



Swiss HepFree in Prisons Programme SHiPP

Final Report

Dr. med. **Claude Scheidegger**, MPH, Programme Manager SHiPP
Dr. med. Nathalie Brunner, MBA, Managing Director, Swiss Hepatitis

27.03.2026



The Swiss Hepatitis in Prisons Programme (SHiPP) is an initiative of Swiss Hepatitis aimed at improving the detection and medical care of individuals with hepatitis B, hepatitis C, or HIV infection in Swiss correctional facilities.

This report concludes by summarising the findings from the entire programme.

1. Programme Overview

The programme ran from early 2019 through the end of February 2026, divided into preliminary assessments and preparatory work from 2019 to 2021 and implementation from 2021 to 2026 (Phase I: summer 2021 to fall 2024; Phase II: fall 2024 to spring 2026). The extended development phase is attributable to significant implementation delays caused by the COVID-19 pandemic.

Local projects were initiated and completed at 16 correctional institutions across 11 cantons. This included facilities from all language regions and all three regional prison concordats in Switzerland. The programme included both pretrial detention and incarceration facilities, institutions of very different sizes (smallest, small, medium, and large units), as well as facilities in which the medical department operates under the jurisdiction of either the justice or health departments, respectively. This ensured that the extremely diverse conditions of incarceration in Switzerland were adequately accounted for.

2. Overview of institutions, testing and prevalence rates

The final results presented below include data from six additional facilities that were added to the programme after preliminary results were presented in an interim report. In adding these additional facilities, care was taken to a) strengthen the representativeness of all Swiss prisons, b) support or adjust observations from the first ten included projects by collecting additional data, and c) specifically test several additional hypotheses.

2.1 Characteristics of the institutions participating in SHiPP

Table 1 (see Appendix 2) illustrates that the facilities participating in the SHiPP through local projects differ significantly in terms of size (measured by the number of detention beds), the type(s) of detention offered, responsibility for medical care, medical care running either under the jurisdiction of a justice or health department, the general testing strategy, and the selection criteria for the screening conducted.

The same screening inclusion criteria did not apply across all local projects. In the majority of cases, the health service included all newly admitted individuals in the screening without restriction. In a minority of cases, stays of very short duration were excluded: in two facilities, in the case of a stay (expected at admission) of <3 days, and in one prison in the case of <5 days.

Three institutions had restrictive pre-screening criteria:

- One correctional facility offered screening only if the newly admitted person was expected to remain there (i.e., screening was not offered if a transfer or release was expected within a few days).
- Two facilities offered screening to incarcerated people only if the sentence was expected to last at least two months.

These pre-selection processes had a significant impact on the results from these three facilities. For example, one of these three facilities recorded 1,050 new admissions during the

project period. Due to the overwhelmingly short duration of stays (primarily for triage before transfer or immediate release within a few days), screening was offered to only 132 (12.6%) newly admitted individuals, with approximately 90% accepting the test offer (i.e., a very high testing rate, though limited to the minority who received an offer). The corresponding test rates for these three institutions therefore apply only to the pre-selected subpopulations. At one institution without an on-site medical service, an external mobile team successfully conducted a one-time testing campaign on a designated day among all individuals incarcerated.

2.2 Total test rates

Table 2 (see Appendix 2) lists the testing and prevalence rates for the infections included in the screening (hepatitis B, hepatitis C, HIV infection). Due to the widely varying conditions and differences in testing strategies mentioned above, it is not appropriate to make direct comparisons between individual facilities.

Over the course of the project, good (>60%) to very good (>90%) testing rates were achieved in the vast majority of cases. For the facilities with testing rates in the 40–50% range, there were good reasons why better results had not (yet) been achieved during the observation period. At the three institutions with test rates below 40%, there was, from an external perspective, a clear lack of motivation at the facility level or among the staff responsible to meet the project requirements and associated objectives.

2.3 Test rates over time

In eleven correctional facilities, officials conducted screening either in the months leading up to the project or (among people already incarcerated at the beginning of the project) right at the start of the project. For these facilities, data on testing rates were provided for the periods before or at the start of the project, respectively, and in the course of the project (Table 3; see Appendix 2).

