Improving Provision of HIV & TB Services in Prison Settings in Sub-Saharan Africa

Guidelines

Guidelines for the Prevention of Mother to Child Transmission of HIV in Prisons

ADVANCE COPY

UNODC
United Nations Office on Drugs and Crime

Southern Africa

UNITED NATIONS OFFICE ON DRUGS AND CRIME

Regional Office for Southern Africa

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This initiative has been made possible through the support of:

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Glossary

AFB	Acid-Fast Bacilli
AIDS	Acquired Immune Deficiency Syndrome
ALT	Alanine Aminotransferase
ANC	Antenatal Care
APGAR	Appearance, Pulse, Grimace, Activity, and Respiration
ART	Antiretroviral Therapy
AZT	Zidovudine
BCG	Bacille Calmette Guerin
CBO	Community-Based Organisation
CD4	Cluster of Differentiation 4 glycoprotein
CG 001	Counselling Guidelines 001 Key Populations
CG 002	Counselling Guidelines 002 Psycho-Social Support
CG 003	Counselling Guidelines 003 HIV Testing & Counselling
CPT	Co-trimoxazole Preventive Therapy
CS 001	Counselling Standard Operating Procedure 001 Key Populations
CS 002	Counselling Standard Operating Procedure 002 Psycho-social Support
CS 003	Counselling Standard Operating Procedure 003 HIV Testing & Counselling
CTM 001	Counselling Training Manual 001 Key Populations
CTM 002	Counselling Training Manual 002 Psycho-social Support
CTM 003	Counselling Training Manual 003 HIV Testing & Counselling
CTX	Co-trimoxazole
DOT	Directly Observed Treatment
DR TB	Drug Resistant TB
DST	Drug Susceptibility Testing
EFV	Efavirenz
EID	Early Infant Diagnosis
ELISA	Enzyme-Linked Immunosorbent Assay
EPI	Expanded Programme of Immunization
FBC	Full Blood Count
FPD	Federation of Professional Development
FTC	Emtricitabine
GP 001	Guidelines HIV Preventative Commodities
GXP	GeneXpert test
Hb	Haemoglobin
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
ICF	Intensified Case Finding
IDU	Intravenous Drug Use
IEC	information, Education and Communication
IgG	Immunoglobulin G

IgM	Immunoglobulin M
ILO	International Labour Organisation
INH	Isoniazid
IPT	Isoniazid Preventive Treatment
KAP	Knowledge, Attitude and Practices
LPA	Line-Probe Assay
M&E	Monitoring and evaluation
MDRTB	Multidrug-Resistant TB
ML	Millilitre
MM^3	Cubic Millimetre
MMC	Medical Male Circumcision
MTCT	Mother to Child transmission (of HIV)
NGO	Non-Governmental Organisation
NSP	Needle Syringe Programme
NTCP	National TB Control Programme
NVP	Nevirapine
OST	Opioid Substitution Therapy
PEP	Post Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHQ-9	Patient Health Questionnaire 9
PITC	Provider-Initiated Testing and Counselling
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PrEP	Pre-Exposure Prophylaxis
PS 001	Standard Operating Procedure for Condom Provision in Prisons
PTM 001	Training Manual 001 HIV Preventative Commodities
RNA	Ribonucleic Acid
RPR	Rapid Plasma Reagin
SADC	South African Development Community
SEARO	South-East Asia Regional Office (of World Health Organisation)
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TasP	Treatment as Prevention
TAT	Turnaround Time
TB	Tuberculosis
TDF	Tenofovir Disoproxil Fumarate
TG 001	Treatment Guidelines 001 PMTCT
TG 002	Treatment Guidelines 002 TB/HIV Integrated Care
TG 003	Treatment Guidelines 003 ART
TS 001	Treatment Standard Operating Procedure 001 PMTCT
TS 002	Standard Operating Procedure 002 TB/HIV Integrated Care
TS 003	Treatment Standard Operating Procedure 003 ART
TTM 001	Treatment Training Manual 001 PMTCT
TTM 002	Treatment Training Manual 002 TB/HIV Integrated Care

TTM 003	Treatment Training Manual 003 ART
UN	United Nations
UNAIDS	Joint United Nations Programme on **HIV** and **AIDS**
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs & Crime
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation
XDR	Extensively Drug Resistant

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1. GENERAL

A. Introduction

These guidelines form part of a toolkit developed to support professionals, practitioners and peer workers providing HIV prevention, treatment, care and support services in correctional settings in Sub-Saharan Africa. The toolkits consist of guidelines, Standard Operating Procedures (SOPs) and training manuals.
Access to and provision of health care services in prisons is uniquely characterised by the security and risk environments, prison culture, often limited resources and restricted range of options for health service provision. While general guiding documents exist for HIV service provision, these are not responsive to the prison environment and cannot be applied one-to-one. The provision of services therefore has to be tailored to the unique characteristics of this environment, provide solutions for prison specific barriers and challenges to ensure access to health service that is equivalent to that available in the community.

This set of toolkits covers seven important areas in human immunodeficiency virus (HIV) and tuberculosis (TB) care in prison settings:

1. General Counselling for key populations in prison settings
2. Psycho-social Counselling & Support for people living with HIV in prison
3. Voluntary HIV Testing and Counselling (HTC) in Prison settings
4. TB/HIV collaborative activities, management and care in prison settings
5. Prevention of mother to child transmission (PMTCT) in prison settings
6. Antiretroviral Treatment (ART) services provision and care in prison settings
7. Provision of HIV Preventative Commodities in Prison settings

These toolkits were commissioned by the United National Office on Drugs and Crime (UNODC) as part of its Regional Programme on HIV and AIDS Prevention, Treatment, Care and Support in Prison Settings in Sub-Saharan Africa. The guidelines were developed on behalf of the UNODC, by a consortium comprising the Trimbos Institute (The Netherlands) and the Foundation for Professional Development (FPD, South Africa), and independent consultants.

The toolkits were developed in cooperative, consultative and inclusive process with experts, professionals and practitioners from relevant government institutions, prison and correctional services, international organisations and civil society organisations from the region. During a high-level meeting on HIV Service Provision in Prison Settings in November 2014, Commissioner Generals of Correctional Services and experts agreed on the need for these documents and in three consecutive thematic expert group meetings the expertise, experience and inputs of these regional experts was sought to ensure that the final documents are responsive to the local situation, while in line with international standards.

The guidelines address the needs among people working in prison settings for guidance and standard operating procedures, consistent with the legal framework of the correctional

services in each country, based on internationally agreed, effective and efficient interventions and standards.

These guidelines and SOPs are complemented by training manuals and curricula, and their national adoption, endorsement and implementation will be supported.

Coding of Guidelines, SOPs and Training Manuals

To express their function, the titles of project documents are coded using these letters:
C = Counselling
G = Guidelines
P = Prevention
S = Standard Operating Procedures
T = Treatment
TM = Training Manual

Letters are combined to describe a document, so: **CS** is a Counselling SOP, **CG** is a Counselling Guidelines document and **TTM** is a Treatment Training Manual

Acknowledgements

This document was commissioned by UNODC Regional Office for Southern Africa (ROSAF). For their contributions to the preparation of these Training Manuals, UNODC ROSAF would like to express their gratitude to the following:

- Trimbos Institute and Foundation for Professional Development Consultants, who developed and prepared the content and final text of the manuals: Franz Trautmann, John-Peter Kools, Heino Stöver and Margot Uys, Louise Badenhorst, Anton la Grange.

- UNODC staff members who contributed to the development of the manuals: Nthabeleng Motsomi-Moshoeshoe, Jason Eligh, Andreas Zeidler and Ehab Salah.

- All Experts who participated in the Expert Group Meetings and other consultations carried out during the development of these manuals. These were representatives from Angola Prisons Service, Federal Prisons Administration of Ethiopia, Lesotho Correctional Service, Malawi Prisons Service, Serviço Nacional Penitenciário de Moçambique, Namibian Correctional Service, Department of Correctional Service of the Republic of South Africa, His Majesty's Correctional Service - Swaziland, Tanzania Prisons Service and Zanzibar Correctional Facilities, Zambia Prisons Service and Zimbabwe Prisons and Correctional Service. Representatives of the Civil Society Organisations from Malawi, Zambia, and Zimbabwe. Representatives from the National AIDS Commission and Ministry of Health in Lesotho, Zambia and Zimbabwe.

- The names of participating members of the expert group meetings are listed in the annex.

B. The Context

1. Background

Sub-Saharan Africa is facing the most serious HIV and AIDS epidemic in the world. In 2012, approximately 25 million of its inhabitants were living with HIV, accounting for nearly 70 percent of the global total. In the same year, there were an estimated 1.6 million new HIV infections and 1.2 million AIDS-related deaths[1]. The epidemic has had widespread social and economic consequences, not just in the health and social sectors, but also education, industry and the wider economy.

Many members of key populations at higher risk[2], such as prisoners, report having had no contact with HIV prevention programmes in the past 12 months. Far greater prevention programme coverage will therefore be required for many target groups, including people in correctional settings[3].

