

# HIV PREVENTION, CARE AND TREATMENT in PRISONS

in the SOUTH-EAST ASIA REGION



**World Health  
Organization**

Regional Office for South-East Asia

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## ACRONYMS AND ABBREVIATIONS

AASRA	Association for Scientific Research on Addictions
AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
DOTS	directly observed therapy, short-course
GFATM	Global Fund to Fight AIDS, TB and Malaria
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IDU	injecting drug user
IEC	information, education and communication
MSM	men who have sex with men
NGO	nongovernmental organization
NSP	needle and syringe programme
OST	opioid substitution therapy
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNHCHR	United Nations Office of the High Commissioner for Human Rights
UNODC	United Nations Office on Drugs and Crime
VCT	voluntary counselling and testing
WHO	World Health Organization

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## EXECUTIVE SUMMARY

The aim of this review was to gather information relating to HIV prevention, care and treatment in prisons in the WHO South-East Asia Region. Countries selected for inclusion in the review were India, Indonesia, Nepal and Thailand.

South-East Asia is second only to sub-Saharan Africa in terms of estimated numbers of people living with HIV. South-East Asia has also been home to some stunning successes in scaling up HIV prevention, care and treatment interventions. However, the role of HIV transmission in prisons as a key factor for the spread of HIV in the community has largely been ignored. Prisoners are often seen as less deserving of health care or other assistance, particularly when resources are scarce. Yet it must be remembered that prisoners are only temporarily removed from the general community. At some stage, most prisoners will be released and resume living in the community. When prisoners are released, so too are their infections and illnesses. The HIV epidemic among injecting drug users (IDUs) in Bangkok in the late 1980s and 1990s is thought to have begun with the mass release of a number of HIV-infected prisoners. The released prisoners, who were likely unaware of their HIV status, returned to their communities, transmitting HIV to their sexual and drug-injecting partners. Each time an HIV-infected prisoner leaves prison and resumes their life, a small-scale version of this scenario is possible. Failure to address the HIV transmission that occurs in prison may undermine the success of HIV prevention programmes in the community.

Prison conditions in the countries reviewed do not meet internationally expected standards. Overcrowding is common, the quality and quantity of food provided are inadequate, and access to medical care is limited.

India, Indonesia and Thailand all have data illustrating HIV prevalence in prisons. In these countries, HIV prevalence in prisons is between two and 15 times greater than in the community. There are no HIV prevalence data from prisons in Nepal. Apart from a higher HIV prevalence, data from Indonesia and Thailand are suggestive of HIV transmission in prisons.

HIV risk behaviours such as injecting drug use, sex and tattooing are common in prisons in all the countries reviewed. Between one third and one half of all inmates with a history of injecting drug use continue to inject in prison. Data around other risk behaviours in prisons in the Region are limited. It is known that both consensual and coerced sexual activity occurs in prison, and that sex in prison may be homosexual or heterosexual. Tattooing is reportedly common in Indonesia and Thailand, as is penile modification.

The prevalence of tuberculosis (TB) is up to 100 times higher in prisons than in the community. HIV/TB coinfecting persons are more likely to progress to active TB disease than are persons infected with TB alone; however, data on HIV/TB are not systematically collected in prisons.



Despite the presence of these high-risk behaviours and a higher prevalence of HIV infection among those incarcerated, few HIV prevention programmes have been introduced in prisons in these countries. Information and education on HIV are provided in all the countries reviewed. No country reviewed has introduced a national condom distribution programme, although all countries have made condoms available in prisons through pilot or ad hoc projects. No country reviewed has implemented a needle and syringe programme (NSP) in prison. India, Thailand and Indonesia all offer drug dependency treatment programmes but only Indonesia has introduced opioid substitution therapy (OST).

In general, among the countries reviewed, access to medical care is severely limited. Prisoners living with HIV have few care and treatment options. With the exception of small-scale programmes in Thailand, no country reviewed routinely provides antiretroviral therapy (ART) for HIV-infected prisoners. Some prisons in India offer treatment and counselling for inmates with other sexually transmitted infections (STIs). Treatment for TB is offered in Thai prisons. In Indonesia, the Directorate General of Corrections has committed to improving treatment of STI and TB in prisons. Peer support groups for prisoners living with HIV/AIDS are available in prisons in Thailand and Indonesia. Early release on compassionate grounds for terminally ill prisoners was not allowed in any of the countries reviewed.

Despite the lack of HIV prevention, care and treatment programmes in prisons in South-East Asia, there are some excellent examples of positive action taken to arrest the spread of HIV in prisons. Indonesia in particular has made great progress in addressing the issue of HIV in prisons. The following recommendations may assist in providing guidance to prison authorities aiming to strengthen and expand their HIV prevention, care and treatment services. These recommendations apply to all prisons, not just those in the correctional systems discussed in this report.

Recommendations for improving HIV prevention, care and treatment in prisons in South-East Asia include the following:

1. Reduce the prison population through interventions such as non-custodial sentencing, effective community-based drug dependency treatment and legal reforms.
2. Increase resources and seek funding specifically for prison health programmes.
3. Engage health ministries closely in improving prisoner health.
4. Improve general prison conditions to meet the standards of the United Nations Office of the High Commissioner for Human Rights (UNHCHR)'s Minimum standard rules for the treatment of prisoners.
5. Introduce prevention and care strategies including condom distribution programmes, NSP, OST, voluntary counselling and testing (VCT) for HIV and treatment for STIs.
6. Ensure equity in health services and access to ART for those entering and leaving prison through adequate discharge planning, pre- and post-release counselling, and other continuity mechanisms.

7. Provide management of HIV-associated opportunistic infections and ART.
8. Strengthen strategic information such as biological and behavioural data on HIV, STI and TB among prisoners.
9. Disseminate best practices to build an evidence base for HIV prevention, care and treatment in prisons in the South-East Asia Region.
10. Create an enabling environment and continue advocacy for HIV prevention, care and treatment in prisons.



## INTRODUCTION

Despite the availability of vastly increased funding towards universal access to HIV prevention, care and treatment, those most vulnerable to HIV and its impact continue to have the least access to HIV prevention, care and treatment services. Among them are high-risk populations and prisoners. The resources devoted to HIV prevention, care and treatment for these populations are frequently not proportional to the HIV/AIDS burden among them.<sup>1</sup> Prisoners tend to be among the most marginalized and discriminated against populations in society due to the concentration of people such as injecting drug users (IDUs) and sex workers, among whom HIV prevalence is much higher than in the general population. HIV prevalence in prisons is often significantly higher than in the general population. While most prisoners living with HIV contract their infection outside the institutions before imprisonment, the risk of being infected in prison through sharing of contaminated injecting equipment and unprotected sex is great, and contributes to further transmission of the virus.<sup>1,2</sup>

Prisons do not exist in isolation from the community. The majority of prisoners return to the cities and towns they came from. Resumption of risk behaviours such as unprotected sex<sup>3</sup> and drug injecting<sup>4</sup> shortly after release from prison is common. HIV-positive prisoners, who may be unaware of their HIV status, risk passing the virus on to their sexual partners and those with whom they share injecting equipment. The high degree of mobility between prison and the community also means that other sexually transmitted infections (STIs), communicable diseases and related illnesses transmitted or exacerbated in prison do not remain there.

Although prisoners are necessarily denied some basic rights such as freedom of movement, they retain all other human rights, including the right to health and to be treated with dignity.<sup>2</sup> HIV prevention, care and treatment programmes must have as their basis the promotion of and respect for human rights.<sup>5</sup> Prisoners have a right to receive health care of the same standard available to the general community, including preventive measures. The information presented in this review demonstrates that effective and humane HIV prevention, care and treatment efforts in prison are possible, even in resource-poor settings. WHO has responded to the growing evidence of HIV infection in prisons worldwide by issuing guidelines on HIV infection and AIDS in prisons<sup>6</sup> and strongly advocates that governments should ensure the establishment of HIV prevention, care and treatment programmes in prisons. Failure to do so may jeopardize the success of community-based efforts to control the HIV epidemic.

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1. *Global AIDS epidemic report*. Geneva, UNAIDS, 2006.

2. *HIV/AIDS prevention, care, treatment and support in prison settings*. Vienna, United Nations Office on Drugs and Crime, 2006.

3. MacGowan RJ et al. Predictors of risky sex of young men after release from prison. *International Journal of STD and AIDS*, 2003, 14:519–523.
4. Dolan K et al. HIV risk behaviour of IDUs before, during and after imprisonment in New South Wales. *Addiction Research*, 1996, 4:151–160.
5. *HIV/AIDS prevention, care, treatment and support in prison settings – a framework for an effective national response*. New York, WHO,UNAIDS and UNODC, 2006.
6. *WHO guidelines on HIV infection and AIDS in prisons*. Geneva, World Health Organization, 1993.

## HIV IN PRISONS: GLOBAL SITUATION

At any given time, there are over nine million people in prison, with an annual turnover of 30 million moving from prison to the community and back again.<sup>1</sup> When people living with HIV are released from prison and return to their communities, their partners face an increased risk of HIV infection and may not be aware that they are at risk. The extent to which this is the case cannot be underestimated. In 1997, in the United States of America, there were more than 3500 prisoners living with HIV on any given day. In the same year, over 15000 of those released had HIV infection. In 1997, 20–26% of all people with HIV (and 29–43% of those infected with hepatitis C virus [HCV]) in the United States passed through a correctional facility.<sup>2</sup> In Russia, each year 300000 prisoners, many of them infected with HIV, HCV or tuberculosis (TB) are released from prison.<sup>3</sup> In 1997, out of the estimated 1600 people with HIV in Ireland, 300–500 had been through the prison system.<sup>4</sup>

The importance of implementing HIV interventions in prisons was recognized early in the epidemic.<sup>5</sup> This was reaffirmed in the 2006 framework for an effective national response to HIV/AIDS in prisons.<sup>6</sup> While an increasing number of countries has introduced HIV programmes in prisons since the early 1990s, many of them are small in scale, restricted to a few prisons, or exclude necessary interventions for which evidence of effectiveness exists.<sup>7,8</sup> Currently available information demonstrates how far prison systems are from achieving universal access to evidence-based prevention, care, treatment and support.

### 2.1. Human rights of prisoners

#### Compulsory HIV testing

Compulsory HIV testing is still practised in some prison systems, but is on the decline. One of the first prison systems to adopt such a policy was the federal prison service in the United States.<sup>9</sup> In 1987, the US federal government mandated that prisoners test negative for HIV before release from federal prison. Prisoners who tested positive were detained involuntarily even after they had completed their sentences for transfer to half-way houses or transitional supervision programmes.<sup>10</sup> Mandatory HIV testing statutes were passed in 15 states during the 1980s and early 1990s, but were modified after a wave of lawsuits.

In Australia, HIV testing of prisoners was authorized in all jurisdictions, but New South Wales repealed the regulation requiring this in 1995 and has since offered voluntary HIV and hepatitis testing.<sup>11</sup> In prisons in Europe, including Eastern Europe, compulsory testing

has been abandoned in nearly all countries.<sup>12</sup> However, in some countries such as the Russian Federation, research among prison populations indicates that compulsory testing continues.<sup>13</sup>

## 2.2. HIV prevalence in prisons

Prisoners are among the most marginalized and discriminated against populations in society due to the concentration of people such as IDUs and sex workers, who already have elevated levels of HIV infection. HIV prevalence in prisons is significantly higher than in the general population. While most of the prisoners living with HIV in prison contract their infection outside the institutions before imprisonment, the risk of being infected in prison through sharing of contaminated injecting equipment and unprotected sex is great, and contributes to further transmission of the virus.<sup>14,15</sup> In the United States, HIV prevalence is three times higher among incarcerated populations than in the general population.<sup>16</sup> In 2002, it was estimated that 8.6–15.4% of all prisoners in Indonesia were HIV positive, compared with a national prevalence of 0.1–0.2%.<sup>17</sup> This pattern is repeated in prisons around the world.

## 2.3. HIV risk behaviours in prisons

### Injecting drug use

In Scotland, a third of 227 prisoners interviewed had injected drugs; of these, 43% reported injecting in prison.<sup>18</sup> A Thai study of 689 prisoners found that half were IDUs, and that 49% of the IDUs had injected while incarcerated.<sup>19</sup> Studies from Australia,<sup>20</sup> the United Kingdom,<sup>21</sup> Brazil<sup>22</sup> and Canada,<sup>23</sup> among others, confirm that drug injecting in prison is a global phenomenon.

Injecting drug use has been identified as a mode of HIV transmission in prisons in Scotland,<sup>18</sup> Australia,<sup>24</sup> Lithuania<sup>25</sup> and Brazil,<sup>22</sup> while having been incarcerated has been established as a risk factor for HIV infection in Russia,<sup>26</sup> Thailand<sup>27</sup> and Iran.<sup>28</sup>

### Tattooing and body modification

Receiving a tattoo in prison has been identified as a risk factor for HIV infection in Thailand<sup>29</sup> and the United States of America.<sup>30</sup>

### Unprotected sexual activity

The prevalence of sexual activity in prisons has been assessed in many countries, with widely varying findings. Of 1009 male prisoners in England and Wales, 2% reported having sex with a man in prison.<sup>31</sup> In Russia, 10–12% of 277 male prisoners had ever had sex in prison.<sup>32</sup> In Thailand, a quarter of 689 male prisoners reported ever having sex with men, of whom more than 80% had sex with men in prison,<sup>27</sup> while in South Africa it is estimated that 65–80% of male prisoners have consensual sex or are raped in prison.<sup>33</sup> Because of the stigma associated with male-to-male sex, particularly in prisons, these results may underestimate the extent of sexual activity in prisons.

Sexual transmission of HIV in prison has been recorded. In Georgia, United States of America, at least 88 male inmates contracted HIV in prison between 1988 and 2005, with male-to-male sex identified as a route of transmission.<sup>30</sup>

### Multiple risk behaviours

In a study of the HIV risk behaviours of prisoners in New South Wales, Australia, just over a quarter reported injecting drugs, 14% had been tattooed and 8% had been sexually active in prison. Thirteen per cent of those surveyed had engaged in two of these risk behaviours and 1% had engaged in all three.<sup>34</sup>

## 2.4. Prevention and harm reduction programmes in prisons

Countries as diverse as Australia, Iran, Indonesia and Spain have implemented a range of programmes and strategies to prevent HIV infection in prisons, including information, education and communication (IEC) programmes, bleach distribution programmes, condom distribution programmes, needle and syringe programmes (NSPs) and opioid substitution therapy (OST).

### Bleach distribution programmes

Bleach distribution is an HIV prevention strategy employed in prisons in Australia, Canada, Iran and many countries in Western Europe and Central Asia.<sup>8</sup> Two studies of the bleach distribution programme in Australia found that when bleach is available, prisoners who inject drugs will clean needles and syringes between uses.<sup>34,35</sup> Both the Australian and Canadian studies reported that no serious safety or security concerns arose as a result of the bleach distribution programmes.<sup>35,36</sup> However, recent studies have concluded that in prisons, bleach is unlikely to be effective in reducing HIV transmission and should only be used as a second-line strategy to NSPs.<sup>37</sup>

### Needle and syringe programmes

NSPs have been implemented in prisons in Switzerland, Spain, Germany, Iran and a number of countries in Central Europe and Central Asia. In most of these countries, they are available in only a small number of prisons.<sup>8</sup> A variety of methods of syringe distribution have been employed. The use of free vending machines is common, with the machines modified so that a used syringe must be deposited before a sterile one is provided. New inmates receive a dummy syringe to allow them to access the exchange programme. Other programmes utilize prison medical staff, peer educators or NGO staff who provide not only sterile needles and syringes, but also sterile water, alcohol swabs, syringe storage containers, condoms and harm reduction education.<sup>38</sup>

Prison NSPs have produced a number of positive outcomes in the institutions in which they have been introduced. Evaluations of Swiss and German prison NSPs found that syringe sharing was drastically reduced. In Switzerland, an evaluation twelve months after the introduction of an NSP in Hindlebank Prison noted that there had been no new cases of HIV, hepatitis B or hepatitis C among the prisoner population. Evaluations in Spain, Germany and Switzerland all found that there was no increase in drug use following the implementation of prison NSPs. Indeed, in Germany, the number of



prisoners accessing drug treatment programmes increased, suggesting that prison NSPs are an effective outreach and referral tool.<sup>38,39</sup>

### Condom distribution programmes

Condoms are provided in some or all prisons in Canada, Australia, Brazil, South Africa, Iran, Indonesia, a number of European countries, some countries from the former Soviet Union and some states of the USA.<sup>8</sup> Condoms are typically provided to prisoners through the installation of vending machines in bathrooms and common areas of accommodation wings. Evaluations of condom distribution programmes in Australia and the USA have found that when available, prisoners will use condoms during sex. Once implemented, both staff and prisoners are generally accepting of condom distribution programmes and no jurisdiction that has introduced condom distribution has later reversed this policy. There have been no serious negative consequences associated with distributing condoms in prisons.<sup>40,41</sup>

## 2.5. Drug dependency treatment in prisons

### Opioid substitution therapy

Methadone maintenance treatment is available in prisons in Australia,<sup>42</sup> Canada,<sup>43</sup> some systems in the United States and many European nations ( e.g. Hungary, Malta, Slovenia and Poland),<sup>44</sup> while pilot methadone maintenance treatment programmes are under way in prisons in Indonesia<sup>45</sup> and Puerto Rico.<sup>46</sup>

## 2.6. Provision of care and treatment in prisons

### Antiretroviral therapy

Antiretroviral therapy (ART) has been provided to many HIV-positive prisoners in high-income countries for the past ten years. As a consequence, AIDS-related deaths in prisons in these countries have decreased dramatically. In the USA, AIDS-related deaths among prisoners decreased by more than 73% between 1995 and 2003, due in large part to improved ART provision.<sup>16</sup>

Some resource-poor countries have also started making ART available in their prison systems, demonstrating that it is feasible to achieve satisfactory outcomes.<sup>47</sup> Spain has achieved good coverage of prisoners with ART; 18% of all prisoners, or 82% of people with problematic drug use in prison receive OST.<sup>48</sup> However, these programmes are often small in scale and reach only a small number of those in need. In the Ukraine, as of 1 July 2007, only 86 prisoners were on ART, although studies have shown very high rates of HIV in prisons (16–32%).<sup>49</sup>

### Assessment and treatment of sexually transmitted and opportunistic infections

Tuberculosis treatment utilizing the WHO directly observed therapy, short-course (DOTS) protocols has been implemented in prisons in several countries, including Russia<sup>50</sup> and Thailand.<sup>51</sup> No data were available on the assessment and treatment of STIs in prisons.

## 2.7. Summary

Worldwide, prison systems are far from achieving universal access to evidence-based prevention, care, treatment and support interventions. When people living with HIV are released from prison and return to their drug-using or sexual partners, their partners are at increased risk of HIV infection without being aware that they may be at risk. Countries as diverse as Australia, Iran, Indonesia and Spain have implemented a range of programmes and strategies to prevent HIV infection in prisons, as well as care and treatment interventions. Efforts must be made to ensure that all prisoners are offered the opportunity to begin and continue on treatment. Assessment and treatment of sexually transmitted and opportunistic infections such as tuberculosis in both HIV-infected and -uninfected prisoners should be a priority to check the transmission of HIV.

