Services for people in prisons and other closed settings

Resource kit for high-impact programming

This Guidance Note is part of the resource kit for-high impact programming that provides simple, concise and practical guidance on key areas of the AIDS response. The resource kit is jointly developed by the the Joint United Nations Programme on HIV/AIDS. The resource kit can be accessed at http://www.unaids.org/en/ourwork/programmebranch/countryimpactsustainabilitydepartment/globalfinancingpartnercoordinationdivision/

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The development of this Guidance Note was led by the United Nations Office on Drugs and Crime (UNODC) in collaboration with the UNAIDS Secretariat, the World Health Organization (WHO) and the United Nations Development Programme (UNDP). This Guidance Note provides simple, concise and practical guidance on services for people in prisons and other closed settings. References and links to full guidance are provided in the last section of the Guidance Note.

WHAT IS NEW?

- UNODC. A handbook for starting and managing needle and syringe programmes in prisons and other closed settings. Advance Copy - UNODC: Vienna; 2014 http://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/ADV_COPY_NSP_PRISON_AUG_2014.pdf

- United Nations Office on Drugs and Crime, International Labour Organization, United Nations Development Programme. Policy brief. HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions. Vienna: United Nations Office on Drugs and Crime; 2012 (http://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf).

- Joint United Nations Statement calls for the closure of compulsory drug detention and rehabilitation centres. Geneva: Joint United Nations Programme on HIV/AIDS; March 2012 (http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint Statement6March12FINAL_en.pdf).

1. Key elements

Globally, prisons and other closed settings[1] are characterized by relatively high prevalence of HIV, hepatitis B and C and tuberculosis (TB) and relatively higher risks for transmission together with lower access to health services. Isolated from public health services, including national AIDS or TB programmes, prisons and other closed settings are often seriously neglected in country responses to address HIV and TB prevention, treatment and care. The United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO) and UNAIDS advocate for the implementation of evidence-based interventions that aim to ensure access to services for populations at higher risk. This includes a comprehensive programme for the prevention, treatment and care of HIV and TB among people in prisons and other closed settings.

All modes of transmission occurring in the broader community (blood-borne, sexual and vertical transmission) also occur in prisons. HIV is transmitted in prison settings through the sharing of contaminated injecting equipment among people who inject drugs; consensual or coerced unsafe sexual practices including rape; unsafe skin piercing and tattooing practices as well as body modifications; and blood-borne transmission resulting from the sharing of shaving razors, so-called brotherhood blood-sharing rituals and the improper sterilization or reuse of medical or dental instruments.

Interventions aim to prevent the transmission of HIV (and TB) among men, women and children living in closed settings; to provide treatment and support when necessary; and to ensure the continuity of treatment.

HIV and TB in prisons, pretrial detention centres and other closed settings are public health issues affecting all regions of the world. HIV and TB are the leading causes of mortality in prisons. The prevalence of HIV, hepatitis B and C and TB among prison populations tends to be much higher (up to 50 times)[2] than prevalence in the community. The higher vulnerability of people entering prison and the overrepresentation of key populations, together with over-crowding, poor hygiene and nutrition, violence, the poor classification[3] of prisoners, a lack of access to basic health services and the higher prevalence of various communicable diseases, are responsible for the high rates of morbidity and mortality related to HIV and TB. Women in prisons represent a minority of the population (5–10%), but are at higher risk for HIV than men in prisons due to their lower socioeconomic background and the reasons for which they are imprisoned, which are different from those for men in the same situation.[4] In particular, people who inject drugs and sex workers are relatively overrepresented in women prisons compared to prisons for men. Women can arrive at prison pregnant or become pregnant while

1 Closed settings include pretrial detention centres, jails, prisons, immigration detention centres and juvenile detention centres.

2 *United Nations Office on Drugs and Crime, International Labour Organization, Joint United Nations Programme on HIV/AIDS. Policy brief. HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions. Vienna: United Nations Office on Drugs and Crime; 2012 (http://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf, accessed 13 June 2014).*

3 For example, by sex, age or whether individuals are at the pre-trial stage or have been sentenced.

4 *United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS. Women and HIV in prison settings. Vienna: United Nations Office on Drugs and Crime; 2008 (http://www.unodc.org/documents/hiv-aids/Women_in_prisons.pdf, accessed 13 June 2014).*

in prison. Some women are accompanied by their young children, give birth or are nursing while in prison. People who use or inject drugs can constitute up to 50% of the population in closed settings.