Because prison populations are often composed of individuals confronted by greater HIV risk factors than the general population, HIV and AIDS are significant health threats to prison populations and prison staff. For prisoners in some settings the HIV burden may be up to 50 times higher that of the general population[4]. Risk factors for tuberculosis (TB), hepatitis A, B and C, and sexually transmitted infections (STIs) are also greater for incarcerated individuals than for members of the wider population. These infections tend to exacerbate one another, 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, and a major cause of death in prisons. As a result of these factors, HIV/AIDS represents a significant challenge to the prison and governmental authorities at local and national levels.

Unprotected sex, multiple sexual partners, low and inconsistent condom use, intravenous drug use incorporating the sharing of syringes, needles and drug use paraphernalia, tattooing and body piercing are among the principal drivers of the global HIV epidemic[4]. Prisoners comprise a key vulnerable population contributing to the epidemic[5].

The South African Development Community (SADC) region is at the epicentre of the global HIV and tuberculosis (TB) epidemics. The 2009 SADC HIV Epidemic Report evidenced that 10 of the 15 SADC member states have high HIV prevalence. TB prevalence rates in these same member states ranged from 300 to 1000 cases per 100 000 of population; the global 2009

1 UNAIDS, Global Report 2013.
http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

2 Definition of key populations at higher risk (both key to the epidemic's dynamics and key to the response). Key populations are distinct from vulnerable populations, which are subject to societal pressures or social circumstances that may make them more vulnerable to exposure to infections, including HIV. (UNAIDS Terminology Guidelines, October 2011)

3 UNAIDS, *Fast-Track. Ending the AIDS Epidemic by 2030*. UNAIDS, 2014, p. 10
http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf

4 UNAIDS, *The Gap Report*, 2014, p. 21
http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf

5 Jürgens R, Ball A, Verster A. Interventions to reduce HIV transmission related to injecting drug use in prison. Lancet Infectious Diseases. 2009;9(1):57–66.

TB prevalence rate was 139 cases per 100 000. Sexually transmitted infections (STIs), especially genital ulcer infections, are known to increase the risk of HIV transmission. Prompt and effective treatment of STIs can therefore reduce individual risk of HIV infection. This makes high-quality STI programmes critical to the containment of the HIV and AIDS epidemic, especially within key populations that face a higher risk of exposure to HIV.

Overall challenges and gaps in the field of HIV/TB in Sub-Saharan African prisons may be summarised as follows:

- High rates of imprisonment leading to severe overcrowding and unhealthy prison conditions;
- High HIV prevalence rates among the general population;
- Presence of high risk and vulnerable populations in prisons, including women and children;
- Prevalence of high risk behaviours for the transmission of HIV in prison settings;
- High prevalence rates of HIV infection and other related infections (TB, Hepatitis, sexually transmitted infections) among the prisoner population;
- Increased staff vulnerability to HIV and TB;
- Poor or inadequate and inaccessible health services in general;
- Structural/cultural barriers to the provision of HIV prevention commodities in prison settings;
- Inadequate and dilapidated infrastructures.

Cramped conditions increase the risk of infection. SADC prison settings are generally overcrowded with an average incarceration rate of 157 per 100,000 inhabitants, and occupancy levels averaging 138%[6]. Evidence shows[7] that an overpopulated prison is a high risk environment for disease transmission, in addition to challenging the provision of adequate health services. Overcrowding reduces the adequacy and quality of ventilation. Moreover, prison sanitation systems are overstretched and prone to breakdown, resulting in unhygienic living conditions. Overcrowding and poor ventilation facilitate the spread of airborne disease such as TB. High rates of HIV co-infection (TB/HIV) as well as multi-drug resistant TB have been reported in prison settings in SADC[8].

Access to HIV prevention, treatment, care and support for people in detention is, therefore, a crucial element of any national HIV response.

[6] SADC (2009): Assessment Report on HIV and AIDS, Tuberculosis, Hepatitis B and C, and other Sexually Transmitted Infections in Prison Settings in the SADC, p. 7 http://www.sadc.int/files/6314/1171/8815/Assessment_Report_on_HIV_and_AIDSTuberculosis_Hepatitis_B_and_C_andother_Sexually_Transmitted_Infectionsin_Prison_Settings_in_the_SADC.pdf

[7] HIV in places of detention: a toolkit for policymakers, programme managers, prison officers and health care providers in prison settings. New York: United Nations; 2008. [8 October 2015]. http://www.unodc.org/documents/hiv-aids/V0855768.pdf

[8] Communicable Diseases Project/Directorate for Social and Human Development and Special Programmes. MINIMUM STANDARDS FOR HIV AND AIDS, TB, HEPATITIS B AND C AND STIs PREVENTION, TREATMENT, CARE AND SUPPORT IN PRISONS IN THE SADC REGION – November 2011

Prisoners are part of society and will return to society at the completion of their sentence. Health and prevention in prison settings is a public health issue that has not been given due consideration by Public Health Agencies[9]. The vast majority of people in prison settings will eventually return to their communities. Any diseases contracted in closed settings, or made worse by poor conditions of confinement, become matters of public health[10].
In addition to access to HIV prevention, treatment, care and support for people in detention, integrated HIV/TB services, incorporating early diagnoses and timely prophylaxis, are crucial elements of any national response to HIV and TB.

The HIV epidemic is being curbed in many countries in the Sub-Saharan Africa region and UNAIDS is urging countries to take a next step in their response to HIV and to raise their treatment targets. The current ambition is 'Towards ending the epidemic' and countries are urged to increase their prevention, testing and treatment programmes so as to reach this goal. The current UNAIDS ambition is called 90-90-90: By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression. By 2030 AIDS should be ended[11].

The TB notification rate in prison settings ranges from 11 to 81 times higher than the general population. The situation is worsened by the emergence and spread of drug-resistant TB, particularly extensively drug-resistant (XDR) TB[12,13]

Prisoners are mainly sexually active males aged between 19 and 35, which places them at high risk of HIV infection. Rape and sexual aggression among prisoners as well as between prison staff and prisoners have received little attention in Sub-Saharan African countries[14] , although they are reported as a genuine problem in prison systems in many other countries across the world.

Prisoners and prison staff often come from communities with high prevalence of infectious diseases, including HIV/AIDS[15]. Risk behaviours for HIV and other infectious diseases that

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[9] Stöver, H.; Knorr, B.; Weilandt, C. (2006): Prison Health is Public Health. In: International Journal of Prisoner Health Vol. 2 Iss 2 pp. 151 - 152

[10] See, e.g. World Health Organization, Regional Office for Europe, Declaration on Prison Health as Part of Public Health, adopted at the joint World Health Organization/Russian Federation International Meeting on Prison Health and Public Health, held in Moscow on 24 October 2003. See also: The Madrid Recommendation: Health Protection in Prisons as an Essential Part of Public Health, adopted at a meeting held in Madrid on 29 and 30 October 2010. Available from www.euro.who.int/__data/assets/pdf_file/0012/111360/E93574.pdf.

[11] http://www.unaids.org/en/resources/documents/2014/90-90-90

12 Mukadi, Y.D., D. Maher, and A. Harries, Tuberculosis case fatality rates in high HIV prevalence populations in Sub-Saharan Africa. Aids, 2001. 15(2): p. 143-152.

13 Stöver, H. (2014): How to improve HIV/TB prevention, treatment and care in prisons. In: Aidspan. Independent observer of the Global Fund. 31 October 2014; http://aidspan.org/gfo_article/how-improve-hivtb-prevention-treatment-and-care-prisons

14 Communicable Diseases Project/Directorate for Social and Human Development and Special Programmes. MINIMUM STANDARDS FOR HIV AND AIDS, TB, HEPATITIS B AND C AND STIs PREVENTION, TREATMENT, CARE AND SUPPORT IN PRISONS IN THE SADC REGION – November 2011

15 Jürgens, R., M. Nowak, and M. Day, HIV and incarceration: prisons and detention. Journal of the International AIDS Society, 2011. 14(1): p. 26.

begin in the community often escalate during incarceration. Evidence suggests that in Sub-Saharan Africa unprotected sexual activity is the most prominent HIV risk behaviour and responsible for the majority of infections, whereas the sharing of razors, tattooing and piercing instruments and injecting drug use are generally less problematic[16,17]

These guidelines provide relevant guidance that can be applied at facility level to help manage TB/HIV among prisoners and prison staff. Current standards should be measured against international standards. Clear policies, guidelines and SOPs are needed for guidance.

Like all persons, prisoners are entitled to receive the highest attainable standard of health care. This right is guaranteed under international regulation: access to health care should be at least equivalent to that provided in the community, in accordance with the United Nations Standard Minimum Rules, which state that, "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[18]

The provision of high quality medical care, coupled with decent living conditions, facilitates the well-being of both prisoners and prison staff. It should be the objective of prison management that prisoners leave prison in a similar or better state of health than on the day they entered.

