GUIDELINES FOR THE PREVENTION AND TREATMENT OF HIV IN ARRESTED, DETAINED AND SENTENCED PERSONS

These guidelines have been developed to aid in the provision of appropriate and quality care for prisoners living with or at risk of HIV infection in detention facilities in southern Africa.

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Definitions
Some of the terms used in these guidelines may have different legal meanings in different countries. For this reason, these guidelines rely on the following broad definitions, unless the context clearly indicates otherwise:

'Arrest' means take into custody by or on the instruction of any state authority for any alleged offence, including detention without charge or detention for questioning.

'ARV' means antiretroviral medicine.

'ART' means ARV treatment.

'Detention facility' means a state facility – or a facility operated on behalf of the state – where arrested persons are detained, including prisons (correctional centres), police holding cells, refugee holding facilities and juvenile detention centres.

'Health care worker' ('HCW') means a trained professional involved in the provision of health care.

'PEP' means post-exposure prophylaxis for HIV and other sexually acquired conditions.

'Prisoner' means any arrested person.

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1. INTRODUCTION

'One of the most unfailing tests of a civilization lies in how a country treats its criminals.'
Winston Churchill

HIV is an everyday reality within southern African detention facilities. Providing prisoners with access to effective and appropriate prevention and treatment services is an essential component for the control of the dual pandemics of tuberculosis (TB) and HIV.

Consequently, correctional services and other related departments throughout southern Africa are facing mounting pressure to provide better health care for prisoners. In response to this pressure, nineteen heads of correctional services from all over Africa – meeting in Swaziland at an All African Symposium on Corrections in August 2007 – agreed to work together to address key challenges facing African prisons. Among other major challenges, they identified overcrowding, HIV/AIDS and inadequate medical care.

Why focus on prisoners when there are so many other marginalised groups who also struggle to access care?

First, prisoners – who lose their right to freedom of movement upon incarceration – still retain all their other basic human rights, including access to health care services. A South African appeal court decision that dates back almost 100 years laid down the fundamentals by accepting the residuum principle. This states that prisoners keep all their rights save for those that are necessary to impose the sentences of the courts.

Second, when the state deprives a person of his or her liberty, it assumes the responsibility to provide appropriate care. People deprived of their liberty cannot, when they are dissatisfied with the service received in a prison or police cell, go out and look for an alternative. They have no choice, being entirely dependent on the services provided to them by or on behalf of the state. It is this dependency that contributes to making them extremely vulnerable.

Third, 'good prison health is good public health'. Most prisoners are not incarcerated for life. Prisoners without effective TB and HIV programmes in detention facilities risk transmitting these diseases to people in their communities on release, further fuelling the TB and HIV pandemics. As a rule of thumb, the turnover of prisoners through the prison system is roughly three times the number in custody. In South Africa, for example, a correctional centre population of 162 000 means an annual turnover of 486 000 people moving through the system.

Finally, a large proportion of people in detention facilities have not yet been convicted of any crime. For example, 30% of South Africa's correctional centre inmates are still awaiting trial. Some of these prisoners may wait up to six years before their case is heard in court. Statistics on other countries are available on the International Centre for Prison Studies (ICPS) website.

2. BACKGROUND

Most prisoners in southern Africa are men between the ages of 18 and 45. In South Africa, 25 - 30% of prisoners are between 14 and 25 years old. A large proportion of these men come from poor communities with low educational standards and high rates of unemployment, homelessness and crime, all associated with increased risk of HIV. These factors may explain, at least in part, why the prevalence of HIV in prisoners is often appreciably higher than the rate in the general population. In Zomba prison in Malawi, for example, an HIV prevalence study revealed an astounding 74% of prisoners with HIV. Other sub-Saharan African countries have prison populations with an HIV prevalence of above 25%.

With already high HIV prevalence rates, issues related to imprisonment – including overcrowding, poor nutrition, disempowerment of the individual, dehumanising prison cultures, unprotected forced and consensual sex, stigmatisation, discrimination and poor access to health care – have a serious impact on rates of HIV infection, the rate of progression of HIV to AIDS and the incidence of opportunistic diseases. Some people enter the prison system with compromised health situations. This is reflected in the statistics showing that some 63% of all natural deaths in prisons occur within the first 36 months after admission to a detention facility. Simply put, incarceration itself may give rise to severe health consequences.

TB in particular has become a major problem in prisons. Overcrowding and poor ventilation contribute to vast numbers of prisoners contracting TB. For example, South Africa's correctional centres are currently running at 142% of capacity (over 160 000 prisoners were detained in 2007 in a system designed for just under 115 000). Within sub-Saharan African populations 70% of people with TB are HIV positive, and TB causes up to 40% of AIDS deaths. This interaction between HIV and TB is the most likely explanation for the massive increase in death rates occurring in southern African prisons. In South Africa, the number of correctional centre deaths rose by 584% between 1995 and 2000.

Access to ART has been shown to reduce the incidence of TB in people infected with HIV by up to 80%. Studies in both developed and developing countries have clearly shown that HIV treatment programmes are both feasible and effective in prisons. Such programmes should result in reduced prisoner morbidity and mortality, as well as lessening the number of new TB and HIV infections in the prison population and in their home communities.

Southern Africa is not alone in having to deal with the challenges raised by HIV/AIDS among prisoners. For an overview of the international perspective, see the United Nations Office on Drugs and Crime's *HIV/AIDS Prevention, Care, Treatment and Support in a Prison Setting: A Framework for an Effective Response* (2006) and the *Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia:*

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Prison Health is Public Health (2004), both of which are included in the bibliography at the end of this document.

3. DUTY OF THE HCW

HCWs are often put in difficult ethical positions in prisons, with dual and often conflicting loyalties to the authorities and to their patients. HCWs should be mindful of several cases that have defined international ethical guidelines and law, stretching from the infamous Steve Biko case involving doctors colluding in torture, to more recent episodes in Guantanamo Bay.