1. Walmsley R. *World prison population list* (6th ed.). London: King's College London, School of Law, International Centre for Prison Studies, 2005.
2. Hammett TM, Harmon MP, Rhodes W. The burden of infectious disease among inmates of and releasees from US correctional facilities, 1997. *American Journal of Public Health*, 2002, 92:1789–1794.
3. Disease control in North West Russia. *Prison Healthcare News*, 2003, 4:6
4. *Prisons and AIDS: UNAIDS point of view*. Geneva, UNAIDS, 1997.
5. Harding TW. AIDS in prison. *The Lancet*, 1987, 2:1260–1263
6. *Framework for an effective national response to HIV/AIDS in prisons*. Geneva, UNODC/WHO/UNAIDS, 2006.
7. Jürgens R, Betteridge G. HIV prevention for prisoners: a public health and human rights imperative. *Interights Bulletin*, 2005, 15:55–59.
8. *Evidence for Action Technical Papers. Effectiveness of interventions to manage HIV in prisons – HIV care, treatment and support*. Geneva, WHO, UNAIDS, UNODC, 2007.
9. Basu S et al. HIV testing in correctional institutions: evaluating existing strategies, setting new standards. *AIDS Public Policy Journal*, 2005, 20:3–24.
10. Starchild A. Mandatory testing for HIV in federal prisons. *New England Journal of Medicine*, 1989, 320:315–316.
11. Magnusson R. A decade of HIV testing in Australia: Part 2: a review of some current debates. *University of New South Wales Law Journal*, 1995, 18:364–408.
12. Harding T, Schaller G. *HIV/AIDS and prisons: updating and policy review. A survey covering 55 prison systems in 31 countries*. Geneva, WHO Global Programme on AIDS, 1992.
13. Sarang A et al. Drug injecting and syringe use in the HIV risk environment of Russian penitentiary institutions: a qualitative study. *Addiction*, 101:1787–1796.
14. *HIV counselling and testing for injecting drug users and prisoners (draft)*. Geneva, UNODC, WHO, 2007.
15. *HIV/AIDS prevention, care, treatment and support in prison settings*. Vienna, United Nations Office on Drugs and Crime, 2006.
16. Maruschak LM. HIV in prisons, 2001. *Bureau of Justice Statistics Bulletin*, January 2004.
17. *National estimates of adult HIV infection, Indonesia 2002*. Jakarta, Ministry of Health of the Republic of Indonesia, Directorate General of Communicable Disease Control and Environmental Health, 2003.
18. Taylor A et al. Outbreak of HIV infection in a Scottish prison. *British Medical Journal*, 1995, 310:289–292.
19. Choopanya K et al. Incarceration and risk for HIV infection among injection drug users in Bangkok. *Journal of Acquired Immune Deficiency Syndromes*, 2002, 29:86–94.
20. Butler T et al. Drug use and its correlates in an Australian prisoner population. *Addiction Research and Theory*, 2003, 11:89–101.
21. Weild AR et al. Prevalence of HIV, hepatitis B, and hepatitis C antibodies in prisoners in England and Wales: a national survey. *Communicable Disease and Public Health*, 2000, 3:121–126.

22. Burattini MN et al. Correlation between HIV and HCV in Brazilian prisoners: evidence for parenteral transmission inside prison. *Revista de Saude Publica*, 2000, 34:431–436.
23. Small W et al. Incarceration, addiction and harm reduction: inmates experience injecting drugs in prison. *Substance Use and Misuse*, 2005, 40:831–843.
24. Dolan K et al. HIV transmission in a prison system in an Australian state. *Medical Journal of Australia*, 1999, 171:14–17.
25. Caplinskiene I, Caplinskas S, Griskevicius A. Narcotic abuse and HIV infection in prisons [Lithuanian]. *Medicina* 2003, 39:797–803.
26. Rhodes T et al. Prevalence of HIV, hepatitis C, syphilis among injecting drug users in Russia: a multi-city study. *Addiction*, 2006, 101:252–266.
27. Thaisri H. HIV infection and risk factors among Bangkok prisoners, Thailand: A prospective cohort study. *BMC Infectious Diseases*, 2003, 3:25.
28. Zamani S et al. High prevalence of HIV infection associated with incarceration among community-based injecting drug users in Tehran, Iran. *Journal of Acquired Immune Deficiency Syndromes*, 2006, 42:342–346.
29. Buavirat A et al. Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok, Thailand: a case–control study. *British Medical Journal*, 2003, 326:308–310A.
30. Taussig J et al. HIV transmission among male inmates in a state prison system: Georgia, 1992–2005. *Morbidity and Mortality Weekly Report*, 2006, 55:421–426.
31. Green J et al. Same-sex sexual activity of male prisoners in England and Wales. *International Journal of STD and AIDS*, 2003, 14:253–257.
32. Dolan K, Bijl M, White B. HIV education in a Siberian prison colony for drug dependent males. *International Journal of Equity in Health*, 2004, 3:7.
33. Goyer KC. *HIV/AIDS in prison: problems, policies and potential* (Monograph 79). Pretoria, Institute for Security Studies, 2003.
34. Dolan K, Wodak A, Hall W. HIV risk behaviour and prevention in prison: a bleach programme for inmates in NSW. *Drug and Alcohol Review*, 1999, 18:139–143.
35. Dolan K, Wodak A, Hall W. A bleach program for inmates in NSW: an HIV prevention strategy. *Australian and New Zealand Journal of Public Health*, 1998, 22:838–840.
36. *Evaluation of HIV/AIDS harm reduction measures in the correctional service of Canada*. Ottawa, Correctional Service of Canada, 1999.
37. *Evidence for Action Technical Papers. Effectiveness of interventions to manage HIV in prisons – needle and syringe programmes and bleach and decontamination strategies*. Geneva, WHO, UNAIDS, UNODC, 2007.
38. Lines R et al. *Prison needle exchange: lessons from a comprehensive review of international evidence and experience* (2nd edition). Montreal, Canadian HIV/AIDS Legal Network, 2006.
39. Dolan K, Rutter S, Wodak A. Prison-based syringe exchange programmes: a review of international research and development. *Addiction*, 2003, 98:153–158.
40. Dolan K, Lowe D, Shearer J. Evaluation of the condom distribution program in New South Wales prisons, Australia. *Journal of Law, Medicine and Ethics*, 2004, 32:124–128.
41. May JP, Williams EL. Acceptability of condom availability in a U.S. jail. *AIDS Education and Prevention*, 2002, 14 (Suppl B):85–91.
42. Black E, Dolan K, Wodak A. *Supply, demand and harm reduction strategies in Australian prisons: implementation, cost and evaluation* (ANCD Research Paper No. 9). Canberra, Australian National Council on Drugs, 2004.
43. Johnson SL, van den Ven JTC, Grant BA. *Institutional methadone maintenance treatment: impact on release outcome and institutional behaviour*. Prince Edward Island, Canada, Addictions Research Centre, Research Branch, Correctional Service Canada, 2001.
44. Kerr T, Jurgens R. *Methadone maintenance therapy in prisons: reviewing the evidence*. Ottawa, Canadian HIV/AIDS Legal Network, 2004.
45. Irawati I et al. Indonesia sets up prison methadone maintenance treatment. *Addiction*, 2006, 101:1525.
46. Heimer R et al. Methadone maintenance in prison: evaluation of a pilot program in Puerto Rico. *Drug and Alcohol Dependence*, 2006, 83:122–129.

47. Winarso I et al. Indonesian National Strategy for HIV/AIDS control in prisons: a public health approach for prisoners. *International Journal of Prisoner Health*, 2006, 2:243–249.
48. EMCDDA (European Monitoring Centre on Drugs and Drug Addiction). *The state of the drugs problem in Europe. Annual report 2005*. Luxembourg, Office for Official Publications of the European Community, 2005.
49. Zhivago S. HIV/AIDS epidemic situation in penitentiary system of Ukraine. Presentation at “HIV/AIDS in prisons in Ukraine – from evidence to action: prevention and care, treatment, and support”. Kiev, 1–2 November 2005.
50. Balabanova Y et al. The directly observed therapy short-course (DOTS) strategy in Samara Oblast, Russian Federation. *Respiratory Research*, 2006, 7:Art No. 44.
51. Nateniyom S et al. Implementation of the DOTS strategy in prisons at provincial level, Thailand. *International Journal of Tuberculosis and Lung Disease*, 2004, 8:848–854.



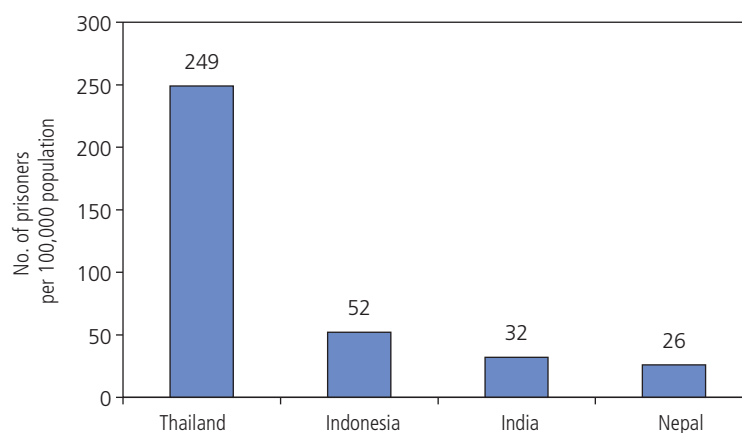
## HIV IN PRISONS: REGIONAL SITUATION

### 3.1. Rates of imprisonment and prison conditions

The number of persons imprisoned per 100 000 population in the Region was generally low (with the exception of Thailand). Imprisonment rates per 100 000 in the four countries were India 32,<sup>1</sup> Indonesia 52,<sup>2</sup> Nepal 26<sup>3</sup> and Thailand 249.<sup>4</sup>

Overcrowding was common to all countries surveyed, with occupancy levels of between 140% and 150% reported (Table 3.1). In Indonesia and Thailand, the prison population has increased rapidly in recent years as a result of increases in the incarceration of drug users. In 2005, the prison capacity in India was 246 497, while the prison population was 358 368; capacity in Indonesia was 70 241 and the prison population 116 688;<sup>2</sup> capacity in Nepal was 5 000 with a prison population of 7 135;<sup>3</sup> and Thailand with a capacity of 114 177 had a prison population of 161 844.<sup>4</sup>

Figure 3.1. Imprisonment rate per 100 000 of national population, by country



Source: National Crime Records Bureau, 2005; International Centre for Prison Studies, 2006 and 2007

### 3.2. Health in prisons

While all countries have a budget allocation for prisons, the amount is grossly inadequate. In India, an average of US\$ 333 (INR 10 474) per inmate per year was spent by prison authorities during the year 2005, distributed under the heads of food, clothing, medical

Table 3.1. Imprisonment rates and prison occupancy levels, by country

	Prison population	Imprisonment rate per 100 000 of population	Capacity of prison system	Occupancy level (%)
India	358 368	32	246 497	145
Indonesia	118 453	52	70 241	147
Nepal	7 135	26	5 000	143
Thailand	161 844	249	114 177	146

Source: National Crime Records Bureau, 2005; International Centre for Prison Studies, Country Briefs, 2006 and 2007

expenses, vocational/educational, welfare activities and others.<sup>1</sup> In 2007, the amount spent on food and health care per prisoner per year in Indonesia was US\$ 0.38. The allocation for food per prisoner per day in Thailand was US\$ 0.73.<sup>5</sup> The quality of food is poor and the quantity provided inadequate in all prisons in the four countries surveyed. Hygiene and sanitation conditions are far from satisfactory.

### 3.3. HIV testing of prisoners

No reports of current, compulsory HIV testing of prisoners in the countries surveyed were identified. In all the countries surveyed, the availability of voluntary counselling and testing (VCT) in prisons appears to be limited. For example, the Indonesian government acknowledges that VCT services in prison are “not optimal”.<sup>6</sup>

Of the four countries reviewed, only Indonesia includes prisoners as a sentinel population for HIV surveillance purposes. A random sample of prisoners is tested anonymously.

### 3.4. Segregation of HIV-positive prisoners

No country surveyed routinely practises segregation of HIV-positive prisoners. However, reports from India<sup>7,8</sup> suggest that some prisons may practice segregation.

### 3.5. HIV prevalence in prisons

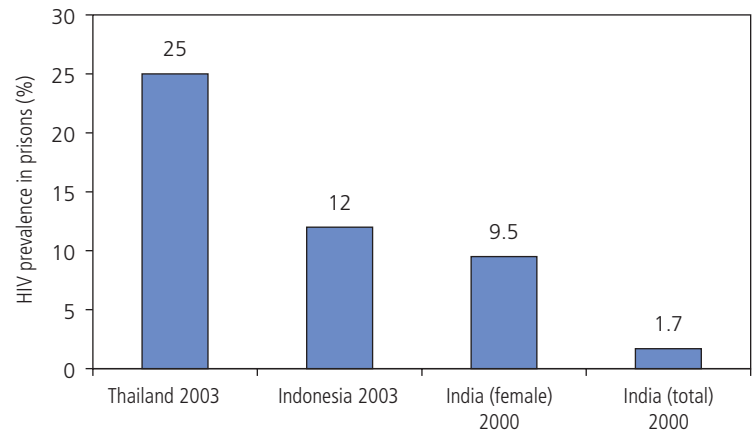
The prevalence of HIV in prisons is significantly higher than in the surrounding communities, largely due to risky behaviours such as injecting drug use and unprotected male-to-male sexual activity.

**Table 3.2.** Policy relating to mandatory testing of prisoners and segregation of HIV-positive prisoners, by country

	Compulsory testing?	Voluntary counselling and testing?	Segregation of HIV-positive prisoners?
India	Policy regarding HIV testing of prisoners is unclear	Prisoner access to VCT is unclear	Reports of segregation of HIV-infected inmates in some prisons. National policy on segregation unclear
Indonesia	No mandatory testing	Prisoner access to VCT is “not optimal”	No segregation of HIV-infected prisoners
Nepal	Mandatory testing in the community is not permitted; policy regarding HIV testing of prisoners is unclear	Prisoner access to VCT is unclear	No segregation of HIV-infected prisoners
Thailand	Mandatory HIV testing of prisoners discontinued in 2000	Prisoner access to VCT is unclear	Anecdotal reports of segregation of HIV-infected inmates in Bangkok. National policy on segregation unclear

Data regarding HIV prevalence in prisons were available for India, Indonesia and Thailand, but not Nepal. Indian data from 2000 show the prevalence in prisons to be 1.7%; among women, this rises to 9.5%.<sup>9</sup> In Indonesia, national prevalence in prisons was estimated in 2002 to be 12% (range 8.6–15.4%).<sup>10</sup> Surveillance data show wide variation between provinces, with prevalence levels in 2003 ranging from 0.36% in East Kalimantan to over 21% in Banten and West Java.<sup>6</sup> No national data exist for Thailand, but in 2003 a quarter of 689 inmates surveyed in Klong Prem Prison, Bangkok, were HIV infected.<sup>11</sup> Data suggestive of HIV transmission in prisons were identified for Thailand<sup>12</sup> and Indonesia.<sup>6</sup>

Figure 3.2. HIV prevalence among prisoners, by country



Source: Nagaraj et al. 2000; Directorate General of Communicable Disease Control and Environmental Health, Indonesia, 2003; and Thaisiri et al. 2003

### 3.6. HIV risk behaviours in prisons

#### Injecting drug use

Drug use occurs in prisons in all the four countries surveyed, although no prevalence data are available for Nepal. More than a third of Thai prisoners with a history of injecting drug use inject in prison, while half of injecting drug users (IDUs) in holding cells inject.<sup>11,13</sup> A study from India found that 0.8% of prisoners injected drugs in prison.<sup>14</sup> In Indonesia, up to a third of IDUs who had been in prison injected during incarceration.<sup>15</sup> Studies from Thailand,<sup>16</sup> India<sup>17</sup> and Nepal<sup>18</sup> suggest that being incarcerated is a risk factor for HIV infection among IDUs in the general community.

#### Unprotected sexual activity

Male-to-male sexual activity occurs in prisons in all the countries surveyed, but only Thailand has prevalence data. Of prisoners with a history of male-to-male sexual activity, 80% had sex with a man in prison.<sup>11</sup>

#### Tattooing and other body modification practices

Reports of prisoners being tattooed in prison were identified from Indonesia and Thailand. A Thai study found that HIV-infected IDUs were significantly more likely to have been tattooed during incarceration than non-infected IDUs.<sup>12</sup>

Other body modification practices identified in prisons include self-circumcision in Indonesia<sup>19</sup> and penile modification (inserting beads into the head of the penis) in Indonesia (Dolan K. *HIV risk behaviour, transmission and prevention in Indonesian prisons: rapid situation assessment*. Unpublished report, 2005) and Thailand.<sup>20</sup> The HIV risks associated with these practices are unknown.

No information regarding tattooing and body modification was identified among prisoners in Nepal.



Table 3.3. Subnational HIV prevalence in prisons, by country

	City/region/prison	Year	Sample size	HIV prevalence (%)
India	Nationally	2000	Data inaccessible	1.7% of inmates; 9.5% of female inmates
	West Bengal	2006	384	2.3%
	Amritsar Central Jail	2005	500	2.4%
	Ghaziabad	1999	249	1.3% of inmates aged 15–50 years
	Orissa, three prisons	1999	377	6.9%
	Madurai	1996	Data inaccessible	4.3%; 2% of male inmates; 14.2% of female inmates
	Central Prison, Bangalore	1995	1114	1.8% of male inmates
	Madras	1995	Data inaccessible	3.5%
	Thirunelveli	1995	Data inaccessible	0.5%
Indonesia	Nationally	2002	Population estimate	12% (range 8.6–15.4%)
	DKI Jakarta	2003	Data inaccessible	17.6%
	West Java	2003	Data inaccessible	21.1%
	East Java	2003	Data inaccessible	4.2%
	Bali	2003	Data inaccessible	10.7%
	Lampung	2003	Data inaccessible	2.8%
	Banten	2003	Data inaccessible	21.3%
	East Kalimantan	2003	Data inaccessible	0.4%
Thailand	Klong Prem Prison (Bangkok)	2003	689	25.4% (the sample may have been selected from high-risk groups in prison)
	Klong Prem Prison Hospital	1995	350	20–30% of patients in the hospital
	Klong Prem Prison	1994	5000	6% (300 cases)
	Bitichitawej Hospital for mentally ill offenders	1994	325	1.9%
	Prisons of ten provinces	1991	Data inaccessible	12% among men newly admitted; 19% among men about to be discharged
Nepal	No data available; a rapid assessment in 1999 reported that drug injectors with a history of imprisonment were 4.6 times more likely to be HIV-positive injectors who had never been imprisoned			

Table 3.4. Prevalence of HIV risk behaviours in prisons, by country

	India	Indonesia	Nepal	Thailand
Drug use, including injecting drug use	There is evidence of drug use in prisons; no prevalence data available	Government acknowledgement of drug use in prisons. Rapid assessment found evidence of drug use and injecting. Thirty-one per cent of IDUs in Surabaya with a history of imprisonment had injected in prison. Eighteen per cent of IDUs in Bandung with a history of imprisonment had injected in prison.	Government acknowledgement of drug use in prisons; no prevalence data available	15.8–38% of IDUs inject in prisons; 51% of IDUs inject in holding cells
Sexual activity	There is evidence of sexual activity in prisons; no prevalence data available	Government acknowledgement of sex in prisons; limited prevalence data suggest sex is common.	Government acknowledgement of sex in prisons; no prevalence data available	Of 689 male inmates, one quarter reported ever having sex with men; of them, more than 80% reported sex with men during incarceration.
Tattooing	No data available	Tattooing reportedly common. No prevalence data available	No data available	Tattooing and sharing razor blades reportedly common. No prevalence data available
Other body modification	No data available	45% of prisoners surveyed in West Timor had practised “self-circumcision” in prison. Penile modification is reportedly common; no prevalence data are available.	No data available	Penile modification is reportedly common; no prevalence data are available.

## 3.7. HIV interventions in prisons

### 3.7.1. HIV prevention interventions

#### *Information, education and communication*

HIV information, education and communication (IEC) programmes were the most commonly implemented HIV prevention measure in prisons in all of the countries surveyed. Indonesia<sup>6</sup> and Thailand<sup>21</sup> provide comprehensive IEC to prisoners. In India<sup>22</sup> and Nepal,<sup>23</sup> there have been some ad hoc interventions in individual prisons.

The focus of IEC programmes is generally HIV transmission and prevention. IEC in Indonesia also includes harm reduction information.<sup>6</sup>

#### *Drug dependency treatment*

Of all the countries surveyed, Indonesia provides the most comprehensive drug dependency treatment interventions. Non-pharmacological treatment options provided include one-on-one counselling, group therapy and therapeutic communities. Opioid substitution therapy (OST) is available in Kerobokan prison in Bali. The Directorate General of Corrections plans to implement OST in other prisons throughout Indonesia.<sup>24</sup>

None of the other countries surveyed provide any form of substitution maintenance therapy in prisons. Both India<sup>14</sup> and Thailand<sup>25</sup> operate therapeutic community programmes. Nepal does not offer any drug dependency treatment in prisons.

#### *Harm reduction programmes*

##### *Bleach distribution*

Despite the limited effectiveness of bleach, distribution programmes exist in Kerobokan prison in Indonesia and there are plans to extend these programmes to other prisons.<sup>6</sup> Prisons in India, Nepal and Thailand do not provide bleach.

##### *Needle and syringe programmes*

No prisons in India, Indonesia, Nepal or Thailand provide access to sterile injecting equipment.

##### *Condom distribution programmes*

There is a condom distribution programme in Kerobokan prison in Indonesia with plans to extend this to other prisons in the country.<sup>6</sup> In Thailand it is reported that medical staff distribute condoms.<sup>21</sup> Condoms have been distributed through ad hoc programmes in prisons in India<sup>26</sup> and Nepal;<sup>23</sup> however, ongoing distribution is uncertain.