The full range of health needs of prison staff should also be addressed. Consideration must be given to the increasingly complex social and psychological demands that prison settings place on staff. Among the problems people who work in prison settings currently face are overcrowding, intercultural conflicts, within-prison gang crime, language issues, drug use, poor environments, frequent instances of staff shortages and inadequate professional training. Additionally, prison staff members are at risk of exposure to serious infectious diseases such as TB. Staff members are frequently subject to the threats of violence, are confronted with desperate situations and have to manage their own stress in addition to the distress of others. People working in prison settings also face stigma, and in several countries a military style prison service, incorporating obligatory relocation (with or without family) and barrack accommodation, compounds psychological stress and increases vulnerability to infectious diseases and other health risks. This might lead to compensation phenomena such as burnout, alcohol and drug use, depression and inability to come to terms with traumatic workplace experiences. On-going prevention and care interventions for prison staff must therefore be kept in mind when designing measures to improve health in prison settings.[19]
A thorough implementation of the guidelines and related Standard Operational Procedures (SOPs) will help to increase the quality of health care and service delivery in prison settings, and will improve the above-mentioned aspects of occupational health and the working

16 Simooya, O.O., et al., 'Behind walls': a study of HIV risk behaviours and seroprevalence in prisons in Zambia. Aids, 2001. 15(13): p. 1741-1744.
17 Goyer, K. and J. Gow, Transmission of HIV in South African prisoners: Risk variables. Society in Transition, 2001. 32(1): p. 128-132.
18 Principle 9 of the Basic principles for the treatment of prisoners, United Nations General Assembly. A/RES/45/111, 1990;http://www.ohchr.org/Documents/ProfessionalInterest/basicprinciples.pdf, accessed 8 October 2015
19 Bögemann, H. (2007): Promoting health and managing stress among prison employees. In: WHO Europe (ed.): Health in prisons. A WHO guide to the essentials in prison health, pp 171-179. Copenhagen; http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf (accessed 8 October 2015)

environment of prison staff. Ultimately, both prisoners and prison staff benefit from good prison health.

Health services in prisons differ from community health services in a number of fundamental ways:

1. Restricted funding means that health services in prisons may be poorer than those provided in the community. In extreme circumstances, a prison may have no prison healthcare service at all.
2. Limited opportunities for professional development can lead to outmoded or incorrect clinical practices.
3. The primacy of security in the organisation and operation of a prison means that prisoners are at times unable to access the healthcare service in their prison, and that healthcare staff are sometimes unable to attend to and monitor patients.
4. Several departments have responsibilities towards prisoners (security or correctional/prison and health) and communication is often lacking
5. The pressured working environment can make recruitment and retention of clinical staff a problem
6. Patients undergoing HIV or TB treatment may be transferred in and out of a prison at very short notice. This makes crucially important continuity of treatment more problematic in prisons than in community settings
7. Stigma and discrimination can result in vital harm reduction services either being unavailable (due to a prevailing unenlightened prison ethos) or underutilized (on account of patients' fear of judgement or intimidation).
8. Endemic overcrowding and poor sanitary conditions make many prisons injurious to (rather than conducive to) good health. TB is a specific danger in prisons, to staff as well as prisoners
9. Increased frequency of injecting drug use and of men having sex with men heighten the risk of HIV transmission in prison
10. Local prison rules or national laws often ban the provision of HIV preventative measures that are available in the local community, such as condom provision and needle and syringe exchange services.

To address these challenges, HIV services for prisoners should be designed and developed by a prison project team that includes a senior prison manager, the head of healthcare, a service user representative, and an NGO representative. The Trimbos/FPD Standard Operating Procedures and Guidelines have been developed to be used as the basis for planning prison HIV services that can be practicably delivered while meeting the security and operational needs of the prison. The principles upon which this work should be done, incorporating international declarations, are set out in Section 2 (below), *Guiding Principles.*

2. Guiding Principles

These guiding principles provide standards from a public health perspective that prison services in all countries should strive to achieve within the field of HIV and TB prevention, treatment and care in prison settings. These guiding principles are particularly important for high-burden TB/HIV co-infected countries[20]:

a) All prisoners have the right to receive health care, including preventive measures, equivalent to that available to the general population of their country without discrimination, especially with regard to their legal status.
b) The general principles and procedures of every country's national AIDS programmes should apply equally to prisons and the community.
c) Preventive measures should address risk behaviours that are known to occur in prison settings e.g. unprotected sexual contacts, needle sharing, tattooing etc.
d) Each country should have specific, detailed policies for the prevention of HIV/AIDS in prison settings and for the care of HIV-infected prisoners. The policies applied in prison settings should be developed through close collaboration between national health authorities, prison administrations and community services, including non-governmental organizations (e.g. organisations that represent the rights of prisoners). These policies should concentrate on prisoners and prison staff. Both groups should participate in the development and application of effective prevention measures, dissemination of information and the combatting of discrimination. These strategies must be incorporated into a wider programme of promoting health amongst prisoners.
e) The needs of prisoners and others in the prison environment should be taken into account when planning national HIV/AIDS programmes and distribution of human resources.
f) The non-discriminatory, humane, and gender-sensitive care of HIV-infected and TB prisoners are prerequisites for the construction of a credible strategy for preventing HIV and TB transmission.
g) Prisoners should have access to medical treatment and preventive measures without discrimination related to their legal status. Health in prison is a right enshrined in international law and international rules, guidelines, declarations and covenants. The right to health includes the right to medical treatment and to preventive measures as well as to standards of health care at least equivalent to those available in the community. Access to health services in prison settings should be consistent with medical ethics, national standards and guidelines. Similarly, prison staff members need a safe workplace and have a right to genuine protection and adequate occupational health services[21].

[20] Based on WHO's Guidelines on HIV infection and AIDS in Prisons

[21] UNODC, ILO, UNDP, WHO, UNAIDS (2013): HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. http://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf (accessed 8 October 2015)

h) Prison policy, legislation, and programmes should be based on empirical evidence for their effectiveness at reducing the risks of HIV and TB transmission, and improving the health of prisoners[22].

Equivalence of prevention, treatment, care and support can best be achieved via the integration of community and prison services. Integration ensures that poor coordination, discontinuity of care and duplication of efforts are avoided wherever possible. In some countries responsibilities for health in prison and health in the community are divided between separate government departments. In such circumstances a joint strategic approach agreed by these separate departments will be essential to the cohesion of disciplinary/operational functions and health services in prison settings.

HIV and TB programmes must involve contribution from civil society, including the public sector, to create high quality services to targeted groups in the prison setting. Relevant non-governmental (NGOs) and community-based organisations (CBOs) can assist with planning, implementation and evaluation of comprehensive HIV services in prison settings and other detention facilities or secure hospitals; they can also facilitate the participation of prisoner representatives or former prisoners at every stage.

Interventions for the prevention of HIV/AIDS and TB, and treatment, care and support for these diseases in the prison setting should be designed as both evidence-based and target-group specific. Evidence-informed planning involves the prioritising of interventions with the highest proven beneficial impact and the targeting of these interventions on the locations and populations where they will have most effect.

In 2013 the UNODC/ILO/UNDP/WHO and UNAIDS developed a 'Comprehensive Package' on "*HIV prevention, treatment and care in correctional settings and other closed settings: a comprehensive package of interventions"* which contained 15 key interventions:

1. *Information, education and communication*
2. *Condom programmes*
3. *Prevention of sexual violence*
4. *Drug dependence treatment, including opioid substitution therapy*
5. *Needle and syringe programmes*
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*

[22] UNODC/WHO-Regional Office for Europe (2013): Good governance for prison health in the 21st century. A policy brief on the organization of prison https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/Good-governance-for-prison-health-in-the-21st-century.pdf (accessed 8 October 2015)

14. Vaccination, diagnosis and treatment of viral hepatitis
15. Protecting staff from occupational hazards

These 15 interventions are essential to the scaling up of prevention, treatment and care of HIV and other infectious diseases in prison and other closed settings. The purposes of concentrating on these activities are to:
(i) Share practical experiences across all 15 above-mentioned interventions;
(ii) Identify barriers and obstacles to the implementation of these interventions; and
(iii) Identify and share models of good practice.

These activities require stakeholders from the Ministries of Justice/Health, prison administration and key prison personnel to join with representatives of NGOs and civil society working in custodial settings to find solutions to the identified problems in the 15 focus areas. The intention is to take a practical-level perspective and assist prison authorities as well as civil society/NGOs to further scale up HIV prevention, treatment, care, and support in correctional settings. As already stated, overcrowding makes prisons an ideal breeding ground for the transmission of TB and Drug Resistant TB (DR TB). Lack of effective infection control measures and structural limitations play an important role in perpetuating airborne disease transmissions in prisons. To successfully address HIV, countries where injecting drug use occurs should prioritise the implementation of Needle Syringe Programmes (NSPs) and evidence-based drug dependence treatment (specifically Opioid Substitution Therapy (OST)), HIV testing and counselling, and access to anti-retroviral therapy.

All prison counselling work, particularly work that involves an issue as sensitive as HIV in prisons, should be undertaken within a Code of Ethics that governs the conduct of counsellors and prison staff. More detail on this subject may be found in Guidelines CG_003, HIV Testing & Counselling

3. Structural Problems to be addressed

In addition to the interventions suggested in the previous chapter, which focused on changes in individual behaviour, structural problems of health in prison settings need to be tackled, especially those that have an impact on infectious diseases. Parallel to efforts that address individual risk behaviour, the prison setting needs to be scrutinised in order to improve the overall structure for delivery of services.

- Confidentiality needs to be guaranteed in all aspects of health-related work, especially regarding HIV and AIDS in prison facilities. However, the legal parameters for consent (e.g. limitations) may differ between countries and must be taken into account.
- Pre-trial detention should be minimised via the use of alternatives to imprisonment and improvement in the efficiency of criminal justice systems
- Custodial sentences for young people should be avoided, except as last resort[23].