The Hippocratic Oath commits HCWs to work 'for the benefit of the sick according to [their] ability and judgment; keeping them from harm and injustice'. In addition, the World Medical Association's *Declaration of Tokyo – Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment* expressly provides as follows:

'It is the privilege of the physician to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity. … A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose.'

It is therefore the role of HCWs to act as advocates for access to health care, and not to restrict or ration care. The ethical duty of a HCW is to treat patients in a manner that serves their best interests, ensuring the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health' – as recognised in Article 12 of the *International Covenant on Economic, Social and Cultural Rights* – without discrimination.

This may mean that HCWs come into conflict with authorities while conducting their duties. Where necessary, HCWs may need to ask their representative associations – whether trade unions or professional bodies – for support when professional, ethical and/or legal guidance is needed. In addition, a range of legal and human rights organisations working in the field of HIV/AIDS could also be approached.

4. AIM OF THESE GUIDELINES

These guidelines are primarily aimed at promoting best practice for the prevention and treatment of HIV infection and related co-morbidities in detention facilities. In addition, they are intended to:

- Provide guidance to HCWs working with prisoners, whether within or outside a detention facility (e.g. a doctor providing care to a prisoner attending a public clinic), with a particular focus on their ethical and clinical responsibilities;
- Frame the expectations of prisoners and their families regarding appropriate levels of health care; and
- Guide governments, professional bodies and other organisations involved in the development and implementation of HIV-related policy in respect of prisoners. While this document is not official policy, it should nevertheless be considered as current good practice when policy is formulated.

5. SCOPE OF THESE GUIDELINES

These guidelines cover the provision of HIV-related health care to persons held in the following situations:

- Detention in police custody, with or without charge;
- Incarceration of prisoners awaiting trial, convicted and/or sentenced;
- Detention in military custody;
- Detention while awaiting deportation;
- Incarceration of children (persons below 18 years); and
- Infants and/or children accompanying persons in any of the above situations.

While the principles of care may be similar, these guidelines are not intended to provide guidance in respect of persons detained solely for medical reasons (e.g. persons detained for psychiatric care).

It is important to note that these guidelines do not provide comprehensive guidance for the prevention and treatment of HIV infection and related co-morbidities in detention facilities. They focus primarily on the particular challenges posed by such facilities and in working with prisoners with HIV. Unless specifically mentioned, the provision of health care should *at least be in accordance with standard adult and paediatric guidelines for the relevant country.* Because detention facilities vary widely, both within and between countries, HCWs should use their discretion and common sense when interpreting and applying these guidelines.

6. RESPONSIBILITIES AND RIGHTS OF THE HCW

As already mentioned, it is the role of HCWs to act, within a legal framework, as advocates for access to health care, and not to restrict or ration care.

- Practitioners should be constantly aware of the lack of volition of prisoners. They are a highly vulnerable population, unable to act independently. Access to care is often limited by non-medical staff (e.g. not allowing attendance at a clinic) and environmental circumstances (e.g. lack of transport or restrictions during lockdown). HCWs should intervene if limitations are compromising patient care.
- Furthermore, responsibilities may extend to other prisoners and detention facility staff. For instance, TB control may require interventions beyond individual patient care.
- Levels of medical and support staffing should meet the health needs of prisoners. Previously acceptable levels may no longer be adequate in the context of the HIV and TB pandemics. HCWs should advocate for adequate staffing.

HCWs have the right to a safe working environment. Detention facilities should therefore ensure:

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- Good infection control, which includes:
  - adequate ventilation and exposure to sunlight (or ultra-violet germicidal irradiation where not practical); and
  - appropriate personal protective equipment; and
- Adequate protection from threats or acts of violence.

Rights of prisoners and their implications for HCWs:

- Prisoners retain the right to health care and the right to be treated with dignity. In addition to the rights recognised in the common law, domestic prison legislation and constitutions, a range of international human rights instruments address the rights of detained persons.
- Prisoners retain the right to refuse treatment. However, HCWs should be cognisant of the lack of information in prisons, and therefore their role as advocates for their patients' health carries greater weight than in the general population. HCWs should satisfy themselves in all situations that refusal of treatment is based on an informed decision, as is widely recognised as an integral part of informed consent laws.

7. CONFIDENTIALITY

Confidentiality of private medical information should be maintained, as is the case in respect of all patients. However, this may be difficult or even impossible in certain circumstances. Inadvertent disclosure to non-medical staff and other prisoners is common, especially where HIV-specific care is provided (e.g. an ART clinic within a prison). Provision of special diets, attendance on certain days and at certain clinics, calls for medication, legal consultations and storage of medication within cells may all lead to inadvertent disclosure.

Prisoners should be educated regarding disclosure and encouraged to disclose relevant medical information to allow the staff of the facility or the HCW to take the necessary steps to allow for appropriate medical care, such as the uninterrupted delivery of essential chronic medication. It is also necessary that security staff be trained to deal with sensitive and confidential medical information.

Personal safety of the HCW should not be placed at risk in the interests of protecting confidentiality. Guards may need to be present during consultations, and should hold in confidence all that is heard, as part of their professional duty. Provision should be made for the volunteering of confidential information out of earshot of guards, if necessary. Examinations should occur in a dignified fashion (e.g. behind a screen).

Written communication to other HCWs at distant sites should be sealed, to ensure that medical details are not available to guards and couriers. In detention facilities, prisoners sometimes provide health care support services and assist with administration. These prisoners should be trained to deal with sensitive and confidential medical information, to ensure that confidentiality is maintained at all times.

HCWs should be mindful of all of the above, and ensure confidentiality is not compromised unnecessarily.

8. PROVISION OF CARE FOR ALL PRISONERS

All prisoners, irrespective of HIV status, should have an immediate brief health assessment on entry to a detention facility to establish medical treatment status (see appendix for an example). Ordinarily, any immediately available member of staff who has been adequately trained can conduct this assessment. However, confidential information may be disclosed – the prisoner may have been assaulted prior to admission, and an affidavit from the person doing the assessment will be required. A security staff member will not be able to do this.