People in prisons and other closed settings should enjoy all their human rights, except the deprivation of their liberty by due process. However, the rights of people in prisons, including their rights to health and protection from discrimination and violence, are not always respected. Substandard hygiene and other conditions, including overcrowding, mandatory testing, forced treatment, sexual and other forms of violence, the segregation of people living with HIV or a lack of access to services, constitute major obstacles to protecting the health of people in prisons and other closed settings (see section 8 below).

Staff working in prisons are also affected by poor prison conditions, especially with regard to TB. Prison staff are also at risk for accidental exposure to blood while searching cells or in the event of fights among prisoners.

Populations in closed settings are not isolated from the general population. Most prisoners will return to their communities in the months or years following their incarceration.

UNODC, together with UNDP, ILO, WHO and UNAIDS,[5] recommend the provision of the following services as a comprehensive package to address HIV in prisons and other closed settings according to the specific situation in a particular country:

- HIV education, information and communication (especially as a peer-based intervention);
- condom distribution programmes (in both men's and women's prisons);
- prevention of sexual violence (including the establishment of conjugal visiting rooms);
- drug dependence treatment, including opioid substitution therapy (OST);
- needle and syringe programmes (NSPs);
- prevention of HIV transmission through medical or dental services, i.e. through the sterilization of equipment and observing universal precautions;
- prevention of HIV transmission through tattooing, piercing and other forms of skin penetration;
- post-exposure prophylaxis for both detainees and staff;
- HIV testing and counselling;
- HIV treatment, care and support;

5 United Nations Office on Drugs and Crime, International Labour Organization, United Nations Development Programme, World Health Organization, Joint United Nations Programme on HIV/AIDS. Policy brief. HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions. Vienna: United Nations Office on Drugs and Crime; 2012 (http://www.unodc.org/documents/hiv-aids/ HIV_comprehensive_package_prison_2013_eBook.pdf, accessed 13 June 2014).

- prevention, diagnosis and treatment of TB including collaborative HIV and TB programmes, screening and regular active TB case finding;
- prevention of mother-to-child transmission of HIV (PMTCT);
- prevention and treatment of sexually transmitted infections (STIs);
- vaccination, diagnosis and treatment of viral hepatitis;
- protecting staff from occupational hazards.

Interventions should be in line with national policies (based on WHO and other international guidelines) and integrated or at least implemented and monitored in close collaboration with ministries of health.

2. Focus populations

HIV and TB in prisons and other closed settings affect all regions and countries in the world. In some countries, the classification of prisoners in a prison is based on the type of offence (for example, prisons for individuals sentenced for drug offences). Similarly, women should be hosted in separate prisons and young people in prisons should be separated from older adults. The response should be tailored to address the specific needs of each type of prison, including pretrial and immigration detention centres.

Specific populations who benefit from the interventions include:

- people in prisons and other closed settings (including pretrial detention centres);
- people who use / inject drugs in prisons and other closed settings (including pretrial detention centres);
- other key populations, including sex workers, men who have sex with men, transgender people in prisons and other closed settings (including pretrial and immigration detention centres);
- women (and their accompanying children) in prisons and other closed settings;
- young women and men in prisons and other closed settings;
- prison staff.

3. Data requirements

In most cases, an assessment of the situation might be necessary in order to gain knowledge of the exact needs and to collect baseline indicators for monitoring and evaluation purposes.

Data collection related to assessment and analysis should include the following types of key information. Where possible, all data should be disaggregated by sex and age group. Age groups should at least indicate prisoners below 18 years of age and young prisoners (18–24).

