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Assessment Report on HIV and AIDS, Tuberculosis, Hepatitis B and C, and other Sexually Transmitted Infections in Prison Settings in the SADC

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ENGLISH

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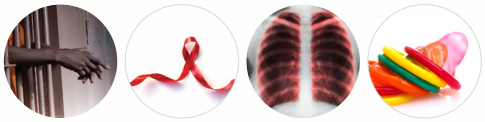

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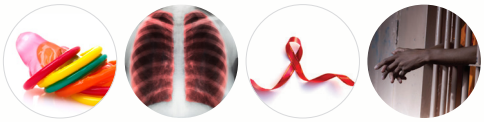
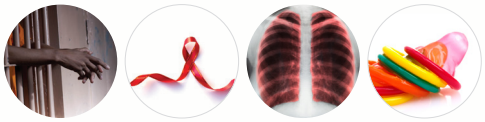
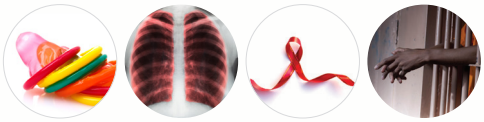




ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
DOTS	Directly observed therapy short course
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HTC	HIV testing and counselling
IDU	Injecting drug use
IPT	Isoniazid preventive therapy
MDR-TB	Multidrug-resistant tuberculosis
NGO	Nongovernmental organisation
NSP	Needle syringe programme
OST	Opioid substitution therapy
PMTCT	Prevention of mother-to-child transmission
SADC	Southern African Development Community
TB	Tuberculosis
UN	United Nations
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
WHO	World Health Organization
XDR-TB	Extensively drug-resistant tuberculosis



1. INTRODUCTION

The Southern African Development Community (SADC) region is at the epicentre of the human immunodeficiency virus (HIV) and tuberculosis (TB) epidemics. The 2009 SADC HIV and AIDS Epidemic Report showed that 10 out of 15 SADC Member States had high national HIV prevalence. The same Member States had TB prevalence rates ranging from 300 to 1,000 cases per 100 000—considerably higher than the global TB prevalence rate of 139 per 100 000 cases (SADC TB report, 2009). Rates of other sexually transmitted infections (STIs) are also high; those infections, especially genital ulcer diseases, increase the risk of HIV transmission and acquisition (WHO, 2006). Prompt and appropriate treatment of STIs reduces the individual risk of HIV infection, making high-quality STI programmes critically important for controlling the HIV and AIDS epidemic in key populations that are at higher risk of acquiring HIV.

The United Nations Office on Drugs and Crime (UNODC), World Health Organization (WHO) and other multilateral agencies have extensively studied the situation of prisoners worldwide with respect to communicable diseases such as HIV and AIDS, TB and STIs. Globally, including in Africa, the rates of these diseases tend to be significantly higher than in the general population.

In recent years, for example, the estimated adult prevalence of HIV in African prisons has been between 6 and 50 times higher than outside prisons (Human Rights Watch, 2006; UNODC, 2008). While the exact HIV prevalence rates in most prisons in the SADC region are unknown, preliminary results of HIV and AIDS Situation and Needs Assessments done by a number of SADC Member States (with the support of the UNODC) also point to higher HIV rates inside prisons, especially among women prisoners.

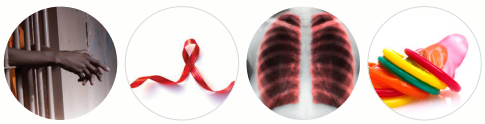
Most prisoners are males between the ages of 19 and 35, many of them sexually active. Prior to entering prison, many will have engaged in activities such as drug use (including injecting drug use, or IDU) and tattooing, while some will have committed sexual violence (including rape)—all of which carries high risks of HIV and other infections. Inside prison, inmates are likely to participate in a number of high-risk behaviours, including unprotected sex between men (either or forced). Drug use (including unsafe drug injecting) and the sharing of needles, blades and other sharp instruments for tattooing are also rife among prisoner populations in most countries (UNODC, 2008).

The United Nations (UN) has established Standard Minimum Rules for the Treatment of Prisoners. These mainly cover medical care, but it remains each Member State's responsibility to implement the standards. The standards emphasise the need to recognise prisoners' fundamental civil, political, social, economic and cultural rights irrespective of their detainee or prisoner situation. Those rights imply a duty from the state to guarantee access to medical and health care, as well as social assistance, along with the right to adequate standards of living for prisoners. The UN Standard Minimum Rules could serve as a starting point for the SADC regional guidelines, if they are adapted to the SADC context.

