
Technical Brief:
**Addressing HIV and TB in Prisons, Pre-Trial
Detention and Other Closed Settings**

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List of abbreviations

ART	antiretroviral therapy
CBO	community-based organization
CCM	Country Coordinating Mechanism
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICRC	International Committee of the Red Cross
IEC	information, education, and communication
ILO	International Labour Organization
M&E	monitoring and evaluation
MDR-TB	multidrug-resistant tuberculosis
NGO	non-governmental organization
OST	opioid substitution therapy
PAHO	Pan American Health Organization
PEP	post-exposure prophylaxis
PMTCT	prevention of mother-to-child transmission (of HIV)
PrEP	pre-exposure prophylaxis
SOP	standard operating procedure
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

This technical brief describes how HIV and TB interventions for people in prison and other closed settings can be incorporated into funding requests to the Global Fund. The Global Fund supports evidence- and rights-based interventions aimed at ensuring access to HIV and TB prevention, treatment, care, and support for key populations, including people in prison.

Global Fund resources should be used to fund interventions that are in line with internationally agreed standards and technical guidance and have a significant impact on the HIV and TB epidemics in a country. Global Fund policy requires upper-middle income countries to focus 100% of their funding on programs benefiting key and vulnerable populations, lower middle income countries must demonstrate that 50% of funding is focused on the same. Low-income countries are also strongly encouraged to target resources to those at highest risk. Global Fund resources can also be used to advocate for laws and policies that enable an effective human-rights-based HIV and TB response and the removal of policies and laws that present obstacles to this.

HIV and TB are leading causes of morbidity and mortality in prisons, and a significant public health issue affecting all regions of the world. The UNAIDS Strategy 2016-2021,¹ the World Health Organization (WHO) Global Health Sector Strategy on HIV 2016-2021,² and the WHO End TB strategy³ identify people in prison as a key population whose needs must be addressed to achieve the targets for ending AIDS and TB.

The interventions outlined in this brief include those recommended in the WHO [Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations](#) (2014, updated 2016 – referred to in this technical brief as the **WHO Key Populations Consolidated Guidelines**), and in the UNODC, ILO, UNDP, WHO, UNAIDS, UNFPA, and UN Women policy brief [HIV Prevention, Treatment, Care and Support in Prisons and Other Closed Settings: A Comprehensive Package of Interventions](#) (2013, to be updated in 2020 – referred to in this technical brief as the **UNODC & Partners Comprehensive Package**). The interventions are also aligned with the Global Fund [Modular Framework Handbook](#) (2019), which provides a list of interventions to address HIV, HIV/TB, and TB for people in prison. Consideration is also given to the prevention and state-of-the-art treatment of viral hepatitis B and C, which are highly prevalent in prison settings and part of the comprehensive package for people in prisons.⁴

Applicants are advised to make use of the [full range of information notes, technical briefs and guidance provided by the Global Fund](#), as well as technical assistance and the numerous technical guides and support documents available from WHO, the United Nations Office on Drugs and Crime (UNODC), the International Committee of the Red Cross (ICRC), STOP TB Partnership, and other partners, some of which are listed at the end of this brief.

- **Section 1** of this brief outlines the vulnerability of people in prison to HIV, TB, viral hepatitis and other infectious diseases.

¹ UNAIDS (2015). [UNAIDS Strategy 2016-2021](#).

² WHO (2016). [Global Health Sector Strategy on HIV, 2016-2021](#).

³ WHO (2015). [WHO End TB Strategy](#).

⁴ Global Fund (2015) [Global Fund Support for Co-morbidities and Co-Infections](#)

- **Section 2** outlines guiding principles for designing and implementing programs.
- **Section 3** outlines the comprehensive package of interventions for HIV, TB, and other health issues recommended by WHO, UNODC, and other partners.
- **Section 4** describes approaches to incorporating prison harm reduction programs within funding proposals, and the health components and strategies for an enabling environment that should be included.
- **Section 5** offers examples of promising practices from around the world.
- **Section 6** lists further publications that may be of assistance in compiling proposals, as well as for technical support in programming. Publications on specific areas are also mentioned throughout this brief and referenced in the footnotes.

The focus of this technical brief is on all people in prison. It recognizes that some population groups within prisons, such as people who use drugs, people living with TB or HIV, men who have sex with men, transgender people, women (and their accompanying children), and young people, have specific vulnerabilities to HIV or TB and particular needs that must be addressed. This technical brief also recognizes that prison staff have specific occupational health needs relating to HIV and TB.

Global Fund position on funding in compulsory detention centers

This brief does not cover compulsory detention centers where people who use drugs and people with TB, among others, are detained in the name of treatment, nor rehabilitation centers for people who use drugs or sex workers as they exist in some countries.⁵ Although similar considerations for HIV and TB apply to such centers, the Global Fund Board decided in November 2014 that the Global Fund will not fund compulsory treatment programs, including those that aim to change sexual orientation or gender identity, to “rehabilitate” sex workers, or drug detention centers. However, consistent with its commitment to addressing gaps in life-saving prevention and treatment for key populations, the Global Fund may finance scientifically sound medical services in facilities in exceptional circumstances, e.g. ensuring access to life-saving treatment to detainees when delivered in **voluntary, community-based treatment programs located outside of such detention facilities**. These exceptions will be determined based on consultation with UN partners, and will require independent oversight to verify the conditions and use of the financing. The Global Fund Secretariat will consult with relevant community organizations within the country in making these decisions.

A note on terminology

Prisons, detention, and other closed settings refers to places of detention that hold people who are awaiting trial or sentencing, who have been convicted or who are subject to other conditions of security. According to jurisdictions this can include jails, prisons, police detention, juvenile detention, remand/pretrial detention, labor camps and penitentiaries, and settings where people are de facto detained following due process, including immigration camps. In this technical brief the term **prison** should be understood to include prisons, detention, and other closed settings.

People in prison refers to those detained or serving a prison sentence, and not to prison staff. The term is preferred to “prisoner” to acknowledge that being imprisoned is not the sum

⁵ Global Fund (2014). [Strategy, Investment, and Impact Committee Decisions and Recommendations to the Board](#) (p.13).

total of a person's identity, because reducing the stigma associated with imprisonment is important for the effective provision of health and social services. For more information, see: Bedell PS, So M, Morse DS, et al. [Corrections for academic medicine: The importance of using person-first language for individuals who have experienced incarceration](#). *Academic Medicine*. 2019;94(2):172-75.

1. Imprisonment and vulnerability to HIV, TB and other diseases

Since 2000, the global prison population has increased rapidly. On any given day there are nearly 11 million people in prison around the world.⁶ Given the high turnover of prison populations, it is estimated that every year about 30 million people spend some time in prison, most of whom will eventually return to the community. Although women make up only around 7% of people in prison, their numbers grew by 53% between 2000 and 2017, compared with an increase in the male prison population of 20% over the same period.⁷

Globally, an estimated 4.6% of people in prison are living with HIV,⁸ a rate more than seven times higher than among adults in the general population. In countries with high incarceration rates of people who inject drugs, the HIV infection rate may be up to 23 times higher among people in prison than in the general population.⁹ An estimated 15.1% of people in prison are living with hepatitis C (HCV), 4.8% have chronic hepatitis B (HBV), and 2.8% have active TB.⁹ TB in prisons can represent one quarter of the total number of TB cases in a country, with prevalence rates up to 100 times higher than in the wider community.¹⁰ Up to 24% of TB cases in prisons are of multidrug-resistant tuberculosis (MDR-TB).⁸

There are numerous reasons for the high prevalence rates of HIV, TB, and hepatitis in prisons. Because of an over-reliance on punitive approaches, the criminalization of key populations (sex workers, men who have sex with men, transgender people, and people who use drugs) and poor access to justice and to health care as a result of stigma and discrimination, a large proportion of prison populations are people who are socio-economically marginalized and/or from key populations particularly affected by TB, HIV, and hepatitis, especially people who use drugs and sex workers.