In most of the institutions, a significant increase in testing rates was achieved over the course of the project, in some cases striking, even when rates were already high at the outset. The two facilities with either persistently low testing rate or massive decline over time are among the mentioned observations in which there was apparently limited on-site motivation for project implementation.

2.4 Prevalence rates

As part of the programme, participants were screened for hepatitis B antigen (HBsAg), hepatitis C antibodies, and HIV antibodies.

Table 2 also shows the screening results, i.e., the prevalence data for the infections under discussion. In general, only a few individuals with HIV infection or active hepatitis B were identified by the screening. Nevertheless, these diagnoses were extremely significant for those affected and their social circles.

The prevalence of hepatitis C antibodies, however, was significantly higher, with figures ranging from approximately 1% to 6% (13% in one facility). Among those with positive hepatitis C antibodies, approximately one-third to one-half (in one case, three-quarters) had chronic hepatitis C.

2.5 Further evaluation, treatment, and follow-up care

The primary goal of the SHiPP initiative was to address and, wherever possible, improve every stage of the diagnostic and treatment pathway for hepatitis B, hepatitis C, and HIV infection in



Swiss correctional facilities. Prevention was addressed in every project. Screening, further diagnostic evaluation, and treatment were the central pillars of the programme from the outset.

It was only through the experiences of the first SHiPP projects that it became clear that follow-up care during incarceration presents particular challenges. On the one hand, this concerns ensuring the continuity of medical care upon release or in the event of often unpredictable, short notice transfers to another facility, frequently to a different context with very different conditions (size of the institution, type of incarceration, organisation, local guidelines). On the other hand, it is generally difficult to ensure follow-up care after release from incarceration.

Optimal communication between the institutions involved in a transfer, as well as with external organisations and agencies upon release, is generally of the utmost importance for incarcerated individuals, and this applies to a very high degree to care regarding hepatitis B, hepatitis C, and HIV infection.

All participating institutions report continuing treatments for hepatitis C or HIV infection (and, in isolated cases, hepatitis B) that were initiated before admission, as well as new referrals for further evaluation and treatment following transfer or discharge (primarily involving individuals with newly diagnosed hepatitis C). In the vast majority of institutions participating in SHiPP, individual hepatitis C treatments were initiated during prolonged stays, including when the diagnosis was made (but treatment had not yet begun) prior to admission or following first detection by screening after admission.

The correctional facility with the highest number of confirmed cases of chronic hepatitis C provided detailed treatment data. In this facility, 15 out of 21 (71%) patients with confirmed chronic hepatitis C received treatment during their stay; three persons had explicitly declined treatment; for two, treatment could not be initiated (for the time being) due to existing viral resistance; and one person was released before treatment could be initiated.

In another facility, 13 out of 13 patients with chronic hepatitis C were treated.

One facility reported that all four individuals with chronic hepatitis C were discharged or transferred “within six months,” which appears to have been the reason for non-treatment.

The following responses were received from the remaining facilities that recorded individuals with chronic hepatitis C (number of individuals with chronic hepatitis C/number treated): 4/4, 2/2, 2/2, 2/3 (one early discharge), 1/2 (one early discharge), 1/1, 1/1.

In summary, it can be concluded that — except for a single institution where the justification for not treating patients with chronic hepatitis C was not convincing — further investigations were always conducted upon diagnosis of a suspected infection and treatment uptake was generally high.

3. Experiences and Findings

3.1 Programme Design

Two fundamental principles have proven crucial to the programme’s design and successful implementation: the bottom-up approach for on-site project development and the opt-out principle for screening.

Based on numerous contacts before the programme’s launch and, above all, on the findings of a survey conducted among Swiss prisons, Swiss Hepatitis recognised the need for each project to be prepared, developed, and implemented separately with local stakeholders, given



the markedly different local conditions, opportunities, and needs. It turned out that this bottom-up approach was highly valued by the institutions and was crucial to the projects' success.