Epidemiology

Epidemiological data should be collected in a way that is ethical and respectful of human rights through means approved by local ethical review committees. Such data should inform the introduction and expansion of HIV and related services, as well as measures to reduce vulnerability to infection. Epidemiological data include:

- prevalence in populations including prevalence of HIV, hepatitis B and C and TB in the prison population and prevalence of HIV and hepatitis among people who inject drugs in the prison population;
- the proportion or number of new infections including the incidence of HIV, hepatitis among the prison population and among key populations and the incidence of TB;
- the estimated size of populations in prisons and other closed settings (disaggregated by setting type) including issues of overcrowding, the estimated sizes for populations of women and young men and women and the estimated size of the population of people who inject drugs;
- factors associated with HIV and TB transmission including reports or prevalence of sexual risk behaviours, reports or prevalence of risk behaviours linked to injecting drug use, the number of pregnant women living with HIV, the number of reported accidental exposures to blood or sexual secretions, sexual violence and overcrowding;
- mortality rates including HIV-related mortality (disaggregated by gender and age group), TB-related mortality (disaggregated by gender and age group) and HIV and TB coinfection mortality (disaggregated by gender and age group).

Programmatic

Data related to programming specific to closed settings include the following:

- national targets for people in prisons and other closed settings, which should be aligned[6] with national targets for the general population and key populations in the community;
- the current coverage of services related to HIV testing and counselling, antiretroviral therapy (ART), OST, condoms, hepatitis B vaccination, post-exposure prophylaxis, PMTCT, and TB screening and treatment;
- information on service providers including identifying the authority in charge of health, TB, HIV, PMTCT and drug dependence programmes in the closed setting, human resources related to health services in prisons, resources for HIV and TB programmes in prisons and access to nongovernmental organizations (NGOs) and community services and resources.

6 For example, if the national target is to reach a coverage of 80% for the prevention of mother-to-child transmission, (at least) the same target should apply to prison populations.

Financial

Financial data include the following:

- the cost of interventions including the cost of equipment and supplies (laboratory, tests, medications, injecting equipment, voluntary counselling and testing (VCT) services, hepatitis B vaccines and condoms), the cost of monitoring and evaluation activities and the cost of human resources related to health staff and outreach workers;
- available funding and sources including human and financial resources for health services in prisons, health services equipment in prisons, resources for HIV and TB programmes in prisons, resources of HIV and TB programme of ministries of health allocated to prisons and NGO and community-based services and resources for prisons.

Policy and legal framework

Key questions to consider related to the policy and legal frameworks include the following:

- Are laws in place that criminalize the use of illicit drugs, sex work and/or sodomy?
- Are alternatives to imprisonment available, regularly utilized and regulated by law?
- Are compassionate releases available, regularly utilized and regulated by law?
- Does the law regulate the equivalence of health-care services in the community and in prisons?
- Are legal regulations in place for pre-release programmes and access to health care after release?
- Are measures in place to ensure a continuity of care and community integration upon release?
- Are treatment for and the prevention of communicable diseases in prisons regulated by law?
- Is access to conjugal visiting rooms available?
- Are standards in place vis-à-vis maximum occupancy (i.e. to avoid overcrowding) and building conditions (e.g. air circulation, natural light)? Are conditions of overcrowding leading to increased violence and the transmission of TB?
- Is HIV testing always performed voluntarily and with informed consent?
- Are people living with HIV (or key populations) segregated and do they have access to the same services and opportunities as others?
- Are guidelines for HIV and TB prevention and treatment in prisons in line with national ministries of health guidelines?
- Are gender-specific policies in place for health care in prisons?

4. Implementation challenges

The following represent challenges which may impede programme implementation and success.