The prison environment, combined with late TB diagnosis, inadequate prevention measures, poor quality of treatment, and incomplete treatment, contributes to the spread of TB and the surge of drug-resistant forms of TB in prison.⁸ Inadequate prevention, testing, treatment, and care for HIV also are a feature of many prison health-care services. Rights to health and to protection from discrimination and violence are often not respected in prisons. Substandard conditions, mandatory HIV testing, forced treatment, sexual and other forms of violence, the

⁶ World Prison Brief, Institute for Criminal Policy Research (2018). [World Prison Population List, Twelfth Edition](#).

⁷ World Prison Brief, Institute for Criminal Policy Research (2017). [World Female Imprisonment List, Fourth Edition](#).

⁸ UNAIDS (2017). [Global AIDS Monitoring 2018: Indicators for Monitoring the 2016 United Nations Political Declaration on Ending AIDS](#).

⁹ Dolan K, Wirtz AL, Moazen B, et al. [Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees](#). *The Lancet*. 2016;388(10049):1089-102.

¹⁰ WHO. [Tuberculosis in prisons](#) (website).

segregation of people living with HIV and/or TB, and a lack of access to health services create major obstacles to protecting the health of people in prison.

Overcrowding (a problem made worse as prison populations grow), poor ventilation and lack of natural light, and poor sanitation, hygiene, and nutrition are further factors contributing to the high HIV- and TB-related morbidity and mortality rates.

HIV and HBV transmission in prisons are also exacerbated by the prevalence of unsafe sex. People newly incarcerated, people from key populations, young people, people living with HIV and women are all especially vulnerable to violence, sexual abuse, and rape in prison. Likewise, prisons expose individuals to a high risk of HIV and HCV transmission through the sharing of contaminated equipment for injecting drugs, and unsafe needle use for tattooing or body piercing. Globally, around 50% of people who inject drugs are living with HCV; it is estimated that between 23% and 39% of all new HCV infections globally are attributable to injecting drug use.^{11,12}

Women, including trans women, are generally at a higher risk for HIV than male prisoners because of their socio-economic profile, the prevalence of sexual and gender-based violence, and lack of access to sexual and reproductive health care. The relatively higher representation of sex workers, and rates of drug use, among female prisoners are further factors.^{7,13} Mother-to-child transmission of HIV in prison is also a risk.

The outbreak of COVID-19, which was declared a global pandemic by WHO in March 2020, has highlighted once again the vulnerability of people in prison – both those incarcerated, and staff – to the spread of infectious disease, above all when people are forced to live in overcrowded conditions. In response, WHO, UNODC, and other bodies have called for appropriate infection control measures and for related health services that respect the right of all people to health care.^{14,15,16} These organizations have also called for policy responses to reduce prison overcrowding through non-custodial measures at the pre-trial, trial, sentencing and post-sentencing stages, particularly for alleged offenders and prisoners with low risk profiles, and those convicted of minor and non-violent crimes. Additional proposed measures include amnesties, pardons, compassionate release of elderly or terminally ill people, and early-release policies that do not compromise public security, with linkages to community health facilities to ensure continuity of medical care and safeguard public health. In response to COVID-19, numerous countries have rapidly taken steps to reduce overcrowding by releasing thousands of prisoners.¹⁵ All these measures are equally relevant – and equally viable – as a way of reducing the transmission of HIV and TB among people in prison and thus protecting public health, and the benefits of legal and policy reform to prevent people from being imprisoned in the first place for non-violent sexual behavior or drug possession and use should not be overlooked.

¹¹ WHO (2017). [Global Hepatitis Report, 2017](#).

¹² Trickey A, Fraser H, Lim AG, et al. (2019). [The contribution of injection drug use to hepatitis C virus transmission globally, regionally, and at country level: a modelling study](#). *The Lancet Gastroenterology & Hepatology*. 4(6):435-44.

¹³ UNODC, UNAIDS (2008). [Women and HIV in Prison Settings](#).

¹⁴ WHO (2020). [Preparedness, Prevention and Control of COVID-19 in Prisons and Other Places of Detention: Interim Guidance 15 March 2020](#).

¹⁵ UNODC (2020). [Position Paper: COVID-19 Preparedness and Responses in Prisons](#).

¹⁶ International Drug Policy Consortium (2020). [Advocacy Note: COVID-19: Prisons and Detention in Southeast Asia](#).

2. Guiding principals for a rights-based approach to health services in prison

The Global Fund is committed to rights- and evidence-based and gender-responsive approaches to the delivery of health services. Strategic Objective 3 in the fund's 2017-2022 strategy commits the fund to "introduce and scale up programs that remove human-rights barriers to accessing HIV, tuberculosis and malaria services and promoting and protecting gender equality".¹⁷

Governments,^{18,19} UNAIDS,²⁰ WHO,²¹ the Global Fund, and civil society have recognized specific programs to integrate human-rights norms and principles into HIV services and remove rights-related barriers, including for key populations. For a description of these programs, see the Global Fund's technical briefs on [HIV, Human Rights and Gender Equality](#) (2019), [Tuberculosis, Gender and Human Rights](#) (2020), [HIV and Key Populations](#) (2019), and the [Tuberculosis Information Note](#) (2019), as well as the UNAIDS guidance on [Key Programs to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses](#) (2012). These approaches should also form part of the comprehensive package of services for people in prisons.

The General Assembly of the UN has adopted two guidelines on the treatment of people in prison, including health care: the [United Nations Standard Minimum Rules for the Treatment of Prisoners](#) (the Nelson Mandela Rules) and the [United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders](#) (the Bangkok Rules). These and other internationally recognized guidance underpin the principles listed below.

Prison health is public health: Because the great majority of people in prison eventually return to their communities, any illnesses they have contracted while in prison, or pre-existing illnesses that have not been adequately treated, become public-health issues upon their release. Addressing HIV and TB as well as hepatitis in prisons is thus a crucial component of efforts to reduce the transmission and prevalence of HIV and TB within wider society, and especially the spread of MDR-TB.

Equivalence of health care: Health in prison is a right guaranteed by international human-rights law. The Nelson Mandela Rules state:

Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status. (*Rule 24*)²²

¹⁷ Global Fund (2016). [The Global Fund Strategy 2017-2022: Investing to End Epidemics](#).

¹⁸ United Nations (2016). [Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030](#).

¹⁹ United Nations (2011). [Political declaration on HIV and AIDS: intensifying our efforts to eliminate HIV and AIDS](#).

²⁰ UNAIDS (2012). [Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses](#).