For the screening of new arrivals, health services in all institutions generally applied the opt-out procedure as part of the assessment on admission. This means that screening was conducted for all new arrivals unless an individual explicitly opted out. This requirement contributed significantly to good-to-very-good testing rates and to their improvement over time.

3.2 Inclusion of institutions and on-site implementation

At the start of the programme's activities, initial contact was made with representatives from institutions that had previously expressed interest in further collaboration. As the programme progressed, new interested representatives from correctional facilities continued to reach out, often during or after conferences at which Swiss Hepatitis had presented the SHiPP initiative.

Following an initial exchange, once interest was confirmed, the programme management presented the framework conditions for participating in the programme to the medical staff (physicians and nurses) and the prison administration on-site, usually in the presence of several other department heads (e.g., heads of surveillance and support services, heads of social services, workplace supervisors, etc.). Early involvement of managers from non-medical areas, particularly surveillance staff representatives, has proven very effective. This helped foster knowledge and understanding among those involved, which was very helpful in the subsequent practical implementation.

Whenever a presentation was given on-site, it was always followed by an agreement to proceed with a project, with two exceptions: officials in two cantons, after giving an equally interested and friendly reception, decided to observe developments elsewhere.

In one canton, SHiPP agreed on and prepared a project with the officials, but it never reached practical implementation; consequently, after about one year without a concrete project launch, the agreement was terminated by mutual consent on good terms. According to local officials, the sole reason for the lack of implementation was a shortage of personnel, caused in part by a long-term absence of a key staff member and other vacancies. The institution in question is not counted among the institutions participating in SHiPP.

In summary, following the presentation of the SHiPP initiative in 14 cantons, 12 subsequently moved into the preparation phase and 11 into project implementation.

3.3 Duration of local Projects

In principle, SHiPP aimed for a project duration of twelve months. At two facilities, the decision-makers chose to limit the duration to six months before the project began. After lengthy discussions, two facilities opted for three-month pilot projects. These projects have a shorter observation period and thus provide very limited insights.

In retrospect, an intervention duration of only 3 months must be considered far too short for the objectives sought by the SHiPP initiative. A 6-month duration may be adequate when testing the impact of introducing a new element (e.g., rapid tests) into already well-established activities.

After the project activities began on-site, implementation was discontinued at a single institution, unfortunately, due to the absence of the person primarily responsible on-site because of illness.

3.4 Leadership and Motivation

For each institution participating in the SHiPP with a project, a local project manager was identified before the activities began - typically a director of medical services. These project managers received intensive support from Swiss Hepatitis during the preparation phase and throughout the project.

The motivation of these key individuals, as well as that of the healthcare team, proved to be the main factor in the success of each project, as measured, for example, by the testing rate achieved.

None of the facilities participating in SHiPP reported that the motivation of the incarcerated individuals posed a fundamental obstacle. If anything, this applied to a minority, mainly at the start of the project (when there might still have been some scepticism toward the healthcare staff or the testing offered).

3.5 Differences Between Pretrial Detention and Incarceration

It is likely no coincidence that most facilities with very high testing rates do not offer pretrial detention or, in one case, did not include individuals scheduled for transfer a few days after admission in their screening process.

Based on initial experiences, some facilities have adjusted their strategy and no longer offer screening to individuals whose very short detention period is known in advance (e.g., those serving a fine).

In fact, with very short periods of detention (or stays on-site prior to transfer), it is difficult for health services to establish the trust necessary to provide good, motivating care to detained individuals. Generally speaking, there is simply not enough time for this, and the short stay is dominated by other concerns and priorities. Under such conditions, information and screening for viral hepatitis and HIV infection can only be promoted to a limited extent in most cases.

The difficulties mentioned in connection with short-term stays inevitably arise primarily in pretrial detention centers or units. In the correctional system (particularly where the length of incarceration ranges from months to years), it is often possible, if not upon admission, then through follow-up contacts during the course of incarceration, to convince even those individuals, who initially declined for whatever reason, of the benefits of screening. Under such conditions, the advantage of venous blood collection prevails, as it allows for further laboratory investigations to be initiated from the same sample material if necessary (depending on the situation including reflex testing in the laboratory, i.e., without a repeat physician's order).

