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HIV testing and counselling in prisons and other closed settings

Technical paper

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Executive summary

This background paper was commissioned in July 2007 to inform discussions about how to scale up access to HIV testing and counselling for prisoners, following the release of the WHO/UNAIDS Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities. The Guidance (and the 2004 UNAIDS/WHO Policy Statement on HIV Testing) only briefly address issues related to HIV testing and counselling for prisoners. As a result, concerns have been raised that prisoners may be left out of efforts to scale up access to HIV testing and counselling and, more broadly, efforts to achieve universal access to comprehensive prevention programmes, treatment, care and support. At the same time, there is concern that the Guidance could also be misinterpreted and used to justify coerced or other forms of testing without informed consent. Therefore, due to the special conditions imposed by incarceration, it is imperative to ensure that guidance for prison settings promotes appropriate access to HIV testing and counselling, mitigates the stigma and discrimination related to HIV, and protects the rights of prisoners, including by upholding standards of informed consent and confidentiality.

The paper serves as the basis of a position statement on HIV testing and counselling for prisoners that will be issued in 2009. Research undertaken for the paper reveals a number of unique challenges with regard to HIV testing and counselling for prisoners, particularly in low-and middle-income countries with high HIV prevalence rates among prisoners. These challenges include the following:

- Many prison systems have discontinued policies of mandatory or compulsory HIV testing (and segregation of HIV-positive prisoners) based on the fact that they cannot be justified on public health grounds and infringe the human rights of prisoners. However, some systems continue to have policies or laws requiring compulsory HIV testing, while others coerce prisoners to be tested for HIV despite official policies of voluntary HIV testing.
- At the same time, voluntary HIV testing and counselling remains difficult to access for prisoners in many countries. Even where testing is available, in practice, many of those tested report not receiving pre-and post-test counselling, breaches of confidentiality, and/or lack of referral to follow-up treatment, care and support.
- Worldwide, access to evidence-based HIV prevention measures (particularly condoms and needles and syringes and other harm reduction interventions and evidence-based drug dependence treatment for prisoners who inject drugs) remains limited for the vast majority of prisoners.
- Most low- and middle-income countries are making efforts to scale up access to HIV treatment, care and support, including antiretroviral treatment, for people living with HIV. However, efforts to scale up access to treatment for prisoners often lag behind efforts to increase access to treatment in the community and are rarely sufficiently coordinated with those efforts.

- All of the above issues are related to the fact that, worldwide, most prisoners belong to marginalized populations in society. In many countries, prison health standards and prison conditions suffer because of a lack of political and public interest.

There is an urgent need to introduce comprehensive HIV programmes in prisons and to scale them up rapidly. As part of these programmes, prison systems need to expand access to HIV testing and counselling, while ensuring that: *(a)* prisoners are able to give informed consent to HIV testing; *(b)* receive adequate pre-test information and post-test counselling; and *(c)* the confidentiality of test results and of the fact of seeking the test is guaranteed.

Building upon the WHO/UNAIDS Guidance and the 2004 Policy Statement, the paper makes the following recommendations:

1. Efforts to scale up access to HIV testing and counselling in prisons should not be undertaken in isolation, but as part of a comprehensive HIV programme aimed at improving health care and at achieving universal access to HIV prevention (including access to condoms, sterile injection equipment and other harm reduction interventions and prevention of mother-to-child-transmission), treatment, care and support for prisoners (including the uninterrupted provision of antiretroviral therapy when available in the community for prisoners living with HIV and, where clinically indicated, treatment of other sexually transmitted infections, viral hepatitis, tuberculosis and other opportunistic infections).

2. Prison systems should review and, if necessary, change prison policies and practices that discriminate against HIV-positive prisoners, recognizing that increasing access to HIV testing and counselling must go hand in hand with greater protection from HIV-related discrimination and abuse. In particular, policies that provide for segregation of HIV-positive prisoners or their exclusion from any programmes or other activity should be repealed and the confidentiality of prisoners' medical information should be protected.

3. WHO and UNODC do not support mandatory or compulsory HIV testing of prisoners on public health grounds. Therefore, countries should review and, if necessary, change their laws, regulations, policies and practices to prohibit mandatory or compulsory HIV testing of prisoners.

4. Prison systems should ensure that all prisoners have easy access to client-initiated testing and counselling programmes, at any time during their imprisonment. Prisoners should be informed about the availability of the service, both at the time of their admission and regularly thereafter.

5. Prison systems should ensure that health-care providers:
   - Offer HIV testing and counselling to all prisoners during medical examinations.

- Recommend HIV testing and counselling if a prisoner has signs, symptoms or medical conditions that could indicate HIV infection, including tuberculosis, and to female prisoners who are pregnant to assure appropriate diagnosis and, for those testing positive, access to necessary HIV treatment, care and support.

6. In order to ensure that prisoners can give informed consent, prison systems should adopt policies according to which prisoners will be offered or recommended HIV testing and counselling, but will not be tested unless they specifically state that they want the test. A different approach (under which prisoners must specifically decline the HIV test if they do not want it to be performed) is only advised for prisoners with signs or symptoms of HIV disease, to assure appropriate diagnosis and, for those testing HIV-positive, access to effective HIV treatment. However this approach should not be implemented if adverse social consequences for prisoners diagnosed HIV-positive outweigh the benefits of the diagnosis being made; and unless there is access to a recommended set of HIV prevention, treatment, care and support services as recommended in the Guidance on provider-initiated HIV testing and counselling in health facilities.

   In all cases, any form of coercion must be avoided and prisoners must provide voluntary and informed consent.

7. Prison systems should develop and adopt a code of conduct for health-care staff providing HIV testing and counselling, which requires that:
   - Prisoners can seek and receive sufficient information to enable them to give informed consent to testing, including information about the specific risks and benefits of HIV testing in the prison setting; and
   - Health-care providers offering or recommending HIV testing must emphasize the voluntary nature of the HIV test and the prisoner's right to decline.

8. Prison systems should ensure that personnel performing HIV testing and counselling receive training, particularly in obtaining informed consent, maintaining confidentiality, counselling and how to offer or recommend the test.

9. National HIV programmes should ensure that prison systems are an integral part of national efforts to scale up access to HIV testing and counselling and, more broadly, achieve universal access to HIV prevention, treatment, care and support.

10. Prison systems working with other criminal justice agencies, health authorities and non-governmental organizations should undertake efforts to ensure continuity of care, including antiretroviral therapy from the community to the prison and back to the community, as well as within the prison system.

11. Prison systems should carefully monitor and evaluate the provision of testing and counselling in prison as part of the national country-level monitoring and evaluation system. This should be done to ensure that prisoners have easy access to HIV testing and counselling; health-care staff offer or recommend testing, and prisoners are not coerced into testing but give informed consent; and testing and counselling is linked with increased access to HIV prevention and treatment, care and support.

Introduction

Objectives

This document was commissioned by UNODC and WHO in July 2007 to inform discussions about how to scale up access to HIV testing and counselling for prisoners, following the release of the WHO/UNAIDS *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* (WHO, UNAIDS, 2007). The WHO/UNAIDS Guidance briefly addresses issues related to HIV testing and counselling for prisoners, but there is a need for more in-depth analysis of these issues, to respond to the following two major concerns:

- The first concern is that the WHO/UNAIDS Guidance may be misinterpreted and used to justify coerced or other forms of HIV testing without informed consent.
- The second concern is that prisoners may be left out of efforts to scale up access to HIV testing and counselling and, more broadly, efforts to scale up access to prevention, treatment, care and support.

The background paper recognizes that:

- Guidance on provision of HIV testing and counselling in prisons cannot be limited to promoting prisoners' increased access to HIV testing and counselling, but must at the same time aim to mitigate the stigma and discrimination related to HIV and protect the rights of prisoners, including by upholding standards of informed consent and confidentiality.
- While all prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community, currently, access to HIV prevention, treatment, care and support remains inadequate in many prison systems. Hence, improving access to HIV testing and counselling must be accompanied by sustained efforts to scale up access to HIV prevention, treatment, care and support, and to improve access to general health care in prisons.

The objectives of this document are:

- Evidence review and current practice
- Minimum requirements for programmes
- Policy framework and recommendations

Target audience

The document is intended to inform United Nations staff at country level, policymakers, prison authorities, health-care providers and other stakeholders about the current information on HIV testing and counselling of people in detention.

The main issues and recommendations are also published separately in the form of an executive summary policy brief. Both documents will be useful in understanding the complexities of and planning for HIV testing and counselling of people in prison and other closed settings.

Development process

The author of this background paper was asked to:

- Collect, review and analyse literature and expert opinion on HIV testing and counselling for prisoners;
- Prepare a background document that address the issue of HIV testing and counselling for prisoners;
- Draft recommendations for national governments (both national AIDS programmes and departments responsible for prisons) and other stakeholders with regard to HIV testing and counselling of prisoners;
- Prepare a draft of the policy brief on HIV testing and counselling for prisoners.

The draft documents were reviewed at various instances as described in more detail in annex 1 at two consultations and two events of wide electronic review.

Methodology

A comprehensive literature search was carried out in 2007 and updated in 2008. Data were identified by searches of electronic library and HIV databases, websites of government and non-governmental bodies, conferences, and prison health and health news sites, as well as by references from relevant articles; numerous articles were identified through searches of the extensive files of the authors. Studies and other materials reported in English, French, German, Italian, Portuguese and Spanish were reviewed.

Attempts were made to obtain as much information as possible from low-and middle-income countries, including through UNODC country officers, some of whom provided detailed information about policy and practice related to HIV testing and counselling among prison populations. Because of the short timeframe available, the author also relied heavily on other reviews of HIV testing and counselling undertaken in 2007. This includes a review of the evidence on HIV testing and counselling in prisons undertaken for WHO, UNODC and UNAIDS as part of a broader project reviewing the evidence of interventions to address HIV in prisons (WHO, UNODC, UNAIDS, 2007); and a background paper on “Scaling up access to HIV testing and counselling while respecting human rights” prepared for the Public Health Program of Open Society Institute (OSI, 2007).

Of over 1,300 documents obtained, about 100 were included in the review. These include a small number of studies, undertaken mainly in the United States and a few other high-income countries, that have scientifically evaluated and peer reviewed various forms of HIV testing and counselling in prison. In most instances data from clinical trials or well-conducted observational studies were not available, hence the expert opinion of the members of the working group was solicited.

Key questions

In July 2007, the secretariat with UNODC and WHO staff in collaboration with the consultant identified the key questions to address in the review. The review examined the following main questions:

- What do we know about policy and practice of HIV testing and counselling in prisons?
- What do we know about the effectiveness of various testing strategies?

Annex 1 describes the development process in more detail including a list of experts involved who provided substantial input into the development of this guidance.

This document as well as the policy brief on HIV testing and counselling in prisons and other closed settings will be reviewed in 2011 and revised if required by WHO and UNODC.

A note on terminology and scope

In some jurisdictions different terms are used to denote places of detention, which hold people who are awaiting trial, who have been convicted or who are subject to other conditions of security. Similarly, different words are being used for various groups of people who are detained.

In this paper, the term "prison" has been used for all places of detention and the term "prisoner" has been used to describe all who are held in such places, including adult males and females detained in criminal justice and prison facilities during the investigation of a crime; while awaiting trial; after conviction and before sentencing; and after sentencing. Although the term does not formally cover persons detained for reasons relating to immigration or refugee status, those detained without charge, and those sentenced to compulsory treatment and rehabilitation centres, nonetheless most of the considerations in this paper apply to them as well.