²¹ WHO (2016). [Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 update](#).

²² United Nations (2015). [United Nations Standard Minimum Rules for the Treatment of Prisoners \(the Nelson Mandela Rules\)](#).

The [International Covenant on Economic, Social and Cultural Rights \(ICESCR\)](#) states that: “Everyone has the right to the highest attainable standard of physical and mental health” (Article 12),²³ and the commentary on the covenant notes:

States are under obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees (...) to preventive, curative and palliative health services. (*Paragraph 34*)²⁴

The ICESCR commentary also states that:

The right to the highest attainable standard of health [is] an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. (*Paragraph 11*)²²

Ensuring continuity of care: Where possible, prison health care should be integrated into public health services. If health care in prison does not fall under the responsibility of public health authorities, services should be organized in close liaison with health services in the community to facilitate uninterrupted care (or “throughcare”) upon entering prison, being moved within or between prisons, and upon release, and to guarantee compliance with norms and standards.^{20,25} This is especially important for antiretroviral therapy (ART) for HIV, treatment for TB or hepatitis, and opioid substitution therapy (OST). Collaboration should be strengthened among prison administrators, ministries of health, justice, and others to ensure the delivery of high-quality health services in prison.

Medical ethics: All medical interventions should always be voluntary, confidential, and carried out with the informed consent of the individual.²⁶ All interventions should be based on international guidelines and in line with national health policies and HIV and TB guidelines for the community, and should represent the best interest of the patient. Health staff should not be involved in disciplinary or security measures, and physicians should have complete clinical independence.²⁷

²³ United Nations (1966). [International Covenant on Economic, Social and Cultural Rights](#).

²⁴ United Nations Economic and Social Council: Committee on Economic, Social and Cultural Rights (2000). General Comment No. 14 on the Right to the Highest Attainable [Standard](#) of Health.

²⁵ UNODC, WHO (2013). [Good Governance for Prison Health in the 21st Century: A Policy Brief on the Organization of Prison Health](#).

²⁶ United Nations (1982). [Principles of Medical Ethics relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment](#).

²⁷ World Medical Association (2016). [WMA Declaration of Tokyo: Guidelines for Physicians concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment](#).

3. Comprehensive package of interventions

WHO and UNODC have developed technical guidance documents on HIV and on TB for key populations and people in prison. The interventions listed in these documents complement each other and should form a part of applications to the Global Fund for programming in prisons.

The guidance published by WHO and UNODC contains essential health interventions, and strategies for an enabling environment, which should be implemented alongside the health interventions.

3.1 Health interventions

The list of health interventions for people in prison includes those found in the WHO [Key Populations Consolidated Guidelines](#) (2016) and the UNODC & Partners [Comprehensive Package](#) (2013), which describe them in more detail. The latest WHO technical guidance on individual interventions can be consulted for up-to-date guidance. The recommendations are relevant according to the context, such as the prevalence of injecting drug use, and whether prisons are for men or women.

Prevention of HIV, TB, and hepatitis

- **Behavioral interventions:** All people in prison should receive information, education, and communication to raise awareness of HIV, TB, and hepatitis, as well as sexual and reproductive health, mental health, drug use, and overdose prevention and management. Where possible, people in prison should be involved as peer educators (for an example of a peer-led education program in prison, see Section 5.1).
- **HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP):** Where available, PrEP can be provided to people in prison who are at risk of HIV and who request it. PEP should be available and provided to people in prison or staff who have been potentially exposed to HIV through blood or sexual contact.
- **Comprehensive condom and lubricant programming:** Male and female condoms and lubricant should be available free of charge, in discreet locations and without people in prison having to request them. For an example of condom programming, see Section 5.2.
- **Prevention of sexual violence:** To reduce the risk of violence, including sexual violence, males and females should be held separately, and juveniles separate from adults. Where it is judged necessary to segregate transgender people and other vulnerable individuals from other people in prison, their psychological well-being must be taken into account: isolation cells or lock-down conditions should be avoided wherever possible, and they should have the same access to programs and services as other people in prison. An effective protection and reporting system for violence should exist in prisons, and people in prison who experience sexual violence should have access to the full range of post-rape care services, including emergency contraception, HIV post-exposure prophylaxis, STI prophylaxis, and psychosocial support.
- **Harm reduction interventions for substance use:** People who inject drugs should have free and confidential access to sterile injecting equipment via needle and syringe programs. (For an example of a needle and syringe program, see Section

5.3.) Information should be provided on opioid overdose prevention and management, including making naloxone available to people in prison and staff who may witness an overdose (see Section 5.4). OST and other evidence-based drug dependence treatment should be available at no cost, on a voluntary, confidential, and uninterrupted basis. OST reduces both the risk of sharing injection equipment – and thus the risk of transmitting HIV and HCV – and the risk of overdose.

- **Prevention of mother-to-child transmission (PTMCT) of HIV, HBV, and syphilis:** Women should have access for themselves and their newborns to HIV prevention, treatment, and care, and to antenatal and postnatal care equivalent to that available for women in the wider community. Women living with HIV should be provided with ART for PMTCT.^{28,29,30} Pregnant women should have access to delivery in public hospitals, and should never be shackled, in particular during or immediately after labor and delivery. Children born to mothers living with HIV should be provided with appropriate treatment and care in line with national guidelines.
- **Prevention of HIV transmission through medical or dental services:** Health services, including gynecological and dental clinics, should be appropriately equipped, supplied, and maintained to ensure the safety of medical procedures. Blood and body-fluid safety measures applied in the prison must be assessed and regularly reviewed. Training activities for health and security staff should cover universal precautions to prevent the transmission of HIV through medical practices (injections, procedures, or examinations), and the basics of TB control.
- **Hepatitis B vaccination and prevention of transmission through tattooing, piercing, and other forms of skin penetration:** Vaccination for hepatitis B should be provided, and sterile equipment for tattooing or other forms of skin penetration should be made available, together with training on its use to prevent the spread of HIV or hepatitis.

Diagnosis and treatment of HIV, TB, and hepatitis

- **HIV testing services:** Voluntary and confidential HIV testing and counselling should be easily accessible to people in prison. Testing must take place with informed consent, with pre-test information and post-test counseling.³¹ HIV testing services can also be an opportunity to offer testing for viral hepatitis and other sexually transmitted infections (STIs).
- **HIV treatment and care:** All people living with HIV, and those newly testing positive for HIV, should have immediate access to ART in line with national HIV guidelines.³² Efforts should be made to ensure that treatment continues without interruption, including upon entry to prison, if the individual is already on treatment, during transfer

²⁸ UNODC (2019). [Prevention of Mother-to-Child Transmission of HIV in Prisons: A Technical Guide.](#)

²⁹ WHO (2017). [Global Guidance on Criteria and Processes for Validation: Elimination of Mother-to-Child Transmission of HIV and Syphilis – Second edition.](#)

³⁰ PAHO, WHO (2017). [EMTCT Plus: Framework for the Elimination of Mother-to-Child Transmission of HIV, Syphilis, Hepatitis B and Chagas.](#)

³¹ UNODC, WHO, UNAIDS (2009). [Policy Brief: HIV Testing and Counselling in Prisons and Other Closed Settings.](#)

³² WHO (2016). [Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach – Second Edition.](#)

within or between prisons, and after release from prison (see Section 4.2.6), and support should be given to ensure adherence to medication.