3.6 Differences between venous and capillary blood collection

Initial results from institutions participating in SHiPP appeared to confirm international observations that testing rates achieved through venous blood draws alone were limited, i.e., to about half of all eligible incarcerated individuals. Literature contains numerous examples in which, starting with programmes relying solely on venous blood draws, the introduction of diagnostics using capillary blood draws or saliva tests, i.e., through on-site testing as a first step, led to a significant increase in testing rates.

Testing this hypothesis in the Swiss context was one of the key questions to be addressed by including additional projects in the programme.

It now turns out that in Swiss prisons, high testing rates are indeed achievable even when relying solely on diagnostics via venous blood draws. In Switzerland, factors beyond the choice of specimen collection method alone are more important for the successful implementation of



screening in this setting. Clearly, the prospects for success depend more heavily on the type of detention, the organisation, the resources, and the motivation of the responsible services within the institutions.

That said, it is striking that, with one exception, the facilities with good-to-very-good testing rates are those that do not offer pretrial detention. This may indicate that diagnosis based solely on venous blood draws can also be very successful, provided that the detainees' stay is prolonged (ranging from months to years). This allows the medical team to encourage those affected to undergo screening for hepatitis B, hepatitis C, and HIV infection on multiple occasions or when a suitable opportunity arises (e.g., when a blood draw is performed for other reasons). In facilities or units with relatively short to very short stays, the advantages of rapid capillary blood- or saliva-based diagnosis become more obvious.

4. Outlook; SHiPP26+

With the conclusion of SHiPP in its current form, the initiative will continue seamlessly as SHiPP26+. The overarching goal remains the sustainable improvement of healthcare in correctional facilities, with a focus on promoting needs-based, integrated care structures. Swiss Hepatitis will continue to support correctional institutions in introducing or expanding regular on-site screening for hepatitis B, hepatitis C, and HIV upon admission, and in establishing subsequent on-site treatment. In the long term, screening and therapy are to be firmly established as an integral part of basic medical care in correctional settings nationwide.

A central focus of SHiPP26+ is on the systematic synthesis of knowledge and engagement in policy-making. The existing publication "Good Practice Along the Treatment Pathway" will be graphically revised in 2026 and specifically disseminated to incorporate evidence-based recommendations into political and operational decision-making processes. Furthermore, the project's expertise will be actively shared with relevant expert panels to enhance the visibility and implementation of the results.

Coordination, networking, and quality assurance form the backbone of the programme. SHiPP26+ promotes interdisciplinary exchange among the medical community, the judiciary, correctional facilities, and NGOs to support continuous quality improvement and identify gaps in care, with the clear goal of sustainably increasing treatment rates.

Dr. med. **Claude Scheidegger** MPH

Programme Manager SHiPP

Dr. med. **Nathalie Brunner** MBA IHM

Managing Director Swiss Hepatitis



Appendix 1: Presentations and Publications

2019

- 29.08. Hepnet, Zürich
Virale Hepatitis und Gefängnis
- 28.11. Forum Justizvollzug SKJV / Forum de la détention et de la probation CSCSP, Bern
Hepatitis-C-Elimination in der Schweiz nur mit den Haftanstalten möglich / Elimination de l'hépatite C en Suisse - impossible sans l'aide des prisons
- 06.12. Gefängnismedizin-Tage, Frankfurt
Neues aus der Schweiz (Chance für ein HCV-freies Gefängnis in Deutschland bis 2030?)

2020

- 08.02. Jahrestagung der Konferenz der Schweizerischen Gefängnisärzte und des Forums für Pflegefachpersonen im Justizvollzug / Rencontre annuelle de la Conférence des médecins pénitentiaires suisses et du Forum du personnel soignant des établissements de détention en Suisse, Solothurn
Virale Hepatitis (und HIV-Infektion) im Gefängnis / Hépatites virales (et infection au VIH) en milieu pénitentier
- 29.05. Abbvie Switzerland, online
Viral hepatitis and prisons – The Swiss perspective
- 24.11. Dienstagsclub Infektiologie Universitätsspital, Basel
Gefängnisse – Brutstätte für oder Schutzort vor Infektionen?