As part of the assessment, it is critical accurately to assess the following:

- Current medication requirements;
- Whether the prisoner has medication on his or her person;
- Where the prisoner previously obtained his or her care, and whether there are any medical records available; and
- Access to current and future medication needs.

If a prisoner is on any chronic treatment, all necessary steps should be taken to ensure that he or she is able to continue medication without interruption.

On admission to any site other than a short-term holding facility (where he or she is held for only a few days), timely access to the following services should be ensured for all prisoners:

- A comprehensive medical history and examination.
- HIV counselling and testing. This is to ensure timely access to appropriate health care, in particular TB prevention and early diagnosis. This must be clearly communicated to the prisoner, who may have concerns as to the motivation for testing. If HIV testing is refused, it must be actively pursued at future health visits.
- TB history, symptom screening and appropriate investigation.
- Sexually transmitted infection symptom screening and appropriate syndromic management.
- In the case of women, specific history in respect of pregnancy and fertility choices, and whether a cervical cytological screen (Pap smear) was ever performed.
- Children accompanying prisoners should also be assessed and immunisation status ascertained.
- Baseline clinical characteristics, including weight, blood pressure, urinalysis and nutritional assessment. Weight should be measured in a consistent manner, with shackles either in place (where permitted by law) or removed.
- If the prisoner is HIV positive, appropriate clinical and laboratory staging should be done according to national guidelines. However, note the recommendation below to initiate ART at a higher CD4 count, owing to the high risk of TB in people in a detention facility.

All prisoners (irrespective of HIV status) should have TB symptom screening and have their weights documented quarterly. This may be done by non-medical personnel, provided they have been appropriately trained. Prisoners who are unaware of their HIV status or who have tested negative previously, should be encouraged to be tested for HIV regularly.

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9. CARE FOR HIV-INFECTED PATIENTS

Normal standards of care, except where noted below, should be according to national HIV management and treatment guidelines. This includes:

- Regular clinical and laboratory evaluations;
- Education and treatment literacy;
- Adherence support (e.g. support groups, alarm clocks);
- Appropriate and timely prophylaxis and treatment of opportunistic infections;
- ARV initiation and follow-up;
- Appropriate nutritional interventions; and
- Management of treatment complications.

In view of the dual pandemics of TB and HIV, and the clear benefit of ART in preventing TB, the initiation of ART in adults at a higher CD4 count (350 cells/µl) should be strongly considered.

Directly observed treatment (DOT) programmes for ART have yet to be shown to be effective in ensuring adherence in the prison setting. In our experience DOT approaches often result in missed doses owing to inadequate staffing, and are therefore not recommended. This could be reconsidered once better programmes have been designed and shown to be effective. Kept on person (KOP) programmes appear to have better outcomes.

Access to immediate care is often compromised in prisoner populations. Patients with HIV may require urgent interventions and experience substantial difficulties in accessing emergency care. A protocol to deal with these situations should be in place at each site. Guards should be trained to detect any visible deterioration or common signs or symptoms in HIV-infected patients.

Treatment that is required on an ongoing basis should be readily available. This includes access to TB treatment, isoniazid (INH), co-trimoxazole, fluconazole, and specific nutritional interventions.

HIV support is key to acceptance of HIV status as well as to continued adherence to ART. Disclosure has unique implications in detention facilities. Family members may not be readily available, and are often not aware of the prisoner's health status. Disclosure of HIV status to family members should be encouraged and assisted, noting that rejection may be particularly devastating in an already isolated person. Disclosure to an adherence supporter and access to support groups must be encouraged, but lack of disclosure should not be used as an exclusionary criterion for the provision of ART.

10. TB AND OTHER DISEASES OF INSTITUTIONALISATION

Prisoners with HIV are particularly vulnerable to certain illnesses associated with institutionalisation and overcrowding, such as TB, non-typhoidal salmonellosis, scabies, infectious enteric disease, invasive pneumococcal disease and herpes zoster virus (HZV). Prisoners are also more susceptible to the complications of influenza, hepatitis B and malaria. Appropriate vaccinations should be considered, including influenza, HZV and rotavirus. Pneumococcal vaccine should be provided for all HIV-infected children. Only adults established on ART, with CD4 counts above 200 cells/µl, should be given this vaccine.

Medical staff should react appropriately to reports of outbreaks, and notify authorities with the necessary urgency.

All people with suspected TB should be strongly encouraged to have an HIV test.

TB culture and drug susceptibility testing on all TB specimens should be standard of care for prisoners and staff, in view of the immediate consequences for the individual and other prisoners and staff in close proximity. TB sputum specimens must be collected in a well-ventilated and sunny area, preferably outside.

10.1 INH PROPHYLAXIS

INH prophylaxis is effective in preventing TB in HIV-infected people. After excluding active TB disease, all HIV-infected prisoners should receive continuous INH prophylaxis. Tuberculin skin testing is unnecessary. Although INH reduces the risk of TB significantly, TB must be entertained as a diagnosis in all patients on INH prophylaxis with suggestive symptoms and signs. INH should be continued until release from the detention facility. It is unclear whether there is benefit in providing INH prophylaxis in patients already on ART. The panel believes it should be used, unless evidence becomes available to the contrary, owing to the high risk of TB in detention facilities generally. ART and INH prophylaxis should not be initiated concurrently (a month apart is suggested, with ART being prioritised), owing to the difficulty of differentiating shared toxicities.

10.2 ART AND TB

All patients with drug-resistant TB should have ART irrespective of CD4 count.

If the prisoner qualifies for ART, it should be started 2 - 4 weeks after TB treatment initiation. Concomitant drug toxicity and immune reconstitution syndromes should be actively managed (see Southern African HIV Clinicians Society adult treatment guidelines).