- **Diagnosis and treatment of viral hepatitis B and C:** Voluntary services for prevention, diagnosis, and treatment of hepatitis B and C should be offered.^{33,34,35} There are important synergies between HIV and HCV, and HBV testing and management will improve public-health outcomes, including for HIV. Global Fund financing can be used to support HBV and HCV testing when part of HIV and/or TB programs including in prisons. Funding for treatment can be considered where the request meets requirements under the “Coinfections and co-morbidities” policy.³⁶ WHO re-recommends a 12-24-week treatment of all people with chronic HCV (around 75% of people who test positive for antibodies) with pan-genotypic direct-acting antivirals (DAAs). These treatments have an overall cure rate of 95%. The cost of medicines and diagnostics for HCV management – including antibody testing, confirmatory viral load testing, liver assessment, treatment, and test of cure – can be as low as US\$100 in low- and middle-income countries. Global Fund resources can be used to increase HCV prevention and management efforts and support advocacy for treatment access and affordability,³⁷ especially in settings where this provides a catalytic investment to support local regulations, registration, and procurement.
- **Prevention, diagnosis, and treatment of TB:** People newly admitted to prison and all people living with HIV should be screened for TB; those diagnosed with TB should be offered isoniazid preventive therapy and advised to have an HIV test.^{38,39} All people living with HIV without symptoms of active TB should be routinely offered isoniazid preventive therapy. All people held in prison being assessed for TB, and those who have been confirmed to have active TB, should be medically isolated until they are no longer infectious, and there should be thorough investigation and monitoring of their close contacts and cellmates. For more information, see the WHO, UNODC, and ICRC publication *Prisons and Health* (2014, Chapter 8: [TB prevention and control care in prisons](#)).
- **Sexual and reproductive health interventions:** Sexual and reproductive health care is an essential component of HIV and TB services in prison. Screening, diagnosis, and treatment of asymptomatic sexually transmitted infections (STIs) should be offered to both women and men, and syndromic case management of symptomatic STIs in the absence of laboratory tests.⁴⁰ Screening for cervical cancer should be offered to women. Contraceptive and family-planning services, including emergency contraception, should be offered without coercion. For more information, see Section 4.3.

³³ WHO (2015). [Guidelines for the Prevention, Care and Treatment of Persons with Chronic Hepatitis B Infection](#).

³⁴ WHO (2016). [Guidelines for the Screening, Care and Treatment of Persons with Chronic Hepatitis C Infection](#).

³⁵ WHO (2017). [Guidelines on Hepatitis B and C Testing](#).

³⁶ Please refer to the [Global Fund Support for Co-infections and Co-morbidities](#) for details on the requirements. Global Fund (2015).

³⁷ Global Fund (2010). [Report of the Technical Review Panel and the Secretariat on Round 10 Proposals](#).

³⁸ USAID, Tuberculosis Coalition, ICRC (2009). [Guidelines for Control of Tuberculosis in Prisons](#).

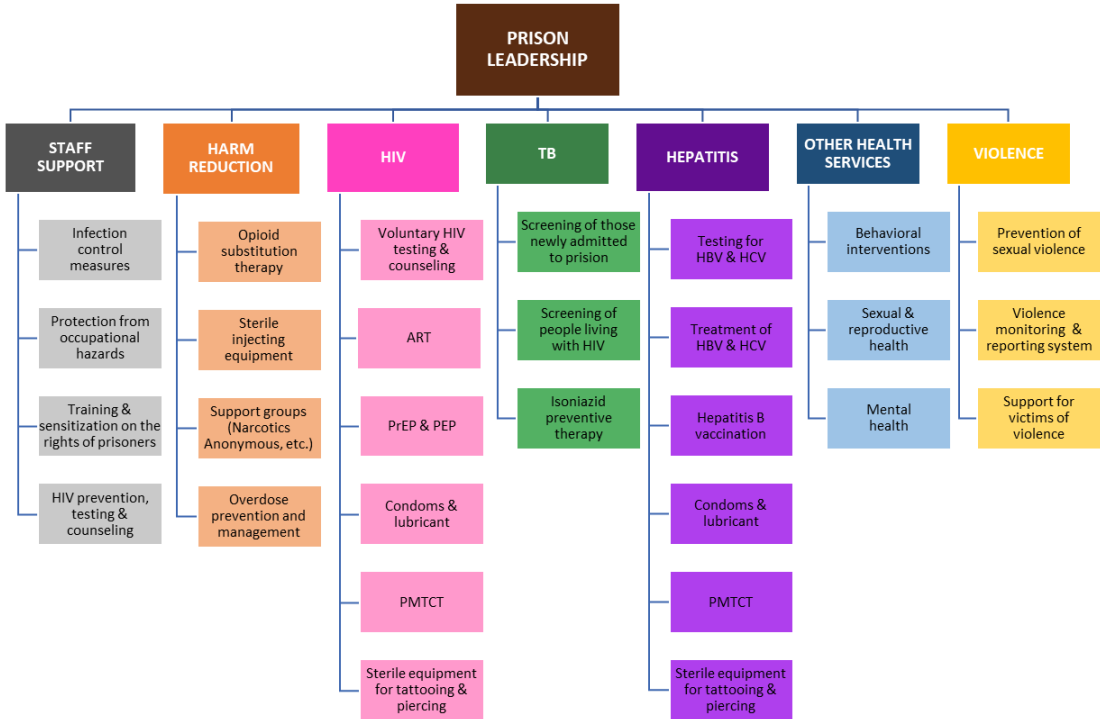
³⁹ WHO (2011). [Guidelines for Intensified Tuberculosis Case-finding and Isoniazid Preventive Therapy for People Living with HIV in Resource-constrained Settings](#).

⁴⁰ WHO (2016). [Guidelines for the Treatment of Chlamydia, Gonorrhoea and Syphilis](#).

Occupational safety and health

- Protecting staff from occupational hazards related to TB, HIV, and other blood-borne infections:** Prison staff and health-care providers, as well as anyone in regular contact with people in prison, should be given timely access to relevant information and educational material on HIV, TB, hepatitis, and universal precautions. Staff should have access to confidential HIV and TB testing, HBV vaccination, and protective equipment, and access to PEP if needed. Testing should never be mandatory.

Figure 1: An example of comprehensive services for HIV, TB and hepatitis in prison



3.2 Strategies for an enabling environment

The UNODC & Partners Comprehensive Package lists a series of specific interventions that are critical to tackling HIV, TB, and HCV in prisons:

- Ensure that prison settings are included in national HIV, TB, hepatitis, and drug dependence programming.
- Adequately fund and reform health care in prisons.
- Ensure the availability of gender-responsive interventions.
- Foster participation and community empowerment.
- Address stigma and discrimination.
- Undertake broader prison and criminal justice reforms:
 - Improve living conditions.
 - Reduce use of pre-trial detention.
 - Reduce incarceration of people who use drugs, sex workers, men who have sex with men and transgender people.
 - Provide access to legal aid.
 - End the use of compulsory detention for the purpose of treatment or rehabilitation.