The provision of adequate and quality medical care, coupled with good prison conditions, could promote the wellbeing of both prisoners and prison staff. It should be the objective of prison management that prisoners leave prison in the same or better health condition than when they entered. Prisoners are members of communities; most of them eventually return to their communities. If they do so with untreated communicable diseases, they put others in those communities at risk.

Communicable diseases in prisons thus pose a serious threat to public health generally, since prisons tend to present a gap in what should be a sound public health system. This is due to the comparatively poor quality of health services delivered in the prison sector, along with poor environmental, sanitary, dietary and other conditions that increase the risks of communicable disease transmission and acquisition. It is therefore critically important to ensure that prisons do not become incubators of communicable diseases, but instead contribute positively to efforts to control communicable diseases in society generally. Good prison health is good community health.

All SADC Member States have mounted responses specifically for communicable diseases in prison settings. However, levels of implementation and commitment differ across the region. In many Member States, prisons settings remain low among development and resource allocation priorities. Thus far Botswana, South Africa, Swaziland, Tanzania and Zambia have developed prison-specific policies for controlling communicable diseases (as has Lesotho, but its policy is yet to be approved). However, some of these policies do not sufficiently address issues related to prisoners.



1.1 Methodology for the assessment

In order to establish the situation of HIV, TB, hepatitis B (HBV) and C (HCV), and STIs in prisons in the SADC region, a desk review of pertinent documents and research was carried out. Member States were then invited to participate in a regional consultation meeting to augment the situation analysis. The consultation was aimed at reviewing the current situation and prevalence of HIV and AIDS, TB, HBV, HCV and STIs in prisons in the SADC region, sharing results of recent surveys and discussing the available information to support the design and implementation of appropriate responses to these communicable diseases.

The meeting also discussed current strategies used by Member States to address these diseases, along with the impediments they face in providing a full range of services to all prisoners (such as restrictive laws and regulations). It recommended the development of a regional response to address the issues of HIV and AIDS, TB, HBV, HCV and STIs among prisoner populations, including providing access to antiretroviral (ARV) and other treatment for foreign prisoners, and onward care after release from prison. The consultation identified key stakeholders to support a regional response to address communicable diseases in prisons.

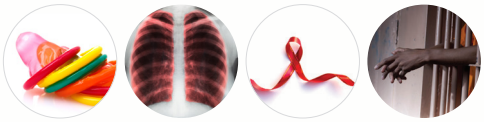
The meeting noted the lack of readily accessible data on communicable diseases in prisons in the SADC region. General surveys do not disaggregate data to reveal the situations in prisons. The situation analysis was therefore informed mainly by data gathered from the UNODC and WHO, much of it general and not specific to the SADC region. In addition, Member States provided information describing their respective situations.

2. CURRENT SITUATION OF HIV AND AIDS, TB, SEXUALLY TRANSMITTED INFECTIONS AND HEPATITIS IN PRISONS IN THE SADC REGION

Living environments and conditions in prisons are notoriously poor around the world. Overcrowding is common and infrastructure is often inadequate. Statistics show that prisons in Africa house approximately 918 000 (almost 10% of the world's prison population) men, women and children—more than 668 000 of them in sub-Saharan African countries. Rates of incarceration (per 100 000) vary significantly, however—from South Africa's 349 per 100 000 to Burkina Faso's 23 per 100 000. SADC countries account for almost one third of the total prison population in Africa. Available information indicates that there are about 14,000 women incarcerated in Africa. However, statistics for juveniles (both girls and boys) are difficult to obtain since they are most often housed with (and tallied as) adult prisoners. Table 1 shows the prison population and occupancy levels in SADC Member States.

Table 1: Prison population and occupancy levels in SADC Member States

Country	Prison population	Prison population rate (100 000)	Occupancy levels
Angola	8,300	52	82.9%
Botswana	5,000	267	131.5%
DR Congo	30,000	57	270.5%
Lesotho	2,525	144	92%
Malawi	11,996	78	197.6%
Mauritius	2,264	176.4	110%
Mozambique	16,284	76	195.1%
Namibia	4,337	194	136.7%
Seychelles	442	516	111.5%
South Africa	161 496	324	93.5%
Swaziland	2,628	219	92.6%



Tanzania	45,000	92	145.1%
Zambia	15,544	120	200%
Zimbabwe	13,361	107	78%
Total/Average	331 586	157	138%

Only five SADC Member States have prison occupancy levels lower than 100%. The average incarceration rate for SADC countries is 157 per 100 000, with occupancy levels averaging at 138%. Overpopulated prisons are high-risk environments for disease transmission and they challenge the provision of adequate health services. Overcrowding reduces the quality and extent of ventilation, lighting and sanitation available to prisoners. This is particularly important for controlling the spread of airborne disease such as TB. High rates of HIV co-infection, as well as multidrug-resistant TB (MDR), have been reported in prisons in the SADC region.