10.3 TB AND INFECTION CONTROL

All sputum smear- or culture-positive TB patients must be transferred to a separate designated isolation area within the facility, with adequate ventilation, sunlight (or, if not available, ultraviolet germicidal light) and infection control and treatment facilities. If a patient is identified as multi-drug-resistant TB infected, they should be transferred urgently to a dedicated inpatient treatment site.

11. MENTAL ILLNESS AND SUBSTANCE ABUSE

Depression is under-recognised in both institutionalised and HIV-infected people. Depression has been identified as one of the major factors that impairs adherence, and must be actively screened for and managed. Similarly, other forms of mental illness are often not recognised or under-treated.

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Substance abuse, including alcohol, marijuana, cocaine, crystal methamphetamine, mandrax and heroin, may negatively affect adherence and immunological progression of HIV disease. Substance use is often highly secretive in the prison environment, and a high index of suspicion should be maintained. Interventions that are appropriate to the kind of substance abuse should be freely available (e.g. methadone programmes, substance-specific support groups) to support prisoners with addiction problems.

Misuse of efavirenz, including smoking of the drug, has been reported. This has implications for adherence and viral resistance in both the intended recipient and ARV-naïve HIV-infected prisoners who abuse it.

Cigarette smoking is very common among prisoners, and is associated with a significant increase in risk of several respiratory illnesses, including TB. Smoking should be discouraged and environmental exposure minimised.

12. NUTRITION

Clinicians should encourage a healthy diet, ideally three regular meals, including adequate fresh fruit and vegetables, with adequate portions. Practically, a target weight should be maintained (see Southern African HIV Clinicians Society nutritional guidelines). Ill patients, including TB patients, and pregnant and lactating women should have their diets evaluated and customised appropriately. Clinicians should note that food is often used as currency, and this may be a reason for loss of weight. Dieticians should be consulted for specialised cases.

Many prisoners' nutritional needs may not be met by institutional diets. Low-dose vitamins and minerals (recommended daily allowance level) may be beneficial in this situation. Specific deficiencies should be corrected. Other supplements should be discouraged, as drug interactions and impact on the immune system are unknown.

Mealtimes may be a major barrier to adherence, especially with those ARVs that require administration with meals and fluids. The routine of the institution may make adherence very difficult, especially as mealtimes may vary, and counselling should be sensitive to these realities.

13. SPECIAL POPULATIONS

13.1 INFANTS AND CHILDREN ACCOMPANYING PRISONERS

All HIV-exposed infants and children should have appropriate HIV testing, as well as access to prophylaxis and treatment according to national guidelines. Mothers should be supported with feeding choices. Children in detention facilities, irrespective of HIV status, are exposed to high levels of TB. INH prophylaxis should be provided to all HIV-infected children, and considered for those who are HIV negative. TB must first be actively excluded.

Clinicians should maintain a high level of suspicion for active TB disease, investigate aggressively and manage appropriately. Infants and children have different nutritional needs to adults, particularly if HIV infected or unwell, and this may require dietary modification and/or nutritional supplements. Immunisation schedules must be adhered to.

Recent evidence strongly suggests that initiation of infants on ART immediately after diagnosis of HIV is beneficial. This is recommended, especially as infants are at high risk of TB exposure.

13.2 CHILD PRISONERS

Children are highly vulnerable to HIV infection and therefore need appropriate life skills and sex education. To decrease the risk of sexual exploitation, children must be segregated from adults at all times. Adult prisoners must never be used to supervise children. Consent for HIV testing should be obtained according to national guidelines, cognisant that legal guardians may not be easily accessible, or that guardianship may legally reside with the detention facility.

13.3 WOMEN IN DETENTION FACILITIES

Women should have adequate access to health care, including pregnancy care, services to prevent mother-to-child transmission of HIV (PMTCT), and regular Pap smears. In deciding on appropriate ART, HCWs should not assume that women prisoners with HIV do not want future pregnancies.

13.4 FOREIGN NATIONALS

Incarcerated foreign nationals should have access to HIV care in line with local guidelines applicable to the general population. These prisoners may be deported or voluntarily leave the country upon release (see Southern African HIV Clinicians Society guidelines on displaced persons).

14. PREVENTION OF HIV INFECTION IN DETENTION FACILITIES

In many southern African countries, HIV prevalence among prisoners exceeds 30%. Generally, the prevalence of HIV in prisons is much higher than in the population as a whole. Hence exposure to bodily fluids within a detention facility carries a significantly greater chance of exposure to HIV than in the community. This underscores the need for comprehensive HIV prevention programmes in detention facilities.

Exposure to HIV in a detention facility could result from:

- Sex, whether consensual or non-consensual;
- Tattooing;
- Sharing of needles, razors and hair clippers;
- Violence; and
- Pregnancy, labour and breastfeeding.

With the exception of South Africa, consensual sex between adult men is effectively criminalised in all southern African countries. While the criminalisation of consensual sex between women is less common, it exists in at least four southern African countries. Notwithstanding criminalisation, it is well recognised that consensual and non-consensual sexual activity takes place in detention facilities. HIV prevention programmes, including the need for access to PEP services, should acknowledge this reality.

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HIV prevention programmes in detention facilities should at least include the following components:

14.1 EDUCATION

All prisoners should be offered and encouraged to participate in ongoing educational programmes that address HIV risk and management, including a focus on wellness and access to ART. In addition, these programmes should clearly identify and explain the range of HIV-related services available in the particular detention facility, as well as include clear messages regarding unsafe sex and other HIV exposure risks. Peer education programmes may be particularly effective in detention facilities. Appropriate programmes for peer educators should therefore also be provided.

14.2 HIV TESTING

In addition to providing a gateway to accessing appropriate treatment and care, HIV testing plays a crucial role in HIV prevention. It should therefore form an integral part of any HIV prevention programme. In particular, HIV testing services must be actively promoted and readily accessible, with access not being dependent on the presence of a doctor. Pre- and post-test counselling remains critical in all situations. HIV testing must be encouraged among family members who have been or may be exposed to HIV-positive prisoners.