These strategies are described in more detail in Section 4. Most are encompassed and supported by the five strategies for an enabling environment (“critical enablers”) presented in the WHO Key Populations Consolidated Guidelines: 1) supportive legislation, policy and financial commitment, including decriminalization of behaviors of key populations, 2) addressing stigma and discrimination, 3) available, accessible, and acceptable health services, 4) community empowerment, and 5) addressing violence against people from key populations.

The Global Fund places particular emphasis on reducing incarceration, given that the increasing use of incarceration, including pre-trial detention, and the inefficiency of criminal justice are responsible for overcrowding in many prisons across the world. Incarceration is often ineffective, inappropriate, expensive, and contributes to the HIV and TB epidemics both in prisons and in the community.

The [United Nations Standard Minimum Rules for Non-custodial Measures](#) (the Tokyo Rules) emphasize that imprisonment should be considered a last resort. The rules encourage the promotion of non-custodial measures and set forth a wide range of such measures for various stages of criminal procedures. Lowering rates of incarceration for nonviolent crime will reduce the number of people exposed to HIV and TB in prison, decrease pressure on resources and staffing for prison health services, and allow those already accessing treatment outside prison to continue doing so.

The Global Fund recognizes that programs to remove human-rights-related barriers, including changing laws, policies, and practices, are essential to increase the effectiveness of Global Fund grants. Applicants are therefore strongly encouraged to include in their funding proposals advocacy for: legal reform, such as decriminalization of drug use, drug possession for personal consumption, sex work, and homosexuality.; alternatives to incarceration; and access in prison to human-rights-

and public-health-based services. This is in line with the pronouncements of numerous United Nations and international organizations.^{19,41,42,43} For more information, see Section 4.3.

4. Incorporating HIV and TB interventions in prisons into Global Fund proposals

National HIV strategic plans should recognize all populations at risk of HIV and TB in the country, and therefore explicitly include people in prison, together with the appropriate comprehensive packages of evidence-based interventions. This section describes:

- the approaches that should be taken in formulating national plans and Global Fund proposals
- the health-sector components of plans and proposals
- the strategies for an enabling environment that should also be part of plans and proposals.

4.1 Approaches

Stakeholder engagement

All relevant stakeholders must be actively engaged in the development of the proposal and national plan, and its implementation. This is essential to ensure that plans are rights-based and gender-responsive (see Section 2). Stakeholders include:

- authorities responsible for prisons (e.g. prison administration, police, ministries of justice or defense and ministry of the interior, depending on the setting and local context)
- authorities responsible for prison health services
- Ministry of Health and agencies responsible for the national AIDS and TB programs
- Non-governmental organizations (NGOs) providing services in prisons, or to people leaving prisons and their families
- community-based services for key populations
- organizations of current or former people in prison
- representatives of other key population groups.

It is critical that representatives of prison authorities and prison health-service providers participate in country dialogue, funding request development and grant making. Their input is essential to formulate plans that clearly specify what services are to be provided, and to delineate the respective roles of prison health authorities, NGOs, and linkages with services outside the prison setting. It is recommended that countries establish a National Committee on Prisons and HIV/TB,

⁴¹ Global Commission on HIV and the Law (2012). [HIV and the Law: Risks, Rights and Health](#).

⁴² United Nations (2011). [Discriminatory Laws and Practices and Acts of Violence against Individuals based on their Sexual Orientation and Gender Identity: Report of the United Nations High Commissioner for Human Rights](#).

⁴³ UNODC (2007). [Handbook of Basic Principles and Promising Practices on Alternatives to Imprisonment](#).

with high-level representation from the Ministry of Justice (or Home Affairs) and Ministry of Health, to coordinate the provision of health services in prisons.

Scale and coverage

Programs should be designed for scale. To be effective, it is important they be extended to all prisons nationwide – bearing in mind that “prisons” in this technical brief also includes jails, police detention, juvenile detention, remand/pretrial detention, and penitentiaries. Programs should not be limited to the central prison, the few largest facilities, or men’s prisons.

Programs should also be designed to achieve high coverage, in line with the United Nations’ global prevention target of 90% coverage of people at risk of HIV with comprehensive HIV prevention services,⁴⁴ to achieve the goal of reducing new HIV infections by 75%, and new hepatitis infections by 30%.^{17,45} Adequate coverage of HIV testing and treatment is essential to meet the UNAIDS Fast-Track targets, i.e., that 90% of people living with HIV know their status, 90% of these are enrolled in ART, and 90% of those on ART have a suppressed viral load.⁴⁶ See also Section 4.2 for information on the design of standard operating procedures.

Sustainability

The long-term sustainability of programs must be considered from the initial planning stage, with a view to integrating programming for people in prison within the relevant national programs and budgets. Because prison health programs are often severely understaffed and under-resourced, integrating prison health care into public health care will encourage funding allocations for prisons that are proportionate to funding for services in the wider community. Sustainability planning should include services provided by NGOs, community-based organizations (CBOs), and organizations led by people formerly in prison, as appropriate. For more information, see [The Global Fund Sustainability, Transition and Co-financing Policy](#) (2016), and Section 4.3.

4.2 Components of proposals

National plans and funding proposals should cover the following components for the design and implementation of effective programs, bearing in mind the human-rights principles set out in Section 2 of this technical brief.

Policy framework

Linking to the CCM, it is recommended that a mechanism be designed to coordinate between relevant ministries and health authorities at national and sub-national levels to promote funding, leadership and support, and long-term sustainability for prison health systems, and specifically for HIV and TB programming.

Baseline data

Behavioral risk surveys and size estimates of key populations provide important data for programming within prisons, and help ensure that resources are targeted at the most appropriate interventions. An assessment of the situation within each prison may be necessary to gain knowledge of the exact status of services and the needs of people in prison, and to collect baseline

⁴⁴ Global HIV Prevention Coalition (2017). [HIV Prevention 2020 Road Map](#).

⁴⁵ WHO (2016). [Global Health Sector Strategy on Viral Hepatitis 2016-2021](#).

⁴⁶ UNAIDS (2014). [Fast-Track: Ending the AIDS Epidemic by 2030](#).

indicators for monitoring and evaluation (M&E). Countries are encouraged to include baseline data in their funding applications.

For each prison, data should be disaggregated by sex and age and ideally include:

- prevalence of HIV, TB, and HCV
- size estimates of key populations within the prison (people who use drugs, sex workers, men who have sex with men, transgender people). Data collection should be anonymized and not include biometric data so as to maintain the rights and confidentiality of key population members in prison
- availability, coverage and accessibility of services for each disease across the cascade of prevention, testing, diagnosis, treatment, and care.

While programs should be based on the available data, a lack of data is no reason for inaction.

Design of prison health services

Plans should incorporate the elements of the comprehensive package described in Section 3, including the health interventions and the interventions for an enabling environment (see also Section 4.3). Facilities should be provided not just for HIV, TB, and HCV, but to treat other health conditions commonly experienced by people in prison, e.g. mental-health conditions, drug dependence, respiratory infections, abscess, skin rashes. Where services cannot be provided within the prison itself, provision should be made to provide them in outside facilities.