Important factors affecting disease transmission in prisons in the region include:

- Dilapidated infrastructure with poor ventilation, sanitation and lighting;
- Health service provision that is limited in both scale and quality;
- The practice of unprotected sex, especially between men. While some sex between men in prisons is consensual, rape and other forms of sexual abuse and violence are reportedly common;
- The vulnerability of women and girls in prison to sexual abuse and exploitation by both prisoners and staff; and
- Violence and brotherhood rituals that involve bloodletting, along with the use and sharing of sharp instruments (including needles for injecting drugs).

2.1 HIV and AIDS in prisons

Given the favourable conditions for disease transmission, the HIV and AIDS epidemic has not spared prisons. Available data suggest that in many countries HIV prevalence in prison is higher than in society overall. Effective policies to prevent HIV and AIDS inside prisons and other correctional institutions are often hampered by the denial of both the problem and the existence of key factors that contribute to the spread of HIV and AIDS. For example, in generalised epidemics such as those in SADC region, HIV transmission occurs mainly during unprotected heterosexual sex. In such contexts, high rates of HIV infection among prisoners largely reflect the high rates of HIV transmission in the wider population. However, the continued spread of HIV inside prisons stems primarily from unprotected sexual intercourse (mainly between men), unsafe medical practices, and the sharing of contaminated injecting and tattooing equipment.

HIV prevalence in prison populations tends to be about twice higher than in the general population. National adult HIV prevalence in South Africa in 2006 was estimated at 18%, while inside prisons it was an estimated 45%. In Zambia, adult HIV prevalence in the general population in 1999 was reported to be 17%, compared with 27% prevalence inside prisons. Due to such high infection rates, prisoners are generally regarded as most-at-risk populations.

Countries with high rates of HIV infection among specific groups of the population (but not in the rest of society) are deemed to have concentrated HIV epidemics. Often the populations in whom most HIV infections occur are also more likely to be imprisoned, and once incarcerated they may continue to practice behaviours that involve high risks of HIV infection. In countries where IDU is rife, high HIV infection rates can stem from the sharing of contaminated injecting equipment both outside and inside prison. Such countries tend to have significantly higher HIV prevalence rates in prison than in society overall. In the SADC region, Mauritius exhibits this pattern; HIV prevalence inside its prisons has been estimated to be 50 times higher than in the general population (UNODC, 2008). This figure has probably decreased to about 30:1, but the ratio remains many times higher than in SADC Member States with generalised HIV epidemics. Table 2 provides estimates of HIV prevelance in prisons in SADC Member States.[1]

1 *Information as per country presentations*

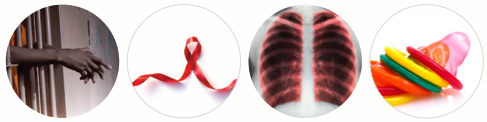


Table 2: Estimated HIV prevalence in prisons in SADC Member States

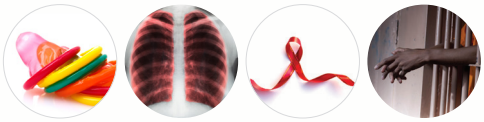
Country	HIV prevalence (%)
Angola	Information not available
Botswana	14
DR Congo	4.1
Lesotho	31.4
Malawi	30
Mauritius	30
Mozambique	16*
Namibia	9.5
Seychelles	0.9
South Africa	Information not available
Swaziland	33.9
Tanzania	8.4
Zambia	27
Zimbabwe	14.2

There is a high turnover of prison populations, since most prisoners are incarcerated for short periods of time; the average duration of imprisonment is less than 36 months. It is therefore vital to control the spread of HIV both within and outside prisons. UNODC is the lead UN agency for HIV and AIDS in prisons. It recommends the following interventions as part of a comprehensive package for effective HIV and AIDS prevention, treatment, care and support in prisons (UNODC, UNAIDS, WHO, 2006):

- Targeted or tailored information, education and communication (IEC),
- HIV testing and counseling (HTC),
- Needle and syringe programmes (NSP),
- Opioid substitution therapy (OST),
- Antiretroviral therapy (ART),
- STI prevention and treatment,
- Condom programming and distribution,
- Hepatitis diagnosis, treatment (for A, B and C) and vaccination (for A and B),
- TB prevention, diagnosis and treatment, and
- Provision of prevention of mother-to-child transmission (PMTCT) services.