[23] UNODC Global Consultation on HIV Prevention, Treatment, Care and Support in Prison Settings, 16-17 October 2014, Vienna. Summary and Conclusions

- Overcrowding is a key challenge, often in combination with insanitary conditions and shortage of harm reduction activities. These factors lead to standards of facilities and services in many prisons that fall significantly short of those set out in international guidelines for prison care
- Among other instances (e.g. against sex workers and drug users), stigma and discrimination towards men who have sex with men remains high, posing a substantial challenge to the delivery of prisoner-friendly health services. Stigma and discrimination contribute to the spread of HIV infection and are a threat to the lives of HIV-infected people[24]. The criminalisation of sex between men in the community and in prison settings poses a particular challenge to HIV-related services. An effective national response is achievable, but this does require significant cooperation from all relevant stakeholders in order to ensure that HIV and AIDS services are available to all men who have sex with men, notwithstanding criminalisation of homosexuality.
- There are other legal barriers to effective HIV programming among prisoners that exacerbate their vulnerability to HIV (e.g. illegality of injecting equipment or condoms). Interventions should address both structural and behavioural aspects of the epidemic, locating evidence-informed interventions in their proper context, while addressing key populations.
- As stated earlier, it is important to involve prisoners in the planning and delivery of HIV interventions and programmes. With the consent of all concerned, members of the prisoner's family should also be involved, in order to support all HIV-related issues. This applies equally to TB, as once released, the prisoner will return to the community and may transmit any airborne disease that has not been effectively treated in prison settings.
- There is an acute need for more qualified health care professionals to respond to the health needs in prison settings, as shortage of skilled clinical staff is one of the most significant barriers to the availability of quality services.
- Strategic planning should ensure the sustainability of interventions, including financial, material and human resources, community ownership, organisational development, service availability, coverage and accountability.
- The principle of human rights necessitates that laws, policies, and education programmes always safeguard the right to access health services, to receive such services via informed consent, and to have protection under the law, particularly for those living with HIV and key populations. Human rights are safeguarded through the promotion of a gender-based HIV strategy that has been designed to remove all impediments to HIV services. This approach would include review and enhancement of the legal, policy, and social elements that encourage access for under-served and vulnerable populations. The human rights of people living with HIV are also preserved via their meaningful engagement in the planning and implementation of interventions, securing their active leadership and feedback in an atmosphere free of stigma and discrimination.

[24] The Vienna Declaration: http://www.viennadeclaration.com/2010/06/the-vienna-declaration-a-global-call-to-action-for-science-based-drug-policy/ Accessed 24.10.2015

- The pervasive detrimental influence of gender discrimination and gender-based violence within penal systems must be recognised and addressed by all HIV programmes. Gender inequality and gender-based violence, sexual assault and rape, to which women and young people in prison and other closed settings are particularly vulnerable, contribute to HIV infection and TB transmission. Inequality of power between men and women leads to violation of women's and girls' rights, restriction of freedom among women and girls to negotiate for safer sex including condom use, sexual assault and rape. The most common forms of gender-based violence are physical, sexual, psychological and economic, including financial deprivation and exploitation. All HIV programme activities need to address the disparities that result from gender discrimination and gender-based violence, and comprehensive sexual and gender education are required at every level of HIV programmes.

Monitoring and evaluation (M&E) of the responses to HIV and AIDS and TB amongst prisoners is critical. M&E activity should generate reliable data that are widely shared among stakeholders and are translated into improved evidence-based interventions and the timely, effective resolution of problems related to service delivery. Information from the prison setting should be integrated within a national database, to inform comprehensive health policy and planning. Research has shown that close cooperation between prison and the community contributes to the effective management of both TB and HIV. This can only be achieved if reliable and accurate data are available to inform planning and practice.

Annex: Participating Experts

Surname	First Name
Ala	Grange
Ali	Ali Abdalla
Ashipala	----------
Badenhorst	Louise
Belay	Mergesa Bekele
Bernardino	Rotafino
Booi	Roeleen
Botha	Francis
Britz	Norman
Byabashaija	Johnson
Chifamba	Dickson Dick
Chileshe	Chisela
Chirenda	Joconiah
Chrispine	Moyo
Dala	Florindo Manuel
Dhlamini	Roy
Dlamini	Thembi Hanna
Dlamini	Makhosazana Rosemary
Dlamini-Nqeketo	Sithembile
Dube	Alford
Edgar	Songanga
Ehab	Salah
Eligh	Joseph
Eligh	Jason
Farirai	Thato
Gaillard	Carmel
Gaka	Evidence
Gebretsadik	Alemu Asgedom
Gwashure	Susan Charity
Hamdu Omar	Haji
Hamunyela	Raphael Tuhafeni
Hangula	T.
Hassen	Abdi Mumed
Henostroza	German
Honwani	Jospeh
Jomane Makamohelo Joyce	Makamohelo Joyce
Kaggwa	Med SK
Kanyerere	Henry Shadreck
Kaonga	Chrispin
Koetle	Tanki
Kools	John Peter

Kueyo	Theopolina Mekondjo
Lekomola	Simon
Letsie	Letsie
Letsie	Puleng
Levi	Owen
Lukhele	Khanyisile Lucia
Mabe	Miriam
Mabena	Maria
Mabeo	Mamosethle
Mabhele	Simphiwe
Magwende	George
Mahao	Matele
Mahloane	Motsentsi
Maile	Limpho
Makhalemele	Matefo
Makungu	Seif Maabadi
Malefane	Malefane
Malefane	Motlatla
Malembeka	Godfrey
Malewa	Juma Alli
Malumo	Derrick
Manhica	Ivan
Manuel	Maria Cacilda
Masache	Macdonald Thomson
Matyayi	Augustinus
Mkingule	Abdilatif Wenceslaus
Mncina	Alfred
Moabe Anli	Cremelde Alice da Silva
Moeno	Kabp
Mohoang	Moeti
Molapo	Teboho
Mopeli	Pasholi
Moshoeshoe	Makholu
Mosisa	Helema Bekele
Motah	Sagar
Motosomi-Moshoeshoe	Nthabeleng
Motsa	Anne Takhona
Moyo	Rhodes
Mselem	Rashid
Mumbauer	Alexandra
Mundjulu	Matias
Musanha	C.
Musanhu	Christine Chiedza
Musukwa	Bright Charles Josephy

Namhindi	Johannes
Ndindi	Henry Emmanuel
Nembaware	Joseph
Ng'omang'oma	Lucius
Ngwenya Thabo Zwelethu	Ngwenya
Nhantumbo	Clementina
Nkhoma	Kennedy Alex Laudesi
Nxumalo	Thokozile Mabel Nohlanhla
Nxumalo	Vusi
Nyamwanza	B.
Nyarugoye	Priscilla
Pamodzi	----------
Pelepel	Hape
Phamotse	Akim
Phiri	Manasseh
Ponde	Teclah
Roto	Limpho
Rugamba	Wilson Emmanuel
Saila	Ernest
Santos	Manuel Pereira Freire Dos
Scout	Phoka Joseph Kheekhe
Seaketso	Winnie
Sepetla	Tlai-Tlai
Shaalulange	Sam Tukondjela
Shalihu	Nauyele
Shongwe	Lindiwe
Shumab	Mambewu
Shumba	Mambeu
Simba	Mashizha
Simwanza	Chali
Sinde	Ibrahim Emmanuel
Songanga Edgar Jamba Martins	Edgar Jamba Martins
Stöver	Heino
Tafadzua	Sekeso
Teklemariam	Ato Mebrate
Tembo	Susan
Thabane	Nkepile
Tlelai	Matsotetsi
Trautmann	Franz
Uys	Margot
Witola	Harold
Xaba	Sinokuthemba
Yotam	Lungu
Yussuf	Ayoub

Zeidler	Andreas
Zimondi	Paradzayi Willings

2. THE GUIDELINES

A. Introduction

1. General

The needs of women held in prison have received little attention worldwide and continue to be neglected by health systems and prison authorities, including those of Sub-Sahara African countries. One reason for this neglect is that women prisoners are a clear minority group within prisons – only approx. 4-5% of the world's prison population are female. However, the female prison population levels have grown much faster than male prison population levels since around the year 2000, with the number of women and girls in prison increasing by 40-50% in the past 15 years. [25] Partly this increase has been explained by the rising involvement of women in drug trafficking. It is only recently that attention has been drawn to the fact that a minority status does not justify widespread ignorance of women's basic rights and the considerable gender insensitivity still dominant within criminal justice systems.

Because their rate of offending is significantly lower than male's, proportionally fewer of the offences they commit involve violence, and they tend to receive shorter prison sentences than males for similar categories of offence[26], there is a relatively small percentage of females in prisons; globally, 4.5% of the prison population is female[27]. In African countries female prisoners comprise between 1% percent (in Zambia) and 10.9 % (in South Sudan) of the total prison population – healthcare services are often insufficient to meet the healthcare needs of these women. At present the health needs of women in prisons – including ante and prenatal care, prevention of mother-to-child transmission (PMTCT) of HIV, and nutritional support during pregnancy and breastfeeding – are not adequately met in many prisons. The responsible Ministries, prison administrations, prison governors, and medical units have, therefore, to ensure that female prisoners' health needs are met satisfactorily and are in line with community services.