The paper does not apply to juvenile offenders, regardless of where they are detained, as special considerations apply to them.

General background

1

Key points

- Global action to combat the HIV pandemic has increased markedly, with countries having committed to "pursuing all necessary efforts . . . towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010."
- By the end of 2007, more than 3 million people living with HIV in low- and middle-income countries were receiving life-prolonging antiretroviral treatment, compared to 1.3 million people at the end of 2005 and fewer than 500,000 people in 2003.
- However, those most vulnerable to HIV and its impacts, including prisoners, continue to receive the least access to HIV prevention, care and treatment services.

The response to HIV

At the end of 2007 an estimated 33.2 million people were living with HIV and high numbers of new HIV infections continue to occur throughout the world. Sub-Saharan Africa remains the hardest-hit region with 22.5 million people living with HIV. Epidemics in Eastern Europe and Asia continue to grow (UNAIDS/WHO, 2007).

In recent years, global action to combat the HIV pandemic has increased markedly. Heads of State and Government representatives from 189 countries made an unprecedented commitment in the United Nations Millennium Declaration (United Nations, 2000) and during the United Nations General Assembly Special Session on HIV/AIDS in 2001 (United Nations, 2001) to halting and reversing the epidemic by 2015. At the 2005 World Summit (United Nations, 2005) and at the 2006 United Nations High Level Meeting on AIDS, world leaders committed "to pursuing all necessary efforts … towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010" (United Nations, 2006).

By the end of 2007, more than 3 million people living with HIV in low- and middle-income countries were receiving life-prolonging antiretroviral treatment (ART), compared to 1.3 million people at the end of 2005 and less than 500,000 people in 2003 (WHO/UNAIDS/UNICEF, 2008).

However, even as increased funding for the response to HIV has become available, those most vulnerable to HIV and its impact continue to receive the least access to HIV prevention, treatment, care and support. Among them are prisoners, people who use drugs, men who have sex with men, and sex workers. In most countries, these populations tend to have higher prevalence of HIV infection than that of the general population because they engage in behaviours that put them at higher risk of becoming infected; and they are among the most marginalized and discriminated populations in society. At the same time, as UNAIDS pointed out in its 2006 Report on the Global

AIDS Epidemic, "the resources devoted to HIV prevention, treatment and care for these populations are not proportional to the HIV prevalence—a serious mismanagement of resources and a failure to respect fundamental rights" (UNAIDS, 2006). Such restrictions effectively exclude entire segments of the population from HIV services, making the goal of universal access impossible to attain. They also represent unsound public health policy, given the links between the health of prisoners and other vulnerable populations and broader community health.

The response to HIV among prisoners

It is estimated that at any given time there are over 9 million people in prisons, with an annual turnover of 30 million moving from prison to the community and back again (Walmsley, 2007).

The rates of HIV infection among prisoners in most countries are significantly higher than those in the general population (WHO/UNODC/UNAIDS, 2007a; Dolan et al., 2007). While most of the prisoners living with HIV in prison contract their infection outside the institutions before imprisonment, the risk of being infected in prison, in particular through sharing of contaminated injecting equipment and through unprotected sex, is great. Studies from around the world show that many prisoners have a history of problematic drug use and that drug use, including injecting drug use, occurs in many prisons (WHO/UNODC/UNAIDS, 2007b). Both consensual and non-consensual forms of sex, including sexual violence and rape, also occur in many prisons and put prisoners at risk of HIV (WHO/UNODC/UNAIDS, 2007c). Outbreaks of HIV infection have occurred in a number of prison systems, demonstrating how rapidly HIV can spread in prison unless effective action is taken to prevent transmission (WHO/UNODC/UNAIDS, 2007a).

The high degree of mobility between prison and community means that communicable diseases and related illnesses transmitted or exacerbated in prison do not remain there. When people living with HIV are released from incarceration and return to their sexual and/or needle-sharing partners in the community, their partners face increased risk of HIV infection and may not be aware that they are at risk.[1]

The importance of implementing HIV interventions in prisons was recognized early in the epidemic (Harding, 1987). After holding a first consultation on prevention and control of HIV in prisons in 1987 (WHO, 1987), WHO responded to growing evidence

[1]The extent to which this is the case cannot be underestimated. For example, in 1997, in the United States there were more than 35,000 prisoners with HIV on any given day. In the same year, over 150,000 of those released had HIV-infection. It has been estimated that, in 1997, 20% to 26% of all people with HIV (and 29% to 43% of all those living with HCV) in the United States passed through a correctional facility (Hammett, Harmon, Rhodes, 2002). In the Russian Federation, each year 300,000 prisoners, many of whom living with HIV, HCV, and/or tuberculosis, have been released in the last few years from prisons (Prison Healthcare News, 2003). In Ireland, according to a 1997 report, with a prison population of around 2,200, the annual turnover of prisoners was about 10,000, and the average sentence was 3 to 4 months. Out of the estimated 1,600 people in Ireland with HIV, 300 to 500 had been through the prison system (UNAIDS, 1997).

of HIV infection in prisons worldwide by issuing guidelines on HIV infection and AIDS in prisons (WHO, 1993). More recently, WHO summarized the evidence on harm reduction in prisons (WHO Regional Office for Europe, 2005) and, together with UNODC and UNAIDS, published a policy brief on the reduction of HIV transmission in prisons (WHO/UNAIDS/UNODC 2004) and a series of comprehensive Evidence for Action Technical Papers on interventions to address HIV in prisons (WHO/UNODC/UNAIDS, 2007). In 2006, a "Framework for an effective national response to HIV/AIDS in prisons" was jointly published by UNODC, WHO, and UNAIDS (UNODC/WHO/ UNAIDS, 2006). These documents emphasize that "all prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination" (WHO, 1993).

An increasing number of countries have introduced HIV programmes in prisons since the early 1990s, but many of them are small in scale, restricted to a few prisons, or exclude necessary interventions for which evidence of effectiveness exists (Jürgens and Betteridge, 2005; WHO/UNODC/UNAIDS, 2007). Detailed information about coverage of, and access to, HIV services for prisoners will be provided in future reports on progress achieved towards universal access (WHO/UNAIDS/UNICEF, 2007, at 38). Currently available information—from the recent review of the evidence of the effectiveness of interventions to address HIV in prisons—demonstrates how far prison systems are from achieving universal access to evidence-based prevention, treatment, care and support. The review concluded that there is an urgent need to introduce comprehensive programmes and to scale them up rapidly. These programmes should include all of the following components (WHO/UNODC/UNAIDS, 2007):

- Information and education, particularly through peers
- Provision of condoms and water-based lubricant
- Other measures to decrease sexual transmission of HIV (in particular, measures to prevent violent and coerced sex)
- Needle and syringe programmes
- Drug dependence treatment (in particular, opioid substitution therapy)
- HIV treatment, care and support, including provision of antiretroviral treatment

As part of these programmes, prison systems need to expand access to HIV testing and counselling while ensuring that prisoners give informed consent to HIV testing.

HIV testing and counselling in prisons and other closed settings

Technical paper

Background on HIV testing and counselling

2

Key points

- In recent years, there has been a call to not only expand and ensure quality in voluntary counselling and testing services but also to explore other models of testing including provider-initiated testing and counselling. These calls have been made in countries with different HIV epidemic scenarios.
- An expansion of HIV testing and counselling is one of the conditions to achieving the aim of universal access to prevention, care, treatment and support for all who need it by 2010.
- In May 2007, WHO and UNAIDS released Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities. The Guidance provides a useful framework and contains important principles and recommendations that should guide the approach to expanding access to HIV testing and counseling for prisoners.
- In particular, the Guidance: *(a)* strongly support efforts to scale up testing and counselling services through diverse methods, including client-initiated and provider-initiated testing and counselling; *(b)* unequivocally opposes mandatory or compulsory testing and counselling; *(c)* emphasizes that, regardless of whether HIV testing and counselling is client- or provider- initiated, it should always be voluntary. People need to receive sufficient information to enable them to give informed consent, confidentiality of the test results must be ensured and counselling must be provided; *(d)* recognizes that populations at high risk of HIV transmission such as prisoners may be more susceptible to coercion, discrimination, violence and abandonment, requiring particular efforts to uphold standards of informed consent and confidentiality for these populations; *(e)* acknowledges that scaling up of testing and counselling must be accompanied by (i) access to HIV prevention, treatment and care services; and (ii) a supportive environment for people living with HIV and those most at risk for acquiring HIV infection.

Introduction

In recent years, an international consensus has emerged that access to HIV testing and counselling must be scaled up, and that in addition to the traditional model of client-initiated voluntary counselling and testing (VCT), new approaches to HIV testing and counselling must be implemented in more settings, and on a much larger scale than has so far been the case (OSI, 2007; UNAIDS Reference Group on HIV and Human Rights, 2007).

WHO estimates that only about 10 per cent of persons living with HIV in low- and middle-income countries know their HIV status (WHO/UNAIDS, 2007). In many of these countries, access to HIV testing remains limited. Many high-income countries also estimate that a significant number of people living with HIV are not aware of their HIV status (OSI, 2007).

An expansion of HIV testing and counselling is one of the conditions to achieving the aim of universal access to prevention, care, treatment and support for all who need it by 2010. Testing and counselling are important for two reasons:

- As part of an HIV prevention programme (i.e., it gives those who may be engaging in risky behaviours information, education to support for behaviour change and other HIV prevention services).
- As a means of diagnosing those living with HIV early and offer them appropriate treatment, care and support.

Earlier identification of HIV-positive persons leads to earlier medical attention and allows for time to engage individuals in important secondary prevention measures. Testing also creates an important opportunity to provide important health information during post-test counselling.

As part of their effort to scale up access to HIV testing and counselling globally, in 2006, WHO and UNAIDS developed draft guidance on provider-initiated HIV testing and counselling (PITC) in health facilities and solicited feedback from a wide range of experts. On 30 May 2007, the final version of the Guidance was launched. It is having a big impact in shaping HIV testing policy and practice in countries around the world.

What does the WHO/UNAIDS Guidance on provider-initiated testing and counselling say?

Although the Guidance only marginally addresses the specific issues related to scaling up access of testing and counselling for prisoners, it provides a useful framework and contains important principles and recommendations that should guide the approach to expanding access to HIV testing and counselling for prisoners. In particular, the Guidance:

- Unequivocally opposes mandatory or compulsory testing.
- Acknowledges that HIV testing and counselling cannot be implemented in isolation and that efforts to scale up testing and counselling must be accompanied by:

  Efforts to scale up access to prevention and to treatment, care and support

  Efforts to create a supportive social, policy and legal environment for people living with HIV and those most-at-risk
- Supports efforts to scale up client-initiated voluntary counselling and testing services.
- Highlights the need for “additional, innovative and varied approaches” to HIV testing and suggests that, in certain settings and under certain circumstances, health-care providers offer and recommend HIV testing to patients and undertake testing unless the patient explicitly declines the offer.

- Emphasizes that, regardless of whether an HIV test is routinely offered to people or whether they initiate HIV testing themselves, they need to be able to give informed consent to testing.
- Recognizes that this raises particular challenges for members of most-at-risk populations such as prisoners, who may feel that they cannot reject an offer of testing by prison health-care staff or may even be coerced into "accepting" an HIV test, suggesting that special efforts are required to ensure that prisoners can provide informed consent to testing.

The following sections provide a more detailed summary of the principles and recommendations in the Guidance that are particularly relevant for the discussion of HIV testing and counselling of prisoners.