### 3.7.2. HIV treatment and care

#### *Provision of antiretroviral therapy*

Some prisoners are receiving antiretroviral therapy (ART) in prisons in India and Thailand but exact numbers are uncertain.<sup>7</sup> In Indonesia ART is not widely available. ART for

Table 3.5. HIV prevention in prisons, by country

	India	Indonesia	Nepal	Thailand
HIV information, education and communication (IEC) programmes	Ad hoc IEC programmes for prisoners	IEC common; professional and peer educators; group and one-on-one programmes available	Ad hoc IEC programmes for staff and prisoners	IEC materials provided on admission and prior to release. Medical staff offer HIV education for prison guards. NGOs (e.g. Raks Thai Foundation) involved in training prison guards and inmates to be peer educators
Drug dependency treatment	Therapeutic community programme in Tihar Jail. No OST is available.	Therapeutic community programmes, counselling, self-help groups. OST available in Kerobokan prison; plans to extend to other prisons	No drug dependency treatment in prison	Therapeutic community programmes. No OST available.
Bleach distribution programmes	No data available	Bleach distribution programme in Kerobokan prison; plans to extend to other prisons	Situation uncertain; bleach distribution is discussed in policy documents	No bleach distribution programmes in prison
Needle and syringe programmes (NSPs)	No NSPs	No NSPs	No NSPs	No NSPs
Condom distribution programmes	No ongoing condom distribution programmes. Condoms have been distributed in at least one prison in Andhra Pradesh.	Condom distribution programme in Kerobokan prison; plans to extend to other prisons	Situation uncertain; condoms previously made available through ad hoc programmes. Condom distribution is discussed in policy documents.	Reports that medical staff distribute condoms. One hundred thousand condoms distributed in prisons in 2004

inmates with AIDS is available in some prisons (where it is available in the community). The Indonesian government is committed to improving access to ART.<sup>6</sup> ART is not provided in prisons in Nepal.

Table 3.6. HIV care and treatment in prisons, by country

	India	Indonesia	Nepal	Thailand
Antiretroviral therapy provision	Some prisoners are receiving ART in prison; exact numbers uncertain	ART is not widely available in prisons. Government commitment to improving prisoner access to ART	No prisoners receiving ART	Some prisoners are receiving ART in prison; exact numbers uncertain
Assessment and treatment of sexually transmitted and opportunistic infections	STI treatment provided in some prisons	Access to general medical care is poor. No programmes targeting treatment of opportunistic infections identified. Government commitment to improving treatment of STI and TB	Access to general medical care is poor. No programmes targeting treatment of opportunistic infections identified	Treatment for TB is provided.
Other support and care services	Counselling provided in some prisons for inmates with STI	Support group for HIV-infected prisoners in Kerobokan prison, Bali	No HIV support and care services identified	Support group for HIV-infected prisoners in Klong Prem Prison, Bangkok

### *Assessment and treatment of sexually transmitted and opportunistic infections*

In all the countries surveyed, access to general medical care in prisons is poor. Treatment for sexually transmitted infections (STIs) is provided in some prisons in India.<sup>26</sup> In Thailand the tuberculosis (TB) directly observed treatment, short-course (DOTS) strategy has been implemented in prisons in Bangkok and surrounding provinces.<sup>27</sup> No information on the assessment and treatment of opportunistic infections was found for prisons in Nepal; in Indonesia, treatment for TB is available in some prisons. However, the Indonesian government has identified improving access to treatment for STI and TB as a priority.<sup>6</sup>

### *Other support and care services*

Ad hoc support and care services are available in prisons in India, Thailand and Indonesia. In India, counselling is provided in some prisons for inmates with STI.<sup>26</sup> A local community group for people with HIV/AIDS has assisted inmates in setting up a peer support group in Klong Prem Prison in Bangkok, Thailand.<sup>28</sup> In Indonesia support groups are offered in some prisons and there are plans to improve support and care services (Winarso I, personal communication, June 2006). No HIV support and care services were identified in prisons in Nepal.

### *Compassionate release for terminally ill prisoners*

There were no reports of compassionate release for terminally ill prisoners in any of the countries surveyed.

1. *Prison statistics India: snapshots 2005*. National Crime Records Bureau, 2005. Retrieved August 2007 from <http://ncrb.nic.in/home.htm>
2. *Prison Brief: Indonesia*. International Centre for Prison Studies, 2007.
3. *Prison Brief: Nepal*. International Centre for Prison Studies, 2006.
4. *Prison Brief: Thailand*. International Centre for Prison Studies, 2007.
5. *Crime prevention: current issues in correctional treatment and effective countermeasures*. UNAFEI, 2002. Retrieved Sept. 2006 from [http://www.unafei.or.jp/english/pdf/PDF\\_rms/no57/57-29.pdf](http://www.unafei.or.jp/english/pdf/PDF_rms/no57/57-29.pdf)
6. *National Strategy Prevention and Control HIV/AIDS and Drug Abuse Indonesian Correction and Detention 2005–2009*. Jakarta, Directorate General Corrections, 2005.
7. Mansuri S, Johari V. *Incarcerated with HIV – an Asian perspective*. Paper presented at the XVI International AIDS Conference, Toronto, 2006.
8. Mudur M. India: campaigners urge check on spread of HIV. *British Medical Journal*, 1995, 310:280.
9. Nagaraj S et al. HIV seroprevalance and prevalent attitudes amongst the prisoners: a case study in Mysore, Karnataka state India. Paper presented at the XIII International AIDS Conference, Durban, 2000.
10. *National estimates of adult HIV infection, Indonesia 2002*. Jakarta, Directorate General of Communicable Disease Control and Environment Health, 2003.
11. Thaisri H et al. HIV infection and risk factors among Bangkok prisoners, Thailand: a prospective cohort study. *BMC Infectious Diseases*, 2003,3:25.
12. Weniger B et al. The epidemiology of HIV infection and AIDS in Thailand. *AIDS*, 1991,5 (Suppl 2):71–85.
13. Buavirat A et al. Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok, Thailand: a case–control study. *British Medical Journal*, 2003, 326:308–312.
14. *Drug abuse among prison population – a case study of Tihar Jail*. UNODC/Ministry of Social Justice and Empowerment, 2002. Retrieved Oct. 2006 from [http://www.unodc.org/india/en/drug\\_abuse\\_%20prison\\_population.html](http://www.unodc.org/india/en/drug_abuse_%20prison_population.html)
15. Devaney M, Reid G, Baldwin S. *Situational analysis of illicit drug issues and responses in the Asia–Pacific Region* (ANCD Research Paper No. 12). Canberra, Australian National Council on Drugs, 2006.
16. Choopanya K et al. Risk factors and HIV seropositivity among injecting drug users in Bangkok. *AIDS*, 1991, 5:1509–1513.
17. Panda S et al. Risk factors for HIV infection in injection drug users and evidence for onward transmission of HIV to their sexual partners in Chennai, India. *Journal of Acquired Immune Deficiency Syndromes*, 2005, 39:9–15.
18. *Nepal HIV drug assessment report*. Kathmandu, Family Health International, 1999.
19. Sadipun CA. Risk behaviour among the inmates in the prison of Penfui and Atambua, Ntt Province, Indonesia. Paper presented at the XIV International AIDS Conference, Barcelona, 2002.
20. Beyrer C et al. Drug use, increasing incarceration rates, and prison-associated HIV risks in Thailand. *AIDS and Behavior*, 2003, 7:153–161.
21. *Thailand's response to HIV/AIDS: progress and challenges*. Bangkok, UNDP, 2004.
22. Mohammed M. HIV prevention program for prisoners in India: a successful experience. Paper presented at the XIV International AIDS Conference, Barcelona, 2002.
23. Upadhyay P. Challenge in implementing HIV/AIDS/STD in the prisons in Kathmandu, Nepal. Paper presented at the XII International AIDS Conference, Geneva, 1998.
24. Irawati I et al. Indonesia sets up prison methadone maintenance treatment. *Addiction*, 2006, 101:1525.
25. Ringrowd P. Plenary Session 6: Sharing of TC practices in Asia: challenges and future direction. Paper presented at the 6th Asian Federation on Therapeutic Community Conference, Tokyo, 2005.
26. Lingamallu B et al. Effective advocacy and involvement: a key to meaningful interventions with prisons and prisoners. Paper presented at the XIV International AIDS Conference, Barcelona, 2002.
27. Nateniyom S et al. Implementation of the DOTS strategy in prisons at provincial level, Thailand. *International Journal of Tuberculosis and Lung Disease*, 2004, 8:848–854.
28. Payapvipapong P. Prison-based AIDS information and support programs. Paper presented at the International AIDS Conference, Durban, 2000.



# 4

## METHODOLOGY

Extensive literature searches were carried out using online databases including Sciences Citations Index and Medline. Relevant websites (e.g. International Centre for Prison Studies; UNAIDS; UNODC Regional Centre for South Asia) were consulted to obtain further data and unpublished reports. Where gaps in the data collected remained, key experts were contacted via email or telephone and requests for specific information were made. Key experts were drawn from a wide variety of sources, including UN and other international agencies, NGOs working in prisons and/or the community in target countries, and officials from relevant government ministries and prison administrative bodies.

Information sought for inclusion in the review was collected under two main headings:

*Community-based data regarding HIV prevention, care and treatment* – including HIV prevalence and distribution in the general population and among high-risk groups such as sex workers, injecting drug users (IDUs) and men who have sex with men (MSM).

*Prison-based data on HIV prevention, care and treatment* – including prison management, HIV situation, and HIV prevention, care and treatment strategies in prisons. As the overall prison environment provides the context in which HIV transmission occurs, and how prevention and care interventions for HIV are delivered, this review also focused on general conditions in prisons. It sought information on the quantity and quality of food, health budgets, provision of medical care, quality of accommodation and levels of overcrowding, and compassionate release of terminally ill patients.

In relation to HIV prevalence and risk behaviours, detailed information was reviewed on injecting drug use, unprotected sexual activity, tattooing and other body modification practices to establish the levels and types of HIV risk behaviours among incarcerated individuals. Similarly, information was also collected on specific prevention and care interventions such as information, education and communication (IEC), needle and syringe programmes (NSPs), bleach distribution, non-pharmacological drug treatments, opioid substitution therapy (OST), condom distribution, diagnosis and treatment of sexually transmitted and opportunistic infections, and provision of antiretroviral therapy (ART) and other support services. National policies were reviewed on HIV testing, availability of voluntary counselling and testing (VCT) services and segregation (or integration) of HIV-positive inmates.





## COUNTRY-SPECIFIC SITUATION OF HIV IN PRISONS

### 5. 1. INDIA

Table 5.1.1. HIV/AIDS and imprisonment statistics, India

Total population	1.1 billion <sup>1</sup>
Adult population	578 million <sup>1</sup>
Number of adults (15+) living with HIV (2007)	2.47 million <sup>2*</sup>
% of adults (ages 15–49) living with HIV (2007)	0.36% <sup>2*</sup>
Imprisonment rate (per 100 000) (2005)	32 <sup>3</sup>
HIV prevalence among prisoners (nationally; 2000)	1.7 <sup>4</sup>

#### 5.1.1. HIV situation in the community

##### *HIV prevalence and distribution*

With around 2.47 million (range 2–3.1 million) adults and children living with HIV/AIDS in 2007, India has the third-highest burden of HIV/AIDS in the world, after South Africa and Nigeria.

Although the number of people with HIV/AIDS in India is very high, current prevalence is relatively low. It is estimated that 0.36% of adults were living with HIV/AIDS in July 2007.<sup>2</sup>

HIV has spread to all of India's states and territories, with five out of 35 states/union territories – Manipur and Nagaland in the north east, and Andhra Pradesh, Karnataka and Maharashtra in the south – reporting prevalence levels exceeding 1% in the general population and accounting for nearly 80% of all reported AIDS cases in the country. Nationally, sexual transmission is driving the AIDS epidemic. This route accounts for approximately 86% of HIV infections in the country, especially in the wealthier states of the south. Injecting drug use accounts for 2% of transmissions; mother-to-child-transmission, 4%; and blood transfusion, 2%. However, in the north-eastern states and

\* In July 2007, India revised its national estimate of the burden of HIV downwards. The new national HIV estimate as per the Government of India is 2.5 million (range 2–3.1 million). Based on this, revised estimates will be released of the number of people living with HIV, the number of deaths, and the incidence of new infections in the South-East Asia Region and the world. These revised regional estimates will be released on World AIDS Day, 2007.

in some metropolitan cities such as Delhi and Mumbai, injecting drug use is possibly the most significant transmission route.<sup>5,6</sup>

Although HIV/AIDS is still largely concentrated in high-risk populations, including sex workers, injecting drug users (IDUs) and men who have sex with men (MSM), surveillance data suggest that the epidemic is moving beyond these groups in some regions and into the general population. While long-standing epidemics in some states may have stabilized, new ones are emerging in areas that had low HIV prevalence. In New Delhi, HIV prevalence among IDUs increased markedly from 7% in 2002 to 23% in 2005. It is also moving from urban to rural districts and is increasingly spreading to the low-risk general population.

However, some states had a higher HIV prevalence among rural than urban populations, namely, Punjab, Uttar Pradesh and Tamil Nadu (based on antenatal clinic [ANC] data). A trend of increasing HIV prevalence among ANC attendees is apparent in Orissa and Rajasthan and some sites in West Bengal. Among migrants in Orissa, HIV prevalence was found to be above 5%.<sup>7</sup>

### *HIV prevalence in high-risk populations*

HIV prevalence rates among sex workers are estimated to range from 21.6% outside major urban areas to 70% in Mumbai.<sup>8</sup> It is reported that 25% of MSM in major urban areas and 5.7% of MSM outside major urban areas are HIV positive.<sup>1</sup> The average seropositivity rate among MSM in high-prevalence states has remained at around 10% in the past few years. New IDU epidemics may have been kick-started in Chandigarh, Punjab and Delhi.<sup>7</sup> National HIV prevalence rates among IDUs range from less than 1% to 24.2%.<sup>7</sup> HIV prevalence among IDUs was 5% or greater in 17 of the 45 valid sentinel sites. Tamil Nadu, Maharashtra, Manipur, Chandigarh, Punjab, Orissa and Delhi had an HIV prevalence of 10% among IDUs.<sup>7</sup> No information was found regarding male or transgender sex workers.

## **5.1.2. Prison situation**

### *Prison management*

#### *Administration*

The governments of states and union territories are responsible for prison administration under the Ministry of Home Affairs.<sup>9</sup>

There are 1328 correctional institutions in India.<sup>3</sup> An average of US\$ 333 (INR 10 474.1) per inmate was spent by prison authorities during the year 2005,<sup>3</sup> distributed under the heads of food, clothing, medical expenses, vocational/educational, welfare activities and others.

Prisons are also used as detoxification centres for drug users.<sup>10</sup> In prisons in Delhi, drug offenders are housed separately from other inmates.<sup>11</sup> It is unclear if this is the policy for all prisons in India.

#### *Inmates*

There were 358 368 prisoners in India in 2005, making for an imprisonment rate of 32 per 100 000 of the national population. Of prisoners, 66.2% were remandees and 3.9% were

women.<sup>3</sup> As so many prisoners are remandees, there is a large inmate turnover; in Tihar Jail (a large prison complex in New Delhi), about 60 000 prisoners are admitted and discharged every year.<sup>12</sup> Around 8–10% of new admissions to Tihar Jail are drug users.<sup>11,13</sup>

### *Women in prison*

In India, social customs make women offenders and ex-offenders vulnerable to suspicion and rejection. Their families often disown them once they enter prison. Low levels of education and poor legal awareness leads to women receiving unduly long sentences.

### *Incarceration of drug users*

The offence of illicit drug possession or use can result in imprisonment for a period of six–twelve months, or a fine, or both. Possession of as small an amount as one quarter of a gram of heroin can result in arrest and punishment. The Narcotics Drugs and Psychotropic Substances (NDPS) Act, 1985 also criminalizes traditional forms of drug use. Evidence suggests that, in ignoring the sociocultural context of traditional drug use, the NDPS Act led to a significant increase in the arrests of low-level drug users. Arrests under the Act in 2001 totalled 16 315, of which 12 400, or 76%, were prosecuted and 4568 convicted.<sup>14</sup> Interviews with 1910 individuals in Tihar Jail, arrested under the NDPS Act, 1985, indicated that 17% were arrested for the possession of small quantities of drugs meant for personal consumption. While the law has provision for these drug users to seek treatment instead of serving a sentence, the provision is rarely utilized.<sup>15</sup>

### *General conditions*

Although India has a low imprisonment rate, occupancy in prisons is generally far above capacity.<sup>9</sup> The national average occupancy rate is 144.7%, but varies from city to city. In 2005, it was 197.1% in Delhi and 318.2% in Jharkhand.<sup>3</sup> The Arthur Road Jail in Mumbai has a capacity of 820 but in 2004 it housed more than 3400 inmates.<sup>16</sup> Tihar Jail has a capacity of 6250 inmates but housed 14 126 prisoners in 2006.<sup>3</sup>

There is a lack of nutritious food, and hygiene and sanitation facilities are severely lacking. Sexual violence is a further concern.<sup>17</sup> A special commission of inquiry, appointed after the 1995 death of a prominent businessman in India's high-security Tihar Central Jail, reported in 1997 that 10 000 inmates held in that institution endured serious health hazards, including overcrowding, "appalling" sanitary facilities and a shortage of medical staff.<sup>18</sup>

### *General medical care*

Tihar Jail in New Delhi employs 78 doctors and 122 paramedical staff for 24-hour support of dispensaries and hospitals. Every prisoner admitted receives a medical examination. Diagnostic facilities are available and specialists in various disciplines are available for consultation. Dental and eye clinics, and leprosy detection and treatment programmes have been implemented with the help of NGOs. Hospitals with specialized medical facilities have been identified as referral hospitals for ill prisoners.<sup>11</sup>

All central prisons in Andhra Pradesh have full-fledged hospitals, and full-time medical officers with supporting paramedical staff. All the district jails except those in Mahaboobnagar and Nalgonda also have adequate medical facilities.<sup>19</sup> In Tamil Nadu, "prisoners are provided adequate medical facilities".<sup>20</sup>

### *HIV testing of prisoners*

In 1995, it was reported that prisoners undergo a medical examination when they begin their sentence, but they are not routinely tested for specific infectious diseases.<sup>21</sup> In 2006, the Tihar Jail web site reported that every prisoner admitted receives a thorough medical examination.<sup>11</sup> However, it is unclear whether this includes either compulsory or voluntary testing for HIV. In an intervention conducted by the Vivekananda International Health Centre in prisons in West Bengal, voluntary and confidential blood testing was made available; however, it is understood that this was not an ongoing service.<sup>22</sup>

### *Segregation of HIV-positive prisoners*

There are reports of segregation of HIV-positive prisoners, with approximately 20 HIV-positive inmates in Maharashtra's prisons lodged in separate cells.<sup>21</sup> In Arthur Road Jail, there is an HIV barrack, which houses all HIV-positive prisoners.<sup>17</sup>

### *HIV prevalence and risk behaviours in prisons*

#### *HIV prevalence in prisons*

Only one national study of HIV prevalence in prisons has been conducted, finding that 1.7% of inmates and 9.5% of female inmates were HIV-infected.<sup>4</sup> There have also been a number of ad hoc studies on HIV prevalence in individual prisons.<sup>22-26</sup>

#### *Injecting drug use in prisons*

No prevalence data regarding drug use in prisons were identified. However, among IDUs, incarceration has been identified as an independent risk factor for HIV infection in some locations. A study conducted in Chennai in 2005 found that the HIV prevalence was 37% among 48 IDUs who were "ever in jail", compared with 21% among 20 IDUs who had never been incarcerated. The authors found that 16% of HIV risk among IDUs in Chennai could be attributed to having been imprisoned.<sup>27</sup>

Many prisoners incarcerated for drug use are discharged and readmitted frequently as remandees.<sup>12</sup> This large turnover in prison population facilitates the transmission of HIV in the general community.