Standard operating procedures (SOPs) are key to ensuring quality of services in prisons. Based on national guidelines, they strengthen the adherence of security and health staff to the policy and strategy. SOPs should cover all elements of HIV and TB prevention and treatment listed in Section 3. They should be widely disseminated, including among any NGOs working in prisons. For each disease, SOPs should cover screening, diagnosis, treatment, care, monitoring, and linkages to services for continuity of care upon release. SOPs should also cover treatment of co-infection of TB/HIV, HIV/HBV, and HIV/HCV; appropriate isolation of people in prison with suspected or confirmed active TB; and provision of harm reduction services and OST for people in prison who are dependent on opioids. For an example of an SOP, see [HIV and TB Intervention in Prison and Other Closed Settings: Operational Guidelines](#) (Government of India, 2018).

Sensitization and training of staff

Prison administrators and staff (not just those directly responsible for providing health services) should be surveyed on their knowledge, attitudes, practices, and concerns regarding HIV, TB, and HCV in their place of work. This information can be used as a basis for sensitizing staff on the importance of programming that is being introduced or expanded, and to help them understand their role as promoters of prison health. Sensitization is equally an opportunity to show prison staff how the prevention and treatment of HIV, TB, and HCV among people in prison also helps protect their own health.

All relevant prison staff should receive specific training on HIV and TB control in prisons, and on health and human rights more generally. Staff of prison health facilities should be trained in the SOPs for HIV, TB, and HCV, and other staff should be trained in the SOPs relevant to their roles. Sensitization and training are not one-off activities: they should be ongoing, particularly where there is high turnover of personnel. A national training curriculum for prison staff should be developed to facilitate a standardized and comprehensive approach to training. For more information, see the Global Fund's technical briefs on [HIV, Human Rights and Gender Equality](#) and [Tuberculosis, Gender and Human Rights](#), the UNODC publication [HIV and AIDS in Places of](#)

[Detention: A Toolkit for Policymakers, Programme Managers, Prison Officers and Health Care Providers in Prison Settings](#) (2008), and the UNAIDS guidance on [Key Programs to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses](#).

Quality assurance of health services

It is important to pay attention to the quality of programs across the cascade of TB and HIV prevention, diagnosis, treatment, and care. Quality standards for health services in prisons should be aligned with standards for health services in the community. Where prison health is not integrated into public-health systems, collaboration should be fostered and strengthened between prison health authorities and ministries of health, justice, and others. These linkages should be funded, with close monitoring and evaluation.

Ensuring continuity of care

The universal and timely provision of ART, TB and hepatitis treatment, and of OST is critical in prisons. The continuity of these treatments is a major challenge in the criminal justice system. Interruptions can occur at all stages of detention: upon arrest, in pre-trial detention, when transferring people within prison or from one prison to another, or upon release. The following steps can help ensure continuity of care.

- **Throughcare systems should be established for patients on treatment for HIV, TB, hepatitis, or opioid dependence:** Throughcare enables people to continue receiving and taking medications upon entering prison and when they are transferred within prison or to another place of detention. Where necessary, medical records should also be transferred to ensure that detailed treatment information is swiftly available for health staff to continue previously initiated treatment. Peer-led and other civil-society organizations working in prisons can play a role in helping those newly arrived in prison to feel safe enough to disclose their health status and treatment needs. Upon release each patient should be provided a stock of medications (ART and/or TB and/or OST) to cover their treatment needs until access to treatment in the community can be fully established.
- **Pre-trial detention centers should be supported and equipped** to serve as a gateway to diagnosis and treatment of HIV, TB, and hepatitis, as well as the provision of OST.
- **All relevant stakeholders should be engaged in the design of harm reduction programs in prison:** These programs include access to needles and syringes, other injection equipment, OST, and condoms.⁴⁷ Stakeholder engagement is essential in order to prevent stigma, discrimination, and violence against those accessing these services.
- **Linkages should be made to both medical and social services and organizations to support reintegration into the community and enable continuity of treatment:** Prisons should establish clear and systematic procedures to link people in prison to services available in the community upon their release. For an example, see Section 5.6. Upon release each patient should be provided with proper identification documents and a copy of their medical file.
- **People dependent on opioids should be supported upon release:** People who inject opioids are at particularly high risk of HIV and of overdose in the weeks following release. In preparation for release they should be linked with peer-led civil-society organizations that can offer trusted support to people with a history of drug use. Those on OST should be

⁴⁷ United Nations (2018). [United Nations System Common Position Supporting the Implementation of the International Drug Control Policy through Effective Inter-agency Collaboration](#).

given information on the risk of overdose after a period of reduced use or abstinence from opioids. Community distribution of naloxone is part of the comprehensive harm reduction package for preventing HIV among people who inject drugs (see the Global Fund technical brief on [Harm Reduction for People Who Use Drugs](#) [2020]). Guidance, including on the distribution of take-home naloxone, is provided in the WHO publication [Preventing Overdose Deaths in the Criminal-justice System](#) (2014). For an example, see Section 5.4.

Monitoring and evaluation

Monitoring of program implementation, outputs, and quality is a further necessary component of planning. National targets and indicators for people in prison should be aligned with those for the general population and key populations in the community. HIV and TB monitoring systems should be aligned with and integrated into national HIV, TB, and other disease surveillance systems. The impact of programmatic improvements should be measured using standard indicators, including through regular documentation of HIV and TB treatment cascades. For examples of program monitoring, see Section 5.7.

4.3 Strategies for an enabling environment

National plans and funding proposals should incorporate the strategies for an enabling environment listed in the UNODC & Partners Comprehensive Package (which incorporate those in the WHO Key Populations Consolidated Guidelines).

Ensure that prison settings are included in national HIV, TB, hepatitis, and drug dependence treatment programming

Including prisons in national plans and programs for HIV, TB, and drug dependence prevention, treatment, and care is an important first step to ensuring that services in prisons are funded and that continuity of care is provided.

Adequately fund and reform health care in prisons

In line with the principle that prison health is public health, health care in prisons should be considered an integral part of the public health sector. Commitment to scale and to comprehensive and high-quality programming means a commitment to adequate funding. Health care should be understood holistically, to include the structural determinants of health and the prevention of disease as well as disease detection and treatment. While an emphasis on high-prevalence and transmissible diseases such as HIV, TB, and HCV is essential, services provided should be broader than this.⁴⁸

Ensure the availability of gender-responsive interventions

Women in prison are more likely to be living with HIV than those in the wider community. The same challenges that lead to women being imprisoned – including punitive laws on sex work and drug use – often also lead to increased risk of HIV infection. The HIV risk of women in prison is exacerbated by stigma, gender-based violence, inequality, and discrimination. Not only are HIV prevention and care services often poor in prisons, but women's specific health needs, including access to sexual and reproductive health services, are frequently neglected.

Because women represent only a small proportion of the prison population, their specific needs are often overlooked. Women in prisons are vulnerable to sexual abuse, including rape, by both male staff and male inmates, particularly when they are detained in facilities adjacent to or within male

⁴⁸ WHO, UNODC, ICRC (2014). [Prisons and Health](#).

prisons, or when women's quarters are supervised by male prison staff. Women are also susceptible to sexual exploitation and may engage in transactional sex in exchange for goods. Women in prison may be or become pregnant, give birth, or be nursing infants.