Mandatory or compulsory testing

The Guidance states unequivocally that "[e]ndorsement of provider-initiated HIV testing and counselling by WHO and UNAIDS is not an endorsement of coercive or mandatory HIV testing" and that "WHO and UNAIDS do not support mandatory or compulsory testing of individuals on public health grounds" (art. 6). It further says that "[i]mplementation of provider-initiated HIV testing and counselling must include measures to prevent compulsory testing …" (art. 30).

Enabling environment

Prevention, treatment, care and support services

The Guidance highlights that implementation of provider-initiated testing and counselling should not be a stand alone initiative, but "should be accompanied by a recommended package of HIV-related prevention, treatment, care and support services" (art. 8). Although it says that "access to antiretroviral therapy should not be an absolute prerequisite" for the implementation of provider-initiated testing and counselling, the Guidance says that "there should at least be a reasonable expectation that it will become available within the framework of a national plan to achieve universal access to antiretroviral therapy for all who need it" (ibid.). The "basic prevention services" that should be available include "promotion and provision of male and female condoms", as well as "needle and syringe access and other harm reduction interventions for injecting drug users" (art. 31).

A supportive social, policy and legal framework

In addition, the Guidance acknowledges that at the same time as provider-initiated testing and counselling is implemented, "equal efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximize positive outcomes and minimize potential risks to patients" (art. 8). It recognizes that "[o]ptimal delivery of provider-initiated HIV testing and counselling in the long term requires that laws and policies against discrimination on the basis of HIV status, risk behaviour and gender are in place, monitored and enforced" and suggests that national plans to achieve universal access to HIV prevention, treatment, care and support should include

the measures needed to protect the human rights of people living with HIV and at risk of exposure to HIV.

Client-initiated voluntary counselling and testing (VCT)

WHO and UNAIDS emphasize that client-initiated voluntary counselling and testing contributes significantly to helping people learn their HIV status, and that provider-initiated testing and counselling programmes are meant to complement, not replace, client-initiated voluntary counselling and testing. Therefore, WHO and UNAIDS "strongly support the continued scale up of client-initiated voluntary counselling and testing" (art. 5). In particular, the Guidance recognizes that specific population groups in all epidemic types are at higher risk for HIV, including sex workers and their clients, people who inject drugs, men who have sex with men, prisoners, migrants and refugees; and that these populations often suffer worse health problems and have more difficulty accessing quality health services. Therefore, the Guidance says that "strategies are needed to increase access to and uptake of HIV testing and counselling for these groups, particularly through innovative client-initiated approaches such as services delivered through mobile clinics, in other community settings, through harm reduction programmes or through other types of outreach" (art. 24-25).

With regard to prisoners, the Guidance says that they "should be able to access client-initiated HIV testing and counselling at any time during incarceration without being subject to mandatory HIV testing" (art. 25).

Generally, "[e]fforts to expand access to client-initiated HIV testing and counselling for most-at-risk populations should include social mobilization and education initiatives to encourage people to learn their HIV status and to access services" (ibid.).

Provider-initiated testing and counselling (PITC)

While WHO and UNAIDS strongly support the continued scale up of client-initiated voluntary counselling and testing, they highlight the need for "additional, innovative and varied approaches" (art. 5). According to the Guidance, health facilities represent a key point of contact with people with HIV who are in need of HIV prevention, treatment, care and support. Evidence from both industrialized and resource-constrained settings suggests that many opportunities to diagnose and counsel individuals at health facilities are being missed and that provider-initiated testing and counselling facilitates diagnosis and access to HIV-related services.

The Guidance recommends an "opt-out" approach to provider-initiated testing and counselling in health facilities (art. 5). With this approach, an HIV test is recommended:

- For all patients, irrespective of epidemic scenario, whose clinical presentation might result from underlying HIV infection
- As a standard part of medical care for all patients attending health facilities in generalized HIV epidemics; and

- More selectively in concentrated and low-level epidemics[2]

Individuals must specifically decline the HIV test if they do not want it to be performed. Pre-test counselling is replaced by provision of so-called "pre-test information". According to the Guidance, this requires giving individuals sufficient information to make an informed and voluntary decision to be tested, including an opportunity to decline the test. Minimum requirements for information that health-care providers should give to patients as part of "pre-test information" are specified in the Guidance (art. 9-10).

Specific guidance for most-at-risk populations

In countries with concentrated epidemics where HIV has spread rapidly among certain populations such as prisoners and people who inject drugs, but is not well-established in the general population, the Guidance suggests that health care providers should not recommend HIV testing and counselling to all persons attending all health facilities. In such settings, the priority should be to ensure that HIV testing and counselling is recommended to those who present to health facilities with signs and symptoms suggestive of underlying HIV infection, as well as to children known to have been exposed perinatally to HIV.

In addition, the Guidance states that "consideration should … be given to recommending" HIV testing and counselling to members of most-at-risk populations in specific health services they are more likely to attend because of their special health needs, such as acute care, STI or drug dependence treatment services (at 25). According to the Guidance, any plans for provider-initiated testing and counselling in such settings should prioritize the implementation of a supportive social, policy and legal framework (ibid.).

The Guidance explicitly recognizes that "[p]opulations most at-risk of HIV transmission may be more susceptible to coercion, discrimination, violence, abandonment, incarceration or other negative consequences upon disclosure of an HIV-positive test result" and that "[h]ealth care providers will usually require special training and supervision to uphold standards of informed consent and confidentiality for these populations" (ibid.). Therefore, in addition to the "minimum requirements" for information that health-care providers should give to patients as part of "pre-test information, the Guidance recognizes that "additional discussion of the right to decline HIV testing, of the risks and benefits of HIV testing and disclosure, and about social support available may be

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[2]In the Guidance, different types of HIV epidemics are defined as follows (WHO/UNAIDS, 2007):

Generalized HIV epidemics: HIV is firmly established in the general population. Although sub-populations at high risk may contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of sub-populations at higher risk of infection. Numerical proxy: HIV prevalence consistently over 1% in pregnant women.

Concentrated HIV epidemics: HIV has spread rapidly in one or more defined sub-populations, but is not well-established in the general population. The future course of the epidemic is determined by the frequency and nature of links between the sub-populations with high rates of HIV and the general population. Numerical proxy: HIV prevalence is consistently over 5% in at least one defined subpopulation but is below 1% in pregnant women in urban areas.

Low-level HIV epidemics: HIV has never spread to significant levels in any sub-population. Recorded infection is largely confined to individuals with higher risk behaviour, e.g. sex workers, people who inject drugs, men who have sex with men. Numerical proxy: HIV prevalence has not consistently exceeded 5% in any defined sub-population.

required for groups especially vulnerable to adverse consequences upon disclosure of an HIV test result" (ibid.). In addition, the Guidance suggests that an "opt-in" approach to informed consent may merit consideration for highly vulnerable populations. Under this approach, HIV testing would be recommended by providers in health facilities, but clients must specifically agree to the test, rather than being tested unless they decline the test. With "opt-out", the default is testing; with "opt-in", the default is no testing.

The Guidance recommends that most-at-risk populations and their advocates be involved in the development of HIV testing and counselling protocols and in the monitoring and evaluation of provider-initiated testing and counselling, so as to ensure that the most appropriate and acceptable practices are followed.

Finally, it says that health services should "ensure that mechanisms are in place for referral to prevention, care and support services provided by community-based organizations and civil society groups" (ibid.).

Informed consent, confidentiality, and counselling

The Guidance emphasizes that, regardless of whether an HIV test is routinely offered (and recommended) to people or whether they initiate HIV testing themselves, they need to be able to give informed consent to testing.

Specifically with regard to provider-initiated testing and counselling, the Guidance says: "When recommending HIV testing and counselling, service providers should always aim to do what is in the best interests of the individual patient. This requires giving individuals sufficient information to make an informed and voluntary decision to be tested, maintaining patient confidentiality, performing post-test counselling and making referrals to appropriate services" (art. 6).

Training and supervision

In an effort to ensure that, in practice, implementation of provider-initiated testing and counselling will not lead to people being tested without their informed consent, and acknowledging "[c]oncerns about the potential coercion of patients and adverse outcomes of disclosure" (art. 5), the Guidance underscores the importance of adequate training and supervision for health-care providers performing provider-initiated testing and counselling.

The Guidance specifies that "[t]raining programmes for personnel who will perform HIV testing and counselling in health facilities, as well as for other staff who deal with clients in health facilities, should be developed and implemented well in advance of the implementation of provider-initiated HIV testing and counselling" (art. 33). According to the Guidance (art. 33-34), training should:

- Provide guidance on the process of obtaining informed consent;
- Emphasize that health-care providers have a responsibility to maintain the confidentiality of HIV test results;

- Raise awareness about HIV and human rights issues among health-care providers and administrators and reinforce their adherence to appropriate standards of practice;
- Include information about the referral needs of patients.

In addition, the Guidance states that health facilities should develop codes of conduct for health-care providers and methods of redress for patients whose rights are infringed; and that "consideration should be given to the appointment of an independent ombudsman or patient advocate to whom breaches of HIV testing and counselling protocols and codes of conduct can be reported" (art. 34).

Monitoring and evaluation

For the same reasons, the Guidance also underscores the need for close monitoring and evaluation of provider-initiated testing and counselling programmes (art. 47). Careful monitoring and evaluation will allow the best use of available resources and help avoid negative outcomes, including stigma, discrimination, violence, breaches of confidentiality, coercion or unmet demand for treatment and other HIV services.

More detailed guidance on monitoring and evaluation of HIV testing and counselling is being developed by WHO.

Adaptation at country level

The Guidance acknowledges that decisions about whether and how best to implement provider-initiated testing and counselling in a particular country or context—such as prisons—requires an assessment of the situation in that country or context. The adaptation process requires an assessment of the risks and benefits of introducing provider-initiated HIV testing and counselling in a particular setting, including an appraisal of available resources, prevailing standards of HIV prevention, treatment, care and support and the existing social, policy and legal framework for protection against adverse consequences of HIV testing, such as HIV-related discrimination and violence. "Where there are high levels of stigma and discrimination and/or low capacity of health-care providers to implement provider-initiated HIV testing and counselling under the conditions of informed consent, confidentiality and counselling, adequate resources should be devoted to addressing these issues prior to implementation" (art. 12). Finally, the Guidance emphasizes that adaptation of the Guidance and implementation of provider-initiated testing and counselling should be undertaken in consultation with all relevant stakeholders, including civil society organizations and people living with HIV.

HIV testing and counselling for prisoners

3

What do international recommendations say?

Key points

- International recommendations: *(a)* state that voluntary and confidential HIV counselling and testing (VCT) should be available to prisoners; and *(b)* reject mandatory or compulsory HIV testing.
- However, in practice, in many prison systems, prisoners have only limited access to testing and counselling. At the same time, mandatory or compulsory testing is still being undertaken in some systems.
- When they have easy access to HIV counselling and testing, and particularly when they are offered such testing and it is accompanied by access to treatment, care and support (including antiretroviral treatment), many prisoners will take up testing and counselling in prison.
- HIV testing is never a goal in itself, but clearly linked to larger HIV prevention and treatment, care and support goals. Consequently, the efficacy of testing policies and programmes is co-determined by the availability of effective HIV prevention and treatment, care and support programmes. In many prison systems, evidence-based HIV prevention measures and/or treatment, care and support (including antiretroviral treatment) remain inaccessible, severely limiting the potential benefits of HIV testing and counselling.