#### *Men who have sex with men*

Sex between men is reported to be common in prisons in India, though homosexuality is illegal in India.<sup>28,29</sup> In a study conducted in Arthur Road Jail, 71.6% of 75 employees and 677 inmates said that they thought sex between men was common in prisons. Eleven per cent of inmates and staff engaged in homosexual activity in prison. A study in a district jail near Delhi found that 28.8% of 184 male inmates had a history of sex with men.<sup>30</sup>

#### *Tattooing and body modification*

No evidence could be found on the prevalence of tattooing and other body modification within prisons in India. However, there were reports of interpersonal violence (involving lacerations, bites and bleeding in two or more participants), which could present risks for transmission.<sup>28</sup>

### 5.1.3. HIV interventions in prisons

#### *Prevention interventions*

##### *Information, education and communication (IEC)*

There have been several interventions conducted in prisons in India. The Government of Andhra Pradesh started a sexual health programme titled Partnership for Sexual Health (PSH Prison Project) in January 2000. The project was managed by the Andhra Pradesh AIDS Control Society and operated in eleven jails in Andhra Pradesh. Three trained staff members provided HIV education. The programme also included counselling, referral and medical treatment.<sup>31</sup>

In Mumbai, the Mumbai District AIDS Control Society and the International Labour Organization together with the Department of Preventive and Social Medicine, Sion Hospital conducted a workplace intervention programme at the Arthur Road Jail from 2004 to 2006. The intervention employed a peer educator's approach to raise awareness of HIV/AIDS. Jail employees and inmates were given training for three half-days, following which peer educators were selected from different cells. The intervention led to the drafting of an HIV/AIDS Workplace Policy for provision of voluntary counselling and testing (VCT) and condoms in prisons, and provision of antiretroviral therapy (ART), with JJ Hospital, Mumbai as the ART centre. The draft policy will be submitted to the Maharashtra Home Ministry for approval (personal communication, Palve A, Mumbai District AIDS Control Society, 12 September 2007).<sup>29</sup>

In West Bengal, Vivekananda International Health Centre has been delivering an AIDS intervention programme in 20 prisons. The programme, reaching 50 000 prisoners and staff, includes education about sexually transmitted infection (STI) and HIV.<sup>22</sup>

In Gujarat, an information and education programme conducted by NGOs aims to change prisoner attitudes and HIV risk behaviours.<sup>32</sup>

##### *Drug dependency treatment*

Treatment and rehabilitation of drug users is not a priority in prisons. Prison staff are yet to be sensitized to the issue of drug use and the needs of drug users. Furthermore, as many of the prisoners who are placed in treatment programmes are on remand, they are frequently released before completing treatment.<sup>12</sup>

Drug offenders received at Tihar Jail are admitted to a "de-addiction" centre for detoxification and treatment of withdrawal symptoms. Treatment components are unclear, but a psychiatrist works with the prisoner for approximately one week.<sup>11</sup> In 2005, there were three detoxification centres with 72 detoxification beds: 60 for adult males and 12 for adolescents. The prison has no centre that caters exclusively to female users.

After detoxification, drug offenders are segregated from the other prisoners and placed in therapeutic communities run by NGOs including the Association for Scientific Research on Addictions (AASRA) and the AIDS Awareness Group. As many as 800 prisoners live within the therapeutic communities.<sup>11,12</sup>

In the therapeutic communities in Tihar Jail, senior prisoners serve as team leaders and supervisors. Staff members from AASRA, including psychiatrists, psychologists, sociologists

and social workers, serve as trainers, facilitators and counsellors. Inmates engage in a range of activities including counselling, education, meditation, family therapy, anger and grief workshops as well as recreational activities. The ideal ratio of staff to inmates is 1:20; however, in practice inmates greatly outnumber staff.<sup>11,12</sup>

The Civil Rights Initiative–Arthur Road Jail Project was started in January 2005 in partnership with and on request from the Sankalp Rehabilitation Trust. Sankalp is given a separate barrack for drug users who opt to undergo a rehabilitation programme. Sankalp provides users with counselling, medicines, treatment, etc.<sup>17</sup>

No other drug treatment programmes in prisons were identified. UNODC has recommended that the Government of India initiate a process of inquiry in major prisons in India, and where necessary, set up the required facilities for the treatment of drug users.<sup>12</sup>

#### *Harm reduction programmes*

The distribution of condoms is against prison policy as male-to-male sex is regarded as a crime in India.<sup>32</sup> However, a government-run prison intervention in Andhra Pradesh includes condom distribution.<sup>33</sup> There are no prison needle and syringe programmes (NSPs) in India.<sup>17,21</sup> No information was available regarding bleach distribution in prisons.

#### *HIV care and treatment*

##### *Provision of antiretroviral therapy*

The total number of HIV-infected prisoners in need of and with access to ART in prisons is not clear. A programme to offer legal aid to prisoners has assisted some HIV-infected inmates to continue ART while in prison.<sup>17</sup> The Government of Andhra Pradesh has started a sexual health programme that provides treatment for HIV, although it is unclear what sort of treatment is provided.<sup>31</sup>

##### *Assessment and treatment of sexually transmitted and opportunistic infections*

Education and counselling services as well as treatment for STI is provided in 42 prisons in Andhra Pradesh by Hindustan Latex Limited under an agreement with the Andhra Pradesh State AIDS Control Society.<sup>33</sup> Partnership for Sexual Health and other NGOs provide STI treatment in prisons in Surat, Gujarat.<sup>32</sup>

##### *Compassionate release for terminally ill prisoners*

No information on compassionate release for terminally ill prisoners was found.

#### **5.1.4. Discussion**

HIV prevalence in prisons in India is much higher than in the community (1.7–6.9%, compared with 0.36%). Among female prisoners, prevalence levels of 9.5–14.2% have been reported.

Injecting drug use is a transmission route for HIV inside prisons and there is evidence to suggest that incarceration is a risk factor for HIV in the IDU community in India. Unprotected sex is another major transmission route and the high levels of overcrowding and lack of access to condoms in Indian prisons would be conducive to unprotected sex. Interpersonal violence is a further risk factor for the transmission of HIV.

There are some good but isolated examples of HIV prevention programmes in Indian prisons. HIV IEC programmes such as those in prisons in Mumbai, Andhra Pradesh and others should be expanded to all prisons across the country. Improving access to drug dependency treatment, including opioid substitution therapy (OST), would be another positive step. Harm reduction strategies, including condom distribution programmes and NSPs, will further assist in reducing the risk of HIV transmission in prisons.

Treatment of HIV and STI is also important in stemming HIV in prisons. Voluntary counselling and testing (VCT) should be promoted and access to HIV, STI and tuberculosis diagnosis and treatment improved.

There are very little data regarding the prevalence of HIV risk behaviours such as injecting drug use and male-to-male sex in prisons. Some HIV prevalence data are available, but such data become obsolete rapidly. Annual, nationwide collection of HIV/STI prevalence data and information regarding HIV risk behaviours in prisons is recommended. This will provide a knowledge base from which to plan further HIV prevention, care and treatment interventions in prisons.

Large numbers of unsentenced prisoners pass through India's prisons each year, burdening prisons and facilitating HIV transmission. Legal reforms to increase non-custodial sentencing options for those incarcerated for minor and non-violent offences, and those who have been charged but not yet tried, are recommended.

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- 1 *Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections: India*. Geneva, WHO, UNICEF, UNAIDS, 2006.
  - 2 [www.nacoonline.org](http://www.nacoonline.org)
  - 3 *Prison statistics India: snapshots 2005*. National Crime Records Bureau, 2005. Retrieved August 2007 from <http://ncrb.nic.in/home.htm>
  - 4 Nagaraj S et al. HIV seroprevalence and prevalent attitudes amongst the prisoners: a case study in Mysore, Karnataka state India. Paper presented at the XIII International AIDS Conference, Durban, 2000.
  - 5 Lisam D. Rapid intervention and care (RIAC) – Manipur's harm reduction programme has led to a significant decline in the HIV seroprevalence among IDUs. Paper presented at the XIV International AIDS Conference, Barcelona, 2002.
  - 6 Eicher AD et al. A certain fate: spread of HIV among young injecting drug users in Manipur, North-East India. *AIDS Care*, 2000, 12:497–504.
  - 7 *Tracking the HIV epidemic in India. Annual Sentinel Surveillance Report, 2006* (draft). New Delhi, National Institute of Health & Family Welfare, National AIDS Control Organization, Ministry of Health & Family Welfare, 2007.
  - 8 Shankaran S. Intervention for women and children in the red-light area. Paper presented at the XIV International AIDS Conference, Barcelona, 2002.
  - 9 *Prison Brief: India*. International Centre for Prison Studies, 2006.
  - 10 Sarkar S et al. A cross-sectional study on factors including HIV testing and counselling determining unsafe injecting practices among injecting drug users of Manipur. *Indian Journal of Public Health*, 1995, 39:86–92.
  - 11 *Infrastructure in Tihar Prisons, 2006*. Retrieved Sept. 2007 from <http://tiharprisons.nic.in/html/infra.htm>
  - 12 *Drug abuse among prison population – a case study of Tihar Jail*. New Delhi, UNODC/Ministry of Social Justice and Empowerment, 2002.
  - 13 *Injecting drug use and HIV/AIDS in India – an emerging concern*. New Delhi, UNODC, 2004. Retrieved Sept. 2006 from [http://www.unodc.org/india/idu\\_and\\_HIV/AIDS\\_in\\_India-Monograph.html](http://www.unodc.org/india/idu_and_HIV/AIDS_in_India-Monograph.html)
  - 14 Charles M et al. *Drug policy in India: compounding harm* (Briefing Paper 10). The Beckley Foundation Drug Policy Program, 2005.



- 15 Annuradha K. The Narcotics Drugs and Psychotropic Substances Act, 1985. In: *Drug culture in India: a street ethnographic study of heroin addiction in Bombay*. Jaipur, Rawat Publishers, 1999:302–308.
- 16 Dey J. HIV stalks the Arthur Road Jail. *Mumbai Newslite*, 19 November 2004
- 17 Mansuri S, Johari V. Incarcerated with HIV – an Asian perspective. Paper presented at the XVI International AIDS Conference, Toronto, 2006.
- 18 *Prisons in Asia*. Human Rights Watch, 2006. Retrieved Oct. 2006 from <http://www.hrw.org/prisons/asia.html#India>
- 19 <http://www.aponline.gov.in/aportal/departments/departments.asp?dep=17&org=117&category=about> (accessed September 2007).
- 20 [http://www.tn.gov.in/policynotes/home\\_prisons.htm](http://www.tn.gov.in/policynotes/home_prisons.htm) (accessed September 2007).
- 21 Mudur M. India: campaigners urge check on spread of HIV. *British Medical Journal*, 1995, 310:280.
- 22 Nag A et al. Prevalence of STDs/HIV infection in prisons of West Bengal and prevention programs in India. Paper presented at the XVI International AIDS Conference, Toronto, 2006.
- 23 Aggarwal A, Arora U, Nagpal N. Seroprevalence of HIV in Central Jail inmates of Amritsar. *Indian Journal of Community Medicine* 2005, 30:151.
- 24 Sundar M, Ravikumar KK, Sudarshan MK. A cross-sectional seroprevalence survey for HIV-1 and high risk sexual behaviour of seropositives in a prison in India. *Indian Journal of Public Health*, 1995, 39:116–118.
- 25 Singh S, Prasad R, Mohanty A. High prevalence of sexually transmitted and blood-borne infections amongst the inmates of a district jail in Northern India. *International Journal of STD and AIDS*, 1999,10:475–478.
- 26 Pal B, Acharya A, Satyanarayana K. Seroprevalence of HIV infection among jail inmates in Orissa. *Indian Journal of Medical Research*, 1999, 109:199–201.
- 27 Panda S et al. Risk factors for HIV infection in injection drug users and evidence for onward transmission of HIV to their sexual partners in Chennai, India. *Journal of Acquired Immune Deficiency Syndromes*, 2005, 39:9–15.
- 28 Donde S. HIV risk behaviour in prisons among drug users in Mumbai. Paper presented at the XVI International AIDS Conference, Toronto, 2006.
- 29 Palve A et al. Workplace intervention program for risk reduction in prisons. Paper presented at the XVI International AIDS Conference, Toronto, 2006.
- 30 Singh S, Prasad R, Mohanty A. High prevalence of sexually transmitted and blood-borne infections amongst the inmates of a district jail in Northern India. *International Journal of STD and AIDS*, 1999, 10:475–478.
- 31 Mohammed M. HIV prevention program for prisoners in India: a successful experience. Paper presented at the XIV International AIDS Conference, Barcelona, 2002.
- 32 Pachpinde P. Knowledge and commitment for action in HIV/AIDS prevention in prisons of Gujarat, India. Paper presented at the XIV International AIDS Conference, Barcelona, 2002.
- 33 Lingamallu B et al. Effective advocacy and involvement: a key to meaningful interventions with prisons and prisoners. Paper presented at the XIV International AIDS Conference, Barcelona, 2002.

## 5.2. INDONESIA

Table 5.2.1. HIV/AIDS and imprisonment statistics, Indonesia

Population	222 781 000 <sup>1</sup>
Adult population (15–49)	124 213 000 <sup>1</sup>
No. of adults (15+) living with HIV/AIDS (2006)	193 000 <sup>2</sup>
% of adults (ages 15–49) living with HIV/AIDS (2006)	0.16 <sup>1</sup>
Imprisonment rate (per 100 000) (2006)	52 <sup>3</sup>
HIV prevalence among prisoners (2002)	8.6–15.4% <sup>4</sup>

### 5.2.1. HIV situation in the community

#### *HIV prevalence and distribution*

Since the first AIDS case was reported in 1987 in Bali, HIV has affected all of Indonesia. What began as mainly an epidemic among injecting drug users (IDUs) in Jakarta, West Java and Bali, has now spread from IDUs to their non-injecting sex partners, prisoners, sex workers and their clients. About 70.8% of IDUs in Depok, Jakarta and up to 23% of sex workers in Papua have been infected as of 2006. Currently, 32 provinces and 169 districts out of a total of 33 provinces and 440 districts, respectively, have reported AIDS cases.<sup>2</sup>

Presently, national HIV prevalence is low, at 0.16%. There were an estimated 193 000 (range 169 000–216 000) people aged over 15 years living with HIV/AIDS in 2006. The majority of infections are in men. At present, HIV infection is concentrated in high-risk groups such as IDUs and sex workers. Injecting drug use accounted for 50% of AIDS cases out of a cumulative number of 8194 AIDS cases reported up to December 2006.<sup>2</sup> In most parts of the country, the epidemic remains concentrated among high-risk groups characterized by those sharing injecting equipment and engaging in unprotected commercial sex. However, the province of Papua has a more generalized epidemic, with an HIV prevalence in the community of 2.4%, which is several times the national average. The reported AIDS cases per 100 000 population are 20 times higher than the national average of two cases per 100 000 population. Among female sex workers in Sorong, HIV prevalence increased from approximately 1% to 20% from 1998 to 2005.<sup>2</sup>

#### *HIV prevalence among high-risk populations*

Nationally, HIV prevalence among female sex workers ranges from 2% to 5%, though much higher prevalence is seen in some areas. Limited data are available of HIV prevalence among male sex workers, which was 3.6% in a small survey conducted in 2002.<sup>5</sup> Some transgender males (*waria*) also engage in sex work. HIV prevalence among *waria* rose dramatically from 6% in 1997 to 23% in 2002.<sup>6</sup> HIV prevalence among IDUs was estimated at 19.8–33.5% in 2002.<sup>4</sup> HIV prevalence among men who have sex with men (MSM) is estimated at 0.4–1.3%.<sup>4</sup>

#### *Provision of harm reduction initiatives in the general population*

Indonesia has adopted a comprehensive approach to harm reduction. A total of 57 community health centres (30 in Jakarta, 12 in West Java, 5 in South Sulawesi and 10

in Bali) are running needle and syringe programmes (NSPs).<sup>7</sup> However, coverage is low and active IDUs receive only enough needles and syringes to protect themselves for less than a month.<sup>2</sup> Previously, there were only two hospital-based clinics and one prison-based opioid substitution therapy (OST) clinic in Bali. In 2006, nine more OST clinics were established with support from WHO. By December 2006, 752 active IDUs were enrolled for OST. However, coverage remained low compared to the estimated need, and rapid expansion of OST and antiretroviral therapy (ART) remains a challenge.<sup>2</sup>

### 5.2.2. Prison situation

Indonesia is the only country in the world to have produced a National Strategy specifically to guide HIV prevention, care and treatment efforts in prisons – the *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention, 2005–2009*. The Strategy provides a comprehensive framework for HIV prevention, care and treatment, with a particular focus on reducing injecting drug use-related HIV transmission.<sup>8</sup> Additionally, Prison Working Committees on HIV prevention are being established to coordinate prevention, care and treatment activities at the provincial level.<sup>9</sup>

#### *Prison management*

##### *Administration*

Indonesia's 378 correctional institutions are operated by the Directorate General of Corrections under the Ministry of Justice and Human Rights.<sup>3</sup> Thirteen institutions are "narcotic prisons" – prisons specifically for drug offenders.

##### *Inmates*

The number of prisoners has increased markedly in recent years. According to official figures, between 2000 and 2004, the prison population increased by 64%, from 54 314 to 88 887.<sup>8</sup> In August 2006, the prison population was 116 688 while the capacity was 70 241; of these, 40.7% were awaiting trial.<sup>3</sup> Approximately 28.84% of the population are incarcerated for drug offences, but research suggests around half the prisoners are drug users.<sup>8,10</sup>

##### *General conditions*

In line with the increase in the prison population, overcrowding has become a concern. Figure 5.2.1 shows that increases in the capacity of the prison system have not kept pace with the increase in the prison population. In 2002, prisons were at 105% of their capacity. By 2004, this had increased to 130%. In 2005, with a population of 99 946 and an official capacity of 68 141, occupancy was 147%.<sup>3</sup> In August 2006, the occupancy level was 166.1%.<sup>3</sup> The increase in overcrowding coincided with an increase in the proportion of prisoners incarcerated for drug offences. In 2002, 10% of prisoners were drug offenders; by 2005, this proportion had gone up to 28.84% (Figure 5.2.2).<sup>8</sup>

##### *General medical care*

The Directorate General of Corrections is responsible for the provision of medical care to prisoners. Sick prisoners are also sometimes referred to hospitals in the community. Basic health-care services are supposed to be available in all prison clinics but frequently this is not

the case. Based on November 2006 data, more than a third of the all prisons had no doctors or nurses (personal communication, Ms Edna Oppenheimer, UNODC Consultant). The Directorate General of Corrections acknowledges the lack of equipment and medication, and the impact this has on the medical care of inmates.<sup>8</sup>

In 2006, the amount spent on food and health care per prisoner per year was Rp 3500 (US\$ 0.38) (personal communication, Ms Edna Oppenheimer, UNODC Consultant).

### HIV testing of prisoners

Voluntary counselling and testing (VCT) is available to prisoners; however, the Directorate General of Corrections notes that access to VCT is “not optimal”.<sup>8</sup> Prisoners in some provinces are included as a sentinel population for surveillance purposes. A sample of prisoners is selected at random and tested anonymously.<sup>11</sup>

### Segregation of HIV-positive prisoners

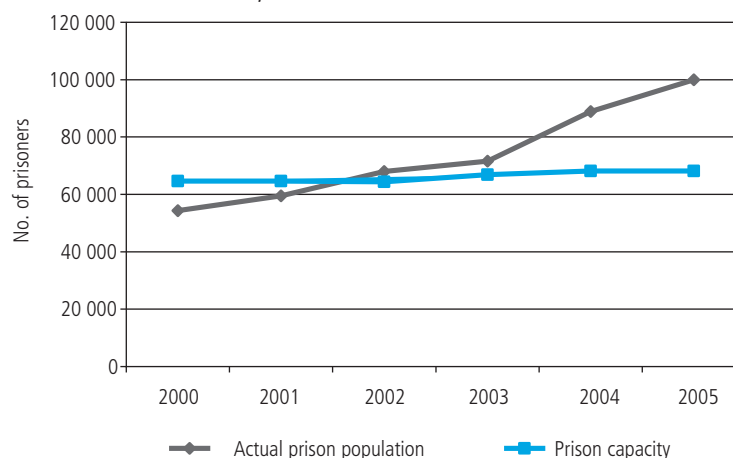
It is the policy of the Directorate General of Corrections that HIV-infected prisoners have the right to confidentiality regarding HIV status and the right to access treatment and support without discrimination. To this end, prisoners living with HIV/AIDS are accommodated with the general prison population.<sup>8</sup>

### HIV prevalence and risk behaviours in prisons

National HIV prevalence among prisoners was estimated at 12% (range 8.6–15.4%) in 2002.<sup>4</sup> The Directorate General of Corrections also collects HIV prevalence data by province. These data show that wide variations exist between provinces, from a high level of 21% in Banten and West Java to a low of less than 1% in East Kalimantan (Ministry of Health, 2004).