Health-care services for women in prison should be responsive to their specific needs and available from a female physician if so desired.⁴⁹ The [Bangkok Rules](#) and the UNODC & UNAIDS publication [Women and HIV in Prison Settings](#) (2008) provide guidance specific to women in the criminal justice system. For information on PMTCT, see the UNODC technical guide on [Prevention of Mother-to-Child Transmission of HIV in Prisons](#) (2019) and the PAHO and WHO publication [EMTCT Plus: Framework for the Elimination of Mother-to-Child Transmission of HIV, Syphilis, Hepatitis B and Chagas](#) (2017). In addition, the [UNAIDS Gender Assessment Tool](#) (2018) is a guide for ensuring that programming and strategies are gender-inclusive, and for identifying broader human-rights barriers faced by women in relation to HIV services and prevention.

Transgender women in prisons have special health-care needs that should be addressed. Due to general rules for the classification of people in prison, transgender women are particularly vulnerable to violence, including sexual violence, from which they should be protected.

Foster participation and community empowerment

People in prison have an important role to play in the development, implementation, and evaluation of HIV and TB services in prisons. To ensure that plans are responsive to the realities and needs of people in prison, HIV or TB task teams and committees should include representatives of male, female, and transgender inmates, as well as people in prison living with HIV and/or TB, and those who use drugs. Resources should be allocated to self-help groups, and for peer-based HIV and TB interventions within prisons to disseminate information on prevention and symptoms, and to support adherence to treatment or for legal-literacy activities.⁵⁰ People in prison should contribute to the development and implementation of peer-based programs. IEC materials for people in prison should be developed collaboratively with them to ensure they are relevant, accessible, and acceptable. Programs can also support the engagement of organizations of people formerly in prison to accompany those who are released and support them in accessing continued health care.

The role of civil-society organizations: Given the lack of trust and fear that people in prison experience regarding prison officials and other authorities, access to services such as HIV testing or participation in IEC activities can be enhanced if these services are implemented by NGOs or CBOs, including those that are peer-led. NGOs and CBOs such as the International Federation of the Red Cross (IFRC) also play an important role in preparing people in prison for release and providing support after release, including for continuity of HIV and TB treatment and care, and prevention and management of drug overdose, especially upon release. They can also advocate for the rights of people in prison, improved health standards, and reduction of stock-outs of health commodities. Global Fund applications can include funding to support the continued work of such organizations on health in prisons.

Address stigma, discrimination, and violence

There is a high prevalence in prisons of stigma, discrimination, and violence against people living with HIV, people with TB, and members of key populations. Training workshops for prison security and health staff, as well as for people in prison themselves, on reducing stigma, discrimination, and the rights of people in prison should be part of a comprehensive response to HIV and TB in prisons

⁴⁹ United Nations (2010). [United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders \(the Bangkok Rules\)](#).

⁵⁰ WHO (2007). [Interventions to Address HIV in Prisons: HIV Care, Treatment and Support](#).

and included in funding applications. People in prison should be made aware of their rights and resources through legal-literacy training and provided access to legal aid. Violence reporting and remediation mechanisms should be in place.

Undertake broader prison and criminal justice reforms

- **Improve living conditions**

In low-income countries, malnutrition rates in prisons can be very high, especially among those who lack support from their relatives. Supplementary nutrition programs are needed in such settings, especially for TB patients, people living with HIV, individuals receiving ART, pregnant and nursing women, and their babies. Other important interventions include distribution of basic hygiene kits with toothbrushes and shavers, basic clothing, and mosquito nets, as needed.

Advocacy can also be undertaken to establish standards for maximum occupancy and for prison architecture, to allow proper ventilation and adequate natural light; for prison hygiene; and for people in prison to have regular and sufficient access to open-air areas.

Terminally ill people in prison should be released on compassionate grounds and receive support in the community to allow them to die with dignity at home in the company of family or friends.

Reduce use of pre-trial detention and the incarceration of people who use drugs, sex workers, men who have sex with men, and transgender people, and provide access to legal aid

It is critical to advocate for ending incarceration for victimless and nonviolent offenses, including drug use and drug possession for personal consumption, and for repealing national laws criminalizing drug use, sex work, and homosexuality, as well as the criminalization of HIV or TB transmission. Efforts also should be made to limit the incarceration of people with disabilities and mental-health conditions, for all crimes.

People who use drugs, sex workers, men who have sex with men, and transgender people – as well as people with disabilities or mental-health conditions – are often held in prison unnecessarily. The criminalization of same-sex relationships, drug use, and drug possession for personal consumption makes it difficult to introduce condoms and harm reduction programs in prison, in particular OST and needle and syringe programs.

The WHO Key Populations Consolidated Guidelines state that countries should “work toward decriminalization of behaviors such as drug use/injecting, sex work, same-sex activity, and nonconforming gender identities, and toward elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men, and transgender people.”

Furthermore, the Outcome Document of the 2016 United Nations General Assembly Special Session on the world drug problem encourages member states to develop and implement alternatives to conviction or punishment for drug use or drug possession for personal consumption.⁵¹ For example, there is a growing body of evidence to show that decriminalization policies that deal with drug use and possession for personal use as a public-health issue dramatically decrease prison populations and related health issues.⁵²

⁵¹ United Nations (2016). [Our Joint Commitment to Effectively Addressing and Countering the World Drug Problem](#).

⁵² Release (2017). [A Quiet Revolution: Drug Decriminalisation across the Globe](#).

To conduct an assessment of the legal environment, see the UNDP & Stop TB Partnership's [Legal Environment Assessments for Tuberculosis: An Operational Guide](#) (2017) or Harm Reduction International's [Monitoring HIV, HCV, TB and Harm Reduction in Prisons: A Human Rights-Based Tool to Prevent Ill Treatment](#) (2016). For more information on Global Fund policy related to harm reduction, see the technical brief on [Harm Reduction for People who Use Drugs](#).

End the use of compulsory detention for the purpose of treatment or rehabilitation

Countries are encouraged to invest in advocacy activities to change laws, regulations, and practices that are used to enforce compulsory treatment or detention. See also p.4 for the Global Fund's position opposing compulsory treatment programs.

For more information on Global Fund policy regarding funding human-rights activities, see the technical briefs on [HIV, Human Rights and Gender Equality](#), [Tuberculosis, Gender and Human Rights](#), and [HIV and Key Populations](#).

5. Promising practices

Implementing a peer-led education program for people in prison (VIETNAM)

In Vietnam, a peer-led education program managed and operated by the prison system has proven effective in improving the health knowledge, attitude, and practice of people in prison. Each prison deploys a team of selected people in prison to assist officials in rolling out activities and maintaining the security of their prison campuses.

Between 2010 and 2018, UNODC provided training to 572 people in prison (527 males, 45 females) to conduct peer education in their respective prisons. A prison health education manual, *Stop HIV and Hepatitis in Prison: A Peer Educational Health Training Manual for Staff and Inmates in Viet Nam*, was developed jointly by UNODC, the Ministry of Health and the national prison authorities to support and facilitate prison peer outreach work.

Program data suggested that people in prisons with strong peer-led education activities were likely to have better knowledge about HIV, TB, and viral hepatitis prevention. Strong peer influencing also made a considerable contribution to HIV service uptake and retention among people in prison, especially for services which were newly introduced, such as OST, HIV voluntary counseling and testing, and ART. Despite challenges such as a high turnover of trained peers, Vietnamese prison authorities consider the peer-led program a valuable resource for improving health conditions and education among people in prison.