The psychological impact of incarceration for women is massive, encompassing damage to family structures, feelings of depression and loss, and guilt around unmet obligations to provide for their children. Unlike male prisoners, women are often isolated while in prisons; many have to care for the children alone, or are single mothers.

Typically, women in prison are young and many are mothers whose children either live in prison with them or are cared for by others outside. They may be pregnant or may even become pregnant during imprisonment; some give birth while in prison.

[25] http://www.prisonstudies.org/news/more-700000-women-and-girls-are-prison-around-world-new-report-shows

[26] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380090/women-cjs-2013.pdf

[27] http://www.prisonstudies.org/sites/default/files/resources/downloads/wfil_2nd_edition.pdf

Women in general, but also pregnant women in prisons, are especially vulnerable to sexual abuse, including rape. The risks of gender-based violence are particularly high when women are detained in facilities adjacent to or within male prisons, or when women's quarters are supervised by male prison staff. Women are also susceptible to sexual exploitation and may engage in sex in exchange for goods such as food, cigarettes, drugs and toiletries. In the case of sexual violence, all women should have access to the full range of emergency services, including emergency contraception, post-exposure prophylaxis and support[28].

Healthcare workers, prison officers and prisoners should be aware of the effects of stigma and discrimination upon every aspect of pregnancy and childbirth, including the handling of the delivery of babies born to HIV-positive mothers.

Ante-natal and post-natal care must reflect the substantial dilemmas that women in prisons face when deciding whether or not to share their HIV status with their sexual partners, family members and others. ART requires life-long adherence and is unlikely to be sustained in an unsupportive relationship. Hence, PMTCT programmes should not be limited to testing and treatment, but must also include ongoing counselling and other supportive initiatives prior to, during and after disclosure, to help women address negative events whenever these occur. Women should also be counselled thoroughly on how to manage expectations and potential negative reactions in the event of partners testing positive.

2. Progress among pregnant women and children

In 2012, over 900,000 pregnant women living with HIV globally accessed PMTCT services - a coverage of 62 percent. Four priority countries, (Botswana, Ghana, Namibia and Zambia), had achieved 90 percent PMTCT coverage.[29]

In the same year, 58 percent of pregnant women living with HIV received ART for their own health, compared with 64 percent of all adults. In many countries, less than half of HIV-positive pregnant women with a CD4 count under 350, (the threshold for ART initiation under the 2010 WHO treatment guidelines), received ART for their own health. Indeed, HIV prevention for pregnant women varies greatly between regions, with over 90 percent accessing these services in Eastern and Central Europe and the Caribbean compared to less than 20 percent in Asia and the Middle East and North Africa (MENA).[30]

However, the global gap between the provision of ART for pregnant women and for all adults is closing[31].
Between 2001 and 2012, new HIV infections among children fell by 52 percent. There were still, however, an estimated 260,000 new HIV infections among this group in 2012[32].
An even bigger gap in ART provision exists for children living with HIV. In 2012, only 34 percent of under 15s living with HIV received ART - nearly half the ART coverage for adults. Only 30 percent of eligible children in priority countries received HIV treatment. Low

[28] See "Sexual Assault Kit" in South Africa – www.
[29] WHO (2013): Global Report 2013
[30] WHO (2013): Global Report 2013
[31] WHO (2013): Global Report 2013
[32] WHO (2013): Global Report 2013

ART coverage among children is mainly due to low levels of early infant diagnosis (EID) of HIV, with three priority countries reporting EID coverage of less than 5 percent.[33]

These background data make it clear that in order to meet the target of reducing new HIV infections among children by 90 percent by 2020, additional efforts in PMTCT and EID services are needed. These MDG goals have now been replaced by 90-90-90 strategy of UNAIDS; 90% of all people living with HIV knowing their status, 90% of HIV-positive people on ART, and 90% of those on treatment virally suppressed[34]. PMTCT programmes need to be expanded significantly to reach these goals.

3. Factors determining the effectiveness of PMTCT programmes

Knowledge of personal HIV status and of the attendant risks of MTCT is vital for pregnant women to access the appropriate treatment and care for themselves and their unborn infants. Ignorance of their HIV status acts impedes women from taking up PMTCT services. Women in prisons often present late to ante-natal care (ANC) or may first present when in labour, without any previous ANC. Consequently, they access PMTCT interventions at a very late stage. Additionally, women in prisons often face specific challenges to follow-up interventions postpartum: Separation from community maternity and generic healthcare services, breaks in continuity of care related to transfers between prisons or between prison and the community. These difficulties can have adverse consequences for their own health and that of their infants, and can decreases the effectiveness of PMTCT interventions. Prison health staff can prevent late presentation by ensuring timely health education of all women prisoners, and by providing pregnancy tests to all women of child-bearing age entering a prison. Detailed strategies need to be developed to promote and support earlier attendance at ANC by pregnant women in prisons.[35]

In resource-poor settings, and especially in many prisons in Sub-Saharan African countries shortages of staff attending to women, interruptions in supplies of medical equipment, breaks in treatment, a lack of privacy in counselling settings and a shortfall in counselling services all act as barriers to the uptake of PMTCT services. These factors often result in increased waiting times for post-test counselling. Women may therefore leave prison before receiving their HIV test results.

Poor monitoring of PMTCT services by healthcare workers also leads to poor retention in care.

Special efforts should be made to understand and overcome barriers to access and to provide acceptable PMTCT services that reach all adult and adolescent females from key populations. Healthcare workers simply introducing the subjects of HIV testing and PMTCT can result in women realising their importance and requesting these services.

[33] WHO (2013): Global Report 2013

[34] UNAIDS (2015): Fast-Track Targets. http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf (accessed 12 November 2015)

[35] WHO (2014): CONSOLIDATED GUIDELINES ON HIV PREVENTION, DIAGNOSIS, TREATMENT AND CARE FOR KEY POPULATIONS, p. 65

4. A comprehensive approach to PMTCT

Effective PMTCT programmes require women and their infants to receive a cascade of interventions including uptake of ante-natal services and HIV testing during pregnancy, entry to antiretroviral therapy (ART) by pregnant women living with HIV, safer childbirth practices, appropriate infant feeding, uptake of infant HIV testing, and other post-natal healthcare services.[36]

Special consideration should be given to ensuring that pregnant female prisoners have ready access to PMTCT services, as women often face greater barriers to HIV testing, counselling, care, and treatment in prison than outside prison.[37]

The World Health Organisation (WHO) promotes a comprehensive approach to PMTCT programmes which includes:

- Prevention of new HIV infections among women of child-bearing age
- Preventing unintended pregnancies among women living with HIV
- Preventing HIV transmission from a woman living with HIV to her baby
- Providing appropriate treatment, care and support to mothers living with HIV and their children and families[38]

The consolidated WHO guidelines on PMTCT (2014) include recommendations for providing lifelong antiretroviral treatment (ART) to pregnant and breastfeeding women living with HIV for the prevention of mother-to-child transmission (PMTCT)[39].
These guidelines recommend two options for pregnant and breastfeeding women living with HIV:

- All pregnant and breastfeeding women living with HIV should initiate triple antiretrovirals (ARV), which should be maintained for at least the duration of risk of mother-to-child transmission. Women meeting treatment eligibility criteria should continue ART for life (CD4 <500 cells/mm3)
- For programmatic and operational reasons, particularly in generalized epidemics, all pregnant and breastfeeding women living with HIV should initiate ART and maintain it as lifelong treatment (this recommendation is favoured in the WHO (2015) consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection[40]).

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[36] Padian, N.S. et al (2011) ' HIV prevention transformed: the new prevention research agenda' Lancet 378(9787):269-278 - See more at: http://www.avert.org/prevention-mother-child-transmission-pmtct-hiv.htm#footnote3_66o7ete

[37] WHO (2014): CONSOLIDATED GUIDELINES ON HIV PREVENTION, DIAGNOSIS, TREATMENT AND CARE FOR KEY POPULATIONS, p. 64

[38] WHO (2010) ' PMTCT strategic vision 2010-2015: Preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals' - See more at: http://www.avert.org/prevention-mother-child-transmission-pmtct-hiv.htm#footnote4_7o6igdk

[39] WHO (2014): CONSOLIDATED GUIDELINES ON HIV PREVENTION, DIAGNOSIS, TREATMENT AND CARE FOR KEY POPULATIONS, p. 64

[40] WHO (2015) http://www.who.int/hiv/pub/arv/policy-brief-arv-2015/en/

For HIV exposed infants, the WHO guidelines recommend that every infant born to an HIV-positive mother should receive a course of medication linked to the ARV drug regimen that the mother is taking and the infant's feeding method.

Breastfeeding

WHO 2013 guidelines state that, "the maximum benefit of breastfeeding in preventing mortality from diarrhoea, pneumonia and malnutrition is in the first 12 months of life and …the risk of transmitting HIV to infants through breastfeeding is low in the presence of ARV drugs". At 6-12 months of age, the baby should be gradually weaned off breastmilk provided a nutritionally adequate alternative is available.

Women are advised to gradually wean over a period of 1 month, to reduce stress to infants and avoid infant mortality. Rapid weaning can also create an increased risk of HIV transmission. By controlling the duration of weaning and allowing ARVs to continue 1 week after breastfeeding has finished, transmission and infant mortality and morbidity are reduced[41]. The infant should receive once-daily nevirapine (NVP) from birth, for 6 weeks.