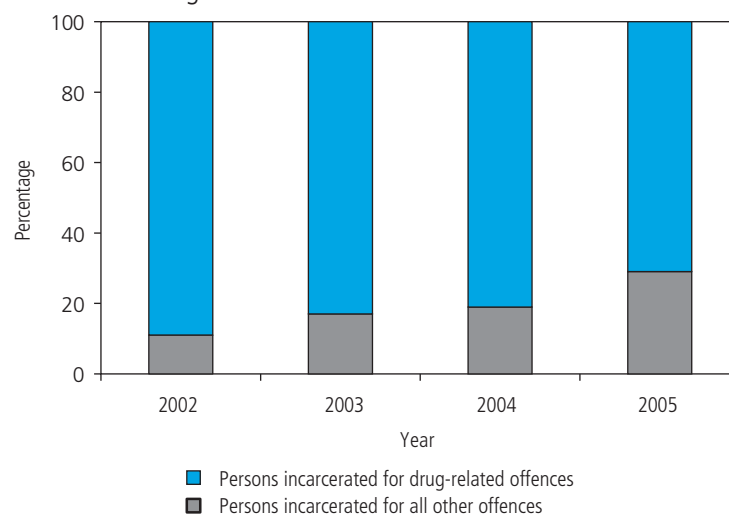
HIV infection in prisons is concentrated in IDUs. A study in Kerobokan prison, Bali, found that 56% of inmates with a history of injecting drug use were HIV infected.<sup>12</sup>

Figure 5.2.1. Actual prison population exceeds prison capacity, Indonesia, 2000–2005



Source: 2000–2004 data: *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention: 2005–2009*. Jakarta, Directorate General of Corrections, 2005. 2005 data: *Prison Brief: Indonesia*. International Centre for Prison Studies, 2006

Figure 5.2.2. Increasing proportion of persons incarcerated for drug-related offences



Source: 2000–2004 data: *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention: 2005–2009*. Jakarta, Directorate General of Corrections, 2005. 2005 data: *Prison Brief: Indonesia*. International Centre for Prison Studies, 2006

### *Injecting drug use*

Although quantitative data are limited, injecting drug use appears to be the most common HIV risk behaviour in prisons. A study of IDUs in Surabaya found that 21% had been in prison in the previous year; of these, 31% injected while in prison. Similarly, 17% of IDUs surveyed in Bandung had been imprisoned in the previous year, of whom 18% injected in prison.<sup>13</sup> The *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention, 2005–2009* also suggests that while drug misuse and injecting in prisons is less common than in the community, it continues to occur at a significant level in prisons.

### *Sexual activity*

Sexual activity between inmates is reported to be “common”. A study in two prisons in West Timor reported that 56% of prisoners had sex with men in prison, although it is unclear if this figure referred to the entire sample or just the proportion of the sample that reported having sex in prison.<sup>14</sup> Most prisoners, guards and prison health staff interviewed for a rapid assessment in prisons in Jakarta agreed that sex between inmates occurred. There have been reports of prisoners exchanging sex for food, money and protection, and of prisoners paying guards for private rooms for having sex (Dolan K. *HIV risk behaviour, transmission and prevention in Indonesian prisons: rapid situation assessment*. Unpublished report, 2005).

### *Tattooing and other body modification*

The proportion of prisoners receiving tattoos in prison is unknown, but as with other HIV risk behaviours, tattooing is known to occur. Ink can be purchased from prison shops and inmates with expertise in tattooing can charge other inmates for their services. Tattoo needles are used on multiple inmates with little to no cleaning between inmates. Penile modification appears to be common among prisoners. The insertion of beads into the head of the penis, known as *pasang tasbih*, has been reported in prisons in Jakarta and West Timor.<sup>14</sup> The West Timor study also found that 45% of prisoners surveyed had practised “self-circumcision” during their imprisonment.<sup>14</sup>

### *Evidence suggestive of HIV transmission in prisons*

Reports of widespread HIV risk behaviours in prisons are supported by the data shown in Figure 5.2.3. These data show HIV prevalence in prisons in Jakarta and West Java, 1999–2003, as determined by anonymous surveillance surveys. Recorded prevalence increased between 1999 and 2001, before a sharp decrease in 2002. This does not represent a real drop in prevalence in the prisons, but reflects a change in data collection methods. In 2002, only newly received inmates were included in the surveillance sample. In 2003, the sampling strategy again included all inmates, and prevalence returned to the levels seen in 2001. These data show that only 5–10% of inmates are HIV positive on entry to these prisons, but that approximately 20% of the total population are infected. While not conclusive, this suggests that HIV is being transmitted in prisons, through unsafe drug injecting, unprotected sexual activity and other risk behaviours.<sup>11</sup>

### 5.2.3. HIV interventions in prisons

#### Prevention interventions

The *National Strategy* on HIV in prison has a strong focus on prevention through information, education and communication (IEC); drug dependency treatment; and harm reduction for prisoners engaging in HIV risk behaviours.<sup>8</sup>

#### Information, education and communication

Information about HIV transmission and prevention, including harm reduction strategies, is provided in all Indonesian prisons. The World Health Organization HIV education programme, HIV 101, has been conducted in Kerobokan prison in Bali. An evaluation found that participants' knowledge of HIV significantly increased after undertaking this programme. Prison staff noted that inmates who had completed the programme showed improved behaviour and violent incidents had decreased. Those who had completed the programme also shared the information they had learnt with their families and other prisoners, and relations between HIV-negative and HIV-positive prisoners had improved.<sup>15</sup>

#### Drug dependency treatment

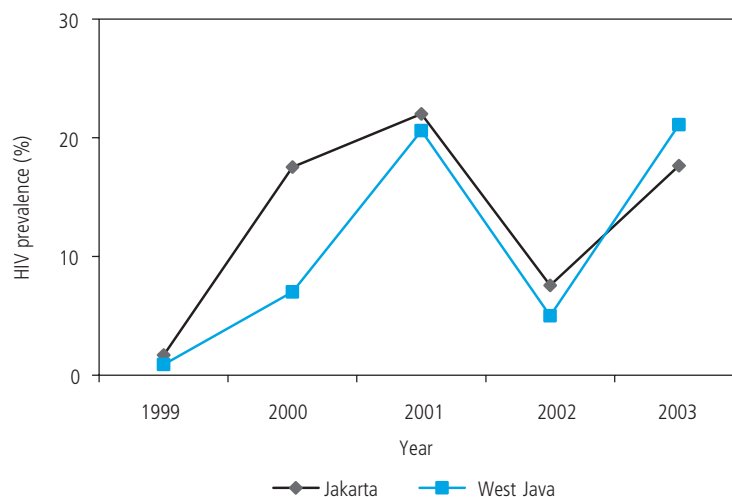
The availability of drug dependency treatments varies between prisons. The most widely available treatment options are non-pharmacological, including individual counselling, cognitive-behavioural therapy groups, therapeutic communities, drug-free units and self-help groups (Winarso I, personal communication, June 2006).

In addition to non-pharmacological treatment options, Kerobokan prison provides OST. There are plans to expand OST both within Kerobokan and to other Indonesian prisons.<sup>16</sup> According to the Indonesian HIV/AIDS Prevention and Care and Project (IHPCP), at the end of 2007, OST had been expanded to three more prisons – Bancuey, Cipinang Narkotika and Rutan Pondon Bambu.

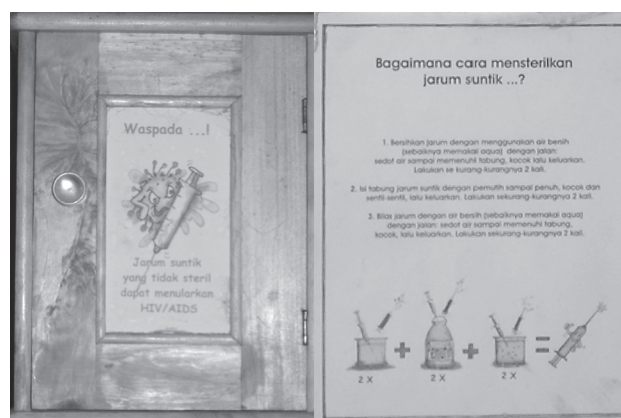
#### Harm reduction programmes

Pilot bleach and condom distribution programmes have begun in a small number

Figure 5.2.3. HIV prevalence in prisons in DKI Jakarta and West Java, 1999–2003



Source: *National Strategy: Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention: 2005–2009*. Jakarta, Directorate General of Corrections, 2005



A cupboard containing bleach and condoms, and an information sheet describing using bleach to clean needles and syringes in Kerobokan prison, Bali. Photos: Kate Dolan

of prisons in Indonesia. However, anecdotal reports suggest inconsistent availability of these supplies. There is high-level support for the expansion of condom distribution programmes, with “provision of access and method of having safe sexual intercourse” listed as an activity to be implemented under the relevant *National Strategy*.<sup>8</sup>

The National Strategic Plan includes a comprehensive harm reduction programme in prisons and detention centres such as education programmes, a health programme and a referral programme. The Plan is due to be implemented in 95 “top priority” correctional facilities in Indonesia.<sup>8</sup>

### *Care and treatment*

#### *Provision of antiretroviral therapy*

Availability of antiretroviral therapy (ART) in prisons is limited. ART for HIV-infected inmates is available in some prisons (where it is available in the community). Some prisons have set up multidisciplinary HIV/AIDS teams (personal communication, Ms Edna Oppenheimer, UNODC Consultant). The Directorate General of Corrections has committed to improving prisoner access to ART.<sup>8</sup>

#### *Assessment and treatment of sexually transmitted and opportunistic infections*

Access to general medical care is poor. The Directorate General of Corrections has identified improving access to treatment for sexually transmitted infections (STIs) and tuberculosis as a priority.<sup>8</sup> Treatment for tuberculosis is available in some prisons (personal communication, Ms Edna Oppenheimer, UNODC Consultant).

#### *Other support and care services*

Kerobokan Prison offers a support group for prisoners living with HIV/AIDS, known as “Positive Chat” (Winarso I, personal communication, June 2006). It is not known if other prisons offer similar support groups. Planned activities to improve support and care services in prisons include education and training for those involved in the care and treatment of HIV-infected prisoners; increasing the number of counsellors available to prisoners; and establishing a peer network for prisoners living with HIV/AIDS.<sup>8</sup>

#### *Compassionate release for terminally ill prisoners*

No reports of compassionate release for terminally ill prisoners were identified.

## 5.2.4. Discussion

Indonesia has taken strong and important steps towards the improvement of HIV prevention, care and treatment in prisons. The *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention 2005–2009* provides a framework for prevention, care and treatment activities, and provincial-level Prison Working Committees on HIV prevention have been and continue to be established to coordinate activity implementation.

Several of the activities described in the *National Strategy*, including condom distribution programmes and OST, have been implemented on a pilot basis. These programmes should

be urgently expanded to other prisons. Narcotic prisons, with their concentration of IDUs, should be prioritized for the implementation of harm reduction and drug dependency treatment programmes.

Lack of funding is a major impediment to the expansion of HIV prevention, care and treatment in prisons. Indonesia has been successful in attracting funding to support prevention and care efforts in the community, and this success can be replicated in prisons. In addition to supporting the expansion of harm reduction and other prevention projects currently in the pilot stage, funds should be sought to improve VCT; to increase the number of prisoners receiving ART; and to improve services for the assessment and treatment of coinfections such as tuberculosis, STI and hepatitis C.

At a broader level, reducing overcrowding in prison will assist in improving the HIV and TB situation. Overcrowding is a recent phenomenon in Indonesian prisons that can be linked to the incarceration of increasing numbers of drug offenders. Options for alternative sanctions for minor drug offences including non-custodial sentencing should be explored.

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- 1 *Epidemiological Fact Sheets on HIV/AIDS and sexually transmitted infections: Indonesia*. Geneva, WHO, UNICEF, UNAIDS, 2006.
  - 2 *Review of the health sector response to HIV and AIDS in Indonesia, 2007*. New Delhi, World Health Organization Regional Office for South-East Asia and Ministry of Health, Indonesia, 2007.
  - 3 *Prison Brief: Indonesia*. International Centre for Prison Studies, 2007.
  - 4 *National estimates of adult HIV infection, Indonesia 2002*. Jakarta, Directorate General of Communicable Disease Control and Environment Health, 2003.
  - 5 Pisani E et al. HIV, syphilis infection and sexual practices among transgenders, male sex workers and other men who have sex with men in Jakarta, Indonesia. *Sexually Transmitted Infections*, 2004, 80:536–540.
  - 6 Riono P, Jazant S. The current situation of the HIV/AIDS epidemic in Indonesia. *AIDS Education and Prevention*, 2004, 16 (Supplement A):78–90.
  - 7 *HIV/AIDS in the South-East Asia Region*. New Delhi, World Health Organization Regional Office for South-East Asia, 2007.
  - 8 *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention: 2005–2009*. Jakarta, Directorate General of Corrections, 2005.
  - 9 Juniartha IW. First HIV eradication committee in prison set up. *The Jakarta Post*, 10 February 2004
  - 10 *Patterns and trends in amphetamine-type stimulants in East Asia and the Pacific: findings from the 2004 Regional ATS Questionnaire*. Bangkok, UNODC Regional Centre for East Asia and the Pacific, 2005.
  - 11 *AIDS in Asia: face the facts – a comprehensive analysis of the AIDS epidemics in Asia*. Washington D.C., Monitoring the AIDS Pandemic Network, 2004.
  - 12 Dolan K et al. *Review of injection drug use and HIV infection in prisons in developing and transitional countries*, 2004. Retrieved Sept. 2006 from <http://www.ceehrn.org/EasyCEE/sys/files/IDUand%20HIV%20in%20prisons,%20refgr.pdf>
  - 13 Devaney M, Reid G, Baldwin S. *Situational analysis of illicit drug issues and responses in the Asia–Pacific Region* (ANCD Research Paper No. 12). Canberra, Australian National Council on Drugs, 2006.
  - 14 Sadipun CA. Risk behaviour among the inmates in the prison of Penfui and Atambua, Ntt Province, Indonesia. Paper presented at the XIV International AIDS Conference, Barcelona, 2002.
  - 15 Angela R, Booker R, Morgan A. *Evaluation of the content, implementation and impact of HIV 101 and cognitive behavioural therapy programs in prisons*. Jakarta, Burnet Indonesia, 2005.
  - 16 Irawati I et al. Indonesia sets up prison methadone maintenance treatment. *Addiction*, 2006, 101:1525.



## 5.3. NEPAL

Table 5.3.1. HIV/AIDS and imprisonment statistics, Indonesia

Total population	27 132 000 <sup>1</sup>
Adult population (15–49 years)	13 337 000 <sup>1</sup>
Number of adults (15+) living with HIV/AIDS (2005)	74 000 <sup>2</sup>
% of adults (15–49) living with HIV/AIDS (2005)	0.5 <sup>1</sup>
Imprisonment rate (per 100 000) (2005)	26 <sup>2</sup>
% of prisoners living with HIV/AIDS	unknown

### 5.3.1. HIV situation in the community

#### *HIV prevalence and distribution*

AIDS was first reported in Nepal in 1988. Currently, HIV prevalence in the adult population (ages 15–49 years) is estimated at 0.5% (range 0.3–1.3%).<sup>1</sup>

Despite the low general prevalence of HIV, concentrated epidemics are under way among high-risk populations such as sex workers, their clients, migrant and transport workers, men who have sex with men (MSM) and injecting drug users (IDUs). The highest prevalence rates are found in the Central Region. HIV infection has been noted in all regions of the country, although it appears to be concentrated in urban areas and districts with high labour migration. There are indications that transmission among housewives is increasing. Though the infection is found everywhere, it is concentrated in the capital.<sup>3</sup>

#### *HIV prevalence in high-risk populations*

In Kathmandu, 17% of sex workers are HIV positive.<sup>1</sup> Prevalence in rural areas is lower but still higher than among the general population.

Transport workers (e.g. truck drivers) are also at risk of HIV infection.<sup>4</sup> Among truck drivers engaging the services of sex workers in the Terai, HIV prevalence was 1.5% in 2000.<sup>5</sup>

A rapid assessment of MSM in 2001 found that there were no support services catering to MSM in Nepal. Many MSM also had female sexual partners. Limited data suggest HIV prevalence among MSM in Kathmandu to be 4%.<sup>6</sup>

HIV prevalence among IDUs across Nepal is estimated at 40%; in Kathmandu, this rises to 70%.<sup>7,8</sup> Involvement with the criminal justice system was common, with 38% reporting having been in police custody for offences such as theft; drug possession and distribution; and violence.

#### *Special situations*

As many as 12 000 women are trafficked across the border to India annually for the purposes of sexual exploitation.<sup>9</sup> Involvement in sex work in India is a risk factor for HIV infection; of the women surveyed in the Terai, HIV prevalence was 17% among those who had worked in India compared with 1% among those who had not.<sup>5</sup> It is likely that

sex workers returning from India might be playing a role in introducing HIV among the IDU population in the Kathmandu Valley. Nepalese men and women bring HIV to Nepal, and cross-border spread of HIV is occurring. This might contribute to consolidating an epidemic zone across the border, involving both the injecting and sexual routes of transmission.<sup>10</sup>

The role of the violent conflict between political rebels and government forces in impeding HIV prevention and treatment efforts has yet to be fully examined. The conflict may have led to increased rural-to-urban, and international migration and subsequent population mixing, while one fifth of sex workers surveyed stated that they had entered the sex trade as a direct result of conflict.<sup>11</sup> The conflict also created difficulties in the implementation of HIV prevention activities and created barriers to accessing HIV prevention services.<sup>12</sup> With the signing of the peace accord between the Government and the rebel forces in November 2006, migrants and displaced persons can be expected to return home. It is unknown whether this development will contribute to increased sexual mixing and perhaps the spread of HIV.<sup>10</sup>

### 5.3.2. Prison situation

Nepal's National HIV/AIDS Strategy guides HIV prevention, care and treatment efforts. The Strategy has been translated into an Action Plan to be financed under a public-private partnership framework.<sup>13</sup> Prisoners are identified in the National HIV/AIDS Strategy as a "vulnerable group" requiring targeted intervention. The Strategy acknowledges that once HIV is introduced into prisons, it can spread rapidly through sex and injecting drug use.<sup>14</sup> The objectives of the Strategy in relation to prisons are twofold: "to increase awareness and understanding among decision-makers as regards HIV/AIDS/STI in prison" and "to ensure that every prisoner is aware of the risks of HIV/AIDS/STI and has the power and means to act on that knowledge".<sup>14</sup> The draft National HIV/AIDS Programme budgets approximately US\$ 400 000 for prison-based HIV prevention, care and treatment activities.<sup>15</sup>

#### *Prison management*

##### *Administration*

Nepal has 73 prisons with an official capacity of 5000.<sup>2</sup> These institutions are administered by the Department of Prison Management within the Home Ministry of the national government. The prisons employ approximately 2000 security staff.<sup>15</sup>

##### *Inmates*

In 2005, the prison population was estimated to have been 7135, with women comprising 8% of prisoners.<sup>2</sup> Over half of all inmates are unconvicted and awaiting trial. The structure of Nepal's penal system is such that the only options for sentencing convicted offenders are fines (for minor offences) or imprisonment. Many offenders cannot afford to pay their fines and are also imprisoned.<sup>16</sup> The death penalty was abolished in 1997.<sup>17</sup>

Male and female prisoners are housed separately. There is no segregation of inmates by offence status or age. Mentally ill offenders and juveniles are housed with the general adult population.<sup>17</sup>

### *Women in prison*

Prior to 2002, abortion under any circumstances was characterized as infanticide and punishable by 20 years in prison. A significant proportion of women in prison were incarcerated for procuring an abortion. Often, women who miscarried pregnancies were also suspected of having abortions and imprisoned. In 2002, abortion was decriminalized; however, women remain imprisoned for abortion-related crimes.<sup>18</sup>

### *General conditions*

Overcrowding is a major concern, with the prison population at 140% of the official capacity. The problem has been exacerbated by the political conflict, with five prisons destroyed by rebels in 2001/2002.<sup>17</sup> In some prisons, overcrowding is so severe that toilet facilities are shared by men and women.<sup>19</sup>

Accommodation, recreational and educational facilities in prisons are reported to be inadequate. Food is of poor quality and is insufficient to sustain good health.<sup>17</sup> In a survey of 57 women prisoners, 72% reported that the food provided in prisons was insufficient for their needs.<sup>17</sup>

### *General medical care*

The Department of Prison Management is responsible for providing medical care to inmates. General medical care as provided by the Department is limited,<sup>19</sup> and access is impeded by the requirement in many cases that prisoners fund their own treatment.<sup>19</sup> A survey of 57 women prisoners found that only one third felt that medical care was “always available”. Just over half felt that medical care was “usually available”, while just over 10% said medical care was rarely or never available. It should be noted that although significant proportions of women felt that medical care was adequate, this must be seen in context. The women interviewed for this survey generally gave low priority to their health needs, evidenced by the finding that although three quarters of the women surveyed said they were ill, one third of them had not requested medical attention.<sup>19</sup>

Medical services provided by the Department of Prison Management are supplemented by those provided by NGOs who enter prisons to provide basic health care and mental health support. The Centre for Victims of Torture (CVICT) operates Mobile Health Clinics that travel to all prisons in Nepal, providing basic medical services, psychiatric care to mentally ill inmates, and documenting the treatment of inmates and physical conditions of the prisons.<sup>20</sup> In the course of their prison visits, CVICT has identified a number of severely mentally ill prisoners. These inmates are transferred to Dulikhel prison and are seen monthly by a psychiatrist who provides and monitors medication.<sup>21</sup>

### *HIV testing of prisoners*

The National Centre for AIDS and STD Control guidelines for voluntary counselling and testing (VCT) state that mandatory HIV testing is not permitted in Nepal.<sup>22</sup> The only reference to HIV testing of prisoners located stated that prisoners are not routinely tested for HIV. Prisoners are not included as a “priority group” for the provision of VCT services in the National HIV/AIDS Strategy.<sup>14</sup>

### *Segregation of HIV-positive prisoners*

Limited information suggests that HIV-positive prisoners are not segregated from the general prison population.<sup>23</sup>

### *HIV prevalence and risk behaviours in prisons*

No data are available on the prevalence of HIV among prisoners. However, a rapid assessment of drug use and HIV carried out in 1999 found that drug injectors with a history of imprisonment were 4.6 times more likely to be HIV positive than those without such a history.<sup>24</sup>

As recently as 1999, the Ministry of Home Affairs denied that sex occurs in prisons, because “men are separated from women in prisons”.<sup>25</sup> However, more recent policy documents including the National HIV/AIDS Strategy and the National HIV/AIDS Action Plan and Budget acknowledge that prisoners engage in sexual activity and discuss the need for condom distribution in prisons.<sup>14</sup> The extent of sexual activity in prisons is unknown; however, one key expert has claimed that male-to-male sex in prisons is “very common”.<sup>25</sup> There has been a report of a female prisoner becoming pregnant and bearing a child after a sexual relationship with a male prisoner, suggesting that heterosexual activity also occurs.