2021

- 04.11. INHSU Swiss Hub, online
Hepatitis C in Prisons – Framework and Recent Data
- 29.11. Swiss Hepatitis Symposium, Zürich
Hepfree Prisons in Switzerland
- 16.12. PWID Preceptorship, Bern
HepC treatment settings – in prisons

2022

- 18.05. Generalversammlung der Vereinigung der Kantonsärztinnen und Kantonsärzte der Schweiz / Assemblée générale de l'Association des médecins cantonaux de Suisse, Genève
Vorstellung SHiPP / Présentation SHiPP
- 11.11. Jahrestagung der Vereinigung der Kantonsärztinnen und Kantonsärzte der Schweiz / Assemblée annuelle de l'Association des médecins cantonaux de Suisse, Naters
Vorstellung SHiPP / Présentation SHiPP
- 28.11. Netzwerkmeeting Hepatitis Schweiz, Zürich
Vorstellung SHiPP



HEPATITIS SCHWEIZ

15.12. Hepnet, Zürich
Virale Hepatitis und Gefängnis

2023

06.06. Conférence des chefs des services pénitentiaires cantonaux, online
Diagnostics et traitement des hépatites virales en milieu carcéral suisse

16.06. Konferenz der kantonalen Leitenden Justizvollzug, online
Abklärung und Behandlung von Virushepatitis in Schweizer Gefängnissen

27.11. Swiss Hepatitis Symposium, Bern
Presentation of SHiPP

2024

24.10. Europäische Konferenz zur Gesundheitsförderung in Haft (Workshop), Wien
Nationale Strategien zur Bekämpfung von HIV und Hepatitiden in Haft bis 2030

02.12. Netzwerkmeeting Hepatitis Schweiz, Bern
Präsentation SHiPP

2025

27.03. Congrès médecine pénitentiaire / Medizin im Strafvollzug, Neuchâtel
Ces étrangers qui nous apportent des infections ... / Diese Ausländer, welche uns Infektionen bringen ...

11.12. Gefängnismedizin-Tage, Darmstadt
Vorstellung SHiPP

Scheidegger C. Hepatitis C: Prävention, Screening und Therapie in Gefängnissen.
Suchtmagazin 48(2022):34-36