It is very important that these services are offered in a confidential and professional manner, while remaining easily accessible.[2]

2 *Annex 1 summarises Member State responses to HIV and AIDS in prisons weighted against the comprehensive package.*



2.2 Tuberculosis in prisons

Globally it is estimated that rates of TB infection are at least 100 times higher among prisoners than in the general population. This is attributed to the poor living conditions, and especially poor ventilation, overcrowding and inadequate nutrition (UNODC, 2008). Unfortunately, there are limited data on the burden of TB in prisons in the SADC region. Available data indicate that TB infection rates are high, especially where HIV prevalence is also high among prisoners. (A 1997 study done in Malawian prisons found a TB infection rate in prisons of 5,142 per 100 000, compared with 209 per 100 000 in the general population; Nyangulu 1997.) As with HIV and AIDS, TB is probably over-represented in prison populations, with infection rates likely to be higher than in the general public. HIV and TB co-infection is understood to be a major cause of mortality in prisons. Table 3 summarises the available data on TB infections in prisons in the SADC region.

Table 3: Tuberculosis in SADC Member States

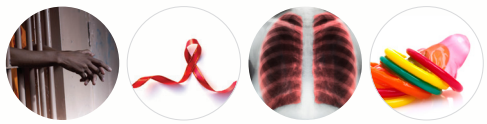
Country	TB prevalence rate per 100 000 inhabitants	TB mortality rate	% of TB patients testing positive for HIV	TB prevalence in prisons
Angola	389	30	15	-
Botswana	534	39[3]	66	-
DR Congo	645	76	20	-
Lesotho	405	9.5	77	-
Malawi	243	22	64	835
Mauritius	40	0.99	6	0.08%
Mozambique	323	31	66	6079
Namibia	588	31	58	15 cases
Seychelles	61	26	20	-
South Africa	808	52	58	-
Swaziland	673	34	84	-
Tanzania	157	11	37	440
Zambia	347	15	67	5256
Zimbabwe	431	37	78	-

Note: TB prevalence data presented here are based on information from SADC Member States, and are provided either as percentages or absolute numbers of cases.

Although prisons offer favourable conditions for the spread of TB, they also provide opportunities to treat populations who otherwise might be hard to reach, thereby limiting the onward transmission of TB. Health service providers should seize this opportunity. Indeed, some SADC Member States are placing TB in prisons higher on their agenda. Countries that are currently implementing a regional UNODC project on HIV and AIDS are busy mainstreaming TB by adopting a more comprehensive approach to overall disease control in prisons.

TB control in prisons should not be undertaken as an isolated technical programme, but should form part of an integrated and comprehensive effort to improve health inside and outside prisons (WHO, 2001). TB control in prisons therefore should involve a system that is directly linked, coordinated and harmonised with the existing TB control programme in the public health system to ensure sustainability. Effective TB control programmes in prisons require early diagnosis and case finding, and treatment until cured.

3 *Botswana had mortality rate of 8 percent in 2008 but in 2011 the rate is five times higher and this shows the importance of disease control especially in environments conducive for its spread like prisons.*



TB control programmes in prisons could be set up in the manner outlined by WHO (2001), with the following main elements:

- Prevention of infection through awareness raising,
- Prevention of disease through Bacillus Calmette–Guérin (BCG) vaccination,
- Prevention of TB transmission,
- Treatment of infectious and latent TB,
- Diagnosis (both laboratory and clinical),
- Treatment regimens (directly observed therapy short course, DOTS), and
- Recording and reporting of disease occurrence.

Poor health service provision for TB treatment in prisons can have a negative impact on controlling drug-resistant strains of TB. When imprisonment interrupts treatment, the risk of drug- resistant TB is likely to increase. In Zambia, for example, the prisons TB programme has detected at least three cases of MDR-TB in prisoners. South Africa has also reported cases of MDR and of extensively drug-resistant (XDR) TB.

Most SADC Member States have DOTS programmes in place in their prisons. Member States report that the lack of proper follow-up upon release from prison limits the effectiveness of TB treatment.

2.3 Other sexually transmitted infections in prisons

Imprisonment does not stop people from having sex, whether consensual or non-consensual. Sex between prisoners appears to be relatively common, and sex between prison staff and prisoners has also been reported. Many prisoners come from disadvantaged backgrounds, which makes it likely that they are in poor sexual health when they enter prison (Stewart, 2007). The presence of ulcerative STIs, which can result in sores or other skin lesions in the genital area, increases the risk of HIV acquisition and transmission. Acute STIs in prisoners are a very good indicator of sexual activity inside prisons. Most SADC Member States have mechanisms in place for the prevention, diagnosis and treatment of STIs. Although data are lacking on the burden of STIs in prisons, STIs appear to account for a large number of visits to health facilities in prisons. The Seychelles has recorded 1.3% prevalence of STIs in its prisons, considerably higher than the national prevalence of 0.92%. STI prevalence of 3% has been reported in prisons in Botswana, 11.4% in Swaziland (for Syphilis), and 15% in Zambia.