14.3 CONDOMS AND WATER-BASED LUBRICANT

Consistent and correct use of condoms remains an essential pillar of any HIV prevention programme. Water-based lubricant is essential to minimise condom tearing and mucosal trauma during anal sex. Condoms and water-based lubricant should therefore be freely and widely available in all detention facilities. Adequately stocked condom and lubricant dispensers should be placed in numerous discreet and accessible locations throughout detention facilities.

14.4 REDUCING VULNERABILITY TO RAPE AND OTHER FORMS OF SEXUAL ASSAULT

With their consent, prisoners who are identified as extremely vulnerable to sexual assault may need to be separated from the general prison population upon admission. Once separated, they should be given a thorough orientation about prison life and the dangers of sexual assault and coercion. In addition to this specific intervention, authorities should develop and implement anti-rape strategies and consistently be aware of the need to minimise the risk of sexual assault.

14.5 PEP

PEP services should be freely available and accessible at all times, particularly because sexual assault is common in many detention facilities. Access to PEP should be guaranteed for all prisoners who could benefit from it and must not be dependent on the lodging of criminal charges and/or complaints. Provision of PEP services for those who have been exposed to bodily fluids through sex (whether consensual or non-consensual), trauma, workplace injury (including needle sticks) and needle sharing should be in accordance with local guidelines (or the Southern African HIV Clinicians Society Guidelines on PEP).

14.6 SUBSTANCE USE

Substance use – including the use of alcohol – is associated with a loss of inhibition and may lead to high-risk behaviour, particularly in detention facilities. Facility-specific harm reduction programmes should therefore be developed and implemented, taking into account local substance-use patterns.

There is clear evidence that needle exchange programmes for injecting drug users decrease HIV transmission. However, injecting drug use in southern African detention centres appears to be uncommon and the provision of potentially dangerous items directly to prisoners may not be feasible or indeed desirable. Nevertheless, officials are still advised seriously to consider needle exchange programmes where there is evidence of injecting drug use in any detention facility. In so doing, they should consider best practices adopted in detention facilities in other parts of the world, such as Moldova and other eastern European countries.

14.7 MALE CIRCUMCISION

Male circumcision is increasingly being recognised as an essential component of HIV prevention programmes. Male prisoners should not be prevented from accessing circumcision services, which should be provided in accordance with local policies. Where male prisoners access such services, they must be offered adequate counselling regarding risk reduction after circumcision.

14.8 SOAP AND DISINFECTANT

Soap and disinfectant should be made available and their use promoted in cleaning shaving blades, clippers and needles.

14.9 PREVENTION PROGRAMMES FOR HIV-POSITIVE PRISONERS

HIV prevention programmes tailored for those who have knowledge of their HIV-positive status appear to yield good results in terms of risk reduction behaviour. Each detention facility's prevention programme should expressly address those living with HIV, covering all the issues listed above.

15. CONTINUITY OF CARE

Continuity of care can be a challenge to both prisoner and HCW. Medication supply and communication between HCWs is often interrupted during the process of being incarcerated, movement between facilities and return to the community. There is a high risk of repeat incarceration in the prison population, which may further disrupt care.

As already indicated, all prisoners should have an immediate brief health assessment on admission to a detention facility. If the prisoner is using any chronic medication, all necessary steps should be taken to ensure that he or she is able to continue medication without interruption or resume treatment as soon as possible.

Awaiting-trial prisoners are particularly vulnerable, as they may be moved unexpectedly between courts, new incarceration areas, or even released. All such prisoners should be provided with a good medical summary using, where

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necessary, official documentation, with clear instructions for further follow-up. Prisoners who are still on TB treatment should not be released without active planning for their continued treatment and written referral to their community TB clinic.

Transfer between institutions should be accompanied by a plan to ensure communication of all relevant medical information, as well as ensuring ongoing supply of medication at the new site. No transfer should take place unless ongoing treatment can be confirmed at the new site. The prisoner's medical file ideally should travel with the prisoner. Where this is not possible, the record should be sealed before being sent to the medical staff member at the receiving facility.

While the patient is incarcerated, appointments should not be compromised owing to lack of transport or other concerns. Escape concerns mean that scheduled visits are often not adhered to, and prisoners may miss off-site appointments. Uninterrupted medication should be arranged in these instances. Prisoners who access treatment off-site should have access to these services sooner should they require more urgent care.

Ideally, to minimise these situations adequate ART and other services should be provided on-site within the detention facility, and all adjuvant therapies, including the treatment of opportunistic infections and palliation, should be available. In situations where stavudine is being used, a lactate meter on site, with adequate training of facility staff, can be very useful to rapidly diagnose lactic acidosis syndromes and exclude shamming.

Preparation for release should include a good medical summary with clear instructions for continued care and medication access, as per the usual guidelines for transfer to any medical site. Inmates should be assessed and counselled on the complexity of and challenges related to the changes in adherence support and environment. Increased access to alcohol, other drugs, new sexual freedom, a breakdown of the strict institutional daily routine and poor access to new accommodation may lead to poor adherence and loss to follow-up.

Disclosure to family members and sexual partners may be very complex, and support should be provided. Where appropriate, prisoners should be advised regarding social assistance. Parole officers can play a vital role in ensuring continuity of care. Day parole programmes introduce challenges in the continuum of care where HIV-specific services are only offered during office hours, and prisoners may need to be counselled about the need to remain on site on clinic days.

Patients on clinical drug trials who are incarcerated should have continuity of care preserved, and there should be access to the trial medical staff. This may require direct explanation to prison authorities.

16. SPECIAL ISSUES

16.1 MEDICAL PAROLE

HIV *per se* should not be a reason for medical parole (where it exists). Prisoners with terminal disease due to HIV complications (e.g. advanced disseminated Kaposi's sarcoma, cryptococcal meningitis where ART is not available) should be considered for parole as per local guidelines for terminal diseases. Parole procedures may take time, and this must be factored into any application consideration and parole regulations.