Replacement feeding

Special effort and initiatives are required to optimize access to care and uptake of adherence support by women from key populations, and to build and support effective linkages to long-term treatment. This is especially important during breastfeeding, a period when follow-up is often poor.[42]

Feeding options should be as safe as possible. UN agencies recommend that HIV-infected women avoid breastfeeding when replacement feeding is acceptable, feasible, affordable, sustainable, and safe. As long as any of these criteria are unmet, exclusive breastfeeding is recommended during the first months of life; mixed feedings should never be recommended. HIV-positive women who breastfeed can, with the assistance of healthcare workers, reduce the risk of transmission by preventing and treating cracked nipples, mastitis, and breast abscess. Under conditions common in resource-limited settings, many experts recommend an exclusive breastfeeding for 6 months, at which age complementary feeding can be introduced, as is recommended by most country guidelines[43].

The HIV exposed infant should receive dual therapy (Nevirapine and AZT) daily according to latest WHO guidelines, or according to country specific guidelines at least Nevirapine from birth until 6-12 weeks of age for all HIV exposed infants as per country-specific guidelines.

[41] Averting HIV and AIDS (2015): http://www.avert.org/hiv-and-breastfeeding.htm#sthash.QizyEDcO.dpuf

[42] WHO (2014): CONSOLIDATED GUIDELINES ON HIV PREVENTION, DIAGNOSIS, TREATMENT AND CARE FOR KEY POPULATIONS, p. 65

[43] WHO/UNAIDS/UNFPA/UNICEF (2010): HIV and infant feeding Guidelines on Principles and recommendations for infant feeding in the context of HIV and a summary of evidence 2010 http://apps.who.int/iris/bitstream/10665/44345/1/9789241599535_eng.pdf (accessed 12 November 2015)

B. Purpose

The purpose of these guidelines is to explain the necessity of programmes and activities aimed at prevention and (eventually) elimination of transmission of HIV from mother to child in prisons.
These guidelines focus on interventions in prisons targeted at all pregnant and breastfeeding women and women within the year following delivery.

C. Scope

These guidelines are intended for healthcare workers involved in ante-natal care (ANC) and post-natal care (PNC) in Sub-Sahara African prisons. They provide guidance on the application of minimum standards of care and treatment for pregnant, breastfeeding and up to one-year post-delivery female prisoners, to prevent HIV transmission from mother to baby.

D. Responsible Person/s

Prevention of Mother to Child Transmission (PMTCT) of HIV in prison can be provided by practitioners trained and qualified to deliver ANC and PNC support and interventions e.g.

- midwives
- professional nurses,
- prison medical officers or general practitioners and
- peer educators trained in PMTCT.

E. Quality Assurance and Monitoring & Evaluation

Quality assurance systems are essential for a coherent and functioning service delivery system at all levels. They help to ensure that needs and expectations of prisoners and the institution are met. Quality assurance is an ongoing process that provides permanent feedback on how well PMTCT programmes are established and functioning.

Examples of quality control outcome indicators:

- It is a basic requirement that all persons providing PMTCT services have the requisite training and skills, and wherever possible receive supportive supervision and support to improve their practice. Ideally, service providers should be trained regularly and should be authorised by their respective national health service or professional regulatory body.
- All service providers should comply with the set SOPs and guidelines.
- All service providers initiating PMTCT services in prisons should be trained according to the country-specific guidelines, and in the use of these guidelines and SOPs. This is to build familiarity with all of the principal ART processes (including PMTCT) and awareness of methods they need to adopt and follow.

- New information and procedures should be communicated to and adapted by practitioners, as they emerge. Regular refresher training should therefore be part of capacity building.
- A reliable referral system should be in place in every prison for the continuity of care and support for HIV and other sexually transmitted diseases and TB. Every person involved should be aware of referral options, and this awareness is probably best promoted by clearly visible charts of referral pathways.
- Compliance with eligibility criteria for ART initiation according to country-specific ART guidelines is needed
- To ensure continuity of care, it is of utmost importance that robust links are established with outside facilities and/or NGOs. These links should be clear and dependable, and exchange of information, cooperation and communication between different units (prisons, other facilities, NGOs) should be monitored on a regular basis.

Monitoring and Evaluation

Prison systems should carefully monitor and evaluate the provision of PMTCT services in prison settings as part of the national-level monitoring and evaluation system. This should be done to ensure that: PMTCT services are readily available in prison settings and that healthcare staff offer or recommend testing when indicated; prisoners are not coerced into testing but give informed consent; and testing and counselling is linked to increased access to HIV prevention, treatment, care and support.

The following indicators can assist monitoring and evaluation:

- Percentage of pregnant females tested for HIV. This rate gives an overall impression of the accessibility and efficacy of the HIV testing services.
- Percentage of pregnant females tested HIV positive. This figure indicates the size of the problem and the need for HIV counselling, testing and treatment services.
- Percentage of pregnant females retested for HIV after a further 12 weeks. Adhering to the policy of re-testing after the window period is an indication of the consistency and quality of the HIV testing services.
- Percentage of pregnant females retested and found to be HIV positive. This figure indicates the necessity for continuing HIV services and the need for HIV counselling services.
- Percentage of pregnant females enrolled for PMTCT. This figure indicates the accessibility and efficacy of PMTCT services in prison.
- Percentage of pregnant females started on or retained on co-trimoxazole preventive therapy (CPT). This figure gives an overview of the scale of preventive measures offered and taken.
- Percentage of HIV exposed infants tested for HIV (PCR) at birth/6 weeks/10 weeks (according to country-specific guidelines). These figures indicate the level of HIV

related problems for infants and women with infants in prisons, and of the responsiveness of testing services.

- Percentage of HIV positive infants. This figure gives an impression of how HIV services need to be scaled up in order to treat infants adequately.
- Percentage of exposed infants that received Nevirapine. This indicates the adequacy of the prison healthcare response to the treatment needs of infants (see G.c.7).
- Percentage of HIV positive infants started on ART. Again, this figure is indicating the size and nature of the problem of infants born in prisons, and the adequacy of the treatment response.

F. Materials

1. Relevant country-specific consent forms and treatment guidelines should be utilized in order to conform to the national standards that apply in the community.
2. Information leaflets and brochures can aid psycho-social support, but these materials should be regarded as complementary to counselling and support services, rather than as substitutes. A leaflet handed out to all individuals entering prison will draw their attention to available counselling, testing and treatment services. Other information, education and communication (IEC) materials (video / awareness sessions / posters) can also raise awareness.

   In general, leaflets should be easy to read. Levels of literacy, language difficulties and impaired vision among prisoners need to be taken into account when drafting and issuing leaflets. Using pictures can facilitate readability. Leaflets should always bear the producer's name. If the information they contain is useful and trustworthy, leaflets can contribute to the credibility of the person handing them out.
3. Also standard testing equipment should be utilized. All testing equipment needs to be available, complete, up-to-date and in good order (e.g. within expiry dates, in sterile packs etc.). See also details in Guidelines and SOP for HIV testing (CG_003 & CS_003).
4. Medication (ART and related) for mother and infant should be readily available and dispensed in accordance with national pharmaceutical standards (e.g. in secure packaging, within expiry dates etc.).
5. Referral forms help facilitate successful referral. These forms need to be country or region specific, taking into account the range of available services.

G. Specific principles to apply during PMTCT

The continuity of ART treatment for female prisoners living with HIV within PMTCT is crucial to the health of the patient and to reduction of the risk of their developing resistance. Continuity of treatment can be a major challenge, particularly when an individual enters the prison system, when they are transferred within that system, and when they are released from prison. Specific systems should be established for effective communication and coordination between services. It is important to ensure that counselling focuses on the early identification of risks related to pregnancy. Among the many aspects of a comprehensive counselling service, the well-being of both mother and baby should be the primary objective of all

interventions and support. The involvement of the male partner in ANC and the birth itself where possible even in a prison environment should (subject to the requisite consent) be targeted as a supportive resource, although this support may be difficult to organise in prisons. Both feeding options and birth plans should be discussed very early on in pregnancy.

All Guiding Principles set out in the Guidelines to the SOPs should be adhered to. In addition, providers of PMTCT services should:

1. Ensure ready access to PMTCT services for pregnant prisoners. This means that PMTCT services (including allied services and referral options) need to be regarded as fundamental components of the infrastructure of female prisons.
2. Provide appropriate treatment, support and care to both women and their babies, i.e. the woman-baby pair. Ideally women should already have been informed about ante- and post-natal support options in prisons during pregnancy. Working jointly with the pregnant woman, healthcare workers should organise a support system for after she has given birth (e.g. other female prisoners with children etc.)
3. Offer individualised care, discuss and attempt to address prison-specific barriers, e.g. possible stock-outs of medication, poor access to health services due to human resources or security control issues, lack of counselling services, threats to confidentiality and issues related to stigma and discrimination. It is critical to focus on the individual prisoner with her individual needs and her social and health background, using all available supportive resources that may be mobilized.
4. Have the prevention of HIV transmission from mother to the baby as the primary objective of all PMTCT services. It is essential that all pregnant women living with HIV should receive ART with appropriate counselling as soon as their status is confirmed regardless of gestational age. The first choice of ART regimen is TDF+FTC+EFV given as a fixed dose combination.
5. Ensure that all pregnant women receive TB symptom screening at every health visit. If symptom screen is positive, send sputum for further investigation (see TS_002). TB screening should be a cross-cutting issue for all HIV and PMTCT related services.
6. Remain aware that according to 2014 WHO guidelines, pregnant women have two options available to them:
    - All pregnant and breastfeeding women living with HIV should initiate triple antiretroviral (ARV) therapy, which should be maintained for at least the duration of risk of mother-to-child transmission. Women meeting treatment eligibility criteria should continue with ART for life (CD4 <500 cells/mm3)
    - For programmatic and operational reasons, particularly in generalized epidemics, all pregnant and breastfeeding women living with HIV should initiate ART and maintain it as a lifelong treatment (This option is favoured by 2015 WHO ART guidelines).