<https://www.suchtmagazin.ch/magazin/schadensminderung-2022-02>



HEPATITIS SCHWEIZ

Appendix 2: Tables

Table 1 Characteristics of participating institutions

canton	institution	detention beds number	types of detention	responsibility for medical care	authority responsible for health care	fundamental testing strategy	pre-selection for the screening
BS	Gefängnis Bässlergut	118	1,4	Cantonal Medical Service	Department of Health	saliva test for all admissions (testing for HCV only)	all new admissions without restriction
BS	Untersuchungsgefängnis Waaghof	142	2,3,4 (±1)	Cantonal Medical Service	Department of Health	saliva test for all admissions (testing for HCV only)	all new admissions without restriction
FR	EDFR Bellechasse	203	1	external GP	Department of Justice	venous blood sampling for all admissions	all new admissions without restriction
FR	EDFR Prison Centrale	100	2,3,4	external GP	Department of Justice	saliva test and capillary blood sampling for all admissions	all admissions with a stay of ≥3 days
GE	Prison de Champs-Dollon	398	1,2,3,4	HUG Prison Hospital Unit	Department of Health	venous blood sampling for all admissions (data for HCV only)	all new admissions without restriction
GL	Gefängnis Glarus	13	1,2,3,5	external GP	Department of Justice	saliva test and capillary blood sampling for all admissions	all admissions with a stay of ≥3 days
GR	JVA Realta	118	1,4,5	external GP	Department of Justice	saliva test and capillary blood sampling for all admissions	all admissions with a stay of ≥5 days
SG	Strafanstalt Saxerriet	135	5 (±1)	external GP	Department of Justice	saliva test and capillary blood sampling for all admissions	all new admissions without restriction
TI	Carcere Giudiziario La Farera	88	1,2,3,4	EOC Prison Medicine Department	Department of Health	saliva test and capillary blood sampling for all admissions	all admissions expected to stay for ≥ 2 months
TI	Carcere Penale La Stampa	140	1	EOC Prison Medicine Department	Department of Health	saliva test and capillary blood sampling for all admissions	all admissions expected to stay for ≥ 2 months
BE	Regionalgefängnis Biel	33	1,2	external GP	Department of Justice	saliva test and capillary blood sampling for all admissions	all admissions for whom no immediate transfer is planned upon arrival
BE	Justizvollzugsanstalt Thorberg	180	1	external GP	Department of Justice	venous blood sampling for all admissions, saliva test and capillary blood sampling as a backup	all new admissions without restriction
NE	Etablissement d'exécution des peines Bellevue	65	1	Neuchâtel Centre for Psychiatry	Department of Health	venous blood sampling for all admissions, saliva test and capillary blood sampling as a backup	all new admissions without restriction
NE	Etablissement de détention La Promenade	112	1,2	Neuchâtel Centre for Psychiatry	Department of Health	venous blood sampling for all admissions, saliva test and capillary blood sampling as a backup	all new admissions without restriction
SH	Kantonales Gefängnis Schaffhausen	43	1,2	external GP	Department of Health	saliva tests and capillary blood samples for all individuals already incarcerated	all persons incarcerated at the start of the project
ZG	Justizvollzugsanstalt Bostadel	120	1	external GP	Department of Justice	saliva test and capillary blood sampling for all admissions	all new admissions without restriction

1 closed custody, 2 pre-trial detention, 3 short-term imprisonment, 4 administrative detention under immigration law, 5 open custody

Table 2 Testing rates and prevalence data

institution	total target population					
	number of tests offered	number of persons tested	HIV-positive	HBV-positive	HCV-positive	chronic hepatitis C
A	761	260 (34.1%)	0 (0.0%)	3 (1.2%)	1 (0.4%)	not available
B	448	92 (20.5%)	5 (1.1%)	2 (0.4%)	6 (1.3%)	2
C	38	35 (92.1%)	0 (0.0%)	0 (0.0%)	2 (6.7%)	2
D	409	386 (94.4%)	4 (0.1%)	1 (0.03%)	9 (2.3%)	4
E	1863	802 (43.0%)	na	na	46 (5.7%)	21 (45.7%)
F	232	149 (64.2%)	0	-	7 (2.6%)	3
G	38	10 (26.3%)	-	-		
H*/**	264	201 (76.1%)	1 (0.5%)	2 (1.0%)	12 (6.0%)	4 (33.3%)
I*/**						
J	192	131 (68.2%)	1 (0.7%)	0 (0.0%)	17 (13.0%)	13 (76.5%)
K	298	200 (67.1%)	1 (0.5%)	3 (1.5%)	9 (4.5%)	1
L	58	51 (87.9%)	0 (0.0%)	1 (2.0%)	1 (2.0%)	0
M**	132	115 (87.1%)	1 (0.9%)	0 (0.0%)	2 (1.7%)	1
N	121	115 (95.0%)	0 (0.0%)	1 (0.9%)	2 (1.7%)	1
O	35	18 (51.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	-
P	187	112 (59.9%)	1 (0.9%)	0 (0.0%)	1 (0.9%)	0

* Data from institutions H and I have been combined subsequently

** Testing offered following a pre-selection process (see text)



HEPATITIS SCHWEIZ

Table 2 Test rates prior to or at the start, respectively, as well as in the course of the project

institution	initially	subsequently
A	73.5%	30.3%
B	15.4%	24.1%
D	77.7%	100.0%
H*	68.6% ¹	76.1%
I*	18.4% ¹	
J	78.8%	68.2%
K	41.1% ¹	67.1%
L	91.8% ¹	87.9%
M	75.0%	92.4%
N	74.0% ¹	95.0%
P	62.5%	67.1%

* Data from institutions H and I were combined subsequently

¹ Data prior to the start of the SHiPP project