16.2 ALTERNATIVE THERAPIES

Alternative therapies, including traditional medicines, homeopathy and others, are commonly accessed by prisoners. While this right must be respected, prisoners with HIV must be warned of possible side-effects, drug interactions and the risk of unknown consequences on their immune systems.

16.3 PRIVATE HEALTH CARE

In certain countries, prisoners may have access to private health care. Prisoners should be encouraged to select a single trusted health care provider for continuity of care. This should not preclude requests for second opinions.

16.4 RESEARCH AMONG PRISONERS

There is a lack of data on clinical and other requirements of care for HIV-infected prisoners. Bureaucratic impediments to research are commonly experienced. Guards may refuse access to prisoners by researchers despite adequate official permission. Research should be actively pursued in this vulnerable group, and this information disseminated to all relevant authorities and interest groups without interference by officials.

16.5 COMPULSORY HIV TESTING

In some countries, the law allows for compulsory testing, including for HIV, in certain situations. In South Africa, for example, a 2007 amendment to sexual offences legislation allows for the compulsory HIV testing of alleged sexual offenders in certain circumstances. Pre- and post-test counselling is particularly important and complex in this situation.

16.6 SEGREGATION OF HIV-POSITIVE PRISONERS

This is unnecessary and should be discouraged. Segregation for TB is covered above.

16.7 OVERSIGHT OF DETENTION FACILITIES

HIV-infected prisoners are particularly vulnerable to poor health care. Access to the media, external complaints bodies and legal service providers are often limited. All countries should have mechanisms for prisoners to report perceived poor treatment anonymously. Independent evaluation of service provision should be a regular feature of all HIV programmes in these institutions. Prisoner representative organisations should be consulted whenever policy is being developed and implemented.

Further guidance on this issue can be obtained from the 2006 *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT), which establishes an international inspection system for detention facilities. OPCAT sets out the general monitoring duty of medical staff, and importantly, deals with their proactive duties.

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16.8 STAFF ISSUES

While the focus of these guidelines is on inmates, a comprehensive staff programme should include infection control, screening, education, exposure prevention and access to TB and HIV treatment. Staff should be regularly screened for HIV and TB (as staff with HIV are at an increased risk of TB), and should be counselled appropriately.

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MYTHBUSTERS

■ **Prisoners get a better deal in detention facilities than the general population.**

While it may be true that prisoners receive regular meals while many in the general population have no such food security, overall prisoners have the same, if not poorer, access to health care, medication, choice of service provider, etc. as the general population.

■ **HIV-infected prisoners got the virus in prison.**

There has not been much research into the rate of HIV infection among new admissions to detention facilities. Statistics often reflect a higher prevalence of HIV than the general population, but this is probably accounted for by the bias of the population group within detention facilities, who may often have engaged in high-risk behaviour before arrest. The majority of HIV infections are probably acquired before admission; this can be deduced from the high numbers of awaiting-trial prisoners who have CD4 counts below 200, which suggests longstanding HIV infection.

■ **There is no sex in prisons, and therefore no access to condoms is needed.**

Many authorities deny this, but sexual intercourse, both consensual and non-consensual, does occur in prisons. Condoms are therefore essential as part of an HIV prevention programme in all facilities.

■ **Prisoners should not get care because the general population can't get care.**

Prisoners have the same rights to health care as the general population. As much effort should therefore be made to provide health care that is accessible to prisoners as to the general population. Evidence shows that limited access to health care in detention facilities is often as a result of the same barriers that limit access to health care for the general population. Such barriers need to be addressed for all.

■ **Don't treat prisoners, as they are criminals and don't deserve it.**

Again, prisoners still have the right to health care, despite the choices they have made. Emotive thinking does not change this.

■ **Prisoners get preferential treatment at hospitals.**

This perception often arises because of the need for prisoners to be guarded to prevent their escape while receiving medical care at hospitals. Prisoners often move straight to the front of the queue at busy clinics – this is not preferential treatment, but is done to limit the time they are outside the detention facilities. Similarly, admission may require a private ward, for the sake of providing adequate 24-hour security.

■ **Prisoners don't want to test for HIV.**

This is not the case. Statistics of HIV testing uptake are not widely known, but many facilities have waiting lists for testing. As in the general population, adequate counselling will almost always facilitate testing.

RESOURCES

Websites on denialism and the science of HIV/AIDS:
http://www.aidstruth.org/
http://aidsmyth.blogspot.com/
http://scienceblogs.com/aetiology/
http://www.physics.smu.edu/~pseudo/AIDS/
http://scienceblogs.com/denialism/2007/05/who_are_the_denialists_part_i_1.php

Websites of relevant civil society organisations:
AIDS Law Project: http://www.alp.org.za
AIDS and Rights Alliance for Southern Africa (ARASA): http://www.arasa.info
Civil Society Prison Reform Initiative: http://www.communitylawcentre.org.za/Civil-Society-Prison-Reform
International Centre for Prison Studies (ICPS): http://www.kcl.ac.uk/depsta/rel/icps/home.html
Rape Crisis: http://www.rapecrisis.org.za/
Treatment Action Campaign: http://www.tac.org.za

CASE STUDY 1

Paul (28) has been arrested and charged with housebreaking. He had previously been arrested for petty theft but released after six months when that case was withdrawn. Paul has consulted a traditional healer recently because of a chronic cough and obvious weight loss. The healer suggested he take a potion called *uBhejane* for a period of three months. Paul has started the course of treatment but has not experienced any improvement. He reports to the prison clinic with a fever and productive cough. The sister suspects TB and sends the sputum sample for acid-fast bacilli (AFB) staining while she initiates a course of antibiotics that seem to give relief. She does suggest that Paul undergoes a HIV test, as he is not aware of his status. Paul refuses an HIV test because he does not believe he is at risk of infection.