The *WHO Guidelines on HIV Infection and AIDS in Prisons* (1993) state:

> 10. Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited.
>
> 11. Voluntary testing for HIV infection should be available in prisons when available in the community, together with adequate pre- and post-test counselling. Voluntary testing should only be carried out with the informed consent of the prisoner. Support should be available when prisoners are notified of test results and in the period following.
>
> 12. Test results should be communicated to prisoners by health personnel who should ensure medical confidentiality.

The 2006 *Framework for an Effective National Response* to HIV in prisons says that prison systems should (UNODC/WHO/UNAIDS, 2006):

> 62. Provide access to voluntary, confidential HIV testing with counselling for prisoners where such testing is available in the outside community. This should include access to anonymous HIV testing in jurisdictions where such testing is available outside of prisons.

63. Ensure prisoners are provided with sufficient information to enable them to make an informed choice about whether to undertake test or to refuse testing if they so choose.

64. Ensure well-informed pre- and post-test counselling as a mandatory component of HIV testing protocols and practice, and ensure effective support is available to prisoners when receiving test results and in the period following.

65. Ensure the confidentiality of HIV test results of prisoners.

66. Ensure that informed consent and pre- and post-test counselling are mandatory for all HIV testing practices in prisons—including diagnostic testing, the use of rapid test kits, and testing as part of post-exposure prophylaxis protocols.

The *International Guidelines on HIV/AIDS and Human Rights* (OHCHR/UNAIDS, 2006) recommend that prison authorities provide prisoners with "access to voluntary testing and counselling" and "prohibit mandatory testing".

WHO and UNAIDS have consistently opposed compulsory HIV testing, stating that it is not effective for public health purposes, nor ethical (WHO, 2003; WHO/UNAIDS, 2007), and that "voluntary testing is more likely to result in behaviour change to avoid transmitting HIV to other individuals" (UNAIDS & WHO, 2004).

In 2003, the United States Centers for Disease Control and Prevention (CDC) recommended that HIV testing be routinely offered to all prisoners during intake medical evaluations (CDC, 2003b). At the time of writing, following the release of new recommendations for testing in health-care settings in the United States in September 2006 (CDC, 2006), a draft guide on "Implementing HIV Testing in Correctional Facilities", prepared by a CDC working group on HIV testing in prisons, was being circulated for comments.

What do we know about policy and practice of HIV testing and counselling in prisons?

Prison systems have typically adopted one of the following kinds of HIV testing policies:

- HIV testing is conducted on all prisoners upon admission, conviction, and/or prior to release, without informed consent (compulsory testing, often also called mandatory testing).[3] Prisoners may or may not be informed, aware, or later recall that an HIV test is/was being conducted.

[3]Compulsory testing, also known as involuntary testing, is defined as testing without a voluntary element—i.e., without informed consent, at the behest of someone or some institution other than the person tested (Canadian HIV/AIDS Legal Network/Center for Health and Gender Equity/Gay Men's Health Crisis, 2006). Mandatory testing is defined as testing that would occur as a condition for some other benefit, such as donating blood or bodily tissues, immigrating to certain countries, getting married, joining the military or as a pre-condition of other kinds of employment. The two terms "compulsory" and "mandatory" are often used, albeit inaccurately, as interchangeable. Often people refer to "mandatory" testing when what they are really talking about is compulsory testing, and the intended meaning has to be deduced from the context.

- HIV testing is considered a standard part of a medical examination on admission, conviction, or prior to release. It is recommended to all prisoners (or to so-called "at-risk prisoners") and undertaken unless they explicitly decline the test ("opt-out of testing).
- HIV testing is offered and recommended to all prisoners on admission, conviction, or prior to release, but is only undertaken if prisoners specifically agree to the test ("opt-in" to testing).
- HIV testing is offered to prisoners on admission, conviction, or prior to release, but it is not recommended (prisoners are not encouraged to take the test).
- Prisoners can receive a test—at any time or only under certain circumstances—if they actively request it, but it is not offered to them (testing on demand).
- Prisoners have no access to HIV testing and counselling.

Usually, policies specify that testing should be accompanied by pre-test counselling (or pre-test information) and post-test counselling.

Comprehensive information about the number of prison systems that have adopted any of these policy options, and the extent to which policy has translated into practice, is not available. Although HIV testing and counselling policies often provide a general description of procedures within prison systems, "factors such as overcrowding, staff availability, and fiscal considerations play critical roles in determining access to HIV testing and prevention services in prisons" (MacGowan, 2006). In practice, access to voluntary HIV testing and counselling remains limited in many prison systems, or testing is used punitively with no or little benefit to prisoners, even where policy does not mandate HIV testing. In some cases, blood drawing has been used as a threat, where lack of sterile collection equipment in medical facilities makes prisoners aware of and afraid of HIV infection (Beyrer, 1998).

The following is a summary of the available information.[4]

Compulsory testing

Compulsory testing is still practised in some prison systems, but has been on the decline.

One of the first prison systems to adopt such as policy was the federal prison service in the United States (Basu et al., 2005). In 1987, the US federal government mandated that prisoners test negative for HIV before release from federal prison. Prisoners who tested positive were detained involuntarily, even after they completed their sentences or met parole eligibility standards for transfer to half-way houses or transitional supervision programmes (Starchild, 1989). These measures had little or no benefit for individual prisoners' health; they did not guarantee access to care, and no effective antiretroviral treatments were available. Routine prophylaxis of opportunistic infections was not provided. Moreover, this testing method prior to release did not provide an opportunity

[4]Within the short timeframe available for this paper it was not possible to contact individual prison systems. The author therefore had to rely on published information and on information provided by UNODC and WHO country officers.

to implement effective prevention strategies, and was more likely to destabilize patients as they re-entered their communities without employment, money, food, or shelter (Basu et al., 2005). Yet statutes requiring some form of mandatory HIV testing were passed in 15 states during the 1980s and early 1990s, mostly under pressure from correctional officers' unions (id). Mandatory testing strategies were modified at the federal level and in some states after a wave of lawsuits in the late 1980s and early 1990s. Many of these lawsuits alleged that the testing strategy did not serve a legitimate objective, but had the potential to cause harm. Some correctional institutions shifted from a mandatory testing policy to a strategy of avoiding HIV testing after antiretroviral treatment was shown to be effective (Diamond, 1994), unwilling to pay for such therapy and sometimes requiring prisoners to actively seek to be tested through court order or state-level approval (Currie, 1998). Many systems continue to require testing following an incident with exposure to blood or body fluids (MacGowan et al., 2006). In September 2007, the United States House of Representatives passed a bill that would alter HIV testing requirements for federal prisoners in the United States (Kaiser Daily HIV/AIDS Report, 2007). Current federal law and Bureau of Prisons regulations require people sentenced to six months or more in prison to receive an HIV test if it is determined that they are at risk for the virus. Under the bill passed by the House of Representatives, HIV tests would be required for prisoners entering and leaving prison. Prisoners would be allowed to opt out of HIV testing unless they were exposed to an HIV risk, such as a pregnancy or a sexual encounter, in prison. In these cases, prisoners would be required to be tested.[5]

In Australia, HIV testing of prisoners was authorized in all jurisdictions, either specifically or through general provisions, but New South Wales, for example, repealed the regulation requiring this in 1995 and has since operated an induction programme for new prisoners that offers voluntary HIV and hepatitis testing (Magnusson, 1995). In 1996, the Western Australian Government was found in breach of the federal Disability Discrimination Act 1992 because of prison policies that segregated HIV-positive prisoners and had them imprisoned in maximum-security prisons (The Editor, 1997). As of 2007, only one jurisdiction, the Northern Territory, was still conducting compulsory HIV testing.[6]

In prisons in Europe, including Eastern Europe (see, e.g., Ukraine: Gunchenko and Andrushchak, 2000; Moldova: Pintilei, 2007) compulsory testing has been abandoned in nearly all countries (Harding & Schaller, 1992). However, in some countries, such as in the Russian Federation,[7] compulsory testing continues, even if it does not represent official prison policy. In some cases, according to the official policy HIV testing

[5]The bill would allow also prisoners to request HIV testing once annually and mandate confidential counselling for prisoners prior to and after testing. Medical workers also must grant HIV tests to prisoners whenever a prisoner has a reason to believe they might have been exposed to HIV (Kaiser Daily HIV/AIDS Report, 2007).

[6]Information provided by Michael Levy on 26 September 2007.

[7]According to correspondence received on 19 July 2007 from Vsevolod Lee, National Programme Officer, UNODC, Regional Office for the Russian Federation and Belarus (on file with author), in "some regions, inmates are tested twice: when entering to the jail and when entering to the colony. In some regions, inmates belonging to the risk groups (IDUs) undergo HIV testing every three months. Besides, inmates undergo testing after each extended visits of their wives. The rest of the inmates undergo testing once a year. However, in general, repeated testing is not widely practiced."

is voluntary, but prisoners are subtly coerced into being tested—including by being told that, unless they submit to HIV testing, they will be treated as if they were HIV-positive and denied certain programmes and privileges.

In Asia and the Pacific, the June 2007 WHO/UNICEF/UNAIDS technical consultation on scaling up HIV testing and counselling noted that different countries in the region "have different experiences of HIV testing and counselling in closed settings such as rehabilitation centres, prisons, camps and juvenile institutions", including "mandatory HIV testing on entry, release, or during the period of detention". It added that "voluntary counselling and testing remains exceptional and is usually not accompanied by access to appropriate prevention or care-related services" (WHO/UNICEF/UNAIDS, 2007).

One study reported that close to a quarter of participants from a prison with compulsory testing did not report receiving an HIV test, suggesting they may not have been aware that an HIV test was performed. This may be because consent was not obtained for an HIV test, participants were not notified of their test results, or both (MacGowan et al., 2006).

Box 1: National HIV/AIDS Policy in Malawi's National HIV/AIDS Policy prohibits compulsory testing

The following text is an excerpt from Malawi's National HIV/AIDS Policy which prohibits compulsory testing:

Prisoners are particularly vulnerable to exploitative and abusive sexual relations because of the environment in which they are living. They, therefore, need to be empowered to make informed decisions in the same way as other vulnerable groups.

The government, through the National AIDS Commission undertakes to:

- Ensure that prisoners are not subjected to mandatory testing, nor quarantined, segregated, or isolated on the basis of HIV/AIDS status.
- Ensure that all prisoners (and prison staff, as appropriate) have access to HIV-related prevention, information, education, voluntary counselling and testing, the means of prevention (including condoms), treatment (including antiretroviral treatment), care and support.
- Ensure that prison authorities take all necessary measures, including adequate staffing, effective surveillance, and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion by fellow prisoners and by warders. Juveniles shall be segregated from adult prisoners to protect them from abuse.
- Ensure that prisoners who have been victims of rape, sexual violence or coercion have timely access to post-exposure prophylaxis, as well as effective complaint mechanisms and procedures and the option to request separation from other prisoners for their own protection.

Provider-initiated testing

In a few prison systems, mainly in the United States (Basu et al., 2005), HIV testing is considered a standard part of a medical examination on admission, conviction, or prior to release, and undertaken unless prisoners explicitly refuse to be tested ("opt out" of the test).

In some systems, primarily in high-income countries, HIV testing is offered to all prisoners, most often to new admissions upon entry into the prison system, but is only undertaken if prisoners specifically agree to HIV testing ("opt in" to testing). For example, the Canadian federal prison system "maintains the practice of actively offering voluntary counselling and testing to all inmates", considering that "testing offered to new admissions upon entry into the federal correctional system may be one of the best opportunities for identifying prevalent infections" (Correctional Service Canada, 2003). In Australia, the National HIV Testing Policy (Commonwealth of Australia, 2006) encourages states and territories "to develop policies that offer HIV testing to inmates on reception and during incarceration and, where appropriate, arrange referrals to community health services for testing following an individuals' release from prison". According to the policy, "[o]ffering testing of prisoners on reception, during incarceration and prior to release has the potential to identify new cases of HIV infection, allowing appropriate assessment, treatment and education to be provided to those individuals" (ibid.).