- Health services in prisons and in pretrial detention are often isolated from public health HIV and TB programmes. In countries where health in closed settings does not fall under the responsibility of the ministries of health, programmes implemented in prisons should be implemented in close collaboration with ministries of health programmes and in line with their guidelines.
- Access to community-based services is often limited. Community-based services can play an important role, especially in the provision of VCT and peer-based interventions to provide support for the continuity of treatment and care beyond the place of detention.
- The continuity of treatment, including OST for drug dependence as well as treatment for TB and HIV and PMTCT, is crucial to protecting the health of the patient and to reduce the risk of developing resistance. Continuity can be a major challenge, particularly when attempting to ensure that an interruption to treatment does not occur when an individual enters the system, when they are transferred within the system and when they are released. Specific systems should be established for well-functioning coordination and communication between services.
- Overcrowding and a lack of adequate air and natural light might impede the implementation of activities and reduce the impact of prevention efforts including those for TB. The architecture of prisons should allow for good ventilation and adequate access to natural light. TB patients who are contagious should be isolated from their fellow prisoners. In the case of overcrowding and poor environmental conditions, it is necessary to conduct regular active TB screening of the entire prison population including prison staff.
- Malnutrition also plays an important role. In resource-poor countries, malnutrition rates in prisons can be very high, especially among prisoners who do not have support from their relatives. Supplementary feeding programmes are needed in such settings, in particular, for people living with HIV, individuals receiving ART, pregnant and/or nursing women and TB patients.
- Health surveillance systems are often poor in prisons and other closed settings, and are often not linked to nor compatible with the national health, HIV and/or TB surveillance systems. As a result, many national prison systems lack the necessary data to inform their programmes and to take the appropriate measures. In the absence of mortality and morbidity data, it may be necessary to conduct surveys or rapid assessments. It is also important to build the capacity of prison staff to monitor health in prisons based on national health surveillance systems.
- There is little or no coordination between different authorities in charge of different settings—such as police station detention, pretrial detention centres and the penitentiary system itself. Often, pretrial detention centres are neglected in the response. It is essential to ensure programme coverage across all settings.
- Human rights violations and a lack of medical ethics are also problematic. (See section 8 below.)

- Changes in criminal law, criminal policies or implementation can result in sudden increases (or decreases) of some key populations, such as people who inject drugs or sex workers, in prison settings.
- Mental health diseases are common among many people in prisons. Thus, any HIV programming in prisons needs to take this into account and the provision of psychosocial support as needed.

5. Main activities

The main activities include:

- a situation and needs assessment, although the results are not necessary to initiate activities;
- development of guidelines and standard operating procedures (SOPs) including their publication and dissemination, which should cover all elements of HIV prevention and treatment as listed in the comprehensive package for HIV in prisons and should include the continuity of treatment and care;
- the integration of services and their monitoring and evaluation within the public health system;
- capacity-building of health staff delivering services in prisons;
- capacity-building of community services and providers;
- monitoring and evaluation.

The following are examples of activities to deliver key services in prison settings.

- **Condoms** need to be easily and discreetly available, ideally in areas such as toilets, shower areas, waiting rooms, workshops or day rooms where prisoners can pick up a condom without being seen by others. Distribution can be carried out by health staff, dispensing machines, trained prisoners (peers) or through a combination of any of these ways. Each prison should determine how best to make condoms available to ensure easy and discreet access. Prisoners should not have to ask for condoms, since few prisoners will do so because they do not want to disclose that they engage in same-sex sexual activity. Condoms should be provided free of charge, and can be made available to all prisoners in a health kit given to them upon entry to the facility. The health kit can also contain HIV and other health information, as well as other items such as a shaving kit, toothbrush, soap, etc. A water-based lubricant should also be provided since it reduces the probability of condom breakage and/or rectal tearing, both of which contribute to the risk of HIV transmission.
- In prisons, the best way to introduce a **needle and syringe programme** is through a mixed system ensuring various points of access, such as through the combination of a peer-to-peer approach and health services approach and or dispensing machines. Awareness materials should be distributed together with the injecting materials and an awareness-raising campaign or training sessions on safe injecting should be regularly organized.
- **HIV testing and counselling** should always be voluntary and performed only with the informed consent of the prisoner and with a clear decision from the prisoner to have the test (opt-out). VCT services should be available to prisoners throughout their incarceration

and should always be accompanied by pre- and post-test counselling and confidentiality. Considering the fear that is common in the prison environment, it is sometimes better if the service is delivered by an external agency such as an NGO or community-based service. VCT should be organized in a separate room where confidentiality can be maintained. All prisoners being tested should be informed in a timely manner of their results. If a result has been confirmed as positive, CD4 counts and a complete check-up should be conducted and, if necessary, ART should be initiated.