7. Be mindful of the necessity for early identification of risks related to pregnancy (high-risk cases). The earlier problems are identified, the sooner treatment and support can be started, and the more likely it is that these will lead to positive results.
8. Discuss birth plans during ante-natal care consultations. A birth plan is a way for a pregnant woman to communicate her wishes either in written or oral form to the health care workers or even to the midwives and doctors who will care for her in labour. It tells them about the type of labour and birth she would like to have. It should be communicated that a birth plan cannot be set in stone: it needs to be flexible, acknowledging that things may not go according to plan.
9. If possible, involve the partner – in most prisons delivery takes place at the nearest referral hospital. The father of the baby may be allowed to be present if this has been arranged prior to delivery and is the wish of the mother. Family engagement, especially of the father, may be of the utmost importance for future support of the woman and her baby.
10. Discuss feeding options throughout pregnancy. There are a variety of possible feeding options, but only those methods that are available and acceptable in the country should be explored. Infant feeding counselling for women living with HIV has three objectives:
    - To provide women with information about the risks and benefits of various infant feeding options;
    - To guide them to choose the one that is most likely to be suitable for their situation;
    - To support them in implementing the method that they have chosen by helping them carry it out safely and effectively[44].

G. Procedure

Every prison with female prisoners should establish and sustain close cooperative relationships with maternity units in the community.

It is crucial that pregnant women are educated about the benefits to themselves and their babies of knowing their HIV status. HIV Testing and Counselling (HTC) should be offered to all pregnant women[45].

Counselling should be offered to women who:

[44] WHO (2015) HIV and Infant Feeding Counselling Tools. Reference Guide. http://apps.who.int/iris/bitstream/10665/43191/1/9241593016.pdf (accessed 7 November 2015)
45 see guidelines and SOP for HCT

- Decline the test (every 3 months to accommodate the window period - focused on prevention of HIV);
- Have tested negative (focused on prevention of HIV); or
- Have tested positive (post-test counselling focused on treatment, care and support).[46]

a) Ante-Natal Care (ANC)

1. Health screening of women prisoners should be comprehensive in range, to determine primary health care needs, incorporating a reproductive health history that includes any previous pregnancies and related reproductive health issues. The same standards that apply in the community should apply equally in prisons. However, many women in Sub-Saharan African countries do not receive key recommended interventions during routine ante-natal care (ANC) including information on pregnancy, related complications, and the importance of skilled delivery attendance[47]. The prison setting offers an opportunity for the delivery of a comprehensive health screening.
2. All women of child-bearing age should be screened for pregnancy (pregnancy test) on admission into prison, to exclude any unknown or undiagnosed pregnancies.
3. ANC should begin as soon as a pregnancy is confirmed. The practitioner should attend to routine ante-natal care, i.e. identify nutritional deficiencies, anaemia, monitor monthly weight gain, baby-wellness and fundal height etc. The earlier the preparation process begins, the better the pregnant woman will be informed, and the fewer fears and doubts she is likely to experience regarding labour and the postpartum period.
4. A comprehensive medical history, including an obstetric history, should be taken, and a thorough physical examination performed. From the detailed information gathered, potential risks should be identified and effective remedial actions taken.
5. The provider should educate the pregnant woman about the benefits to her and to the baby of knowing her HIV status. Again, knowledge of personal HIV status can be critical for the mother and her baby, as measures can be taken to reduce risks to them both.
6. If at any stage during ANC a current complication and/or a potential labour complication are identified (e.g. breech delivery), a referral should be made to specialist care. Practitioners should use all available referral systems and support schemes.
7. The ANC provider should offer HIV counselling and voluntary testing to all pregnant women (see HTC Counselling SOP: CS_003). If a woman declines

[46] See Guidelines and SOPs on Counselling

[47] Magoma, M. et al. (2011): How much time is available for antenatal care consultations? Assessment of the quality of care in rural Tanzania. In: BMC Pregnancy & Childbirth, Published online 2011 Sep 24. doi: 10.1186/1471-2393-11-64; (accessed 7 November 2015)

the HIV test, the offer should be repeated with every ANC visit (or as per country- specific guidelines) or during any other medical consultation or patient contact with health services.

8. If the HIV test is *negative*:
    i. Post-test counselling should be provided, focused on prevention and risk reduction of HIV (safer sex, and consistent and correct condom use).
    ii. The woman should be offered a re-test at every follow-up visit, as well as during labour and breastfeeding (or as per country-specific guidelines).
    iii. The provider should discuss the need for testing and HIV status disclosure to sexual partner(s)

9. If the HIV test is *positive*, the provider should:
    i. Confirm the result with a second rapid test to be sure that the result of the test can be communicated to the woman. This is important to ensure that no false result is reported.
    ii. If the result is confirmed positive, start post-test counselling - focus on treatment, care and support to ensure that all necessary steps are taken, and that every available support is provided.
    iii. Undertake blood tests as per country-specific guidelines (e.g. CD4 count, creatinine, FBC, RPR and ALT, and TB screening). These activities establish key health functioning baselines and provide indications of co-infection by syphilis and TB, both of which can exacerbate HIV.
    iv. Initiate lifelong ART without delay, supplemented by adherence counselling. The importance of uninterrupted treatment should be stressed, as a safeguard against the development of resistance.
    v. Encourage disclosure of HIV status to the father of the baby, any other sexual partner, a peer, friend or family member. Disclosure is a helpful basis for the integration of an HIV-infected mother into normal life.
    vi. Discuss the risk of HIV transmission to the infant and the benefit of PMTCT/ART care of the mother. Practitioners should avoid the use of imperatives ("you must; do not") in conversation with the woman. Instead, they should endeavour to remain impartial, simply setting out the medical advantages of PMTCT/ART to the woman.
    vii. Discuss infant feeding options: the benefit of breast milk vs. formula milk, the necessity to abstain from mixed feeding options (NO mixed feeding!). This can be stated plainly as it is evidence-based, from data gathered in WHO feeding manuals[48].

[48] WHO (2015) HIV And Infant Feeding Counselling Tools. Reference Guide. http://apps.who.int/iris/bitstream/10665/43191/1/9241593016.pdf (accessed 8 November 2015)

viii. Symptom screen all pregnant women for active TB at each visit; if the screen is positive, then test and treat according to guidelines.

ix. Provide Co-trimoxazole prophylaxis (CPT) and Isoniazid preventive therapy (IPT) to all pregnant women living with HIV with a negative TB screening outcome. CPT is a well-tolerated and cost-effective intervention which can extend and improve the quality of life for people living with HIV[49] Clinical trials have shown that IPT dramatically reduces the incidence of TB among people living with HIV[50]. These interventions give a woman living with HIV a reassurance that all is being done to secure her well-being.

x. Discuss the birth/labour plan (see F.8).

xi. If confirmation test result is discordant, draw blood for ELISA test

xii. Ensure the patient is calm and stable before ending the appointment; refer for further medical attention if this is not possible. The practitioner should be mindful that being pregnant and HIV-positive in a prison setting is an extremely vulnerable position (See HTC Guidelines and SOP for details).

Note: ***Indeterminate*** *or inconclusive laboratory HIV results require that another HIV test be done.* ***Discordant results*** *occur when the two HIV test results (laboratory or rapid) do not agree, e.g. the screening test (1st test) is reactive and the confirmatory is non-reactive. This may be a consequence of incorrect administration of the test, malfunction of one of the tests, or other host-related factors. A discordant test requires an ELISA confirmation test*

b) Labour

1. With the onset of labour, the provider should transfer the woman to the nearest maternity unit outside prison unless the prison has a labour ward, which in most parts of the Sub-Saharan countries is not the case. A maternity unit outside prison is a step towards normality – a woman being attended to there is less likely to feel inferior or guilty than if she were giving birth inside prison.
2. The practitioner should send a transfer note with all the relevant obstetric history and current medication, highlighting any possible risks or anticipated complications. This gives the health practitioners in charge a satisfactory clinical picture and an insight into problems that might occur during labour.
3. If she is in advanced labour and there is no option to transfer out, the woman should be prepared for delivery. A prison protocol should be in place for this contingency. The protocol should be written jointly by prison medical staff

[49] WHO (2009) Implementation of co-trimoxazole prophylaxis and isoniazid preventive therapy for people living with HIV http://www.who.int/bulletin/volumes/88/4/09-066522/en/

[50] WHO (2009) Implementation of co-trimoxazole prophylaxis and isoniazid preventive therapy for people living with HIV http://www.who.int/bulletin/volumes/88/4/09-066522/en/

and a community obstetric services. It should include the instruction that all relevant persons including family members are informed of the birth.