In some systems, the offer of HIV testing may be accompanied by a recommendation to be tested.

Testing on demand

In many prison systems, particularly in low- and middle-income countries, HIV testing is not actively offered to prisoners on admission or conviction, but prisoners can obtain an HIV test if they ask for it. In some systems, access to a test may be relatively easy, and prisoners may receive a test at any time, while in other systems prisoners may have limited access to the test and only be able to obtain it under certain circumstances.

No or little access to testing

Finally, prisoners in some prison systems in low- and middle-income countries continue to have little or no access to HIV testing.

Counselling

Where prison systems have adopted policies on HIV testing and counselling, they generally require that HIV testing be accompanied by pre- and post-test counselling. In practice, however, as in the community, counselling is often not provided or is of insufficient quality. One study found that less than half of the prisoners who were tested for HIV reported receiving counselling (MacGowan et al., 2006). Among the many concerns related to the lack of counselling is that prisoners often are not told when they will receive the results of the HIV test.

Confidentiality

Research has shown that protection of the confidentiality of prisoner medical information is often insufficient, and that policies vary widely from system to system and are often interpreted differently even within one system (MacDonald, 2006).

What do we know about the effectiveness of various testing strategies?

"Mandatory" and compulsory testing

Those advocating compulsory testing (and, sometimes, segregation) of all prisoners have said that such testing would:

- Allow prison systems to know exactly how many prisoners are living with HIV;
- Provide those living with HIV with necessary care, support and treatment;
- Protect staff and fellow prisoners from contracting HIV in prisons;
- Protect third parties, such as partners and other persons with whom a prisoner is likely to have contact after release from prison, from contracting HIV.

However, no direct comparisons of outcomes data have established that compulsory testing provides a superior form of HIV management to other testing approaches, and efficacy data have not accompanied defences of the compulsory testing approach (Basu et al., 2005). Indeed, most public health officials and disease specialists see policies of compulsory testing and segregation as counterproductive (Hoxie et al., 1990; Jacobs, 1995).

Attempts to identify and segregate known HIV-positive prisoners to "contain" the epidemic will miss seroconverting persons who are in the "window" period (i.e., the period after infection and before antibodies can be detected by current testing methods; this period is also the period when people are most infectious). Correctional-officer unions in several countries have lobbied for disclosure of the HIV status of prisoners, but ignoring universal precautions when interacting with prisoners who are presumed to be HIV-negative may increase the risk of occupational exposure to hepatitis B and C as well as primary HIV infection by providing a false sense of security (Spaulding et al., 2002). HIV is not transmissible via casual contact and therefore compulsory testing and segregation of people living with HIV in prisons is not necessary for public health purposes. Instead of testing without consent—which is unethical and potentially infringes the right to security of the person, the right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment, and the right to privacy (Betteridge and Jürgens, 2004; Canadian HIV/AIDS Legal Network, 2006)—prisoners can be provided with the means necessary to act responsibly and to protect themselves and others from the risk of contracting HIV, such as access to voluntary counselling and testing, education, condoms, bleach, sterile needles and syringes, opioid substitution therapy and other drug dependence treatment (WHO, UNODC/UNAIDS/2007; Jürgens, 2001; Lines 1997/98).

No data are available on the effectiveness of separate housing for HIV-positive prisoners as an HIV prevention strategy. Separate housing of HIV-positive prisoners:

- Does not reduce the spread of other sexually transmitted, opportunistic or blood-borne infections.
- Might increase the risk of tuberculosis outbreaks: tuberculosis outbreaks resulting from the implementation of segregated housing have been documented in California and South Carolina (CDC, 1999; CDC, 2000). In a prison in South Carolina, United States, segregating HIV-positive prisoners contributed to a tuberculosis outbreak in which 71 per cent of prisoners residing in the same housing area either had new tuberculosis skin-test conversion or developed tuberculosis disease. Thirty-one prisoners, and one medical student in the community's hospital, subsequently developed active tuberculosis (Patterson et al., 2000).
- Raises concerns about disclosure of prisoners' HIV status and access to prison programmes.
- Does not prevent transmission by prisoners who are unaware that they are infected or by HIV-positive prison staff (CDC, 2006).

Furthermore, inadequacies have been reported in the HIV treatment and care standards of several segregated units, including in high-income countries (Basu et al., 2005). Segregating prisoners provides no conceivable benefit to medical care. As stated by Basu et al. (2005):

> In their current form, segregation units ostracize prisoners and exclude them from valued activities … Segregation has lead to the reassignment of inmates to distant sites that are far from family members — possibly reducing the quality of prisoners' lives, destabilizing their social support networks, and mixing inmates with different security status.

According to Paris (2006), segregation of HIV-positive prisoners "is not a real option":

> To cohort or segregate so as to ensure the existence of "guaranteed HIV-free prisons," one would have to consider the very real possibility that in such perceived "HIV-free prisons" inmates may forego precautions and embark in risky behavior because of the assumed safety. It is quite possible that in such facilities introduction of HIV by a single case within the testing window, or by infected staff […], may spread the virus rapidly and infect large numbers of inmates. In order to guarantee that a prison is "HIV-free," one would have to test at intake--whether tested previously at another prison or not re-test at the end of the window (e.g., at 6 months) and periodically re-test all inmates, perhaps as frequently as every 6 months. I posit that it would be very difficult and expensive to maintain a "guaranteed HIV-free prison."

Other forms of testing

Only a small number of studies undertaken mainly in the United States and a few other high-income countries have evaluated voluntary forms of HIV testing and counselling

in prison. Therefore, much remains unknown about the effectiveness of various testing strategies in prison, particularly in low- and middle-income countries. The following is a summary of some of the most important findings.

Importance of improving access

Efforts to improve access to voluntary HIV testing and counselling in prisons are important, as they reach a clientele at high risk of HIV infection that often has not used testing and counselling services on the outside (Beauchemin and Labadie, 1997; Sabin et al., 2001). In the United States, AIDS has tended to be diagnosed at a younger age and at an earlier stage of disease in prisoners than in non-incarcerated persons (Dean-Gator and Fleming, 1999), offering important prevention and care opportunities.

Rates of HIV testing

In New York State prisons, where prisoners attended an AIDS education class at intake, and prisoners considered to be at risk of HIV were given the opportunity for HIV testing, only 22 per cent of prisoners who attended the class were tested for HIV (Lachance-McCullough et al., 1994). When all prisoners are offered HIV counselling and testing, much higher rates of acceptance can be achieved, ranging from 39–84 per cent (MacGowan et al., 2006). For example, high levels of acceptance have been reported by researchers examining the testing programme in Wisconsin (United States), which tested a relatively low-prevalence population: voluntary testing was accepted by 71 per cent of all entrants and 83 per cent of entrants reporting injecting drug use (Hoxie et al., 1990). A more recent study in Wisconsin reported that prisons that routinely offer voluntary HIV testing to all prisoners at medical intake achieved rates as high as 84 per cent (Hoxie et al., 1998). Cotton-Oldenburg et al. (1999) reported an acceptance rate of 71 per cent among 805 women. In contrast, rates of acceptance were lower (47 per cent) in Maryland (United States), a prison system with a higher prevalence of HIV among prisoners. HIV-positive prisoners who refused testing were later found to be more likely to test positive on blinded tests than those accepting voluntary counselling and testing. As a result, although 47 per cent of prisoners accepted testing, the programme identified only 34 per cent of the HIV-seropositive prisoners. Low perceived risk of HIV, fear of testing HIV-seropositive, and lack of interest were given as key factors for refusing testing (Behrendt et al., 1994).

Not surprisingly, the few prison systems that have implemented forms of testing under which prisoners are tested unless they explicitly decline testing have reported high HIV testing rates of more than 90 per cent (Grinstead et al., 2003; Ramratnam et al., 1997; MacGowan et al., 2006). In one jurisdiction (Rhode Island in the United States) that has adopted such a system, about one third of all HIV-positive persons first learn of their HIV infection while incarcerated (Dixon et al., 1993; Desai et al., 2002).

Factors determining testing uptake

Several factors may account for the wide variability in uptake of HIV testing, but the nature and relative importance of such factors are difficult to determine based on the

existing published literature. Where testing and counselling is not offered to all prisoners, "the need for prisoners to actively request the test when dealing with the myriad issues involved in prison life may be a large part of the problem" (Basu et al., 2005). A low rate of acceptance may also be due to the structure of the testing programme: testing acceptance rates may be particularly low where testing is done in the view of other prisoners, with inadequate counselling services and confidentiality measures, and with inadequate follow-up care, treatment and support for those testing HIV-positive (Basu et al., 2005). In this context it is notable that the Rhode Island testing programme that reported the highest acceptance rates features comprehensive care after testing at entry; while many of the studies documenting lower testing uptake were undertaken before antiretroviral treatment became available.

In at least one study, uptake of HIV testing increased significantly after implementation of saliva testing procedures, suggesting that some prisoners may delay or refuse testing because of their fear of needles (Bauserman et al., 2003). It has also been suggested that in countries where male-to-male sex is the most common risk behaviour associated with HIV, homophobia within the prison environment may be a factor in males avoiding HIV testing, since in such settings for many, being HIV-positive is associated with being homosexual (Basu et al., 2005).

Finally, in one study, predominant motivations for testing were injecting drug use or fear of infection inside prison (possibly through contact with blood, during fights, or even by casual contact), suggesting that HIV testing should be accessible and that prisoners should receive appropriate counselling and information to allow a realistic assessment of risk (Burchell et al., 2003).

Testing experience

Post-discharge surveys have indicated that 78 per cent of former prisoners in Rhode Island welcomed the opportunity to receive testing as it was part of comprehensive HIV treatment and case management discharge programmes (Ramratnam et al., 1997).

However, testing policies under which prisoners are tested unless they explicitly decline testing may lead to testing without informed consent. A survey of medical service providers reported that "routine testing policies in some cases amounted to mandatory testing when inmates just 'went along' with whatever was asked of them, because of confusion or fear (Basu et al., 2005, with reference to Grinstead et al., 2003). Another study, of young imprisoned men's perception of and experiences with HIV testing, revealed that some perceived that testing was mandatory. The authors concluded that "[t]he nature of prison environments, coupled with the crowded, rushed, and overwhelming aspects of the intake process itself, may fuel some men's beliefs that testing is mandatory and inhibit some men from refusing an HIV test" (Kacanek et al., 2007). They suggested that, to "minimize the risk of misperception, staff in prison settings that routinely offer HIV testing upon entry could assure incarcerated people that testing is voluntary and provide adequate, safe opportunities for individuals to refuse testing" (ibid.).

Rapid HIV testing

One study examined the feasibility and acceptability of rapid HIV testing in a jail in the United States, concluding that "rapid HIV testing was feasible and highly acceptable" but noting that "[f]urther studies are needed to successfully incorporate rapid HIV testing into jail screening programs" (Beckwith et al., 2007). In another study, health departments in Florida, Louisiana, New York and Wisconsin collaborated with jails to implement stand-alone voluntary rapid HIV testing programmes (MacGowan et al., 2007). HIV testing was provided by the health department, correctional facility or a community-based organization. Prisoners whose rapid test was reactive were offered confirmatory testing, medical evaluation, prevention services, and discharge planning. From December 2003 through May 2006, rapid HIV testing was provided to 33,211 prisoners, more than 99.9 per cent of whom received their test results. A total of 440 (1.3 per cent) rapid HIV tests were reactive, and 409 (1.2 per cent) of the results were confirmed positive. The testing programmes identified 269 (0.8 per cent) previously undiagnosed cases of HIV infection. The study concluded that rapid HIV testing should be available to all prisoners.