The result of the sputum test is received and AFB organisms are seen. The clinic sister informs Paul of the results and suggests a chest X-ray and starting with TB treatment. She also advises him again to take an HIV test. Paul refuses an X-ray but agrees to an HIV test, and after he has undergone the counselling, the rapid test comes up positive. Paul is visibly shocked with the result, but agrees to submit a sample for a confirmatory test which is also positive.

Paul refuses the offer of TB treatment and requests access to *uBhejane* instead. The sister decides to allow Paul to seek counsel from his peers but only for a period of one week. He returns to her clinic within a week and agrees to start TB treatment but does not want ART. He is very compliant with his DOTS and improves rapidly but refuses further testing or treatment for HIV. He is, however, receptive to advice on lifestyle changes, stops smoking and has more interest in his health and diet.

The sister decides to continue her appeal for Paul to consider further testing and possibly starting ART.

CASE STUDY 2

John approaches his prison doctor, saying that a condom tore during consensual anal sex the previous evening. He was the passive partner and is concerned that the other man may have HIV, as he had TB the previous year. The prison does not provide lubricant to prisoners, although it is suggested in a national prison policy document.

The doctor counsels John, saying that an HIV test is indicated and that PEP may be considered. After consulting with the central office, it becomes clear to the doctor that PEP after consensual sex is not advocated in national policy.

John is found to be HIV positive and is counselled, especially concerning the need for continued use of condoms. His CD4 count is normal and he is commenced on INH prophylaxis in keeping with national guidelines. The prison doctor raises the issue of adequate access to lubricant with the prison authorities, and, despite initial resistance, finally succeeds in having lubricant dispensed alongside the condom providers.

CASE STUDY 3

Maria is 28 weeks pregnant when she is sentenced to five years' imprisonment. Prior to her arrest she had tested HIV positive and she is concerned about her own health and the health of her unborn child and her seven-year-old son Thabo.

Thabo was staying with her partner, Sipho, who has never been tested for HIV, but is aware of Maria's HIV status.

She undergoes a medical examination and is found to be in good health with no symptoms suggestive of active TB. Her CD4 count is 550.

She goes into labour at 37 weeks and delivers a baby girl weighing 2 700 g before she can be transferred to the nearest hospital. She did not access any PMTCT services prior to delivering the baby.

She is taken to the local provincial hospital where she is examined and found to have no complications related to her pregnancy or labour. Her new baby, Sindisiwe, is examined and found to be in good health. Sindisiwe is given a dose of nevirapine and feeding options are discussed with Maria. At first she considers breastfeeding, but then decides that she is unlikely to be able to breastfeed exclusively in prison. She is given a six-week supply of formula milk, advised on how to prepare the bottles and given a follow-up date for six weeks.

In prison, she is pressurised by the female warders to breastfeed and feeds predominantly formula milk, but occasionally gives breastmilk. She takes her baby back to the local hospital at six weeks. Sindisiwe is found to be underweight, is started on co-trimoxasole prophylaxis and undergoes HIV-PCR testing. Four weeks later she is told that Sindisiwe's HIV-PCR is positive, a CD4 count is done and a referral letter given for the closest paediatric ART site.

A few months later she is released from prison and returns home. She realises she has missed her child's appointment date and that Sindisiwe has not received any of her routine immunisations.

Over the next few months Sindisiwe is started on ART and receives her EPI vaccines, Maria is admitted to hospital with lobar pneumonia and is then also started on ART, Thabo undergoes testing and is found to be HIV negative, and finally Sipho agrees to be tested and discovers he is also HIV positive.

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APPENDIX. BRIEF ASSESSMENT FORM

This form is to be used in either of the following circumstances in order to limit the number of different forms

Initial Health Assessment

(to be completed within 24 hours of admission to facility, to maintain continuity of care)

Transfer Record

(to be completed and kept on person, including by all awaiting trial prisoners who may be released or transferred at short notice)

Name: ________________________________ Med/Prisoner No: ____________________

Name of Facility: ____________________Date admitted:________________________

Medical History:

Has the patient ever been treated for the following illnesses?

☐ Diabetes ☐ Epilepsy ☐ Asthma

☐ Hypertension ☐ STD's ☐ Other

Any other illnesses/operations ____

____

Special Investigations ____

Tuberculosis History

Has the patient ever had TB? ☐ No ☐ Yes When?________ Site_____________

If Yes, how many times?_____________ How long was treatment taken for?_________________

HIV

Has the patient previously tested for HIV? ☐ Yes ☐ No

If yes, result______ Date Tested________CD4________VL __________Date________ WHO____

If not tested, or previously tested negative, **offer VCT.**

Any allergies?_________________ Alcohol history?______________ Drug use?_____________

Current problems

Screen for the following TB symptoms: ☐ Cough? ☐ Night sweats? ☐Wt loss?

If any of these symptoms are present, send sputum for TB culture.

Any other health problems? ____

____

____

Current Treatment

☐ TB treatment Date started__________ Current regimen_______ _______Wt_________

☐ ARV's Date started __________ Current regimen_______ CD4________VL________

Treatment will last until_______________ Arrange more meds________Y/N ☐

☐ Co-trimoxazol Any other –specify_________________

Healthcare Worker Check List

☐ TB screen done. Date________ ☐ Special investigations_______________

☐ HIV status positive, or HIV test offered ☐ Date of HIV Test______ Follow up visit_____

☐ Sputum sent (if needed) **Does this patient urgently need to see a doctor? ☐Y ☐N**

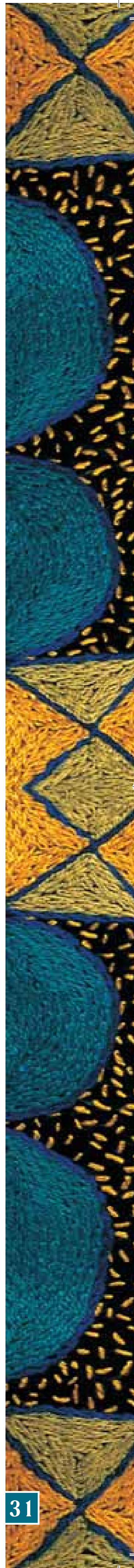
Does this patient urgently need any chronic medication,esp ARV's or TB treatment?☐ Y☐ N