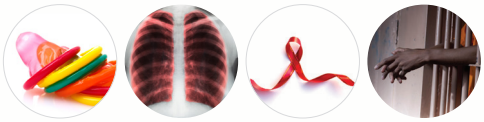
In Lesotho prisons, there has been a reported decline in the number of STI cases after condoms[4] were made available to prisoners, though it is not clear whether the decline was due to condom use. Other SADC countries that make condoms available in prisons include South Africa (where both staff and inmates reportedly have access to condoms), Tanzania and Zambia. The prevention, and early detection and treatment of STIs can play a vital role in preventing HIV infections.

2.4 Hepatitis B and C in prisons

HBV and HCV are particularly important in prison settings since they are blood borne infections that are usually associated with the sharing of contaminated drug injecting, tattooing and other sharp instruments. About 2000 million people have been infected with hepatitis B virus worldwide, of whom more than 350 million are chronically infected, and between 500 000 and 700 000 people die annually as a result of hepatitis B virus infection. Some 130–170 million people are chronically infected with hepatitis C virus.-- from http://www.cdc.gov/Features/dsHepatitisAwareness/index.html

Seychelles currently has a prevalence rate of 1.3% in prisons, which is almost ten times higher than in the general population. HCV is found in blood and other body fluids. Like HIV, percutaneous and mucous membrane exposure is the main route of infection. However, HBV and HCV can spread more easily than HIV. Infection can be prevented by reducing the risks associated with sharing contaminated injecting equipment, shaving paraphernalia, tattooing instruments, and participating in unprotected sex. It is also important to ensure that infection control is improved during medical procedures, especially in resource-limited settings.

4 *Condoms should always be distributed with a water-based lubricant. Oil-based lubricants and saliva increase condom failure rates. Research shows that thicker condoms are no less likely to fail or slip off during anal intercourse than thinner ones, as long as adequate quantities of lubricant are used. Spermicidal lubricant should never be used for anal intercourse as it causes the lining of the rectum to slough off, making the recipient more susceptible to STIs, including HIV and AIDS. A condom demonstration should be done as part of condom distribution programme; it enables recipients to see proper use and decreases condom failure rates.*



It is generally recommended that prisoners are screened for HBV and HCV upon admission, and this should be followed with periodic, regular screenings. Cases should be notified where required, and post- exposure management procedures should be introduced. Where there is chronic hepatitis, vaccination for Hepatitis A and HBV should be carried out, and treatment for substance abuse should be available (Weinbaum et al., 2003).

Swaziland is currently the only country in the region that vaccinates prison staff for HBV. It and most other SADC Member States also offer prevention, diagnosis and treatment for hepatitis infections. However, Botswana, Malawi and Mozambique do not have services specifically for HBV and HCV prevention, diagnosis and treatment.

2.5 Special groups within prisons

Special groups, such as women, juveniles and non-national prisoners, can pose major challenges. Many Member States appear to lack clear guidance for dealing with issues related to these groups. Some services are not available to non-national prisoners. In Botswana and Mozambique, for example, ART is available free of charge only to citizens. Although women and juvenile prisoners are known to be especially vulnerable to sexual abuse, they have limited access to tailored health services in prisons. Member States are aware of the need to separate juveniles for the adult prison population, but implementation appears to be difficult (due to space limitations and other constraints).

A large number of individuals in prison are awaiting trial, and programmes are especially weak in addressing their needs. Member States indicated that guidance in this area was also lacking. Women constitute a small portion of the prison population—about 1% of inmates are women. Women are most commonly imprisoned for drug-related offences and/or sex work (which entail greater vulnerability HIV and AIDS, STIs, and HBV and HCV. Generally, imprisoned women have poor health status. In prison they are vulnerable to sexual abuse by staff and male prisoners. Several Member States report that women prisoners occasionally trade sex inside prison for basic commodities (such as food and soap).

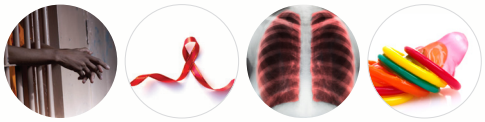
Some female prisoners enter prison while pregnant or become pregnant during their prison term. Antenatal services for these women are limited, and at least four Member States were found not to offer PMTCT services for pregnant HIV-positive women in prison. The box outlines a checklist for HIV and AIDS services for women in prisons, as developed by the UNODC.