Linkage with HIV prevention and treatment, care and support

Research has tended to focus on uptake of HIV testing and, to a much lesser extent, prisoners' experience with HIV testing. In contrast—although HIV testing is not a goal in and of itself, but is clearly linked to prevention and treatment, care and support goals—there has been very little investigation of whether increased rates of HIV testing and counselling in prison also result in greater uptake of HIV prevention and treatment, care and support interventions. In some prison systems, efforts to increase uptake of HIV testing have clearly been linked to efforts to increase access to HIV treatment, care and support, including antiretroviral treatment (see, for example, the Rhode Island prison system (Desai et al., 2002). But even in those systems, access to evidence-based HIV prevention measures has remained very limited, if not nonexistent.

Worldwide, prison systems are far from achieving universal access to evidence-based HIV prevention, treatment, care and support.

HIV prevention

- Eighteen of the 23 prison systems in the pre-expansion European Union (Stöver et al., 2001), as well as prison systems in Australia, Brazil, Canada, Indonesia, the Islamic Republic of Iran, South Africa, some countries from the former Soviet Union, and a small number of jail and prison systems in the United States, provide condoms to at least some prisoners (WHO/UNODC/UNAIDS, 2007c). However, even in these systems condoms are often not easily accessible to prisoners and/or not available in all prisons. In most other systems, condoms are not at all available.
- Many systems continue to deny the existence of rape and other forms of sexual violence among prisoners and between prisoners and prison staff, and fail to adopt methods to document incidents of prisoner sexual violence, undertake prevention efforts, provide staff training, undertake investigation and response efforts, and

provide services to victims, including access to post-exposure prophylaxis (WHO/UNODC/UNAIDS, 2007c).

- Prison systems that offer opioid substitution therapy to at least some prisoners with opioid dependence remain the exception. They include most systems in Canada and Australia, some systems in the United States, most of the systems in the pre-expansion European Union (Stöver at al., 2001), some of the "new" EU member States (such as Hungary, Malta, Slovenia and Poland), a small number of systems in Eastern Europe and the former Soviet Union (such as the Republic of Moldova and Albania) and a few systems in other countries, including Albania, Iran (Islamic Republic of) and Indonesia (WHO/UNODC/UNAIDS, 2007d). However, even in these countries programmes often remain small and benefit only a small number of prisoners in need (MacDonald, 2005). Good coverage has been achieved in Spain, where 18 per cent of all prisoners, or 82 per cent of people with opioid dependence in prison, receive methadone maintenance therapy (EMCDDA, 2005).
- Needle and syringe programmes have been introduced (or are about to be introduced) in only 12 countries in Western and Eastern Europe and in Central Asia. In most of these countries, they are only available in a small number of prisons (WHO/UNODC/ UNAIDS, 2007b).
- The most common form of "HIV prevention" in prisons is the provision of some form of information and education about HIV. Such programmes are important. However, most studies have concluded that the effectiveness of current educational efforts in influencing prisoners' behaviour and in reducing HIV transmission among prisoners remains largely unknown and that simply providing information on HIV and the harms associated with risk behaviours is not enough. In particular, studies have pointed out that education and counselling are not of much use to prisoners if they do not have the means (such as condoms and/or clean injecting equipment) to act on the information provided while they are in prison (WHO/UNODC/UNAIDS, 2007a).

HIV treatment

Antiretroviral treatment has been provided to many HIV-positive prisoners in high-income countries for the last ten years. As a consequence, AIDS-related deaths in prisons in these countries have decreased dramatically (Centers for Disease Control and Prevention, 1999; Mackenzie et al., 1999; Maruschak, 2001; Babudieri et al., 2005). More recently, many low- and middle-income countries have also started making antiretroviral treatment available in their prison systems, demonstrating that it is feasible to provide such treatment in these settings and to achieve satisfactory outcomes (Srisuphanthavorn et al., 2006; Winarso et al., 2006). However, these programmes are often small in scale (Simooya and Sanjobo, 2006; Hassim, 2006) and reach only a small number of those in need. For example, in Ukraine, as of 1 July 2007, 86 prisoners were on antiretroviral treatment (Zhyvago, 2007), although studies have shown very high rates of HIV (Zhyvago, 2005: 16 per cent to 32 per cent) in prisons in which seroprevalence studies have been undertaken and physicians report that many prisoners are dying of AIDS-related causes every months.

Discussion and recommendations

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This paper has revealed a number of unique challenges with regard to HIV testing and counselling for prisoners, particularly in low-and middle-income countries with high HIV prevalence rates among prisoners. These include the following:

- Many prison systems have discontinued policies of compulsory HIV testing (and segregation of HIV-positive prisoners) based on the fact that they cannot be justified on public health grounds and infringe the human rights of prisoners. However, some systems continue to have policies or laws requiring compulsory HIV testing, while others coerce all prisoners to be tested for HIV despite official policies of voluntary HIV testing.
- At the same time, voluntary HIV testing and counselling remains difficult to access for prisoners in many countries. Even where testing is available, in practice, many of those tested report not receiving pre-and post-test counselling, breaches of confidentiality, and/or lack of referral to follow-up support and care.
- Worldwide, access to evidence-based HIV prevention measures remains limited for the vast majority of prisoners.
- Most low- and middle-income countries are making efforts to scale up access to HIV treatment, care and support, including antiretroviral treatment, for people living with HIV. However, efforts to scale up access to treatment for prisoners often lag behind efforts to increase access to treatment in the community and are rarely sufficiently coordinated with those efforts, resulting in prisoners developing resistance to HIV drugs (Laurent, 2007).
- All of the above issues are related to the fact that, worldwide, most prisoners (many of whom are people who use drugs) belong to marginalized populations in society. In many countries, prison health standards and prison conditions suffer because of a lack of political and public interest in prisoners' health.

The WHO/UNAIDS Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities explicitly states that

- "Implementation of provider-initiated HIV testing and counselling must include measures to prevent compulsory testing and unauthorized disclosure of HIV status" (art. 30).
- Provider-initiated HIV testing and counselling should be accompanied by a recommended package of HIV-related prevention services, including condoms and needle and syringe access and other harm reduction interventions for people who inject drugs (art. 30-31).
- Although access to antiretroviral therapy should not be an absolute prerequisite for the implementation of provider-initiated HIV testing and counselling, "there should at least be a reasonable expectation that it will become available within the framework of a national plan to achieve universal access to antiretroviral therapy for all who need it" (art. 30).
- At the same time as provider-initiated HIV testing and counselling is implemented, "equal efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximize positive outcomes and minimize potential harms to patients" (art. 32).

All of these issues will have to be addressed as countries scale up access to HIV testing and counselling for prisoners as part of their commitment "to pursuing all necessary efforts … towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010" (United Nations, 2006).

Ensuring prisoners' access to evidence-based HIV prevention, treatment, care and support

This background document statement is part of a set of documents produced by UNODC, WHO and UNAIDS aimed at providing up-to-date, relevant, and authoritative information and guidance to countries on HIV prevention, treatment, care and support in places of detention. Countries should act on the recommendations contained in the following documents to ensure that efforts to improve access to HIV testing and counselling in places of detention will indeed be accompanied by sustained efforts to scale up access to HIV prevention, treatment, care and support:

- Evidence for Action Technical Papers on Effectiveness of Interventions to Address HIV in Prisons (2007). These papers provide a comprehensive review of the effectiveness of interventions to address HIV in prison settings. Currently available in English and Russian via www.who.int/hiv/topics/idu/prisons/en/index.html; or
- HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response (2006). This document provides a framework for mounting an effective national response to HIV in prisons, based on the evidence reviewed in the Evidence for Action Technical Paper and on accepted international standards and guidelines. Available in many languages via www.unodc.org/unodc/en/hiv-aids/publications.html.
- Policy Brief: Reduction of HIV Transmission in Prisons (2004). This document provides a two-page summary of the evidence related to HIV prevention programmes in prisons. Available in many languages via www.who.int/hiv/topics/idu/prisons/en/index.html.

HIV testing and counselling should not be a goal in itself, but a means to enable people to access prevention services, and treatment, care and support if HIV-positive.

Linking HIV testing and counselling with HIV treatment, care and support is essential to encourage prisoners to participate in HIV testing and counselling programmes. HIV testing and counselling should never be done without assured links for each prisoner to care and support, and to appropriate access to treatment, including antiretroviral therapy (ART) where available.

Successful HIV treatment, care and support requires the uninterrupted provision of antiretroviral therapy and, where clinically indicated, treatment for tuberculosis and other opportunistic infections. Large numbers of prisoners move in and out of the prison system as well as within the prison system. It is therefore essential to ensure continuity of treatment and care, particularly of ART.

In addition, prisoners also need access to the means to protect themselves from infection. Knowledge of HIV status alone, even if accompanied by HIV information and education programmes, is not sufficient to prevent HIV transmission in prisons (WHO/UNODC/UNAIDS, 2007). Prisoners need access to evidence-based prevention measures to prevent transmission of infection, including condoms (WHO/UNODC/UNAIDS, 2007c), sterile injecting equipment (WHO/UNODC/UNAIDS, 2007b), and other harm reduction interventions (WHO/UNODC/UNAIDS, 2007).

Recommendation 1

Efforts to scale up access to HIV testing and counselling in prisons should not be undertaken in isolation, but as part of a comprehensive HIV programme aimed at improving health care and at achieving universal access to HIV prevention (including access to condoms, sterile injection equipment and other harm reduction interventions and prevention of mother-to-child-transmission), treatment, care and support for prisoners (including the uninterrupted provision of antiretroviral therapy when available in the community for prisoners living with HIV and, where clinically indicated, treatment of other sexually transmitted infections, viral hepatitis, tuberculosis and other opportunistic infections).

Protecting prisoners against HIV-related discrimination and abuse

Increasing HIV testing and counselling must also go hand in hand with much greater investment in real protection—in practice, and not just on paper—from HIV-related discrimination and abuse of people living with HIV and those most at risk, including prisoners. In the Guidance, WHO and UNAIDS recognize that "equal efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximize positive outcomes and minimize potential harm to patients" (art. 32). This recognizes that stigma and discrimination and the abuse that prisoners living with HIV often suffer provide powerful disincentives to HIV testing.

Prison policies and practices need to be reviewed and changed, if necessary, to ensure that they do not segregate HIV-positive prisoners from the rest of the prison population simply because they are HIV-positive and do not exclude them from any programmes, family visits or jobs. There is no evidence that segregation of HIV-positive prisoners is an effective HIV prevention strategy. Indeed, separate housing for HIV-positive prisoners may increase the risk of TB outbreaks (CDC, 1999; CDC, 2000), does not prevent transmission by prisoners who are unaware that they are infected or by HIV-positive prison staff (CDC, 2006), and may create a false sense of security among prisoners and prison staff.

Attention must also be paid to ensuring that confidentiality of prisoners' medical information is protected and not released by health-care staff to custodial staff or management; and to avoiding stigma and the negative consequences of testing: prisoners will not agree to participate in testing if they face discrimination or abuse. In some prison

systems, health-care staff do not currently have enough independence from prison management, making it difficult for them to protect confidentiality of medical information, and resulting in less trust of prisoners in health-care staff. In these systems, efforts to increase access to voluntary counselling and testing will have to be undertaken in the context of a larger effort to improve health-care and to secure independence of health-care staff.

