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HOW TO IMPROVE HIV/TB PREVENTION, TREATMENT AND CARE IN PRISONS

At the global epicenter of the HIV epidemic, intravenous drug use and sharing of syringes, needles and drug use paraphernalia, unprotected sex, multiple sexual partners, and low and inconsistent condom use are among the drivers of the spread of the virus [1]. Equally, prisoners comprise a key vulnerable population contributing to the epidemic.

Because prison populations often consist of individuals with greater risk factors for contracting HIV than the general population, HIV and AIDS are significant health threats to the entirety of the prison population — both inmates and employees [2].

The TB notification rate in prisons ranges from 11 to 81 times higher than in the general population. The situation is worsened by the emergence and spread of drug-resistant TB, particularly multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB.

Risk factors for tuberculosis (TB), hepatitis A, B and C, and sexually transmitted infections (STIs) are also greater for incarcerated individuals than those in the general population [2]. These infections tend to exacerbate each other, as in the case of HIV/TB co-infected individuals: TB infection is the leading cause of death among HIV-infected individuals in sub-Saharan Africa [3].

These are among the considerations that contribute to the challenges to prison and government authorities in responding to the risk of HIV infection.

Prisoners and prison staff often come from communities with high prevalence of infectious diseases, including HIV/AIDS [2]. Risk behaviors for HIV and other infectious diseases that begin in the community

often escalate during incarceration[2]. Evidence suggests that in Southern Africa unprotected sexual activity is the most prominent HIV risk behavior and responsible for the majority of infections, whereas sharing of razors, tattooing and piercing instruments and injection-drug use are less problematic [4, 5].

Rape and sexual aggression among prisoners as well as between prison staff and prisoners has received little attention in Southern Africa, although it is reported as a reality in prison. Few studies have documented the context in which sexual activity is occurring in prisons in Southern Africa.

Without this information, proposed HIV prevention interventions for Southern African prisons will be based on assumptions, which could lead to futile efforts in the face of an ongoing epidemic.

In Eastern Europe and Central Asia intravenous drug use is the key driver of the HIV epidemic [8].Overcrowding, poor ventilation, access to clean drinking water, and food are key problems in the prison settings in most of the countries at the epicenter of HIV and TB.

Overcrowding is an especially acute problem for many other infectious diseases. In the main prison in the Mozambican capital, Maputo, more than 2,000 men are incarcerated in a premises designed to hold a maximum 875 inmates. This situation is exacerbated by the near-total absence of means of protection like condoms, clean needles and syringes, ventilation, lighting, water and proper food. The high rate of deaths occurring in prisons in many prisons in Southern Africa is alarming: predominantly attributable to HIV co-infection with TB.

It will be critically important for global health advocates at the policymaking level to help define contextually relevant guidelines for how to manage TB/HIV among the incarcerated, that can be applied at the facility level. Current standards should be measured against international standards. Clear policies and guidelines are needed for guidance. Let HIV be the door-opener for further improvements of prison health.

Separate from the structural and population density problems are the challenges posed by poor hygiene standards and a shortage of harm reduction activities, leading to a gulf between most facilities and the international standard for prison care. There is an acute need for more qualified health care professionals to respond to the health needs in prison settings, as these are among the predominant barriers to access to services.

However, it is globally observed that government policies and legal implications regarding prevention modalities limit the scope of prevention activities (e.g. condom provision).

Many countries fail to link their programs in prisons to the national AIDS, tuberculosis or public health programs, leaving them isolated and without the ability to draw on existing national resources or even awareness campaign materials. Also many countries fail to provide adequate occupational health services to staff working in prisons.

To ensure best practice is observed by countries implementing Global Fund grants going forward, with a focus on this key population, the following recommendations have been made:

• Prompt detection of TB among prisoners should be ensured through a combination of screening methods (screening on entry, mass screening at regular intervals, passive screening, contact screening) based on clinical questionnaires, chest X-rays, smear microscopy and self-referrals.

• Drug susceptibility testing (DST) should be performed on all patients with treatment adapted to the resistance pattern to help further amplification of resistance.

• Effectiveness is improved when treatment is administered under the direct observation of health care

staff and in line with national TB program (NTP) guidelines.

• Adequate procurement, supply and management of quality medication and effective administration should
be in place. Airborne infection control, including protective measures for staff, should be ensured, and provider-initiated HIV counselling and testing to detect HIV and TB/HIV co-infected individuals should be
promoted to provide the necessary support and care.

• Continuity of care is imperative for released prisoners who are on treatment and for individuals who are on
treatment before entering the prison services.

• TB control is strengthened in prison-based programmes by raising awareness of TB among prisoners and prison
medical and non-medical staff through continuous educational activities.

• Operational research should be promoted to contribute to evidence-building for effectiveness.

From visits and assessments of prisons in Southern Africa and Eastern Europe it can be concluded that same-sex contacts are happening in various forms, as are risky behaviors with respect to intravenous drug use. Additionally, factors related to the prison infrastructure, prison management and the criminal justice system also contribute to vulnerability to HIV, TB and other health risks in prisons. These factors include violence, poor prison conditions, corruption, denial, stigma, lack of protection for vulnerable prisoners, lack of training for prison staff, and poor medical and social services [10].

Addressing HIV and TB in prisons effectively cannot be separated from broader questions of criminal justice and national policies. In particular, reducing the excessive use of pretrial detention and greatly increasing the use of non-custodial alternatives to imprisonment are essential components of any response to HIV/TB and other health issues in prisons.

UNODC/ILO/WHO/UNDP and UNAIDS developed a comprehensive package of interventions for “HIV prevention, treatment and care in prisons and other closed settings” [9]. The suggested interventions are evidence-based and have to be the basis for any funding in the prison setting. This package comprises of 15 key interventions, which should be reflected in any funding process:

1. Information, education and communication

2. Condom programs

3. Prevention of sexual violence

4. Drug dependence treatment, including opioid substitution therapy

5. Needle and syringe programs

6. Prevention of transmission through medical or dental services

7. Prevention of transmission through tattooing, piercing and other forms of skin penetration

8. Post-exposure prophylaxis

9. HIV testing and counselling

10. HIV treatment, care and support

11. Prevention, diagnosis and treatment of tuberculosis

12. Prevention of mother-to-child transmission of HIV

13. Prevention and treatment of sexually transmitted infections

14. Vaccination, diagnosis and treatment of viral hepatitis

15. Protecting staff from occupational hazards

Heino Stoever is a professor at the Bremen Institute of Drug Research, at the University of Applied Sciences in Frankfurt, Germany

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