Box: Providing comprehensive HIV and AIDS prevention, treatment, care and support for women in prisons

Women in prisons are more vulnerable than male prisoners and therefore require extra efforts to ensure access to quality health services. UNODC recommends the following comprehensive package of HIV and AIDS interventions for women in prisons:

- Information on modes of HIV transmission and ways to reduce those risks;
- Information on testing and treatment;
- Access to essential prevention commodities, such as male and female condoms, sterile injecting equipment, and safe tattooing equipment;
- Voluntary confidential HTC services;
- Diagnosing and treating STIs;
- Drug dependence treatment, including substitution therapy for opioid dependence;
- Appropriate diet and nutritional supplements;
- ART, preventing and treating TB, other opportunistic infections and other blood-borne infections such as HBV and HCV;
- Access to reproductive health and family planning services;
- Care during pregnancy and delivery in appropriate settings and PMTCT services for HIV-positive pregnant women;
- Post-exposure prophylaxis (PEP) to women who have been exposed to infection;
- Care for children, including those born to HIV-positive mothers; and
- Palliative care and compassionate release for AIDS sick and terminally ill patients.

Source: UNODC (2008)



3. DEBATES AND CHALLENGES RELATED TO HIV AND AIDS, TUBERCULOSIS, SEXUALLY TRANSMITTED INFECTIONS AND HEPATITIS B and C IN PRISON SETTINGS

3.1 Prisoners' rights to equitable HIV and AIDS, tuberculosis, sexually transmitted infections and hepatitis C services

International law states that states have an obligation to provide humane prison services irrespective of whether or not they lack resources. In 1998, UNAIDS and UNHCHR issued the following statement:

"Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered."

Prisoners' rights continue to be matter of debate in Member States and have proved very difficult to realise. Prison authorities in Member States appear to be seeking adequate resource allocation to ensure that prisoners have access to the same types of services for HIV and AIDS, TB, HBC and HCV, and STIs that are available to the general population outside prisons. Such undertakings are sometimes complicated further by the need to respect prisoners' rights to decline such services. Although this presents problems for disease control, human rights must prevail, including in prison settings.

3.2 Criminalisation of homosexuality

STI cases in prisons have been documented in all SADC Member States, confirming that unprotected sex occurs inside prisons. Yet policy makers in most Member States continue to deny this reality. Most SADC Member States criminalise sex between men and lack provisions for supporting men who have sex with other men. South Africa is the only country in the region with laws that protect men who have sex with men.

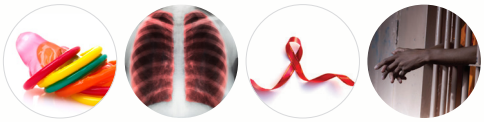
Service providers report that criminalisation and broader social stigma regarding same-sex relationships makes it extremely difficult to openly provide support services. There is very little positive public awareness about these issues in most countries. Only Lesotho and South Africa currently make condoms available to prisoners (mainly to male prisoners). This continues to be a core issue in debates about comprehensive health service provision in prison settings.

3.3 Methods to counteract overcrowding

Member States, as well as human rights organisations, are concerned about the need to address overcrowding in prisons. Overcrowding facilitates the spread of communicable diseases, and undermines sound prison administration and management. Overcrowding is a complex challenge that is related to inappropriate admission policies. International guides for reducing prison population exist and some SADC Member States have considered implementing interventions to address overcrowding. However, the use of parole, amnesties and compassionate releases appears to be insufficient to significantly reduce prison overcrowdings. Mozambique recently drafted a law on alternatives to imprisonment, which will allow for more appropriate classification of crimes and make provision for non-custodial sentencing. Zambia's Ministry of Home Affairs has outlined targets for amnesty and parole releases, but it has been unable to meet those targets (because too few potential beneficiaries have met the criteria).

3.4 Methods to control and manage drug use

Injecting drug use in prisons is not widely acknowledged by policy makers in Member States, and interventions to address IDU-related health issues are lacking generally. International guidelines state that all services that are available to the general public should be made available to prisoners, as well. However, most SADC Member States do not provide harm reduction services such as NSP and OST for the general public, and those services are also not available in prisons.



In the SADC region, Mauritius is the only state to provide OST, but the service is available only to prisoners who had been on treatment prior to incarceration. Since the HIV epidemic in Mauritius is fuelled mainly by injecting drug use, there is a major need to make OST available to all who need it.

In addition, rates of IDU appear to be on the increase in other Member States, making it important that they also design and introduce interventions that can reduce the transmission of HIV and hepatitis through the sharing of contaminated drug-injecting equipment.