Follow up plan____

____

____

Name of assessor: ________________ **Contact Details** ________________ **Date assessed:**_________



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This form is to be used in either of the following circumstances in order to limit the number of different forms

Initial Health Assessment ✓

(to be completed within 24 hours of admission to facility, to maintain continuity of care)

Transfer Record

(to be completed and kept on person, including by all awaiting trial prisoners who may be released or transferred at short notice)

Name: FRANS NKOSI Med/Prisoner No: 01837387
Name of Facility: LEUKOP Date admitted: 1.4.2008

Medical History:
Has the patient ever been treated for the following illnesses?

☐ Diabetes ☐ Epilepsy ☐ Asthma
☒ Hypertension ☒ STD's ☐ Other

Any other illnesses/operations Hx of U/Discharge 2005

Special Investigations

Tuberculosis History
Has the patient ever had TB? ☒ No ☐ Yes When?____ Site____
If Yes, how many times?____ How long was treatment taken for?____

HIV
Has the patient previously tested for HIV? ☐ Yes ☒ No
If yes, result____ Date Tested____ CD4____ VL____ Date____ WHO____
If not tested, or previously tested negative, **offer VCT.** (WILL THINK ABOUT IT)

Any allergies? NIL Alcohol history? SOCIAL Drug use? NIL

Current problems
Screen for the following TB symptoms: ☒ Cough? 3/52 ☒ Night sweats? ☐ Wt loss? ? NOT SURE
If any of these symptoms are present, send sputum for TB culture.
Any other health problems? SENDING SPUTUM FOR CULTURE
BLOOD PRESSURE – BP 130/80 – HAS Rx
NIL ELSE, WILL CONSIDER HIV TEST.

Current Treatment
☐ TB treatment Date started NO Current regimen____ Wt____
☐ ARV's Date started NO Current regimen____ CD4____ VL____
Treatment will last until____ Arrange more meds____ Y/N☐
☐ Co-trimoxazol Any other –specify____

Healthcare Worker Check List
☒ TB screen done. Date 1/4/2008 ☐ Special investigations SPUTUM SENT.
☐ HIV status positive, or HIV test offered ☐ Date of HIV Test____ Follow up visit____
☐ Sputum sent (if needed) **Does this patient urgently need to see a doctor?** ☒ **Y** ☐ **N**

Does this patient urgently need any chronic medication,esp ARV's or TB treatment? ☐ **Y** ☐ **N**
Follow up plan MAY REQUIRE TB TREATMENT.
ON HYPERTENSION MEDS – WILL REQUIRE 1/12ly.
HAS ENOUGH FOR 2/52.
CONCERN: cough + N/SWEATS – Possible CXR.

Name of assessor: Dr JONES **Contact Details** 011 488 3576 **Date assessed:** 1.4.08

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This form is to be used in either of the following circumstances in order to limit the number of different forms

Initial Health Assessment

(to be completed within 24 hours of admission to facility, to maintain continuity of care)

Transfer Record ✓

(to be completed and kept on person, including by ~~all awaiting trial prisoners~~ who may be released or transferred at short notice)

Name: JACOB MAZIBUKO Med/Prisoner No: C 18 37 138

Name of Facility: MODER B Date admitted: 14 · 2 · 2001

Medical History:

Has the patient ever been treated for the following illnesses?

☐ Diabetes ☐ Epilepsy ☐ Asthma

☒ Hypertension ☐ STD's ☐ Other

Any other illnesses/operations GUNSHOT ABDOMEN JAN 2001.

Special Investigations

Tuberculosis History

Has the patient ever had TB? ☐ No ☒ Yes When? 2002 Site PULMONARY

If Yes, how many times? ×1 How long was treatment taken for? 6 MONTHS.

HIV

Has the patient previously tested for HIV? ☒ Yes ☐ No

If yes, result (+)ve Date Tested 3/10/02 CD4 180 VL 750 000 Date 11/11/02 WHO IV

If not tested, or previously tested negative, **offer VCT.**

Any allergies? NO Alcohol history? Yes Drug use? DAGGA

Current problems

Screen for the following TB symptoms: ☒ Cough? ☐ Night sweats? ☐ Wt loss?

If any of these symptoms are present, send sputum for TB culture.

Any other health problems? SPUTUM SENT OFF & CULTURE NEGATIVE DEC 2007. CMV RETINITIS, INTRA-OCULAR GANCYCLOVIR @ JHB HOSPITAL – NEEDS REGULAR F/UP.

Current Treatment

☐ TB treatment Date started ______ Current regimen ______ Wt ______

☒ ARV's Date started 1/4/04 Current regimen 1a CD4 354 VL –40

Treatment will last until 30 · 4 · 2008 Arrange more meds YES Y/N ☒

☐ Co-trimoxazol Any other –specify GANCYCLOVIR @ JHB HOSPITAL AREA 256.

Healthcare Worker Check List

☒ TB screen done. Date FEB 2005, 12/2007 ☐ Special investigations ______

☐ HIV status positive, or HIV test offered ☐ Date of HIV Test ______ Follow up visit ______

☐ Sputum sent (if needed) **Does this patient urgently need to see a doctor?** ☒ **Y** ☐ **N**

Does this patient urgently need any chronic medication,esp ARV's or TB treatment? ☐ **Y** ☐ **N**

Follow up plan 1) ARV CLINIC · JHB HOSPITAL NUMBER 4700700 82

2) OPTHALMOLOGY DEPT JHB HOSPITAL " "

Name of assessor: Dr JONAS **Contact Details** 011 488 – 3556 **Date assessed:** 14·3·2008

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