4. If the woman in labour is **HIV positive**, practitioners should**:**
    i. Avoid artificial rupture of membranes
    ii. Avoid prolonged labour
    iii. Avoid unnecessary vaginal examinations
    iv. Avoid routine episiotomy, prevent tearing if at all possible
    v. Administer ART as per country specific-guidelines in cases of late HIV diagnosis and precipitated labour. A single dose of NVP and Truvada (emtricitabine & tenofovir disoproxil) with AZT 3-hourly during labour may be administered before switching to FDC ART.
5. If the **HIV status is unknown**, the provider should:
    i. Explain the benefits of knowing one's status and offer HIV testing. Test if consent is obtained. This is the best option for all involved.
    ii. If the woman refuses testing, she should be provided with "post-refusal" counselling and be offered HIV testing at every subsequent visit to the health facility, in a non-coercive manner. The woman might have her reasons for refusing the test. The practitioner should identify and acknowledge her reasons for future reference.
    iii. As a precaution, try to ascertain if the woman is possibly on ART and adherent to treatment, but reluctant to disclose. This is very important because feelings of shame and guilt might lead her to a decision not to disclose her treatment status.
    iv. If period on ART is not clear, give ART as per late diagnosis and/or precipitated labour as per country-specific guidelines.

c) Immediate neonatal care

In the caring for a woman living with HIV and her infant, service providers should adhere to the following instructions:

1. Do not suction the baby unless meconium-stained liquor is present.
2. Cut the cord under cover of light gauze.
3. Assess APGAR score.
4. Weigh the baby and take anthropometric measurements.
5. Support the mother's feeding choice. Don't force her into another feeding mode; at this stage she will have chosen the right mode for herself.
6. If breastfeeding is chosen, put the baby to the breast within an hour of birth.
7. Administer oral Nevirapine (NVP) to the baby according to dosing instructions within 72 hours after birth and continue NVP for 4-6 weeks (as per country-specific guidelines).
8. Administer Vitamin K and BCG to the baby (Bacille Calmette Guerin) according to country-specific EPI (Expanded Programme of Immunization) schedule.

9. If the baby is clinically sick and an at-birth PCR (Polymerase Chain Reaction) is positive, or if mother is on TB treatment, DO NOT give BCG.
10. Administer eye ointment within an hour of birth.
11. If the delivery and neonatal care has taken place outside the prison, communicate with the hospital to ensure that the discharge summary, transfer notes and any medication that the patient requires for immediate care (1 week-2 weeks) accompany her on her return to the prison.

d) Post-Natal Care

Providers of post-natal care should:

1. Ensure bonding of mother and baby (promote kangaroo care).
2. Ensure the Post Natal visit to health facility (*in prison*) as per country-specific guidelines (Day3-7).
3. Weigh the baby regularly to monitor his/her physical development– weight gain is one of the crucial indicators of infant health
4. Continue to counsel the mother on infant feeding.
5. Support the mother's choice of infant feeding, whether it is exclusive breastfeeding or infant formula. The importance of NO mixed feeding should be emphasised.
6. Conduct a physical assessment on the mother. Key criteria of examination are:
    - Check uterine contraction
    - Check lochia
    - Check Haemoglobin (for iron deficiency)
    - Monitor for breast engorgement and breast infections e.g. mastitis, Candida.
    - Wound care in case of episiotomy and caesarean section, e.g. salt sitz baths
    - Monitor for danger signs for both mother and baby, e.g. depression in the mother (see CS_002 for PHQ-9 Depression Assessment tool), dehydration in the baby.
    - Continue to give the mother adherence support for lifelong ART.

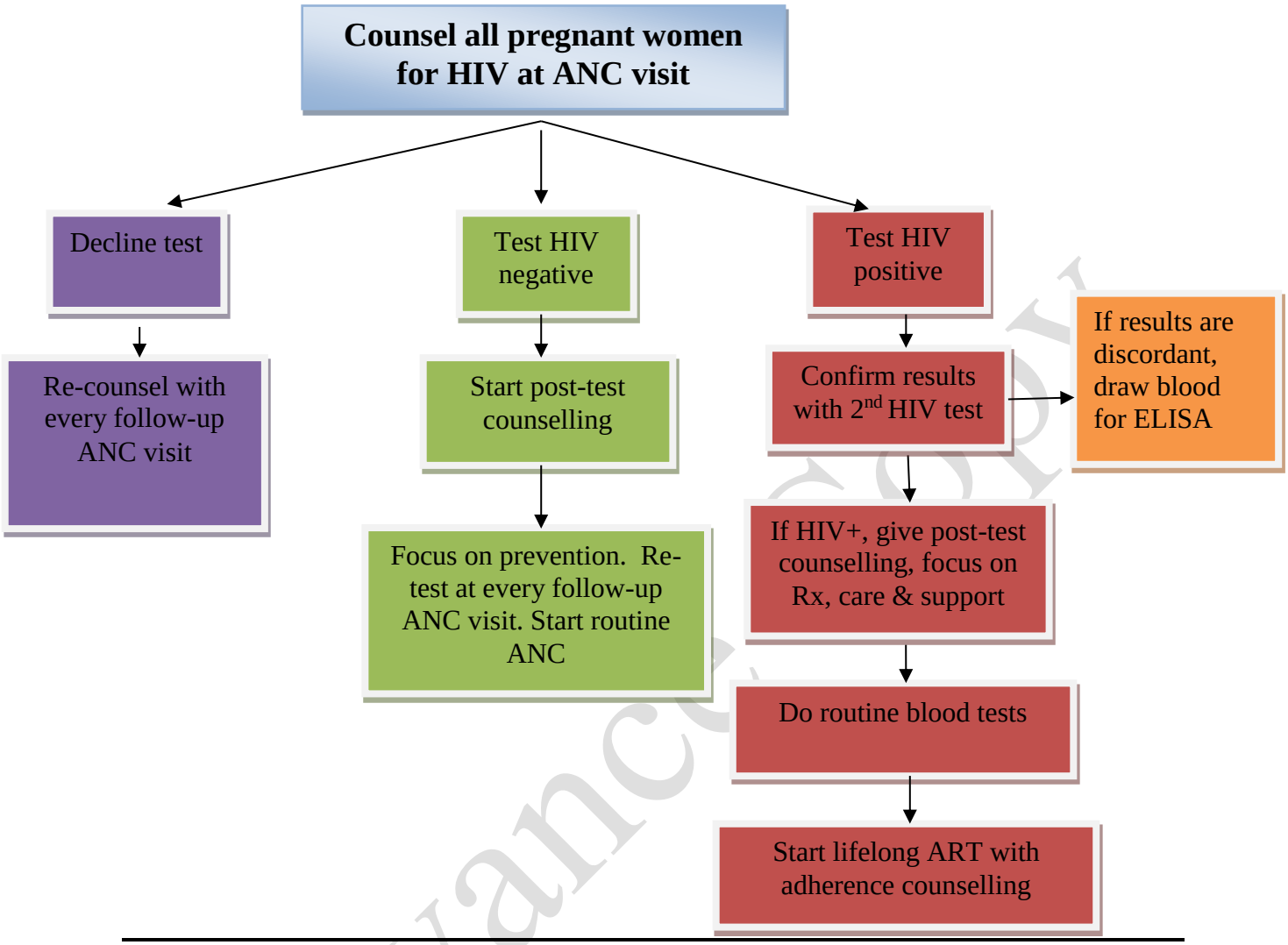
e) For the HIV exposed neonate/infant, providers should:

1. Supply and refill Co-trimoxazole (CTX) and ART to the infant, linked to the mother's treatment regimen and her chosen feeding option (as per country-specific guidelines).
2. Administer dual therapy (Nevirapine and AZT) daily according to latest WHO guidelines, or according to country specific guidelines at least Nevirapine from birth until 6-12 weeks of age for all HIV exposed infants as per country-specific guidelines.
3. Adjust the NVP/AZT dosage according to baby's weight as the baby grows.
4. Stop Nevirapine/AZT at 6 weeks if the mother is on lifelong ART and adherent to treatment.

5. Give CTX from 6 weeks to all HIV exposed babies until PCR test result is available. Start ART according to guidelines and continue.
6. Give CTX if PCR positive.
7. Continue with CTX until 1 year of age, after which treatment will depend on WHO clinical staging (according to country-specific guidelines).
8. If there is an inter-prison transfer prior to the baby's first birthday, or if the baby is released to an outside facility, transfer notes, (and Road to Health chart if applicable) to facilitate continuity of treatment and care

f) In general, providers should:

1. Advise and assist with neonatal care, including care of umbilical cord.
2. Educate on early infant diagnosis of HIV and the need to undertake a PCR test or repeat a PCR test at 6 weeks.
3. Educate on contraception (supply where indicated) to prevent transmission of HIV, prevent unwanted future pregnancies and to plan for future pregnancies once released.
4. Ensure that immunisation for the baby is administered as per country-specific EPI schedule.
5. Give advice on medical male circumcision (MMC) for male infants.
6. Ensure linkages with community organisations and support structures prior to discharge from prison.
7. Record all interventions in prescribed stationery.



Different stages of the PMTCT cycle (from WHO)

ANNEX:

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