Macneil J, Pauly B. **Needle exchange as a safe haven in an unsafe world**. *Drug Alcohol Rev*. 2011;30(1):26-32.

Maruschak L, Chari KA, Simon AE, DeFrances CJ. **National survey of prison health care: selected findings**. *Natl Health Stat Report*. 2016;(96):1-23.

Maurer K, Gondles EF, Efeti D, Strom HV. ***Hepatitis C in Correctional Settings: Challenges and Opportunities***. American Correctional Association and Coalition of Correctional Health Authorities. 2015.

Mazur WP. Management of hepatitis C in Delaware prisons: approaching microenvironmental eradication. *Dela J Public Health*. 2019;5(2):20-27. doi: 10.32481/djph.2019.05.006.

Minton TD, Zeng Z. *Jail Inmates in 2015*. Bureau of Justice Statistics. 2016.

Moyer VA. **Screening for hepatitis C virus infection in adults: US Preventive Services Task Force recommendation statement**. *Ann Intern Med*. 2013;159(5):349-357.

National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on a National Strategy for the Elimination of Hepatitis B and C; Buckley GJ, Strom BL, eds. *A National Strategy for the Elimination of Hepatitis B and C, Phase Two Report*. National Academies Press; 2017.

Rich JD, Allen SA, Williams BA. **Responding to hepatitis C through the criminal justice system**. *N Engl J Med*. 2014;370(20):1871-1874.

Rich JD, Chandler R, Williams BA, et al. **How health care reform can transform the health of criminal justice-involved individuals**. *Health Aff (Millwood)*. 2014;33(3):462-467.

Ruiz JD, Molitor F, Sun RK, et al. **Prevalence and correlates of hepatitis C virus infection among inmates entering the California correctional system**. *West J Med*. 1999;170(3):156-160.

Schoenbachler BT, Smith BD, Sena AC, et al. **Hepatitis C virus testing and linkage to care in North Carolina and South Carolina jails, 2012-2014**. *Public Health Rep*. 2016;131(Suppl 2):98-104.

Spaulding AC, Kennedy SS, Osei J, et al. Estimates of hepatitis C seroprevalence and viremia in state prison populations in the United States. *J Infect Dis*. 2023;228(Suppl 3):S160-S167. doi: 10.1093/infdis/jiad227.

Spaulding AC, Weinbaum CM, Lau DT, et al. **A framework for management of hepatitis C in prisons**. *Ann Intern Med*. 2006;144(10):762-769.

Spaulding AC, Seals RM, McCallum VA, Perez SD, Brzozowski AK, Steenland NK. **Prisoner survival inside and outside of the institution: implications for health-care planning**. *Am J Epidemiol*. 2011;173(5):479-487.

Spaulding AC, Thomas DL. **Screening for HCV infection in jails**. *JAMA*. 2012;307(12):1259-1260.

Spaulding AS, Kim AY, Harzke AJ, et al. **Impact of new therapeutics for hepatitis C virus infection in incarcerated populations**. *Top Antivir Med*. 2013;21(1):27-35.

Spaulding AC, Sharma A, Messina LC, et al. **A comparison of liver disease mortality with HIV and overdose mortality among Georgia prisoners and releasees: a 2-decade cohort study of prisoners incarcerated in 1991**. *Am J Public Health*. 2015;105(5):e51-e57.

van der Meer AJ, Veldt BJ, Feld JJ, et al. **Association between sustained virological response and all-cause mortality among patients with chronic hepatitis C and advanced hepatic fibrosis**. *JAMA*. 2012;308(24):2584-2593.

Varan AK, Mercer DW, Stein MS, Spaulding AC. **Hepatitis C seroprevalence among prison inmates since 2001: still high but declining**. *Public Health Rep*. 2014;129(2):187-195.

Volkow ND, Frieden TR, Hyde PS, Cha SS. **Medication-assisted therapies--tackling the opioid-overdose epidemic**. *N Engl J Med*. 2014;370(22):2063-2066.

Weinbaum C, Lyerla R, Margolis HS, Margolis HS. **Prevention and control of infections with hepatitis viruses in correctional settings**. *MMWR Recomm Rep*. 2003;52(RR-1):1-36.

Wennerstrom A, Manogue S, Hardeo H, Robinson WT, Thomas DL, Irvin R. Incarceration, inequality, and hepatitis C treatment: the story of two southern states. *J Health Care Poor Underserved*. 2023;34(3):1129-1135.

World Health Organization. *Global Health Sector Strategies on, Respectively, HIV, Viral Hepatitis and Sexually Transmitted Infections for the Period 2022-2030*. Published 2022. Accessed May 1, 2025. https://iris.who.int/bitstream/handle/10665/360348/9789240053779-eng.pdf?sequence=1.

World Health Organization. *Guidelines for the Screening, Care and Treatment of Persons With Chronic Hepatitis C Infection*. Published April 2016. Accessed May 1, 2025. https://iris.who.int/bitstream/handle/10665/205035/9789241549615_eng.pdf?sequence=1