Recommendation 2

Prison systems should review and, if necessary, change prison policies and practices that discriminate against HIV-positive prisoners, recognizing that increasing access to HIV testing and counselling must go hand in hand with greater protection from HIV-related discrimination and abuse. In particular, policies that provide for segregation of HIV-positive prisoners or their exclusion from any programmes or other activity should be repealed and the confidentiality of prisoners' medical information should be protected.

Prohibiting "mandatory" and compulsory HIV testing

In some countries, HIV testing is conducted on all prisoners upon admission, conviction, prior to release, or under certain other circumstances, without informed consent. In some cases, such testing is required by legislation or policy. In other cases, official policy provides for voluntary HIV testing, but prisoners may be coerced into being tested. For example, prisoners may be treated as if they were HIV-positive and lose privileges unless they submit to HIV testing. Such mandatory or compulsory forms of HIV testing violate ethical principles and the basic rights of consent, privacy and bodily integrity. They are not necessary for the protection of prisoners, staff or visitors, and cannot be justified from a public health perspective.

Recommendation 3

WHO and UNODC do not support mandatory or compulsory HIV testing of prisoners on public health grounds. Therefore, countries should review and, if necessary, change their laws, regulations, policies and practices to prohibit mandatory or compulsory HIV testing of prisoners.

Ensuring that prisoners are included in efforts to expand access to HIV testing and counselling

It is undisputed that access to quality HIV testing and counselling that respects the principles of confidentiality, counselling and consent ("Three Cs") is essential for an effective global response to HIV. There is consensus among AIDS and human rights activists, public health officials and policymakers in favour of scaled up access to affordable and high-quality HIV testing and counselling (UNAIDS Reference Group on HIV and Human Rights, 2007; Heywood, 2005). In this context, greater access to HIV

testing and counselling for prisoners is both a public health and a human rights imperative, and an integral component of countries' efforts to reach universal access to prevention, care, treatment and support by 2010.

Scaling up access to HIV testing and counselling for prisoners could have many benefits, as long as prisoners:

- Have assured access to care and support and to appropriate HIV treatment;
- Have access to evidence-based HIV prevention measures that enable them to reduce the risk of transmission to their partners; and
- Are protected from stigma, discrimination and violence through prison policies and practical measures aimed at ensuring that the prison environment is supportive of prisoners living with HIV.

Therefore, national AIDS programmes, working with prison systems, should ensure that prison populations are included in efforts to expand access to HIV testing and counselling and that the necessary financial resources are secured.

Donors supporting national efforts to expand access to HIV testing and counselling in low- and middle-income countries should provide adequate support for efforts to expand access to HIV testing and counselling for prisoners.

Providing prisoners with easy access to client-initiated HIV counselling and testing (also called "voluntary counselling and testing" [VCT])

Currently, in many prison systems, prisoners only have limited access to HIV testing and counselling. WHO and UNAIDS "strongly support the continued scale up of client-initiated voluntary counselling and testing" (art. 5). It should be free and available to prisoners on their request, at any time during their imprisonment. When appropriate, it should include provision of voluntary counselling and testing provided as an outreach to the prison by outside testing and counselling services, or taking prisoners to outside VCT centres for testing and counselling.

> Recommendation 4
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> Prison systems should ensure that all prisoners have easy access to client-initiated testing and counselling programmes on request and at any time during their imprisonment. Prisoners should be informed about the availability of the service, both at the time of their admission and regularly thereafter.

Offering or recommending HIV testing and counselling through provider-initiated HIV testing and counselling (PITC)

While providing prisoners with easy access to VCT is essential, it may not be enough. There is evidence that uptake of HIV testing is higher where HIV testing and counselling is proactively offered or recommended to all prisoners, as many prisoners may not

request a test upon their own initiative when dealing with the myriad issues involved in prison life. When a health-care provider initiates the HIV testing and counselling process, this should include providing adequate information, obtaining informed consent, maintaining confidentiality and ensuring that the process is voluntary.

Depending on the circumstances, health-care providers should either offer or recommend the service.[8] HIV testing and counselling should be offered to all prisoners during medical examinations. Health-care staff should go further and recommend HIV testing and counselling to prisoners with signs, symptoms or medical conditions that could indicate HIV infection; and to prisoners who are pregnant.

> Recommendation 5
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> Prison systems should ensure that health-care providers offer HIV testing and counselling to all prisoners during medical examinations. They should also recommend HIV testing and counselling if a prisoner has signs, symptoms or medical conditions that could indicate HIV infection, including tuberculosis, and to female prisoners who are pregnant to assure appropriate diagnosis and for those testing positive access to necessary HIV treatment, care and support.

Recognizing that prisoners may deal with many difficult issues at the time of their admission to prison, and that admission may be a difficult time to have HIV testing and counselling (and a potential HIV diagnosis), health-care workers should be trained to be particularly sensitive about the offer of HIV testing and counselling during the initial medical examination. In particular, they should highlight the potential benefits of HIV testing and counselling and offer or recommend HIV testing, but emphasize that testing is voluntary and that prisoners will be able to access HIV testing at any time during their imprisonment; and refrain from making the offer to prisoners who may not be able to give informed consent at the time of admission, such as prisoners going through withdrawal from drugs. For prisoners who have not been offered HIV testing at the time of admission, they should renew the offer or recommendation of HIV testing at subsequent visits.

In order to make it feasible for health-care staff in prison to offer HIV testing to all prisoners, in some settings it may be justified to relax, to some extent, pre-test counselling requirements. Human rights and public health do not require cumbersome procedures for pre-test counselling. But human rights—and public health imperatives—do require that prisoners can seek and receive sufficient information to enable them to give informed consent to testing, regardless of whether an HIV test is offered and recommended to them during certain medical examinations or whether they initiate HIV testing themselves. In addition, human rights and public health concerns also require that prisoners (whether they test HIV-positive or HIV-negative) receive post-test counselling and that confidentiality of test results and of the fact of seeking a test are guaranteed.

[8]The definition of the term offer is "to present for acceptance or rejection". The word recommend is defined as "to represent or urge as advisable".

Ensuring that prisoners can give informed consent

While health-care staff should proactively offer (or recommend) HIV testing and counselling, every effort needs to be made to ensure that prisoners can give informed consent. In every area of life, prisoners bargain for privileges, better conditions, and, ultimately release. Unless additional safeguards are taken, prisoners may feel they cannot decline offers of HIV testing (Grinstead et al., 2003; Kacanek et al., 2007).

Requiring prisoners to specifically agree to HIV testing

In other settings, WHO and UNAIDS recommend an approach to provider-initiated testing and counselling under which individuals "must specifically decline the HIV test if they do not want it to be performed"[9] (WHO/UNAIDS, 2007). However, WHO and UNAIDS recognize that this approach to informed consent "may not be appropriate for certain highly vulnerable populations" such as prisoners (ibid).

For highly vulnerable populations, such as prisoners, HIV testing and counselling should be offered or recommended by the health-care provider but should normally only proceed if the client specifically states that he or she wants the test. In prisons, there is a power imbalance between staff and prisoners, and in order to ensure the voluntary nature of HIV testing, the test should be done only when the prisoner explicitly agrees to it. There is evidence that prisoners sometimes feel they cannot refuse (or "opt-out") when health-care providers state that they will proceed with testing unless prisoners say no (Grinstead et al., 2003; Kacanek, 2007; Basu et al., 2005). This is often considered virtually synonymous with mandatory or compulsory testing (Walker et al., 2004; but see Boutwell, Allen, Rich, 2004).

Thus, WHO and UNODC recommend that testing and counselling services provided in prison settings use an approach in which prisoners, after receiving all the information they need to be able to make an informed decision, are specifically asked whether they want an HIV test, and only tested if they respond that they do. This approach ensures that prisoners are not put in a position where they have to say no to a person of authority if they do not want to be tested—something that may be difficult for them.

A different approach (under which prisoners, after receiving the information they require to understand the implications of HIV testing, must specifically decline the HIV test if they do not want it to be performed) is only advised for prisoners with signs or symptoms of HIV disease and to female prisoners who are pregnant, to assure appropriate diagnosis and, for prisoners testing HIV-positive, effective HIV treatment. However, this approach should not be implemented:

- If adverse social consequences for prisoners diagnosed HIV-positive outweigh the benefits of the diagnosis being made; and/or

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[9]In the WHO/UNAIDS Guidance on provider-initiated HIV testing and counselling in health facilities, this approach to provider-initiated testing is called "opt-out" approach.

- Unless there is access to the set of HIV-related prevention, treatment, care and support services as recommended in the Guidance on provider-initiated HIV testing and counselling in health facilities. This includes education, psychosocial and peer support for management of HIV; periodic clinical assessment and clinical staging; management and treatment of common opportunistic infections; co-trimoxazole prophylaxis; tuberculosis screening and treatment when indicated, preventive therapy when appropriate; malaria prevention and treatment, where appropriate; sexually transmitted infections case management and treatment; palliative care and symptom management; advice and support on other prevention interventions, such as safe drinking water; nutrition advice; infant feeding counselling; and antiretroviral treatment, where available in the community outside prisons.

In all cases in which testing is offered to prisoners, coercion in any form must be avoided and prisoners must provide informed consent before testing can be undertaken.

Recommendation 6

In order to ensure that prisoners can give informed consent, prison systems should adopt policies according to which prisoners will be offered or recommended HIV testing and counselling, but will not be tested unless they specifically state that they want the test. A different approach (under which prisoners must specifically decline the HIV test if they do not want it to be performed) is only advised for prisoners with signs or symptoms of HIV disease, to assure appropriate diagnosis and, for those testing HIV-positive, access to effective HIV treatment. However this approach should not be implemented if adverse social consequences for prisoners diagnosed HIV-positive outweigh the benefits of the diagnosis being made; and unless there is access to a recommended set of HIV prevention, treatment, care and support services as recommended in the Guidance on provider-initiated HIV testing and counselling in health facilities.

Ensuring that prisoners receive the information they need

In the Guidance on Provider-initiated HIV Testing and Counselling in Health Facilities, WHO and UNAIDS (art. 36), specify the following “minimum information for informed consent” that health-care providers should provide patients when recommending HIV testing and counselling. This includes:

- The reasons why HIV testing and counselling is being recommended;
- The clinical and prevention benefits of testing and the potential risks, such as discrimination, abandonment or violence;
- The services that are available in the case of either an HIV-negative or an HIV-positive test result, including whether antiretroviral treatment is available;
- The fact that the test result will be treated confidentially and will not be shared with anyone other than heath-care providers directly involved in providing services to the patient;

- The fact that the patient has the right to decline the test;
- The fact that declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status;
- In the event of an HIV-positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV;
- An opportunity to ask the health-care provider questions.

In addition, the Guidance states that "patients should also be made aware of relevant laws in jurisdictions that mandate the disclosure of HIV status to sexual and/or drug injecting partners" (ibid.). The Guidance recognizes that in some cases, for populations most at risk of HIV transmission and more susceptible to coercion to be tested and to adverse outcomes of testing, "additional measures" to ensure informed consent may be necessary beyond the "minimum requirements" defined in the Guidance.