The Ministry accepts that drug use occurs in prisons. A study of five prisons in Eastern Nepal carried out in-depth interviews with 95 inmates, of whom 27 (28%) were drug users. It is unclear if they had access to and were using drugs in prison. Of the drug users, 75% “always” shared needles when injecting. Again, it is uncertain if this referred to behaviour in prison or in the community.<sup>25</sup> Prisoners caught using drugs are subjected to “increased punishment”, although it is unclear what form this may take.<sup>25</sup>

No information regarding any other risk behaviours such as tattooing, violence or body modification among prisoners was located.

Policy documents acknowledge the lack of awareness of HIV risk behaviours in prisons. The National HIV/AIDS Action Plan for 2005–2006 lists “behavioural studies of prisoners” as an activity to be undertaken to remedy this situation.<sup>14</sup>

### 5.3.3. HIV interventions in prisons

#### *Prevention interventions*

As noted above, prisoners have been identified in the National HIV/AIDS strategy as a vulnerable population requiring targeted HIV prevention activities. Planned prevention activities include sensitization workshops for both prison officers and prisoners, and condom distribution to enable prisoners to reduce the risk of sexually transmitted HIV.<sup>14</sup> There are no NGO-initiated HIV prevention activities in prison (Adhikari P, personal communication, September 2006).

#### *Information, education and communication*

The National HIV/AIDS Strategy and National HIV/AIDS Action Plan both emphasize the role of information, education and communication (IEC) strategies in HIV prevention in prisons. These documents state that staff are to receive training on HIV and STI, while

peer educators are to be trained to provide information and education to inmates.<sup>13,14</sup> IEC materials on HIV and STI, hepatitis and condom use are to be developed and provided to inmates.<sup>15</sup>

HIV education for both prison staff and inmates has been commenced on an ad hoc basis. The UNODC Regional Office for South Asia recently conducted training in HIV prevention among incarcerated drug users with prison staff. The training aimed to sensitize prison officials to the issues of drugs and HIV in prison settings.<sup>26</sup>

An education project carried out in one women's and two men's prisons in Kathmandu trained peer educators in HIV prevention and counselling. The peer educators helped to design and implement HIV education strategies suitable for prisons and distributed educational materials to other inmates.<sup>27</sup>

#### *Drug dependency treatment*

UNODC Regional Office for South Asia has reported that no drug dependency treatments are provided in prisons.<sup>9</sup> No reports of treatment programmes, be they therapeutic communities, psychosocial interventions or OST, were located to contradict this.

#### *Harm reduction programmes*

There are no needle and syringe programmes (NSPs) in Nepal's prisons. The Draft National HIV/AIDS Programme for Nepal makes reference to the distribution of bleach to prisoners;<sup>15</sup> however, bleach distribution is not discussed in finalized policy documents such as the National HIV/AIDS Action Plan and Budget. No reports were located to confirm the commencement of bleach distribution in prisons.

Information regarding condom availability was conflicting. According to a 1998 report, condoms were made available in two male prisons in Kathmandu.<sup>28</sup> However, more recent policy documents state that there are no condom distribution mechanisms in prison.<sup>14</sup> Both the National HIV/AIDS Strategy and the National HIV/AIDS Action Plan include condom distribution as a programme to be implemented.<sup>13,14</sup>

#### *HIV care and treatment*

##### *Provision of antiretroviral therapy*

No prisoners are receiving antiretroviral therapy (ART) (Adhikari P, personal communication, September 2006). No policy documents specify the provision of ART to prisoners as an activity for implementation.

##### *Assessment and treatment of sexually transmitted and opportunistic infections*

No information could be located on the assessment and treatment of sexually transmitted infections (STIs) and opportunistic infections. However, access to general health care is limited, reducing the likelihood that coinfections are identified and treated.<sup>17</sup>

##### *Other support and care services*

No information was located on other support and care services available to HIV-positive prisoners.

### *Compassionate release for terminally ill prisoners*

No information regarding release of terminally ill prisoners on compassionate grounds was identified.

#### 5.3.4. Discussion

There is recognition in government policy documents that prisons and prisoners require greater attention if Nepal is to effectively stem the HIV epidemic. However, the information reviewed reveals that action is lacking. Nepal is not unique in this regard; prisons are often neglected in HIV prevention efforts.<sup>28</sup> This neglect threatens the success of communitywide HIV prevention efforts.

There have been some ad hoc HIV prevention efforts in prisons, mostly education programmes but also a condom distribution programme. While small pilot projects such as these are useful for demonstrating the feasibility of an intervention, they can have little impact if not implemented on a broader scale.

The National HIV/AIDS Strategy and National HIV/AIDS Action Plan and Budget provide a strong framework for the improvement of HIV prevention in prisons. The activities outlined are vital to the development of an environment conducive to the implementation of further HIV prevention, care and treatment activities. Planned activities, if not already under way, should urgently be implemented.

The current National HIV/AIDS Strategy is due for review. In addition to reiterating support for and scale-up of the activities outlined in the current Strategy, the revised Strategy could incorporate a wider range of prevention interventions, such as bleach distribution, sterile needle and syringe exchange, and drug dependency treatment.

The lack of discussion in the current Strategy around care and treatment for prisoners living with HIV is notable. This may in part relate to the lack of knowledge of HIV prevalence in prisons. This is an issue that must be addressed in the revised Strategy for the care and treatment needs of prisoners to be established. VCT should be made available to prisoners, and an anonymous, linked surveillance study could be conducted in several prisons. This would provide information valuable for planning future care and treatment service provision.

Given the limited resources available to implement HIV prevention, care and treatment programmes in prisons, the Department of Prison Management is encouraged to identify and collaborate with external partners such as NGOs. Together, the Department and partners could develop, seek funding for, implement and evaluate culturally appropriate HIV prevention, care and treatment programmes.

Finally, interventions and legal reforms aimed at reducing the size of the prison population should be encouraged. The provision of OST to prisoners reduces re-incarceration, leading to reductions in prisoner numbers.<sup>29</sup> The introduction of OST in prisons, in conjunction with a similar linked community-based programme, is warranted. Reforms that encourage reductions in the prison population and alternatives to incarceration are strongly recommended.

- 1 *Epidemiological Fact Sheets on HIV/AIDS and sexually transmitted infections: Nepal*. Geneva, WHO, UNICEF, UNAIDS, 2006
- 2 *Prison Brief: Nepal*. International Centre for Prison Studies, 2006.
- 3 <http://www.youandaids.org/Asia%20Pacific%20at%20a%20Glance/Nepal/> (accessed September 2007)
- 4 Khadka G. A qualitative study of sexual practices of transport workers on highway routes in central Nepal. Paper presented at the XV International AIDS Conference, Bangkok, 2004.
- 5 *STD and HIV prevalence survey among female sex workers and truckers on highway routes in the Terai, Nepal*. Kathmandu, Family Health International, 2000.
- 6 *Rapid ethnography of male to male sexuality and sexual health*. Kathmandu, Family Health International, 2001.
- 7 Aceijas C et al. Global overview of injecting drug use and HIV infection among injecting drug users. *AIDS*, 2004, 18:2295–2303.
- 8 Panda S, Sharma M. Needle syringe acquisition and HIV prevention among injecting drug users: a treatise on the “good” and “not so good” public health practices in South Asia. *Substance Use & Misuse*, 2006, 41:953–977.
- 9 *South Asia Regional Profile*. New Delhi, UNODC Regional Office for South Asia, 2005.
- 10 Nepal B. Population mobility and spread of HIV across the Indo-Nepal border. *Journal of Health, Population and Nutrition*, 2007, 25 (in press).
- 11 Rijal S. Insurgency fuelling flesh trade. *The Kathmandu Post*, 29 March 2005. Available from: <http://www.kantipuronline.com/kolnews.php?&nid=35647> (accessed 26 October 2007).
- 12 Singh S et al. HIV in Nepal: is the violent conflict fuelling the epidemic? *PLoS Medicine*, 2005, 2:e216.
- 13 *National HIV/AIDS Action Plan and Budget 2005–06*. Kathmandu, National Centre for AIDS and STI Control, 2005.
- 14 *Nepal's National HIV/AIDS Strategy*. Kathmandu, National Centre for AIDS and STI Control, 2002.
- 15 Steinberg M et al. *Draft National HIV/AIDS Programme for Nepal (2003–2007)*. Kathmandu, National Centre for AIDS and STI Control, 2003.
- 16 *Department of Prison Management Project: Project Document (Phase 1)*. Kathmandu, HMG Ministry of Home Affairs, Department of Prison Management, 2003.
- 17 *Abolitionist and retentionist countries*. Amnesty International. Retrieved Oct. 2006 from <http://web.amnesty.org/pages/deathpenalty-countries-eng>.
- 18 *Abortion in Nepal: women imprisoned*. Centre for Reproductive Law and Policy/Forum for Women, Law and Development, 2002. Retrieved September 2006 from [http://www.reproductiverights.org/pdf/nepal\\_2002.pdf](http://www.reproductiverights.org/pdf/nepal_2002.pdf)
- 19 *Nepal's penal system: an agenda for change*. Kathmandu, Centre for Victims of Torture, 2001.
- 20 *Mobile health clinics in prison*. Centre for Victims of Torture. Retrieved Sept. 2006 from <http://www.cvict.org.np/prison.html>
- 21 Sharma B, van Ommeren M. Preventing torture and rehabilitating survivors in Nepal. *Transcultural Psychiatry*, 1998, 35:85–97.
- 22 *National guidelines for voluntary HIV/AIDS counseling and testing*. Kathmandu, National Centre for AIDS and STI Control, 2003.
- 23 *HIV/AIDS Strategy 2002–2006*. Family Planning Association of Nepal. Retrieved Sept. 2006 from <http://www.fpan.org/demo/hivaid%20strategy.html>
- 24 *Nepal HIV drug assessment report*. Kathmandu, Family Health International, 1999.
- 25 Paul C et al. Awareness, perception and risk behaviours of drug users in the prisons. Paper presented at the International AIDS Conference, Barcelona, 2002.
- 26 *National Training Programmes in Nepal*. UNODC Regional Office for South Asia. Retrieved Sept. 2006 from [http://www.unodc.org/india/nepal\\_info.html](http://www.unodc.org/india/nepal_info.html)
- 27 Upadhyay P. Challenge in implementing HIV/AIDS/STD in the prisons in Kathmandu, Nepal. Paper presented at the XII International AIDS Conference, Geneva, 1998.
- 28 *HIV/AIDS prevention, care, treatment and support in prison settings*. Vienna, United Nations Office on Drugs and Crime, 2006.
- 29 Dolan K et al. Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, re-incarceration and hepatitis C infection. *Addiction*, 2005, 100:820–828.

## 5.4. THAILAND

Table 5.4.1. HIV/AIDS and imprisonment statistics, Thailand

Population (2005)	64 232 000 <sup>1</sup>
No. of adults (2005)	35 595 000
No. of adults (15+) living with HIV/AIDS (2005)	560 000
% of adults (ages 15–49) living with HIV/AIDS (2005)	1.4%
Imprisonment rate (per 100 000) (2006)	249 <sup>2</sup>
HIV prevalence among prisoners	1.9–25%

### 5.4.1. HIV situation in the community

#### *HIV prevalence and distribution*

Thailand has achieved substantial success in HIV control with the estimated annual number of new HIV infections decreasing from 142 819 in 1991 to 17 000 in 2005. National HIV prevalence was 1.4% in 2005, down from 1.8% in 2003 and more than 2% a decade earlier.<sup>3</sup> However, the AIDS epidemic is far from over and infection levels in the most at-risk populations are much higher than in the general population.

Of the HIV infections reported to date with a known route of transmission, heterosexual transmission accounts for the highest proportion of cases (82%), followed by injecting drug use (5%) and perinatal transmission (4%).<sup>4</sup> The pattern of the HIV epidemic has been changing over the years. In the early years of the epidemic, injecting drug use and commercial sex work contributed the largest proportion of new infections.<sup>4</sup>

Over time, male clients of sex workers and male injecting drug users (IDUs) have infected their wives and girlfriends, with the result that as many as half of new HIV infections each year occur within marriage or long-term heterosexual relationships where condom use tends to be very low.<sup>4,5,6</sup> Having spread beyond vulnerable groups to the general population, the epidemic is threatening to gain momentum among young people. There is evidence that transmission of sexually transmitted infections (STI) and HIV may be on the rebound in several areas. On a national level, STIs are being seen for the first time in those 15 years and above, though few clinics are reporting these.<sup>7</sup> It is estimated that 10–25% of tuberculosis (TB) patients are coinfecting with HIV and that TB morbidity in individuals with HIV is around 20–40%.<sup>7</sup> Mortality due to TB is high in Thailand (10%), mainly due to HIV, but also due to the relatively higher numbers of patients in the older age groups.<sup>8</sup> The prevalence rate of TB in the general population in 2004 was 208/100 000 and the overall cure rate was 73%. Mortality due to TB was 19/100 000/year in 2004.<sup>9</sup>

#### *HIV prevalence among high-risk populations*

HIV prevalence among sex workers peaked in the mid-nineties, declining since then largely as a result of a government-supported 100% condom programme. Prevalence varies greatly between Bangkok (4.3%) and rural settings (0–30.8%), between direct (16.6%) and indirect sex workers (5.1%) and between venue-based (4.7%) and street-



based (43.3%) sex workers. HIV prevalence among male sex workers is also high, at 9.6%. In recent years, condom use among brothel-based sex workers has decreased from 96% in the mid-1990s to as low as 50% in some locations.<sup>10</sup>

There are an estimated 50 000–100 000 IDUs in Thailand.<sup>11</sup> This group accounts for an estimated 5% of total HIV infections<sup>12</sup> and about 25% of all new infections.<sup>13</sup> HIV in drug users spreads to non-injecting sex partners and children. In Thailand, approximately 3% of the estimated 29 000 new HIV infections in 2000 occurred among women with partners who injected drugs and shared injecting equipment.<sup>14</sup>

In late 2002, a law requiring the treatment and rehabilitation of drug users was enacted, and the Thai government declared a “war on drugs”. All drug users were required to seek treatment. In the three months from February 2003, drug users seeking treatment were placed in an existing facility or one of thousands of newly established rehabilitation centres or military-style facilities. The aim of these centres and camps was to provide skills to assist users to live drug-free.<sup>15</sup>

## 5.4.2. Prison situation

### *Prison management*

#### *Administration*

Prisons are administered by the Department of Corrections under the Ministry of Justice. In 2005 there were 138 establishments with an official capacity of 114 177.

Health care in prisons is administered by the Medical Services Division of the Department of Corrections.<sup>16</sup>

#### *Inmates*

In 2006, there were 161 844 prisoners in Thailand, making for an imprisonment rate of 249 per 100 000 people. Of these, 15.2% were women and 32.6% were pre-trial detainees. Officially, pre-trial detainees are to be housed separately from the sentenced population; however, lack of facilities often results in the two groups being housed together. Nationally, the staff/inmate ratio was 1:23 in 2002.<sup>17</sup> Also in 2002, 71% of prisoners were between 20 and 40 years of age.<sup>17</sup>

#### *Incarceration of drug offenders*

Drug offences are the most commonly prosecuted crimes in Thailand. In 2005, almost two thirds (64%) of prisoners in Thailand were drug offenders.<sup>18</sup> In 2002, the proportion of inmates prosecuted for drug offences was more than three times as great as the proportion prosecuted for the second most common offence, property crime (Figure 5.4.1).

Severe penalties for drug offences contributed to a rapid increase in the imprisonment rate, from 270 per 100 000 in 1998 to a peak of 402.6 per 100 000 in 2002.<sup>19,20</sup> The imprisonment rate has recently returned to levels similar to those seen in the late 1990s.

The war on drugs required that all drug users who did not seek voluntary treatment be detained for compulsory treatment. Depending on the amount of drugs used by an individual, and the amount found in their possession on arrest, drug users detained for

compulsory treatment are assigned to one of four treatment options: military boot camp for four months; an inpatient drug treatment facility; supervision in their local community; and regular reporting to probation authorities.<sup>15</sup>

#### *Incarceration of women*

Although there was a dramatic increase in the general prison population in 2002 and 2003, there was a greater increase in the number of female prisoners. In 1991, 7% of prisoners were women. By 2002, 20% were women.<sup>21</sup> In the same year, 87% of female prisoners were drug offenders, an increase from 39% in 1990.<sup>17</sup> In mid-2006 female prisoners accounted for 15.8% of the prison population.

#### *General conditions*

Overcrowding is a concern. Nationally, prison occupancy was 145.6% in 2005 and the space per inmate was 2.25 square meters.<sup>16</sup>

The budget that the Department of Corrections receives for food for each prisoner per day is US\$ 0.73. The Department concedes that the quality and quantity of the food is insufficient and has thus allowed the establishment of a store in front of the prison to cook and sell food to relatives. Poor sanitation and hygiene are also of concern.<sup>16</sup>

#### *General medical care*

In each prison there is a nursing home that provides basic medical services for sick prisoners. Prisoners in need of long-term treatment are transferred to the Central Correctional Hospital in Bangkok, the only hospital of the Corrections Department. The hospital has a capacity of 300 beds.<sup>16</sup> The hospital receives US\$ 5.32 per patient per year.<sup>22</sup>

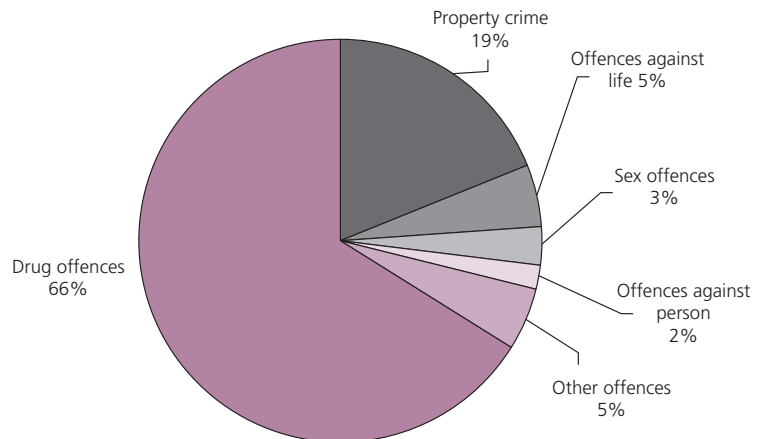
The Corrections Department employs 14 doctors and 5 dentists for a total prison population of over 100 000.<sup>23</sup> The majority of prisons in Bangkok have physicians, registered nurses, laboratory capacity and an ambulatory unit. Provincial prisons have no physicians or laboratory facilities, and only one or two licensed practical nurses with two years of education in nursing college.<sup>24</sup>

There is a high incidence of deaths in custody from AIDS-related illnesses and those such as tuberculosis in prisons in Thailand. Lack of appropriate treatment contributes to this outcome.<sup>22</sup>

#### *HIV testing of prisoners*

Compulsory HIV testing for prisoners was stopped in 2000.<sup>3</sup> No further information regarding access to voluntary counselling and testing (VCT) was identified.