Providing access to condoms to all people in prison (ARGENTINA)

Condoms with water-based lubricants need to be easily and discreetly available, free of charge, ideally in areas where individuals can pick them up without being seen by others and without having to ask, such as toilets, shower areas, waiting rooms, workshops, or day rooms. Each prison is different and the design of the program needs to be developed in consultation with all stakeholders in the prison, including those incarcerated and staff. In Argentina in 2013, the Federal Prison System developed and implemented a policy to make condoms available to all people in prison. Dispensing boxes have been placed in corridors with a high footfall in each unit, and in the conjugal visiting rooms (including for men who have sex with men and transgender people). The introduction of condoms in prison was accompanied by an IEC campaign. No problems have been reported.

Needle and syringe program in prison (MOLDOVA)

The first needle and syringe exchange program in prison in Moldova was introduced in Branesti prison in 1999, initially through the medical department. However, despite the high prevalence of injecting drug use, uptake was low, due to limited opening hours of the health service. In response, peer-to-peer exchange was successfully introduced. Peer volunteers were trained to provide harm reduction services, including needles and syringes and condoms, in different sites in the prison, under the supervision of health-care staff. Services are available on a 24-hour basis because the sites are based in living units. With the introduction of the peer model, participation in the program increased, and after one year, based on the results, the program was extended to other prisons. SOPs have been developed to ensure training and support from staff.

Reducing risks for post-release overdose (SCOTLAND)

Since 2011, Scotland has implemented the National Naloxone Program in which all prisons provide naloxone kits to at-risk individuals upon release to reduce fatal opioid overdoses. Following training, take-home naloxone kits are issued to people at risk of opioid overdose. In 2016-2017, almost 6,500 kits were issued in the community and 700 kits were issued in prisons upon release.

Controlling TB in prisons (MONGOLIA)

Between 2001 and 2010, the number of reported TB cases among the 6,000 people in prison in Mongolia decreased by nearly two-thirds, with the notification rate declining from approximately 2,500 cases per 100,000 population to fewer than 900 cases per 100,000. Implementation of a TB policy in prisons developed jointly by the ministries of health, justice, and defense, systematic case detection, and the upgrading of health services in prison and improved living conditions contributed to this result. Upon being admitted to detention centers or prison, each individual is screened for TB by symptom screening and X-ray. Microscopy is used where cases are suspected based on the results of the first two methods. TB treatment can be started at the detention center. Men with TB are transferred to the prison TB hospital for treatment, and women with TB are sent to a female prison unit where treatment is also available. In parallel, prison conditions were improved, including building renovations, reduced prison population density and improved food intake. The TB infection rate among people in prison, which in 2001 was 18 times higher than among the general population, was reduced to five times higher by 2009.⁵³

Post-release integration of formerly incarcerated people (ZAMBIA)

PREO (Prisoner Reintegration and Empowerment Organization) is an NGO established by formerly incarcerated people to advocate for the rights of people in prison and support reintegration into the community. PREO facilitates the referral of formerly incarcerated people living with HIV to HIV services and other health services, and links them to income-generating activities. Through partnerships, PREO establishes linkages for the formerly incarcerated person to education and employment organizations, legal-aid services, and supportive family ties.

Monitoring HIV services in prisons (MULTIPLE COUNTRIES)

In selected countries, including Vietnam, Tajikistan, and Seychelles, UNODC is helping prison systems to review and integrate their monitoring systems for data on HIV and TB services. This includes:

⁵³ Yanjindulam P, Oyuntsetseg P, Sarantsetseg B, et al. (2012). [Reduction of tuberculosis burden among prisoners in Mongolia: review of case notification, 2001-2010](#). *International Journal of Tuberculosis and Lung Disease*. 16(3):327-9.

- Revision and compilation of the current indicators, methods, and tools for M&E of the HIV epidemiological situation and related services for people in prison.
- Consultations with relevant government authorities, civil-society organizations, and international organizations, to develop a comprehensive list of M&E indicators covering all people in prison (not just those living with HIV). The list will meet the needs of the national prison and health authorities for purposes of management and development of programs funded by donors (Global Fund) and the state budget, and be aligned with the international reporting requirements, particularly UNAIDS Global AIDS Monitoring (GAM) with regard to estimates of the size of prison populations, HIV prevalence among people in prison, and HIV prevention programs in prisons.
- Consultation meeting with relevant partners on the introduction and implementation of the indicators and data collection methods.
- Development of an electronic tool and a manual for M&E, with pretesting and revision based on feedback and inputs from relevant stakeholders, prison health and national AIDS authorities.
- Capacity-building activities.

6. Further reading and resources

1. United Nations Office on Drugs and Crime. Publications – Prisons and HIV (website).

https://www.unodc.org/unodc/en/hiv-aids/new/publications_prisons.html

2. World Health Organization Regional Office for Europe. Prisons and Health (website).

<http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health>

3. World Health Organization. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update*. Geneva: WHO; 2016.

<https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>

4. United Nations Office on Drugs and Crime, International Labour Organization, United Nations Development Programme, World Health Organization, Joint United Nations Programme on HIV/AIDS, United Nations Population Fund, UN Women. *Policy brief: HIV prevention, treatment, care and support in prisons and other closed settings: A comprehensive package of interventions*. Vienna: UNODC; 2013.

https://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf

5. United Nations Office on Drugs and Crime, European Monitoring Centre for Drugs and Drug Addiction. *HIV in prisons: Situation and needs assessment toolkit*. Vienna: UNODC; 2010.

https://www.unodc.org/documents/hiv-aids/publications/HIV_in_prisons_situation_and_needs_assessment_document.pdf

6. World Health Organization, United Nations Office on Drugs and Crime, International Committee of the Red Cross. *Prisons and health*. Copenhagen: WHO; 2014.

http://www.euro.who.int/_data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf?ua=1

7. International Committee of the Red Cross. *Health care in detention: A practical guide*. Geneva: ICRC; 2015.

<http://icrcndresourcecentre.org/wp-content/uploads/2015/10/icrc-002-4213-1.pdf>

8. World Health Organization, United Nations Office on Drugs and Crime. *Opioid substitution treatment in custodial settings: A practical guide*. Oldenburg: BIS-Verlag der Carl von Ossietzky Universität Oldenburg; 2008.

http://www.unodc.org/documents/hiv-aids/OST_in_Custodial_Settings.pdf

9. United Nations Office on Drugs and Crime. *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings*. Vienna: UNODC; 2014.

http://www.unodc.org/documents/hiv-aids/2017/ADV_PNSP_REV_FEB2015with_cover1.pdf

10. United States Agency for International Development, Tuberculosis Coalition, International Committee of the Red Cross. *Guidelines for control of tuberculosis in prisons*. Washington, DC: USAID; 2009.

http://pdf.usaid.gov/pdf_docs/PNADP462.pdf

11. Harm Reduction International. *Monitoring HIV, HCV, TB and harm reduction in prisons: A human rights-based tool to prevent ill treatment*. London: HRI; 2016.

https://www.hri.global/files/2016/02/10/HRI_MonitoringTool.pdf