Prisoners require such "additional measures". In particular, they require more information than others to make informed decisions about taking an HIV test. When offering HIV testing, health-care staff in prison need to emphasize the voluntary nature of the HIV test and the prisoner's right to decline it. Additional discussion of the risks and benefits of HIV testing in the prison setting is also needed. To give informed consent, prisoners must understand the institutional consequences of a positive HIV test. In particular, they need to be informed:

- In case the test result is not treated confidentially;
- Whether they will be segregated if found to be HIV-positive; and
- Whether there is a likelihood that they could be denied access to certain programmes, family visits or jobs.

Recommendation 7

Prison systems should develop and adopt a code of conduct for health-care staff providing HIV testing and counselling, which requires that:

- Prisoners can seek and receive sufficient information to enable them to give informed consent to testing, including information about the specific risks and benefits of HIV testing in the prison setting; and
- Health-care staff offering or recommending HIV testing must emphasize the voluntary nature of the HIV test and the prisoner's right to decline.

Training of testing providers

As prison systems scale up access to HIV testing and counselling, they will have to ensure that health-care staff are properly trained to provide testing and counselling and, in particular, on the process of obtaining informed consent. As emphasized by the WHO/UNAIDS Guidance, such training programmes for personnel who will perform HIV testing and counselling should be developed and implemented well in advance of the implementation of expanded access to HIV testing and counselling. Where there

are high levels of stigma and discrimination and/or low capacity of health-care providers to expand HIV testing and counselling under the conditions of informed consent, confidentiality and counselling, "adequate resources should be devoted to addressing these issues prior to implementation" (WHO/UNAIDS, 2007, at 12).

Training should be based on protocols addressing issues such as informed consent, confidentiality and avoiding stigma and discrimination, and should emphasize the importance of treating all prisoners at risk of, or living with, HIV with respect; as well as the need for strict adherence to confidentiality of all medical information, including HIV status.

> Recommendation 8
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> Prison systems should ensure that personnel performing HIV testing and counselling receive training, particularly on obtaining informed consent, confidentiality, counselling and how to offer or recommend the test.

Integrating prison HIV programmes into national strategic HIV/AIDS plans

Currently, most countries do not report on how and to what extent their prison systems provide HIV testing and counselling to prisoners and, more broadly, access to prevention, treatment and care services. In fact, in many countries, efforts to scale up access in prisons are not integrated into national scale-up efforts. This is of concern, particularly in countries with concentrated epidemics among people who inject drugs, many of whom spend time in prisons and require access to prevention and treatment both in the community and in prisons.

Sustainable HIV prison programmes, integrated into countries' general HIV plans or at least linked to them, are needed (WHO/UNODC/UNAIDS, 2007e).

At the international level, efforts to achieve universal access to prevention, treatment, care and support should ensure that:

- Prison systems are included in technical and funding assistance missions;
- Data about HIV prevention and treatment access and coverage in prisons is collected and published;
- Best practice models are developed and disseminated;
- The public health and human rights implications of inadequate access to prevention, treatment and care in prisons are brought to the attention of policymakers.

At the country level:

- Prison departments should be a member of national AIDS coordinating committees;
- Prisons should be part of the agreed AIDS action framework and monitoring and evaluation system;

- Prison departments should be involved in all aspects of scale-up, from funding applications (to ensure that funds are specifically earmarked for prisons), to development, implementation, and monitoring and evaluation of national plans to achieve universal access; and
- The ministries responsible for health and for the prison system should collaborate closely, recognizing that prison health is public health; alternatively, governments could assign responsibility for health care in prisons to the same ministries, departments and agencies that provide health care to people in the community.

Finally, at the regional and local level, prisons should

- Form partnerships with health clinics, hospitals, universities and NGOs, including people living with HIV organizations, to provide services for prisoners; and
- Develop integrated rather than parallel HIV prevention, treatment, care and support programmes.

> Recommendation 9
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> National HIV programmes should ensure that prison systems are an integral part of national efforts to scale up access to HIV testing and counselling and, more broadly, efforts to achieve universal access to prevention, treatment, care and support.

Ensuring continuity of care and treatment

Successful HIV care requires the uninterrupted provision of antiretroviral treatment, and treatment for TB and other opportunistic infections. Large numbers of prisoners move in and out of the prison system as well as within the system. It is therefore essential to ensure continuity of care, particularly with regard to antiretroviral treatment, from the community to the prison and back to the community, as well as within the prison system. Treatment discontinuation for short or long periods of time may happen upon arrest and detention in police cells, when prisoners are sent to pre-trial detention facilities, when prisoners are sent to prison, within the prison system when prisoners are transferred to other facilities or have to appear in court, and upon release. Each of these situations should be addressed and mechanisms established to ensure uninterrupted antiretroviral treatment (see, e.g., Pontali, 2005; National Commission on Correctional Health Care, 2005). Particular attention should be devoted to discharge planning and linkage to community aftercare.

> Recommendation 10
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> Prison systems, working with other criminal justice agencies, health authorities and non-governmental organizations, should undertake efforts to ensure continuity of care, including antiretroviral therapy, from the community to the prison and back to the community, as well as within the prison system.

Ensuring adequate monitoring, evaluation and research

Ultimately, any form of HIV testing and counselling in prison—whether initiated by the prisoner or offered and recommended by health-care staff—will have to be carefully monitored and evaluated to ensure that, in practice, prisoners have easy access to HIV testing and counselling, health-care staff offer and recommend testing, and prisoners are not coerced into testing, but give informed and voluntary consent to the test.

Prison systems should closely monitor progress towards achieving universal access in prisons, as part of broader efforts to monitor progress towards achieving universal access to prevention, care, treatment and support by 2010. Routine monitoring should be complemented with targeted evaluations and research, as appropriate to various settings. This is particularly important because many of the discussions and assumptions around HIV testing and counselling have occurred in the absence of empirical data, either from studies or from monitoring of existing programmes, particularly from low- and middle-income countries. But even in high-income countries, deeper research questions beyond simply the numbers of people getting tested have not been adequately addressed to ensure that testing and counselling are having their intended effect. Questions such as the following should be addressed: What is the experience of prisoners being tested as a result of approaches in which HIV testing is offered and recommended to them? Does increased uptake of testing lead to increased uptake of care, treatment and support? Under what conditions are prisoners most likely to accept HIV testing and counselling? What is the impact of HIV testing in prison on prisoners' risk behaviours in prisons?

> Recommendation 11
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> Prison systems, working with the national country-level monitoring and evaluation system, should carefully monitor and evaluate provision of testing and counselling in prison. This should be done to ensure that prisoners have easy access to HIV testing and counselling; health-care staff offer or recommend testing, and prisoners are not coerced into testing but give informed consent; and testing and counselling is linked with increased access to HIV prevention and treatment, care and support.

Addressing issues specific to short-term imprisonment

Efforts to scale up access to HIV testing and counselling, as well as to evidence-based HIV prevention and to care, treatment and support, have traditionally neglected those prison settings in which prisoners spend short prison sentences of often no more than 30 days on average. These settings pose special challenges, related to the often chaotic nature of the settings, the high rates of turnover of prisoners, the various states of intoxication and withdrawal of at least some of the prisoners, the lack of availability and/or time of health-care staff, and other issues. In such a setting, it is particularly challenging to ensure that prisoners are able to provide informed consent to HIV testing, at a time of great stress in their lives. If they undergo HIV testing and counselling,

prisoners may be released prior to receiving their results or starting any type of treatment, and follow-up services may be lacking or insufficient. A small number of programmes in U.S. jails have been documented in which rapid testing has been combined with comprehensive jail- and community-based care, including follow-up services for up to 30 days after release and housing assistance (Basu et al., 2005; see also MacGowan et al., 2007). However, such programmes may be resource-intensive and difficult to replicate in low- and middle-income settings. Studies will be required to determine this. Generally, during short-term imprisonment prisoners should be able to obtain access to HIV testing and counselling, and should receive information about the fact that testing and counselling are available. Special efforts need to be made to combine HIV testing and counselling with prison- and community-based care and follow-up services after release.

Deciding on how best to scale up—programmatic considerations

Decisions on how best to implement the recommendations in this paper will depend upon an assessment of the situation in a particular country and prison system, including epidemiology, available infrastructure, financial and human resources, available prevention, treatment, care and support and the existing framework for protecting prisoners against HIV-related discrimination. Decisions around implementation should be made in consultation with all relevant stakeholders, including civil society groups and people living with HIV.

HIV testing and counselling in prisons and other closed settings

Technical paper

Annex: Development process

The consultant conducted a comprehensive literature search of published and unpublished documents (see methodology section in the Introduction chapter) and drafted a first version of the document which included a review of the evidence. This first draft was discussed and reviewed by a group of experts at an international consultation on HIV testing and counselling for prisoners held in Varna, Bulgaria, on 26 September 2007.

On the basis of the consultation a revised version of the technical paper and a first separate policy brief were developed and sent for peer review at two intervals, in February-April and in July-September 2008.

In the first round of peer review in February-April 2008 an ad hoc electronic consultation took place to address a specific issue that came up and that had not been discussed at the consultation in September 2007. This issue related to the "opt-in" versus "opt-out" policies of HIV testing and counselling with regard to people who are sick and show signs and symptoms of HIV related illness. Three additional specific questions were identified and submitted to this ad hoc group of experts (including five physicians with experience in working in prisons and two prison experts as listed below):

1. Where there is no access to HIV care and treatment (including ART) would we still recommend PITC?
2. Do we recommend PITC if the environment is not favourable (e.g. risk of segregation, no confidentiality, loss of access to activities, jobs etc)?
3. Do we recommend PITC on an "opt-out" basis for people who are sick and for women who are pregnant?

The response to this ad hoc consultation involving seven experts is summarised as follows:

1. Yes, prison systems need to do both: increase access to HIV testing and counselling, among other things by introducing PITC—provided measures are in place ensuring that prisoners can give informed consent—and increasing access to treatment, care and support (and to HIV prevention)
2. Where there are high levels of stigma and discrimination and/or low capacity of health-care providers to implement PITC under the conditions of informed consent, confidentiality and counseling, adequate resources should be devoted to addressing these issues prior to implementation.
3. Yes:
   (a) But everybody has to give informed consent, whether they are symptomatic or not.
   (b) Delete the use of the terminology of "opt-in" vs "opt-out" because it creates too much confusion and is prone to misunderstanding, particularly when translated to other languages.
   (c) "Opt-out" strategy is acceptable in case people are sick and for pregnant women provided the addition "that health-care staff can not test inmates without their informed consent".

On the basis of this first review process and this second consultation a second draft of both documents (technical paper and policy brief) was developed. A message was sent to WHO and UNODC databases containing experts on prison health and HIV and a message was also posted on the WHO and UNODC websites soliciting feedback. A special mailbox was opened and people showing interest received an electronic pdf copy of the draft documents in the preferred language (the policy brief was translated into all official United Nations languages, the background document was only available in English) and a standard form to enter their feedback in August 2008. Feedback from 30 people from all regions was collected and graded and entered into a spread sheet in October 2008. This was then reviewed by technical staff from UNODC, WHO, UNAIDS and the consultant and included in the final documents in November 2008.

Some feedback still included concern regarding the use of the concept of "opt-out" for testing people who are sick and show signs and symptoms in the specific prison setting for fear of forced testing and stigma and discrimination. The final version is phrased as carefully as possible to allow for all to agree.

List of experts

At several stages different individuals have been involved and provided significant input to the process and the text of the policy statement and they have been acknowledges at the start of this document. Only those people who provided significant input were invited to fill in and sign the form of potential conflict of interest.

Of the ten external experts nine specifically declared not to have any conflict of interest. Ralf Jürgens reported no conflict of interest as defined by the GRC but added that he advises the secretariat of the United Nations Reference group on HIV and Human Rights.

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