Figure 5.4.1. Imprisonment by offence type



Source: *Statistics*. Department of Corrections, Thailand, 2002. Retrieved Sept. 2006 from <http://www.correct.go.th/statis.htm>

### *Segregation of HIV-positive prisoners*

No recent reports of segregation of prisoners were identified.

### *HIV prevalence and risk behaviours in prisons*

There have been no national-level studies of HIV in prisons in Thailand. However, there have been a number of studies conducted on the general prison population and among risk groups. Prevalence levels vary from less than 2% to 25%. Of all male AIDS cases in Thailand, 2% have been diagnosed in prison.<sup>25</sup>

Having been incarcerated is an independent risk factor for HIV infection among Thai men, especially IDUs and MSM.<sup>26,27</sup> Despite high levels of HIV-related knowledge among prisoners, high levels of drug use, sexual activity and tattooing within correctional facilities have been reported.<sup>28</sup>

### *Injecting drug use*

There are several studies which indicate that injecting drug use and sharing of needles is common in prisons and holding cells. In a study of male IDUs in a treatment centre in northern Thailand, 15.8% who had ever been jailed had injected in prison.<sup>26</sup> In a prospective cohort of 705 drug injectors in Klong Prem Prison, 38% had injected while in prison and 97% of those who had injected had shared injecting equipment while in prison.<sup>29</sup> A case–control study of former prisoners found that 51% of 175 HIV-infected cases had injected heroin while in holding cells, compared to 36% of 172 non-infected controls. Half of the cases had shared needles in holding cells, compared to 31% of controls.<sup>30</sup>

Incarceration has been known to be a risk factor for HIV infection among IDUs in Thailand for over ten years.<sup>26,27,31</sup> A risk assessment among a large cohort of Bangkok IDUs found only two risk factors to be independently associated with HIV infection: having shared needles in the previous six months and having been in prison. Bangkok IDUs with a history of imprisonment were about twice as likely to be HIV infected than those who had never been in prison and, in terms of absolute risk, 80% of all IDUs with HIV infection had ever been imprisoned.<sup>31</sup>

In a prospective cohort of 689 male inmates in Bangkok Central Prison in 2002 the HIV incidence was 4.18 per 100 person-years among all inmates, and 11.10 per 100 person-years among injection inmates, which is higher than that of Bangkok IDUs. All inmates who seroconverted during the study were IDUs.<sup>29</sup>

Among a cohort of IDUs in Bangkok between 1995 and 1998, inmates who injected while incarcerated had a higher incidence of HIV infection (35.3 per 100 person-years of observation) than those had been incarcerated but had not injected (11.3 per 100 person-years) and those who had not been incarcerated (4.9 per 100 person-years). The authors of this study concluded that “it is likely that a large proportion of this risk results from the sharing of drug injection equipment in settings where access to clean syringes and needles is severely limited”.<sup>32</sup>

Considerable evidence suggests that incarceration of IDUs was an important component of the HIV epidemic among IDUs in Bangkok as HIV transmission remained uncontrolled

in and outside of prisons. A prison amnesty in 1987 saw the release of hundreds of prisoners, including many who were IDUs. Shortly thereafter, HIV prevalence among IDUs presenting for drug treatment in Bangkok rose dramatically from 2% to 27%. A number of studies have reported the relationship between incarceration and HIV infection among IDUs in Bangkok.<sup>33,34</sup>

#### *Sexual activity*

More than one quarter of 689 male inmates surveyed in Bangkok reported ever having sex with men; of them, more than 80% of them reported sex with men during incarceration.<sup>29</sup> Sexual risks involving male inmates and staff, or between female inmates and male staff may be primary HIV risks for prisoners who do not inject.<sup>29</sup>

#### *Tattooing and other body modification*

Tattooing in prison occurs in unhygienic conditions and is a possible risk factor for the transmission of HIV. Tattooing and sharing razor blades are common in prisons in Thailand.<sup>26,29</sup> A case-control study found that a significantly greater proportion of HIV-infected IDUs (59%) than non-infected controls (42%) had received a tattoo during incarceration.<sup>30</sup>

The insertion of penile implants (*fang muk* in Thai) is common among Thai male prison populations and may increase HIV transmission risk.<sup>26</sup>

#### *Evidence suggestive of HIV transmission in prisons*

A study conducted in 1991 in prisons in ten provinces found that HIV prevalence was 12% among newly admitted men, but 19% among men about to be discharged. This suggests the transmission of HIV in prisons.<sup>35</sup>

### 5.4.3. HIV interventions in prisons

#### *Prevention interventions*

To date, the response to HIV in prisons has been uncoordinated and access to prevention programmes has been poor. The Ministry of Justice recognizes this and has welcomed collaboration with external United Nations entities to consider new methods to assess and improve the HIV/AIDS situation in prisons.<sup>3</sup>

#### *Information, education and communication*

Prisoners are presented with HIV/AIDS-related information when they start their sentence and again just before they are released. It is unclear how widespread or consistent this practice is. There are reports that some medical staff serving in prison facilities, of their own accord, try to provide HIV/AIDS education and counselling. Medical staff also provide some HIV/AIDS training for prison guards.<sup>3</sup>

The Population and Community Development Association has delivered HIV education programmes in Klong Prem prison. Guards and selected inmates were trained to be peer educators. Staff from the Ministry of Public Health have provided instruction on pre- and post-test counselling.<sup>36</sup>

In addition, the Global Fund has recently provided funding to the NGO Raks Thai Foundation to deliver educational workshops to increase the capacity of prison staff to provide HIV prevention information to IDUs in prisons.<sup>37</sup>

### *Drug dependency treatment*

Opioid substitution therapy (OST) is not provided in prisons in Thailand.

Therapeutic communities have operated in Thai prisons since 1994. Therapeutic communities are coordinated by the Orthopaedic Nurses Certification Board, Thanyarak Institute of Drug Abuse and private sector organizations. The aim of therapeutic community programmes is abstinence, achieved with the support of the peer group and families. There are three categories of therapeutic communities operating in prisons:

1. *Eighteen-month programme*: A long-term programme with orientation, rehabilitation, re-entry and follow-up phases. Prisons that operate this programme need to provide a specific area for therapeutic community residents to live separately from other prisoners.
2. *Four-month intensive programme*: A programme for short-term or pre-release prisoners. Apart from therapeutic community principles and practices, short-term vocational training programmes are provided to assist prisoners find jobs after release.
3. *Combination programme*: This programme is arranged for prisoners who do not qualify for the above programmes and where a specific area for the therapeutic community cannot be provided. Only some therapeutic community principles are practised.<sup>18</sup>

All drug users are required to participate in activities such as group counselling, social support group activities, and educational and vocational training. Inmates who do not satisfy the requirements of the drug treatment programme are referred back to the judicial system for further sentencing or treatment.<sup>38</sup>

In 2005, the Department of Corrections implemented a project entitled “Vivat Polamaung Rachatan” in five correctional institutions across Thailand. The four-month programme consists of military disciplinary practice, therapeutic community programmes and vocational training. Inmates who complete this programme receive consideration for special parole. In 2005, 1600 prisoners were enrolled in this programme.<sup>18</sup>

### *Harm reduction programmes*

There are no needle and syringe or bleach distribution programmes in Thai prisons.<sup>26</sup>

It is reported that medical staff serving in prisons sometimes distribute condoms.<sup>3</sup>

### *HIV treatment and care*

The Global Fund has provided the Raks Thai Foundation with funds for the training of prison staff in the HIV care, treatment and support of inmates who are IDUs. However, the

funding proposal submitted does not include a budget for the provision of antiretroviral therapy (ART) or care and support of inmates who are HIV positive. It is hoped that once the success of the project is demonstrated, opportunities for more sustained funding from national and international sources will arise.<sup>37</sup>

#### *Antiretroviral therapy*

According to the Thai Medical Correctional Institute, ART was available in three Thai prisons as of 2004. Over 400 patients were enrolled in the programme between 2004 and 2005, and CD4 counts improved in over 90% of the treated inmates.<sup>39</sup>

#### *Assessment and treatment of sexually transmitted and opportunistic infections*

By 2005, Thailand had implemented the directly observed treatment, short-course (DOTS) strategy for TB in all 138 prisons and all MOPH health facilities.<sup>40</sup> The overall treatment outcomes of 1158 new smear-positive patients treated in sixteen prisons located in four geographical regions were: 68.7% cured, 17.6% died, 10.5% were transferred out, 2.6% failed and 0.5% completed treatment.<sup>24</sup> The high mortality rate in this prison DOTS programme was possibly due to HIV coinfection. However, the programme did not offer HIV counselling and testing to newly registered TB cases. The mortality of TB cases with HIV infection was observed to be high in many studies among Thai prisoners, varying from 74.2% (95/128) in the north, 57.1% (88/154) in the centre<sup>41</sup> to 39.5% (17/43) in the south.<sup>42</sup> In a recent study carried out in 27 prisons in Thailand among 71 594 prisoners, 254 were confirmed by sputum smear to be positive for TB, a prevalence of 354.8/100 000.<sup>43</sup> No information on the treatment of other opportunistic infections was found.

#### *Other support and care services*

A local community group for people with HIV/AIDS, the Wednesday Friends Group, has assisted inmates in setting up a peer support group in Klong Prem Prison.<sup>36</sup>

#### *Compassionate release for terminally ill prisoners*

No policy that allows the compassionate release for terminally ill prisoners in Thailand was found.

### 5.4.4. Discussion

The lack of HIV prevention interventions in prisons was a likely contributor to the first HIV epidemic among IDUs in Bangkok in the late 1980s.<sup>33</sup> A prison amnesty in 1987 saw the release of a number of HIV-positive IDUs in the community. Extensive sharing of injecting equipment transmitted HIV among IDUs; the HIV prevalence rose from 2% to 27% between February and September 1988.<sup>33</sup> Though the country has achieved substantial success in curbing the HIV epidemic since then, prevalence in high-risk populations, particularly IDUs, but also MSM and sex workers, is several times that of the general population. Prevalence among IDUs remains extremely high, at 20–56%.

HIV prevalence among IDUs in prisons is also very high. Incarceration is a risk factor for HIV infection among IDUs and has been for over ten years. Holding cells are a particularly high-risk environment.

There have been some HIV prevention efforts within prisons, such as HIV education provided by NGOs. However, there is an urgent need for harm reduction programmes, including condom distribution and needle and syringe programmes (NSPs), which are not generally supported in Thailand. Currently, Bangkok has 20 OST clinics operating in 65 health centres.<sup>4</sup> Prevention interventions should be expanded to include all detention facilities, including holding cells.

HIV care and treatment interventions in prisons are still in the pilot stages, though about 60% of those in need are receiving treatment in the community.<sup>44</sup> The National Access to Anti-retroviral Treatment (ART) programme, which provides subsidised ART throughout Thailand, should be expanded to include free ART for prisoners. The same clinical criteria for determining treatment eligibility in the community should be applied to prisoners.

The punitive approach to drug dependence has reduced the willingness of drug users to seek drug treatment or harm reduction services. A large number of IDUs have been imprisoned and many continue to inject in prison, contributing to the spread of HIV. The imprisonment of drug users has also contributed to high levels of overcrowding in prisons. An approach to drug dependence that focuses on adopting a public health perspective on drug use with the provision of effective drug treatment and harm reduction interventions to prevent HIV transmission among IDUs inside and outside prisons rather than sole reliance on law enforcement is recommended.

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- 1 *Epidemiological Fact Sheets on HIV/AIDS and sexually transmitted infections: Thailand*. Geneva, UNAIDS, 2006.
  - 2 *Prison Brief: Thailand*. International Centre for Prison Studies, 2007.
  - 3 *Thailand's response to HIV/AIDS: progress and challenges*. Bangkok, UNDP, 2004.
  - 4 *HIV/AIDS in the South-East Asia Region*. New Delhi, WHO Regional Office for South-East Asia, 2007.
  - 5 *AIDS epidemic update*. Geneva, UNAIDS, 2005.
  - 6 *HIV/AIDS in the Asia Pacific Region 2003*. Geneva, World Health Organization, 2004.
  - 7 *External review of the health sector response to HIV/AIDS*. New Delhi, Ministry of Public Health, Thailand and World Health Organization Regional Office for South-East Asia, 2005.
  - 8 [http://www.searo.who.int/en/Section10/Section2097/Section2100\\_10643.htm](http://www.searo.who.int/en/Section10/Section2097/Section2100_10643.htm) (accessed on 14 September 2007)
  - 9 [http://www.searo.who.int/LinkFiles/TB\\_in\\_SEAR\\_Thailand\\_profile.pdf](http://www.searo.who.int/LinkFiles/TB_in_SEAR_Thailand_profile.pdf) (accessed on 14 September 2007)
  - 10 Buckingham R, Meister E. Condom utilization among female sex workers in Thailand: assessing the value of the health belief model. *Californian Journal of Health Promotion*, 2003, 4:18–23.
  - 11 Devaney M, Reid G, Baldwin S. *Situational analysis of illicit drug issues and responses in the Asia-Pacific region*. Canberra, Australian National Council on Drugs, 2006.
  - 12 *Review and assessment of the current organisational structure of the Office of the Narcotics Control Board, Thailand*. UNODC, 2004. Retrieved Sept. 2006 from [www.unodc.un.or.th/drugsandhiv/Project\\_findings/output1.htm](http://www.unodc.un.or.th/drugsandhiv/Project_findings/output1.htm).
  - 13 Inkochasan M et al. Predictors of needle sharing and improved programming for intravenous drug users (IDUs) in Thailand. Paper presented at the XVI International AIDS Conference, Toronto, 2006.
  - 14 *Not enough graves: the war on drugs, HIV/AIDS, and violations of human rights*. New York, Human Rights Watch, 2004.
  - 15 Vongchak T et al. The influence of Thailand's 2003 'war on drugs' policy on self-reported drug use among injection drug users in Chiang Mai, Thailand. *International Journal of Drug Policy*, 2005, 16:115–121.
  - 16 *Crime prevention: current issues in correctional treatment and effective countermeasures*. UNAFEI, 2002. Retrieved Sept. 2006 from [http://www.unafei.or.jp/english/pdf/PDF\\_rms/no57/57-29.pdf](http://www.unafei.or.jp/english/pdf/PDF_rms/no57/57-29.pdf)

- 17 *Statistics*. Department of Corrections, Thailand, 2002. Retrieved Sept. 2006 from <http://www.correct.go.th/statis.htm>
- 18 Ringrowd P. Plenary Session 6: Sharing of TC practices in Asia: challenges and future direction. Paper presented at the 6th Asian Federation on Therapeutic Community Conference, Tokyo, 2005.
- 19 *Research on the trends in drug abuse and effective measures for the treatment of drug abusers in Asian countries*. Tokyo, UNAFEI, 2005.
- 20 *24th Asian and the Pacific Conference of Correctional Administrators Conference Report*. Singapore, APCCA, 2004.
- 21 *The Criminal Justice System and community based treatment of offenders in Thailand*. UNAFEI, 2003. Retrieved Sept. 2006 from [http://www.unafei.or.jp/english/pdf/PDF\\_rms/no61/ch17.pdf](http://www.unafei.or.jp/english/pdf/PDF_rms/no61/ch17.pdf)
- 22 *Thailand - Widespread abuses in the administration of justice*. Amnesty International, 2002. Retrieved Sept. 2006 from <http://web.amnesty.org/library/index/engasa390032002>
- 23 *Country reports on human rights practices: Thailand*. US Department of State, 2003. Retrieved Oct. 2006 from <http://www.state.gov/g/drl/rls/hrrpt/2003/27790.htm>
- 24 Nateniyom S et al. Implementation of the DOTS strategy in prisons at provincial level, Thailand. *International Journal of Tuberculosis and Lung Disease*, 2004, 8:848–854.
- 25 *HIV/AIDS in Thailand up to April 30, 2000*. Bangkok, AIDS Division, Ministry of Public Health, 2000.
- 26 Beyrer C et al. Drug use, increasing incarceration rates, and prison-associated HIV risks in Thailand. *AIDS and Behavior*, 2003, 7:153–161.
- 27 Choopanya K et al. Incarceration and risk for HIV infection among injection drug users in Bangkok. *Journal of Acquired Immune Deficiency Syndromes*, 2002, 29:86–94.
- 28 Buavirat A, Sacks R, Chiamwongpaet S. HIV risk behaviors during incarceration among intravenous-drug users in Bangkok, Thailand: a qualitative approach. *AIDS & Public Policy Journal*, 2002, 17:77–89.
- 29 Thaisri H et al. HIV infection and risk factors among Bangkok prisoners, Thailand: a prospective cohort study. *BMC Infectious Diseases*, 2003, 3:25.
- 30 Buavirat A et al. Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok, Thailand: case-control study. *British Medical Journal*, 2003, 326:308–312.
- 31 Choopanya K et al. Risk factors and HIV seropositivity among injecting drug users in Bangkok. *AIDS*, 1991, 5:1509–1513.
- 32 Vanichseni S et al. Continued high HIV-1 incidence in a vaccine trial preparatory cohort of injection drug users in Bangkok, Thailand. *AIDS*, 2001, 15:397–405.
- 33 Wright NH et al. Was the 1988 HIV epidemic among Bangkok's injecting drug-users a common source outbreak? *AIDS*, 1994, 8:529–532.
- 34 Choopanya K. *AIDS and drug addicts in Thailand, Bangkok*. Bangkok, Metropolitan Authority Department of Health, 1989.
- 35 Weniger B et al. The epidemiology of HIV infection and AIDS in Thailand. *AIDS*, 1991, 5 (Suppl 2):71–85.
- 36 Payapvipapong P. Prison-based AIDS information and support programs. Paper presented at the International AIDS Conference, Durban, 2000.
- 37 *Grant performance report: preventing AIDS and increasing care and support for injection drug users in Thailand*. Raks Thai Foundation, 2006. Retrieved Sept. 2006 from [http://www.theglobalfund.org/search/docs/3THAH\\_749\\_280\\_gpr.pdf](http://www.theglobalfund.org/search/docs/3THAH_749_280_gpr.pdf)
- 38 Sungkawan D. *Thai community-based correctional programmes for narcotics addicts in response to the 2002 Rehabilitation Act: a system approach*. Tokyo, UNAFEI, 2004.
- 39 *Treatment and care for HIV-positive injecting drug users: training curriculum*. New Delhi, USAID, ASEAN, WHO and FHI, 2007
- 40 [http://www.who.int/tb/publications/global\\_report/2006/pdf/tha.pdf](http://www.who.int/tb/publications/global_report/2006/pdf/tha.pdf) (accessed on 14 September 2007)
- 41 Pleumpanupat W et al. Resistance to anti-tuberculosis drugs among smear-positive cases in Thai prisons 2 years after the implementation of the DOTS strategy. *International Journal of Tuberculosis and Lung Disease*, 2003, 7:472–477.
- 42 Sretrirutchai S et al. Tuberculosis in Thai prisons: magnitudes, transmission and drug susceptibility. *International Journal of Tuberculosis and Lung Disease* 2002, 6:208–214.
- 43 Jittimane SX et al. A prevalence survey for smear-positive tuberculosis in Thai prisons. *International Journal of Tuberculosis and Lung Disease*, 2007, 11:556–561.
- 44 *Towards universal access. Scaling up priority HIV/AIDS interventions in the health sector*. Geneva, World Health Organization, UNAIDS, UNICEF, 2007.





## CONCLUSIONS AND RECOMMENDATIONS

The aim of this review was to gather information relating to HIV prevention, care and treatment in prisons in the WHO South-East Asia Region. Countries selected for inclusion in the review were India, Indonesia, Nepal and Thailand.