3.5 Financing the prison sector

Prison health services are often severely under-funded, leading to a lack of resources for infrastructure, equipment, transport, staff and public health-related consumables (such as diagnostic materials or medicines). Most Member States report that the available diagnostic and treatment procedures are often out of date, poorly applied or unnecessarily costly. Certain services, such as medical screening, may be abandoned because of damaged equipment. Inadequate funding also leads to poor disease surveillance and reporting, which may in turn lead to further funding restrictions. Funding shortages lead to delayed or low remuneration, lack of training and equipment, and undermine the morale and productivity of prison health staff. Member States need to seek ways to counteract these trends and establish mechanisms to achieve sustainable funding to the prison sector.

4. INITIATIVES TO RESPOND TO HIV AND AIDS, TUBERCULOSIS, SEXUALLY TRANSMITTED INFECTIONS AND HEPATITIS B and C IN PRISON SETTINGS

There is growing awareness about HIV and AIDS in prison settings across the SADC region, and this is leading to collaboration around several ongoing initiatives.

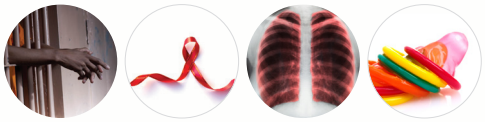
4.1 HIV and AIDS prevention, treatment, care and support in prison settings—UNODC regional project

This UNODC project covers Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe. The aim is to support national responses that are rights- and evidence-based, suit countries' epidemics, promote their priorities, and make the most of the available resources. UNODC also prioritises the development of a regional response to HIV and AIDS in prisons as a means to address the challenges countries face in the SADC region. In related fashion, the African HIV and AIDS Prison Partnership Network (AHPPN) develops and disseminates tools, guidelines and standards, documents best practices and encourages a multisectoral approach to HIV and AIDS responses in prison settings. The project also aims to advance advocacy, create an enabling environment for learning, and address the lack of services available in prisons. It seeks to do so by assessing and enhancing current programmes and, where necessary, by supporting prison services and other stakeholders to start new programmes that offer services for prisoners and prison staff.

4.2 Projecto Inclusão ("Inclusion Project")—HIV and AIDS prevention in Mozambican prisons

The "Inclusion Project" is being implemented by a partnership between the Ministry of Justice in Mozambique, UNFPA and Pathfinder International of Mozambique. The initiative aims to improve prisoner and prison staff access to information and prevention materials, encourage HIV testing and counselling, support the establishment of quality referral systems, help reduce factors that increase the risk of infection, and strengthen the capacity of key stakeholders for addressing HIV and AIDS in prisons. The project seeks to ensure that human rights are respected, along with diversity in religion, culture and sexual orientation. The intended beneficiaries (prisoners and prison staff) play a leading role in implementing the project, which covers about 30% of the prison population of Mozambique.

One key lesson from this project is that a lack of empirical evidence should not always delay action. The project developed out of a similar initiative intended for youth outside prisons, and it is flexible enough to be adapted and refined during implementation.



4.3 TB management and control in Zambian prisons

Zambia's Ministry of Home affairs, in partnership with its Ministry of Health and several UN agencies (including UNODC), has launched this project to reduce the transmission of TB in prisons. The project has several elements, including reducing overcrowding in prison cells, creating TB isolation wards, training prison staff in the prevention and control of TB, and supporting peer education. It also seeks to ensure that PMTCT, as well as male circumcision and condom distribution services are available to staff. Other aspects include improving administrative and environmental control of prisons (including the construction of new buildings), providing TB drugs, ensuring that nutrition is sufficient both in quantity and quality, and establishing referral systems that link the prison health system to the overall public health system.

The project has reinforced the importance of HIV/TB collaboration, and highlights the need to link TB management in prisons to TB management in the general public.

4.4 Condom distribution in Lesotho prisons

Lesotho has a developed a strong draft HIV and AIDS policy for prisons, which reflects most of the principles recommended by international and national guidelines. Lesotho now distributes free condoms in prisons even though sex between men is criminalised and the policy has not yet been formally approved. This initiative shows that effective steps can be taken even before an enabling legal environment has been achieved. The box summarises key elements of the policy.