6. Key indicators

As a matter of principle, all indicators, including outputs, outcomes and impact indicators, used to monitor activities within the community should be used in the prisons settings, including harm reduction indicators. However, in order to monitor the situation in closed settings, these indicators should be disaggregated not only by sex and age group, but also by setting.

Key indicators include:

- the incidence of HIV in closed settings (disaggregated by sex and type of setting);[7]
- the incidence of TB in closed settings (disaggregated by sex and type of setting);
- HIV- and TB-specific mortality rates;
- the coverage of PMTCT, including the percentage of pregnant women accessing family planning, the percentage of pregnant women tested for HIV, the percentage of pregnant women living with HIV receiving ART and the percentage of nursing women living with HIV receiving ART;
- the coverage of VCT;
- the coverage of ART;
- the number of individuals receiving OST and the estimated coverage of OST;
- the coverage of NSPs and/or the number of needles and syringes exchanged and the percentage of settings where such services are available;
- the number of condoms distributed and the percentage of settings where condoms are available;
- the percentage of the prison population screened for TB;
- the percentage of people living with HIV screened for TB;
- the percentage of TB patients offered HIV testing;
- the number of individuals receiving post-exposure prophylaxis;
- the number of deaths related to HIV and TB

7 Data should be collected in such a way that it is ethical and respectful of human rights, and through means approved by local ethical review committees.

7. Approaches to costing

Health services in prisons are often poorly staffed, equipped and budgeted. Their access to ministries of health resources is often limited or non-existent. Below are some of the goods and services that can be included and costed in programmes for prison settings:

- the procurement of laboratory, medical and prevention supplies including laboratory equipment, tests, medications (such as antiretrovirals, isoniazid and cotrimoxazole for preventive therapy, anti-TB drugs, methadone, etc.), injecting equipment; VCT-related materials; hepatitis B vaccines; condoms; reproductive health services, protective equipment for staff, etc.;
- the development of guidelines and standard operating procedures;
- the procurement of information technologies;
- training costs;
- technical support costs;
- meeting costs;
- information, education and communications materials development, publication and dissemination;
- peer-based prevention costs;
- technical assistance costs;
- monitoring and evaluation activities costs.

8. Addressing gender, human rights and equity issues

The following considerations should be taken into account when working in prisons and other closed settings in order to address gender, human rights and issues of equity:

- At a minimum, the **principle of equivalence of health care** defines the rights of people in prisons and pretrial detention centres to access health services equivalent to those available in the broader community. These services should be provided free of charge. Equivalent health care encompasses preventive, diagnostic, curative, reproductive and palliative care. The multiple vulnerabilities of prison populations and the fact that needs (and costs) are relatively higher in prisons than in the general population should be considered when planning services. In addition, because prisoners have no control over their environment and are totally dependent on state-provided facilities, there is a high burden of responsibility for the state to at least meet the minimum standards and preferably to achieve higher standards to address vulnerabilities.

- All medical interventions (diagnosis or therapeutic) should follow the principles of medical ethics. They should be voluntary, confidential and carried out with the informed consent of the individual.[8] All interventions should be evidence-based, in line with national health policies and guidelines for the community and represent the best interest of the patient. Health staff should not be involved in disciplinary or security measures.
- Health research in prisons should be conducted only if the primary beneficiaries are the prisoners. In addition, individuals in prisons should be able to enrol if they wish and, with their informed consent, participate in clinical studies implemented in the community. The ethical review committee should include at least one member who advocates on behalf of prisoners.
- HIV testing should never be mandatory. HIV testing should be recommended when an individual has been diagnosed with TB or for pregnant women.
- Prisoners living with HIV should not be segregated, discriminated or stigmatized, nor excluded from activities such as sport, work, educational or cultural activities.
- Confidentiality should be maintained. In particular, the health status of prisoners should be confidential. There is no justification for communicating to anyone outside of the health professionals in charge of the patient on the health status of the individual, including their HIV status.
- Arbitrary detention and compulsory detention centres for people who use drugs or sex workers should be ended. The detention of sex workers or people who use drugs in so-called compulsory treatment/rehabilitation centres represents a breach of their human rights. When a state is unable to close such centres rapidly and release all of the individuals detained, those who are confined under such circumstances and who have a serious health condition such as HIV or TB should be released for treatment. If this is not possible, they should be provided with life-saving services while in detention. These services should include ART, TB screening and treatment and treatment for other opportunistic infections. These services should be provided with the informed consent of the individual and preferably by the ministries of health.
- Gender-specific services are often unavailable. Reproductive and general health-care services should be available to all women and available from a female physician if so desired. Some women are pregnant or become pregnant while in detention. Some women give birth or are nursing infants while in prison. The needs related to HIV prevention, treatment, care and support for women and their children are often neglected. Similarly, transgendered people in prisons have special needs that should be addressed, including protection from sexual violence.