South-East Asia is second only to sub-Saharan Africa in terms of estimated numbers of people living with HIV. South-East Asia has also been home to some unusual successes in HIV prevention in the developing world. However, the role of HIV transmission in prisons as a key factor for the spread of HIV in the community has largely been ignored. Despite national and international legislation to protect prisoner health, they are often seen as less deserving of health care or other assistance, particularly when resources are scarce. Yet it must be remembered that prisoners are only temporarily removed from the general community. At some stage, most prisoners will be released and resume living in the community. When prisoners are released into the community, so too are their infections and illnesses. The HIV epidemic among injecting drug users (IDUs) in Bangkok in the late 1980s and 1990s is thought to have begun with the mass release of a number of HIV-infected prisoners. Released prisoners, who were likely unaware of their HIV status, returned to their communities, transmitting HIV to their sexual and drug-injecting partners. Each time an HIV-infected prisoner leaves prison and resumes their life, a small-scale version of this scenario is enacted. Failure to address the HIV transmission that occurs in prisons may undermine the success of HIV prevention programmes in the community.

Currently available information demonstrates how far prison systems are from achieving universal access to HIV prevention, care, and treatment. Very limited interventions for the prevention, care and treatment of HIV and other sexually transmitted infections (STIs) have been implemented in prisons. However, the review has highlighted some innovative programmes that can serve as models for the Region. Indonesia in particular has made excellent progress in improving the provision of HIV prevention, care and treatment in prisons.

The importance of implementing HIV interventions in prisons was recognized early in the epidemic.<sup>1</sup> The following recommendations may assist in providing guidance to prison authorities aiming to strengthen and expand their HIV prevention, care and treatment services. These recommendations apply to all prisons, not just those in the correctional systems discussed in this report.

### 6.1. Introduce interventions to reduce prison populations

Overcrowding of prisons leads to difficulties in prison management and increases the transmission of infectious diseases such as tuberculosis and HIV. Reducing prison

populations removes people from a high HIV-risk environment and contributes to healthier, safer prisons.

### 6.1.1. Opioid substitution therapy in the community

In addition to reducing HIV transmission among IDUs, opioid substitution therapy (OST) reduces criminal activity among heroin users.<sup>2</sup> Providing OST in the community is a crime-control measure that can lead to reduction in the prison population.

### 6.1.2. Alternatives to imprisonment

As imprisonment involves depriving an individual of their liberty, it should be reserved only for the most serious offenders, for example, those convicted of violent crimes. Yet in some prison systems, the only options for sentencing offenders are fines or imprisonment. This leads to the imprisonment of people convicted for relatively minor offences, such as possession of illicit drugs for personal use.

Imprisoning large numbers of minor offenders is costly and produces few, if any, benefits. A range of alternatives to incarceration have been developed, including:

*Warnings:* Police issue an official warning or admonition to the offender.

*Supervision and support:* The offender can maintain their daily routine, but must report to a nominated authority such as the police or a probation officer.

*Restrictions of liberty in the community:* This includes, for example, house arrest or electronic monitoring.

*Community integration:* The offender is required to perform community service work.

*Treatment orders:* The offender is required to attend treatment, for example, drug dependency treatment.

*Mediation:* The offender is required to meet with the victim of their crime and complete formal mediation proceedings.<sup>3</sup>

The introduction of alternatives to imprisonment such as these to assist in reducing prison populations is strongly recommended.

Many prison systems house large numbers of individuals who have been charged with an offence but are not yet convicted. For example, in India almost three-quarters of the prison population are pre-trial detainees.<sup>4</sup> Reducing the number of pre-trial detainees imprisoned would have a significant impact on prison overcrowding. Alternatives to imprisonment for this group, such as community supervision, are recommended.

## 6.2. Increase resources and seek funding specifically for prison-based programmes

The overall budgetary allocation for health in prisons is low as prisoners are a marginalized population. Policies should be put in place to rectify this so that HIV prevention, care and treatment services in prisons are offered at the same level as those available in the community. Improving HIV prevention, care and treatment in prisons may require significant

financial resources. Prison authorities should seek funding for prison-based programmes. External funding could be sought to initiate prison-based programmes, while ensuring adequate budgetary allocation of national resources in the long term. Prison authorities may wish to identify partners such as health authorities, local or international NGOs and other development partners that can assist in project implementation and evaluation.

### 6.3. Engage health ministries closely in improving the prisoner health

The primary role of prison authorities is to ensure security and order in correctional institutions. In the majority of countries around the world, prison authorities are also expected to take responsibility for the delivery of health care to inmates. These responsibilities often compete, resulting in security concerns taking priority over health care.

A more appropriate way to provide health care to prisoners may be through public health authorities such as the local Ministry or Department of Health. Several countries, including Norway, France, Italy and some jurisdictions in Australia, have recognized this and have transferred responsibility for prison health care to health ministries. This ensures a consistent approach to health care for all citizens, including those in prison, and often leads to improvement in the quality of care available to prisoners.<sup>5</sup>

### 6.4. Improve general prison conditions

Prison conditions should be improved to meet the standards of the *Minimum standard rules for the treatment of prisoners*.<sup>6</sup> This may mean improving the quality or quantity of food and water provided; improving the standard of accommodation or providing increased access to general medical care.

### 6.5. Introduce prevention and care strategies

Prevention should be a key component of the response to the HIV epidemic. A variety of programmes that have been successful in community-based prevention strategies can also be implemented in prisons. Prevention programmes introduced in prisons should also be implemented in holding cells and other short-term detention facilities, as research from Thailand suggests these are high-risk environments for HIV transmission.<sup>7</sup>

#### 6.5.1. Condom distribution programmes

Despite prohibitions against sex in prison, prisoners are sexually active. To prevent sexual transmission of HIV, condoms should be provided in prisons. Prisoners should be able to access condoms discreetly and without repercussions. Prisons should also consider introducing conjugal visits for inmates.

#### 6.5.2. Needle and syringe programmes

Drug use and injecting are common in prisons the world over. The introduction of prison needle and syringe programmes (NSPs) is recommended, particularly in countries where there are NSPs in the community. NSPs are preferred to bleach distribution programmes, which are not as effective in preventing HIV transmission.

### 6.5.3. Opioid substitution therapy

Opioid substitution therapy (OST) is a drug dependency treatment that has been shown to reduce HIV transmission among IDUs.<sup>8</sup> It is a long-term treatment approach (a number of years), which provides the opportunity for patients to distance themselves from a drug-using lifestyle and to re-enter “normal” society. It helps in controlling drug craving and opioid use. In countries where OST is available in the community, it should also be made available in prisons. Pilot programmes under way in Indonesia have shown that these are feasible.<sup>9</sup>

### 6.5.4. Voluntary counselling and testing

Voluntary counselling and testing (VCT) for HIV should be available to prisoners. It may be provided by prison medical services or NGOs. Prisoners should receive pre-test counselling and must give voluntary and informed consent prior to the collection of their blood sample and they must be given the option of declining to have an HIV test. Steps to minimize threats to maintaining confidentiality should be considered. Prisoners who test HIV positive should have access to care, treatment and support services.

Offering VCT to prison inmates diagnosed with active TB as part of the TB directly observed treatment, short-course (DOTS) programme in prisons should be considered.

### 6.5.5. Treatment of sexually transmitted infections

Untreated STIs increase the vulnerability to HIV infection. All inmates should be offered screening and treatment for STI following the syndromic approach to diagnosis and treatment promoted by WHO.<sup>10</sup>

### 6.5.6. Interventions for vulnerable populations

Women in prison have special needs in relation to HIV prevention, care and treatment. Female prison populations often have high levels of STI, increasing their vulnerability to HIV infection. STI screening and treatment should be made available. Women prisoners are vulnerable to sexual assault by male guards or, in mixed-sex institutions, male prisoners. Wherever possible, female guards should be employed to work in women’s prisons. In mixed-sex institutions, men and women should be segregated. Pregnant women prisoners should be offered VCT and, if they test HIV seropositive, offered antiretroviral therapy (ART) and other assistance to prevent mother-to-child transmission of HIV.

Juveniles are another prison population requiring specialized HIV prevention, care and treatment services. Juvenile prisoners should be segregated from adult prison populations to reduce the risk of sexual assault, and age-appropriate HIV information, education and communication (IEC) should be provided.

## 6.6. Provide management of HIV-associated opportunistic infections and antiretroviral therapy

Specific training for ART should pay particular attention to the uninterrupted supply of antiretroviral drugs (ARVs) to avoid treatment interruption, and ensure treatment adherence to prevent the emergence of HIV drug resistance. As access to treatment in the community

improves, increasing numbers of individuals receiving ART will enter prison. Prison health-care services should ensure treatment continuity while in prison.<sup>11</sup> On release, ART should be continued and appropriate services for continuation of ART identified pre-release.

In addition to ensuring continuity of treatment, prison health-care services should expand access to ART so that prisoners can commence treatment. Eligibility for ART in prisons should be determined using the same clinical criteria applied in the community.<sup>11</sup>

The clinical management of HIV disease including ART is complex. Prison doctors and nurses should receive training in determining patient eligibility for prophylaxis as well as the diagnosis and therapy of common opportunistic infections (OIs). This should include the prevention and treatment of *Pneumocystis jiroveci* pneumonia with co-trimoxazole and the diagnosis and treatment of TB following the WHO recommended Regional Strategic Plan for the Prevention and Control of TB.<sup>12</sup> Screening and treatment for TB should also be provided in prisons.

### 6.7. Strengthen strategic information by introducing routine data collection processes

In order to better understand HIV in prisons, authorities should collect data regarding HIV and STI seroprevalence and risk behaviours among prisoners. In addition, the prevalence of TB is up to 100 times higher in prisons than in the community.<sup>13</sup> HIV/TB coinfecting persons are more likely to progress to active TB disease than are persons infected with TB alone. Data from periodic tuberculin surveys can be used for TB prevalence estimates as well as data from VCT among newly registered active TB cases to document the TB/HIV situation.

Data collection should be conducted in a regular fashion. Sampling methods that have been used among inmates for HIV and common STIs are cluster sampling, stratified random sampling and systematic random sampling. Conducting HIV surveillance among prisoners raises a number of ethical and legal issues.<sup>13</sup> Prisoners are often unable to give true voluntary and informed consent. Because of their unique situation, special efforts are required to ensure the privacy, rights and safety of prisoners having an HIV test. Prisoners asked to participate in surveillance activities should understand the potential threats to their confidentiality and the impact of breached confidentiality. Increasingly, the use of data from VCT as part of HIV health services is being promoted to replace HIV surveillance. The provision of adequate care if inmates are found to be HIV infected, and the safety and security of staff conducting the collection and processing of blood samples, should be part of planning HIV testing.

Producing a regional overview of the current situation of HIV prevention, care and treatment in prisons should be done regularly. The four countries included herein should also be included in future reviews and the addition of other countries in the South-East Asia Region should be considered.

### 6.8. Disseminate best practices

Much of the scientific evidence for HIV prevention, care and treatment programmes in prisons has been generated in countries outside the Asian region. Countries that implement HIV programmes in prisons should disseminate the results of their work

through conference presentations and journal articles, in order to build an evidence base for HIV prevention, care and treatment in prisons in Asia.

## 6.9. Create an enabling environment

### 6.9.1. Develop specialized responses to HIV in prisons

An enabling environment should be promoted to scale up and allow universal access to HIV prevention, care and treatment programmes. Marginalized populations should be included in all scale-up activities.

Drawing on lessons from the scale up of HIV interventions over the past few years, WHO has established priorities for its technical work and support to countries towards achieving universal access for HIV prevention, care and treatment. However, as mentioned above, prisons have often been neglected in the overall response to HIV. Prison and health authorities must ensure that specialized responses to HIV in prisons are included in existing frameworks.

### 6.9.2. Develop national strategies for prison health care

Attention can be drawn to the needs of prisons by developing national strategies for prison health including HIV prevention, care and treatment, the syndromic management of STIs<sup>14</sup> as well as diagnosis and treatment of TB following the WHO recommended Stop TB strategy.<sup>12</sup> The strategy should be consistent with and refer to the national strategic plans for the prevention and control of HIV/AIDS. The *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention*, produced by the Indonesian Directorate General of Corrections, is an excellent example of a national prison HIV strategy.<sup>15</sup>

### 6.9.3. Form prison working groups

Focused working groups that report to the national HIV/AIDS coordinating authority can help to guide the implementation of activities outlined in national strategies. Working groups should comprise representatives from prisons, government health planners and service providers, and NGOs. In Indonesia, prison working groups have been established at the national and provincial levels. This has improved coordination of HIV prevention, care and treatment activities between prisons.<sup>16</sup>

### 6.9.4. Conduct HIV sensitization workshops with key stakeholders

An understanding of HIV is imperative for creating an environment supportive of HIV prevention, care and treatment in prisons. Key stakeholders, including prison security and health staff, government officials and policy-makers, must be informed about the issues of HIV prevention, care and treatment in prisons. HIV education and training workshops, such as the WHO HIV 101 programme conducted in Kerobokan prison, Bali, Indonesia should be conducted with all key stakeholders.<sup>17</sup>

1. Harding TW. AIDS in prison. *The Lancet*, 1987, 2:1260–1263.
2. Lind B et al. The effectiveness of methadone maintenance in controlling crime: an Australian aggregate-level analysis. *British Journal of Criminology*, 2005, 45:201–211.
3. Lappi-Seppala T. *Techniques in enhancing community-based alternatives to incarceration: a European perspective. Annual Report for 2002 and Resource Material Series No. 61*. Tokyo, UNAFEI, 2003.
4. *Prison Brief: India*. International Centre for Prison Studies, 2006.
5. *Prisons and AIDS: UNAIDS Technical Update*. Geneva, UNAIDS, 1997.
6. *Standard minimum rules for the treatment of prisoners*. Office of the United Nations High Commissioner for Human Rights. Retrieved Oct. 2006 from <http://www.ohchr.org/english/law/pdf/treatmentprisoners.pdf>
7. Buavirat A et al. Risk of prevalent HIV infection associated with incarceration among injecting drug users in Bangkok, Thailand: case–control study. *British Medical Journal*, 2003, 326:308–312.
8. Metzger DS et al. Human immunodeficiency virus seroconversion among intravenous drug users in- and out-of treatment: an eighteen month prospective follow-up. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 1993, 6:1049–1056.
9. Irawati I et al. Indonesia sets up prison methadone maintenance treatment. *Addiction*, 2006, 101:1525.
10. *Guidelines for the management of sexually transmitted infections*. Geneva, WHO, 2003.
11. Pontali E. Antiretroviral treatment in correctional facilities. *HIV Clinical Trials*, 2005, 6:25–37.
12. *Regional Strategic Plan for TB Control 2006–2015*. New Delhi, WHO, 2006 (SEA-TB-288).
13. *HIV surveillance training modules. Surveillance of populations at high risk for HIV transmission (Module 6)*. New Delhi, WHO, 2007.
14. *Guidelines for the management of sexually transmitted infections*. Geneva, WHO, 2003.
15. *National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention: 2005–2009*. Jakarta, Directorate General of Corrections, 2005.
16. Prabawanti C, Puteranto H. Establishment of prison working group to mobilize resources for developing prison intervention in Indonesia. Paper presented at the 7th International Conference on AIDS in Asia and the Pacific, Kobe, 2005.
17. Angela R, Booker R, Morgan A. *Evaluation of the content, implementation and impact of HIV 101 and cognitive behavioural therapy programs in prisons*. Jakarta, Burnet Indonesia, 2005.





## APPENDIX 1

### ORGANIZATIONS/PROJECTS PROVIDING HIV PREVENTION, CARE AND TREATMENT IN PRISONS

The following table lists nongovernmental organizations (NGOs) and bilateral donors known to be active in HIV prevention, care and treatment in prisons in each country discussed in this report. This is not an exhaustive list but does include all organizations and projects identified during the development of this report.

	Organization/project	Areas of work
India	Vivekananda International Health Centre	Information, education and communication (IEC) programmes in 20 prisons in West Bengal
	AASRA	Therapeutic community in Tihar Jails
	AIDS Awareness Group	Therapeutic community in Tihar Jails
Indonesia	Indonesia HIV/AIDS Prevention and Care Project (funded by AusAID)	Advocacy and support for methadone maintenance treatment and harm reduction services in prisons. Care and support programme for prisoners living with HIV/AIDS
	Tanpa Batas Foundation	Establishing prevalence of HIV risk behaviours; advocacy for HIV prevention, care and treatment for prisoners
	Burnet Indonesia	Train-the-trainer projects; evaluation of an HIV IEC programme in prison
Thailand	Wednesday Friends Group	Peer support group in Klong Prem Prison
	Raks Thai Foundation	Training of prison staff in the HIV care, treatment and support of inmates who are injecting drug users
	Population and Community Development Association	Training of guards and inmates to be HIV peer educators
Nepal	No organizations are working in HIV prevention, treatment and care in prisons.	



## APPENDIX 2

### KEY DOCUMENTS

#### 1. Policy documents

*Standard minimum rules for the treatment of prisoners.* Office of the United Nations High Commissioner for Human Rights. Available from [http://www.unhchr.ch/html/menu3/b/h\\_comp34.htm](http://www.unhchr.ch/html/menu3/b/h_comp34.htm)

*WHO Guidelines on HIV infection and AIDS in prisons.* Geneva, World Health Organization, 1993. Available from [http://data.unaids.org/Publications/IRC-pub01/JC277-WHO-Guidel-Prisons\\_en.pdf](http://data.unaids.org/Publications/IRC-pub01/JC277-WHO-Guidel-Prisons_en.pdf).

*HIV/AIDS prevention, care, treatment and support in prison settings: a framework for an effective national response.* Geneva, UNODC/WHO/UNAIDS, 2006. Available from [http://data.unaids.org/pub/Report/2006/20060701\\_HIV-AIDS\\_prisons\\_en.pdf](http://data.unaids.org/pub/Report/2006/20060701_HIV-AIDS_prisons_en.pdf)

*National Strategy Prevention and Control HIV/AIDS and Drugs Abuse Indonesian Correction and Detention, 2005–2009.* Jakarta, Ministry of Law and Human Rights, Directorate General of Corrections, 2005.

#### 2. Evidence for HIV prevention, care and treatment programmes in prison

##### 2.1 Overview

*Evidence for Action Technical Papers. Effectiveness of interventions to manage HIV in prisons.* Geneva, WHO, UNODC, UNAIDS, 2007.

*Evidence for Action Technical Papers. Interventions to address HIV in prisons: HIV care, treatment and support.* Geneva, WHO, UNODC, UNAIDS, 2007.

*Evidence for Action Technical Papers. Interventions to address HIV in prisons: needle and syringe programmes and decontamination strategies.* Geneva, WHO, UNODC, UNAIDS, 2007.

*Evidence for Action Technical Papers. Interventions to address HIV in prisons: prevention of sexual transmission.* Geneva, WHO, UNODC, UNAIDS, 2007.

##### 2.2 Condom distribution programmes

Dolan K, Lowe D, Shearer J. Evaluation of the condom distribution program in New South Wales prisons, Australia. *Journal of Law, Medicine and Ethics*, 2004, 32:124–128.

May JP, Williams EL. Acceptability of condom availability in a U.S. jail. *AIDS Education and Prevention*, 2002, 14 (Supplement B):85–91.

### 2.3 Needle and syringe programmes

Lines R et al. *Prison needle exchange: lessons from a comprehensive review of international evidence and experience*, 2nd ed. Montreal, Canadian HIV/AIDS Legal Network, 2006.

### 2.4 Opioid substitution therapy

Dolan K et al. A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system. *Drug and Alcohol Dependence*, 2003, 72:59–65.

Dolan K et al. Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, re-incarceration and hepatitis C infection. *Addiction*, 2005, 100:820–828.

Irawati I. Indonesia sets up prison methadone maintenance treatment. *Addiction*, 2006, 101:1525.

### 2.5 Antiretroviral therapy

Pontali E. Antiretroviral treatment in correctional facilities. *HIV Clinical Trials*, 2005, 6:25–37.



**A**t any given time, there are over nine million people in prison, with an annual turnover of 30 million moving from prison to the community and back again. The role of HIV transmission in prison as a key factor for the spread of HIV in the community has largely been ignored. Despite national and international legislation to protect prisoner health, they are often seen as less deserving of health care or other assistance, particularly when resources are scarce.

This review of four countries in the South-East Asia Region shows that very few interventions have been implemented in prisons for the prevention, care and treatment of HIV and other sexually transmitted infections, despite a higher prevalence of HIV among those incarcerated. However, it highlights that such services are not only feasible in resource-poor settings, but also provides some excellent examples of innovative and positive action that can be taken to arrest the spread of HIV in prisons. Recommendations to strengthen and expand services are provided, as failure to address the transmission of HIV in prisons may jeopardize the success of HIV prevention efforts in the Region.



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