Box: Lesotho policy on distribution of HIV and AIDS prevention materials

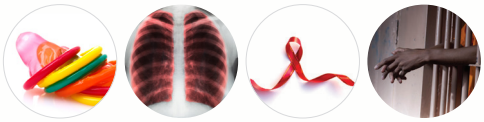
Distribution of prevention materials

Rationale
Although consensual sex (mostly sodomy) between inmates is prohibited, sexual activity between inmates takes place and has been identified as one of the common ways in which HIV is transmitted in correctional institutions. Safer sex practices should be encouraged for all sexually active inmates, and this should be accompanied by the provision of safer sex materials such as condoms and water-based lubricants. The use of water-based lubricants can help prevent condom breakage during anal intercourse, thus making the condoms currently available more useful in the prison context. In addition, because lubrication reduces tearing of the rectum as a result of anal intercourse, the risk of transmission is further reduced. For this reason, condoms and other preventive materials for both male and female inmates should be provided throughout their detention and prior to leave or release.

Tattooing, which is widespread among inmates, has also been identified as a potential mode of transmission within correctional service institutions. One way of reducing the risk of infections due to tattooing would be the provision of sterilising agents.

Policy Statement
Lesotho correctional services shall:

- Provide HIV and AIDS education to both inmates and staff, which is comprehensive enough to change behaviour;
- Ensure a sustainable supply of condoms and other safer sex materials, such as water-based lubricants to use with condoms, female condoms and dental dams for both male and female inmates;
- Ensure that condoms and other safer sex materials are accessible in a confidential manner, for instance by placing them in toilets and showers, where they can be obtained discreetly and without requiring face-to-face interaction and in non-discriminatory fashion;
- Distribute bleaches and other disinfectants so that inmates can sterilise implements used for tattooing.



5. RECOMMENDATIONS

5.1 Determining the disease burdens in prisons

The ideal starting point for Member States is to conduct a comprehensive situation analysis. Basic information on the burden of disease, risk factors, key stakeholders, legislative frameworks, and available services, as well as capacity and infrastructure needs, is vital. It serves as a basis for policy reform advocacy and for mobilising resources.

UNODC has developed a toolkit that can be used as a guide for such analysis. The toolkit has been piloted in some Member States and is proving to be very useful. As with any instrument of this sort, the toolkit has to be adapted to suit Members State's specific needs and situations.

5.2 Increased coordination and collaboration with key stakeholders

Member states should ensure that stakeholders have a platform for coordinating efforts to address communicable diseases in prisons. This could help minimise the duplication of efforts, and serve as a forum for exchanging information and experiences. Combining the various comparative advantages of stakeholders could result in the design and implementation of more effective programmes and interventions.

The forum should be linked to, and represented on other national coordinating bodies for HIV and AIDS, TB, STIs, and HBV and HCV. Where possible the forum should develop a work plan that is applicable to national strategies and plans. The strategies should be evidence-based and should fit local needs and contexts.

The key stakeholders include prisoners and they should have opportunities to contribute to the development of the programmes and interventions. Prison authorities should seek ways to involve prisoners.

5.3 Improved information collection and management

Information collection and management should rank among the first tasks of a coordinating body, and needs to build on the rapid situation analysis. Once evidence is collected, the coordinating body should then devise a dissemination and advocacy strategy for raising awareness, while working towards:

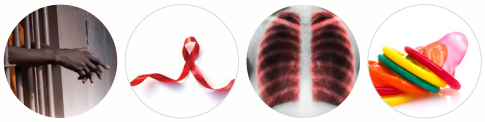
- More committed support from senior leadership;
- Revision or reform of laws, policies and/or regulations to facilitate comprehensive HIV and AIDS, TB, STI, and HBV and HCV programming;
- Decriminalisation of same-sex relations based on findings of prisoners' sexual behaviours and activities;[5]
- Provision of comprehensive, acceptable and accessible HIV and AIDS, TB, STI, and HBV and HCV services (prevention, treatment, care and support) to people involved in same-sex relations and those who inject drug use within prison settings; and
- Allocation of adequate sustainable resources for effective in-prison disease management and general prison administration, including improved diets for prisoners and more hygienic conditions.

Member States should improve the documentation of their efforts, and share those experiences regionally as well as globally. In addition to offering lessons and guidance, this could also help clarify the relevance or practicality of internationally developed guidelines and tools. Information collection is also vital for monitoring and evaluating interventions, and for identifying corrective steps.

5.4 Establishment of mechanisms for ongoing stakeholder capacity building

Member states should ensure that prison health service providers are up-to-date on new research, techniques and experiences in related fields, such as sexual health reproductive services, drug dependency treatment etc. Prison health authorities should take advantage of relevant existing platforms to tap into current best practices. Ongoing capacity building (such as short courses, study tours or conference participation) will improve advocacy, planning and implementation strategies of more effective interventions.

5 *This is arguably the strongest impediment to HIV and AIDS, TB, STIs, and HBV and HCV interventions in prisons.*



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