8 Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (A/RES/37/194, 1982). New York: Office of the High Commissioner for Human Rights, 1982 (http://www.ohchr.org/EN/ProfessionalInterest/Pages/MedicalEthics.aspx).

- Women in prisons are especially vulnerable to sexual abuse, including rape, by both male staff and male prisoners. The risks are particularly high when women are detained in facilities adjacent to or within male prisons or when women's quarters are supervised by male prison staff. Women are also susceptible to sexual exploitation and may engage in sex in exchange for goods such as food, drugs, cigarettes and toiletries[9]. In the case of sexual violence, women should have access to the full range of services, including emergency contraception, post-exposure prophylaxis and support.
- Some people are particularly vulnerable to violence, abuse HIV and other negative health outcomes in prisons, including people who use drugs, young adults, people living with HIV, transgender people and men who have sex with men. Stigma and discrimination against these people need to be addressed.
- Reducing the incarceration of people who use drugs, people with mental health problems or individuals committing petty crimes should be given priority. In many regions, the majority of the prison population should not be incarcerated, but should be living within the community. Alternatives to incarceration include noncustodial measures and legal reforms, including reforming drug laws to reduce detention for the use or possession of drugs for personal use.
- The lack of an enabling environment is of particular relevance to closed settings. The criminalization of sodomy or drug use and/or the absence of laws supporting harm reduction initiatives and HIV prevention among men who have sex with men and people who inject drugs in the wider society make the introduction of condoms and harm reduction programmes—in particular, NSPs—in prisons difficult.
- Laws and policies in the criminal justice system have a serious impact on the response to HIV. It is necessary to address these elements to enable an effective HIV response through reforms of the criminal justice system and laws.
- Pretrial detainees represent on average 30% of the population in closed settings.[10] This should only be an exceptional measure. In some countries, access to health care in pretrial detention is even lower than in prisons.
- Children (below 18) are particularly vulnerable in prisons.

9 Plugge E, Douglas N and Fitzpatrick R. The health of women in prison study findings. Oxford, Department of Public Health, Oxford University, 2006.

10 The issue. Penal Reform International, http://www.penalreform.org/priorities/pre-trial-justice/issue/.

9. Additional information

Interventions should be delivered using a range of modalities, including community outreach and peer-to-peer work, and should be implemented in close collaboration with national health programmes for HIV, TB, drug dependence treatment and sexual and reproductive health. Specifically, it is important to ensure that these programmes have a feature that actively links people in detention back to accessible HIV community services once they exit the place of detention.

National guidelines for HIV, TB and drug dependence treatment and for sexual and reproductive health should be implemented in prison settings. Protecting prison staff should also be addressed.

Implementing partners

Programme partners should include the following:

- the authorities responsible for closed settings (e.g. prison administration, police, ministries of justice and ministries of the interior depending on the setting and local situation);
- the authorities responsible for health services in closed settings;
- the ministries of health and agencies responsible for the national AIDS and TB programmes;
- organizations actively providing community-based services to people leaving detention and the families of those released;
- community-based services for key populations, including networks of people living with HIV.

Technical assistance

In-country programme planners are advised to make use of the full range of guidance provided by UNODC, WHO and UNAIDS (and the Global Fund to Fight AIDS, Tuberculosis and Malaria if funding is requested from the Global Fund), as well as the technical assistance on offer from various partners. In addition, the numerous technical guides and support documents available should be consulted, including those listed below.

Reference materials and related tools

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